MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT

Call to Order: By Rep. Bob Pavlovich, on March 20, 1989, at 9:00 a.m.

ROLL CALL

Members Present: All

Members Excused: None

Members Absent: None

Staff Present: Paul Verdon and Sue Pennington

Announcements/Discussion: None

HEARING ON SENATE BILL 18

Presentation and Opening Statement by Sponsor:

Sen. Williams, Senate District 15, presented SB 18 to the committee for reconsideration. We had discussed the bill quite thoroughly about 6 weeks ago. It got into the House and hit a snag of some sort. What I would like to do is just go through the title of the bill with you. Within the title itself, it is an act to allow the Public Service Commission to treat advertising cost that promotes increased use of regulated communications services as an expense deductible from income or capital assets when setting or regulating rates. As far as I am concerned what this does is it allows the PSC to do what they are elected to do for the state of Montana and for the protection of the people within the state of Montana paying the bill.

Testifying Proponents and Who They Represent:

Dennis Lopach, US West Communications
Gene Phillips, Northwestern Telephone Systems

Proponent Testimony:

Mr. Lopach said that there are a couple of points that I want to repeat for openers. First, this applies only to telephone communications companies. There is no issue involving companies like Montana Power, MDU, electric or

natural gas companies. The significant distinction between telephone companies and energy companies is that what we are talking about is increased usage of a network that is already in place so that there is no cost to society of using additional resources. Secondly, we are talking mainly about regulated services. Certain services have been deregulated by the PSC and by law and SB 18 will affect only those services that remain regulated.

Mr. Phillips stated that the purpose of this bill is to allow only those advertising expenses to be considered in the ratemaking process that will result in lower cost to our subscribers. Secondly, this is discretionary with the PSC. They can allow these advertising expenses to be included if they determine that it will, in affect, actually result in lower costs to the subscriber. If they don't the PSC doesn't have to allow it. We support this bill and urge a do pass.

Testifying Opponents and Who They Represent:

Rep. Ben Cohen
Earl Riley, MT Senior Citizens
Pam Marshall, MT Low Income Coalition
Bill Thomas, MT Rainbow Coalition
Terri McBride, Common Cause
Brant Quick, Northern Plains Resource Council

Opponent Testimony:

Rep. Cohen asked who was here to represent the consumers of Montana? The Consumer Federation of America? No, they are in Washington, DC. You and I are here to represent the consumer of communications utilities. That is just about every citizen and small businessman, every homeowner in our districts. This is an important bill because it is a major change in public policy of this state. We do not allow advertising to be included in the cost and basically in the ratemaking. If we pass this bill then there will be a cost to every consumer of communications service in this state.

Ms. Marshall submitted written testimony. See exhibit 2.

Mr. Riley said his organization considers this bill an anti-consumer bill. Why should we pay to have them tell us to use US West or the telephone company in our area? Do we have a choice? Can I go some place else to another telephone company? No! The cost will come right back to the consumer. My bill has tripled in the past 6 years. I never heard of a phone bill going down! This will simply add more cost to consumer. I urge you to not support this bill.

Mr. Thomas said this rate increase is not for better service, it just pays for more advertising. This bill is bad public policy. See his written testimony, exhibit 3.

Ms. McBride submitted written testimony, exhibit 4.

Mr. Quick said his organization does not support SB 18. Most of our members live in rural areas and depend heavily on the telephone. If the companies are allowed to include the cost of advertising in their operating expense, for example, if they spend .5 million dollars on advertising this would increase their operating revenue by 1 million dollars. This is a very anti-business bill. I urge you to vote against SB 18.

Questions From Committee Members: Rep. Thomas asked Rep. Cohen if he was on the PSC and a regulated utility came in and was able to show that by making this investment whether it was the equipment or whatever it might be, a capitol outlay that would go into this formula somewhere as an expense but yet in having that equipment whether it would save money just by having it, getting rid of old equipment or whatever the situation was, but by doing that you improved also on the other side of the scale your operating revenue would go up so that the thing made money. So the expense was less than the income, so therefore, the revenue requirement in this formula would be less by doing this. Would you vote to do that if state law allowed you to do that? Rep. Cohen said the first thing he would have to do as a member of the PSC and we have never had this kind of a factor tossed into the ratemaking, the first thing I would probably do is hire an outside consultant and ask the legislature for a larger appropriation in the future, then I'm going to expect the consumer council to also analyze that proposal. I'll certainly want to see some records or history showing me this is, in fact, taking place in other states or other places. Then if all of that data were available to me and the results are what you might claim they might be, I think that, yes, I might make that favorable decision. Now, let me point out to you that if that were a arguable and easily arguable rate and one that could obviously be shown, any utility would do it even without adding it to the ratebase. Why spend all your money in your advertising revenue on warm fuzzy ads when you could be out there getting new customers for specific services that are going to benefit the entire community?

Rep. Thomas asked Mr. Lopach what kind of services are we talking about that we would advertise to promote versus the warm, fuzzy ads? I do not suggest that the warm fuzzy would fit under this bill. Mr. Lopach said the warm fuzzy ad is what we call institutional advertising which is primarily designed to enhance the image of the company. That advertising is strictly borne by the shareholders. We are talking about promotional advertising directly addressed to

services. An example is INTRALATA long distance which is just the short rate of long distance that we are permitted to carry, for example, between Missoula and Helena or Helena and Great Falls. We can't carry from Helena to Billings, that has to be by interchange carrier. But that local long distance is one example of an optional service that we would try to promote. Other examples include custom calling services like call-waiting, call-forward, and three-way calling.

Rep. Bachini asked Mr. Lopach that one of the opponents said that this would hurt a business that had most of its business over a telephone. Don't they have a special rate different from a resident phone? Mr. Lopach said that this bill would not affect interstate businesses. The companies that this would affect are the smaller companies and the residential customers. Shareholders are bearing the cost while the ratepayers are benefitting. The real argument is the fairness, if the ratepayers benefit then they should pay the cost as well. The consumer council and the PSC have representatives here if you wish to address questions to them. Rep. Bachini asked all the opponents why they did not appear when the Senate and our committee heard this bill before? Why weren't you here before? The meeting was advertised and posted in plenty of time for you to be here.

Rep. Simon asked somebody from the PSC to please come forward. Mr. Chuck Evilsizer, staff attorney, for PSC answered questions for Rep. Simon. Would you interpret this bill that any and all advertising costs could be added to the rate base if this bill passes? Mr. Evilsizer said his interpretation of this statute in terms of the expenses incurred by the public utility relates to operating expenses and what should be or not be considered by the PSC. The main difference between the rate base recovery and the operating expense recovery, rate base is 12 percent or 13 percent, whatever you are talking about, return, my interpretation is that it would be allowed as an operating expense.

Rep. Bachini asked Bob Nelson, from the consumer council, if the people were aware of the bill before it went before the Senate? Is this bill going to increase the rates, decrease the rates, did you appear before the Senate committee? Can you explain whether you oppose the bill or not? Mr. Nelson said they were aware of the bill even before it was introduced. We looked at what other states were doing, what the possible impact of the bill would be and decided we would neither oppose or support the bill. We have been frustrated and troubled with the fact that as the opponents here today that the costs of telephone service have

increased dramatically over the last few years. We are trying to do everything we can to keep those costs down. It is not inconceivable to us that something like advertising would increase revenues that there would be net benefit to the consumers.

Closing by Sponsor: Sen. Williams said he wasn't sure what the people were testifying against, I thought this was the same bill we heard in this committee 6 weeks ago. In answer to Rep. Cohen, I consider myself as being elected here to represent the people of Montana and that is what I intend to do. That is one of the reasons that I introduced this bill. I am in a small business and if I couldn't write off the advertising that I do as a business expense, why be in business. People would not know I was in business. One of the businesses I'm in involves telephones and I'm in direct competition on a small scale with US West and A T & T. The low-income people are the ones this bill is intended to help. If we can increase the revenue generated by the long distance calls, the residential monthly rate today is $13.84, this monthly rate can be reduced. The maximum that could be added to phone charges is $1.11 per phone, per year. I'm glad the opponents are here today, but I would like to know where they were for the first hearing and the second hearing. I ask you to give this bill a do pass.

HEARING ON SENATE BILL 182

Presentation and Opening Statement by Sponsor:

Sen. Keating said this bill addresses the statutory limits on insurance coverage for alcoholism and mental illness and also addresses the definition of mental illness. One thing that seemed to slip by in the last hearing was that what we are dealing with in this bill is strictly group insurance. It has nothing to do with individual purchase of insurance policies. An employee gets only the benefits provided within the particular group policy.

Testifying Proponents and Who They Represent:

Steve Waldron, Mental Health Center, Helena
Cindy Horn, Jackson & Rice, Helena
Joanne LaMettery, Helena
Mike Ruppert, CDPM, Helena
Greg Campbell, Helena
John Thorson, MT Mental Health Association
Ann Scott, Director, Rocky Mountain Treatment Center, Great Falls
Judy Griffith, Helena School District, Helena
Jim Ahrens, Helena

Proponent Testimony:

Mr. Waldron stated that a compromise has been worked out that addresses the concerns of a number of the committee members. There have been a number of reductions and changes. We suggest that the original definition of mental illness be put back in the bill, and secondly we cut the requested increase in half to $5,000 for inpatient and $1,500 for outpatient services. I have handouts for the committee showing the new amendments.

Ms. Horn said she was raised in an alcoholic home, married and divorced twice a man who is an alcoholic. I have 4 children, 2 sons and 2 daughters, my sons are high achievers, good in sports and academics, but my 17 year old son is an alcoholic. He has had 3 professionals diagnose him as an alcoholic. He needs treatment. My 14 year old son has had some serious drinking problems, is right now, in a support group through Capitol High School. My kids aren't into drugs but do have alcohol problems. I need help right now financially, my son is on the brink of going into a treatment center. I have had my children into counselling because I am trying to bring them into the awareness of what the disease is. My children are the next generation. I am doing what I can emotionally to stabilize them, to give them coping skills and to really help them understand what this disease is and the devastation it has brought in to our family and home. This increased benefit will help my children to have the help they are going to need to get their lives back together.

Ms. LaMettery said she has 2 young boys that are alcoholics, one is 24 and the other is 19. When the oldest made it apparent to us that he was an alcoholic, we chose to ignore it. When the second came along, we put him into treatment. We were shocked at the cost of this treatment. If we had not had very good insurance we would not have been able to do this. He just got out of treatment in December, he is now 19. He is dedicated to remaining sober. Our insurance covered 90 percent of the cost and did not have the problem of coming up with the extra money like some families have. I have seen people go into debt for several thousands of dollars for this treatment. There is a lot of emotional issues involved, to come out owing $5-10,000 on top of the treatment is hard for a family to deal with. There is a lot of treatment the family needs to learn to reshape their lives. We are all under recovery and that takes insurance benefits. If we did not have this coverage we could not help ourselves. I ask you to give this bill a do pass for those people needing treatment.

Mr. Rupert urges the committee to give SB 182 a do pass. I have spoken to this committee and my arguments are the same as in the past.

Mr. Campbell said he works for Fish, Wildlife and Parks. I am also a recovering alcoholic. I went into treatment when I was 16 years old at the request of a counselor who said I was dependent on alcohol. Had it not been for insurance provided by the state of Montana for my parents, I would not have been allowed to go for treatment. I am thankful for the treatment centers and the money provided by the insurance coverage. Alcohol is a disease and my 2 children face the possibility of being alcoholics too. I urge your support of SB 182.

Mr. Thorson said his association urges the support of the committee for SB 182.

Ms. Scott gave a brief history of this bill. When it was introduced 6 years ago, it equalized the benefits between mental illness, alcoholism, chemical dependency, and physical illness. There has been a long history of discrimination by society, in general, against the mentally ill and chemically dependent people.

Ms. Griffith said she is the chemical awareness coordinator for the Helena school district. I ask the committee to support this legislation. In working with student assistant programs and counselors in the school system in Montana and being in touch with those throughout the state, I can't tell you how devastated our efforts have been by youngsters involved in alcohol and drug abuse. We have kids coming into the 10th and 11th grade that already have 3-6 years under their belt. We know that the younger kids begin using alcohol and drugs the higher the risk that they will be addicted. When we can identify these youngsters through preassessment process, refer them to professionals, who often times see that they get into treatment centers, we have a much better chance of avoiding complications and problems that can and do occur. When youngsters are not treated early and treated well, as they are in some of the programs in this particular state, what happens often is that they come back into the system often times not finishing school, or the cost in terms of lowered standards of education, higher law enforcement and mental health costs are enormous. In a survey among our 11th and 12th graders we found that 53 percent had been drunk 2-10 times or more in the 30 days prior to the survey and that 18-20 percent of all of our 7th through 12th graders had their first drunk, not their first drink, but first drunk at age 12 or before. We only asked down to age 7. The reality is that things are available out there for kids to get into difficulty with in ways that they never have before. We have to be prepared to treat these youngsters early. The problems for families that are dealing with this are simply enormous, and some families are financially devastated by the experience. We need this legislation and your support.

Mr. Ahrens said his association supports this bill.

Testifying Opponents and Who They Represent:

David Evenson, U of M, Missoula
Tom Hopgood, Health Insurance Associations of America

Opponent Testimony:

Mr. Evenson said their major concern is the cost. Our second concern is not that drug and alcohol treatment is something we don't want to pay for, we do. We feel that the testimony we heard is important.

Mr. Hopgood said the position of his association is that they oppose mandatory coverage because it will drive the cost of insurance up.

Questions From Committee Members: Rep. Bachini asked Mr. Waldron if we have the treatment facilities here in Montana to take care of what we need to do with chemical and alcohol dependencies? Mr. Waldron said I believe we do. Second, is the concern Rep. Driscoll had with this bill, does it allow treatment out of state, would it be very expensive, would this bill allow this? Mr. Waldron said there is some language in the bill at the request of the state auditor's office for consumer protection that says "or a state licensed authority". It will not increase cost because you still have the limits on the amount of coverage available whether in state or out of state. This language is on page 2, lines 2 and 3.

Closing by Sponsor: Sen. Keating said in closing that the university system, which seems to be the principal opponent of this measure, covers probably less than 1 percent of the people that would be covered in the state, whereas Blue Cross/Blue Shield who support this measure provide coverage for about 35 percent of the recipients. When the university system begins to be handled by a third party, self-insured, they are no longer affected by this measure. In fact, one of the principal bidders for this is Blue Cross/Blue Shield. They may be taking over the university system before too long. I don't understand the attack by the university system. The single opponent of this bill. I ask you to give this bill favorable consideration.

DISPOSITION OF SENATE BILL 18

Motion: Rep. Nelson moved BE CONCURRED IN.

Discussion: Rep. Bachini asked if the utilities could deduct all advertising costs from their taxes, is this included as part of their operating expense? Rep. Pavlovich said he thought they were allowed a percentage.

Rep. Simon said when we talk about taxes paid and the allowable deductions we are talking about revenue setting, not taxes. I think we should not confuse the two. This bill addresses what components go into the revenue setting requirements set forth, it has nothing to do with their tax structure and what tax they will pay.

Rep. Bachini said his question was if they are able to deduct those costs from their taxes and then we come back and the PSC would allow them to put them into ratemaking, it seems like they are able to deduct at tax time and include them in the rate base they are getting two benefits.

Rep. Bachini said if this bill passes and the utility under federal law allows them to deduct this expense and then the PSC allows these into the rate base how does this affect their taxes? Rep. Thomas said if it was allowed and increased the rate base with no increased revenue, you would have the same taxes as before but the revenue requirement would be higher. If revenue would come in which is the only way they would approve it then essentially the taxes will go up from that corporation because there is more revenue exceeding the deductions. So the taxes would go up.

Rep. Kilpatrick asked what that $1.11 was? Rep. Thomas said that is the most we could be impacted as ratepayers. This is if there is no return. Rep. Thomas said no one in business is going to advertise unless it generates a return. That is why you advertise.

Amendments, Discussion, and Votes: None

Recommendation and Vote: SB 18 BE CONCURRED IN 11-5 vote.

DISPOSITION OF SENATE BILL 182

Motion: Rep. Simon moved BE CONCURRED IN and moved the amendments.

Amendments, Discussion, and Votes: The amendments DO PASS. See the attached amendments.

Recommendation and Vote: SB 182 BE CONCURRED IN as amended 11-5.

DISPOSITION OF HOUSE BILL 746

Motion: Rep. Bachini moved the action on HB 746 be reconsidered. Rep. Blotkamp moved DO PASS.

Discussion: None

Amendments, Discussion, and Votes: See the attached 3 pages of amendments.

Recommendation and Vote: HB 746 DO PASS as amended 9-6 vote.

DISPOSITION OF SENATE BILL 87

Motion: Rep. Thomas moved to reconsider the action on SB 87. Rep. Thomas moved BE CONCURRED IN.

Discussion: None

Amendments, Discussion, and Votes: None

Recommendation and Vote: SB 87 BE CONCURRED IN 10-5 vote.

DISPOSITION OF HOUSE BILL 627

Motion: Rep. Simon moved the gray bill DO PASS as amended.

Amendments, Discussion, and Votes: Rep. Bachini said the subcommittee considered two issues, one was the protection for the employees involved in the event of the sale of the liquor stores of Montana and secondly the amendments were minor amendments. Section 43, a new section protects the employee, the department shall give them preference. I have tried to provide something for these employees that would lose their jobs. I think this is very important that the state of Montana do this. The benefit would be the severance pay of $50,000 and the proceeds from the sales would take care of these severance payments. I have been opposed to this bill and the two prior bills because of not having any labor protection, that is why these amendments are being submitted. These provisions for the employees are printed in the gray bill on page 39, section 43, 44, and 45.

Rep. DeMars asked Rep. Bachini if these amendments could be stricken out at any time? Rep. Bachini said it was very possible, the subcommittee voted 2-1, with Rep. Simon voting against it. He had softer amendments and in looking at them, they did nothing for the employees in my opinion. There is no guarantee that these amendments will stay in the bill but I will do everything I can to see that these amendments say in the bill if it goes through.

Rep. Nelson had questions on Section 43, lines 27 and 28 of the gray bill and asked Rep. Bachini if this was not a little hazy and should be defined stronger than it is? What do you really mean? Rep. Bachini said he stands to be corrected but I understand that there are some provisions already, I think they are negotiated.

Rep. Pavlovich asked Rep. Simon where we are right not. Rep. Simon wanted to explain the gray bill as it exists and go from there. Rep. Simon explained that one of the major provisions is the protection of the employees. Another area that was a major concern in the bill is on page 16 and 17 of the gray bill, you recall that I proposed a tax by the liter, there was some problems involved with that from 2 or 3 standpoints. So, we adopted some changes in the tax structure that will make the tax based on the cost of the liquor plus freight. It is based on a different base but would still be cost driven rather than volume driven. The idea of these amendments is to generate the same amount of revenue as currently being generated by the taxes and the profits. The bill would end up being revenue neutral from the standpoint of taxes and profits. The concern that Mr. Lehm had for in state distillers or bottlers is taken care of in (2) on page 16 and 17, the first 200,000 gallons would be taxed at a rate 10 percent less than the normal rate to give them a break which is already provided in existing law. We reinserted that in the bill to give them that break. The rest of the bill remains largely intact. There are some technical amendments.

Rep. Pavlovich asked Rep. Simon if the state would lose any money? Rep. Simon said it would not, that it would balance itself out.

Rep. Thomas asked Rep. Simon if everybody who had a license would buy from the state warehouse? Rep. Simon said yes. Rep. Thomas asked him if there was a preference for a person who operates a state agency store now? Rep. Simon said there was not a built-in preference in the bill.

The gray bill DO PASS as amended. The language will be inserted into the original bill.

Rep. Bachini said everybody knows I am opposed to this issue even when Mr. Chairman carried his bill of privatizing the liquor business. The outfit isn't broke, so why try to fix it with this bill? We have a lot of good people out there running the business, they are doing a good job, bringing good money into the state. This will open up the liquor establishments all around the state. You will have them in every place of business and won't be able to stop it. They will challenge it if you try to stop them. Rep. Bachini said he was opposed to the bill even as amended.

Rep. Johnson said I speak in opposition to the bill also from the standpoint of the proliferation of package stores that would occur.

Rep. Bachini made a substitute motion to TABLE the bill.

Recommendation and Vote: HB 627 is TABLED 10-6 vote.

ADJOURNMENT

Adjournment At: 1:15 p.m.

REP. BOB PAVLOVICH, Chairman

BP/sp

6103.min

DAILY ROLL CALL

BUSINESS & ECONOMIC DEVELOPMENT COMMITTEE

51th LEGISLATIVE SESSION -- 1989

Date 3 20 89

NAME	PRESENT	ABSENT	EXCUSED
PAVLOVICH, BOB	✓		
DeMARS, GENE	✓		
BACHINI, BOB	✓		
BLOTKAMP, ROB	✓		
HANSEN, STELLA JEAN	✓		
JOHNSON, JOHN	✓		
KILPATRICK, TOM	✓		
McCORMICK, LLOYD "MAC"	✓		
STEPPLER, DON	✓		
GLASER, BILL	✓		
KELLER, VERNON	✓		
NELSON, THOMAS	✓		
SIMON, BRUCE	✓		
SMITH, CLYDE	✓		
THOMAS, FRED	✓		
WALLIN, NORM	✓		
PAUL VERDON	✓		

ROLL CALL VOTE

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

DATE 3/20/89 BILL NO. SB87 NUMBER

NAME	AYE	NAY
Bob Pavlovich	X	
Bob Bachini	X	
Rob Blotkamp	X	
Gene DeMars		X
Bill Glaser	X	
Stella Hansen		X
John Johnson	X	
Vernon Keller	X	
Tom Kilpatrick	—	
Lloyd McCormick	X	
Thomas Nelson	X	
Bruce Simon	X	
Clyde Smith		X
Don Steppler		X
Fred Thomas	X	
Norm Wallin		X
TALLY	10	5

Sue Pennington
Secretary

Bob Pavlovich
Chairman

MOTION: Rep Thomas moved be concurred in.

ROLL CALL VOTE

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

DATE 3/20/89 BILL NO. HB 746 NUMBER 1

NAME	AYE	NAY
Bob Pavlovich	✓	
Bob Bachini	✓	
Rob Blotkamp	✓	
Gene DeMars	✓	
Bill Glaser	✓	
Stella Hansen	✓	
John Johnson		✓
Vernon Keller		✓
Tom Kilpatrick	✓	
Lloyd McCormick	✓	
Thomas Nelson		✓
Bruce Simon		✓
Clyde Smith	✓	
Don Steppler		✓
Fred Thomas	—	
Norm Wallin		✓
TALLY	9	6

Sue Pennington
Secretary

Bob Pavlovich
Chairman

MOTION:

ROLL CALL VOTE

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

DATE 3/20/89 BILL NO. HB 746 NUMBER 2

NAME	AYE	NAY
Bob Pavlovich		
Bob Bachini		
Rob Blotkamp		
Gene DeMars		
Bill Glaser		
Stella Hansen		
John Johnson		
Vernon Keller		
Tom Kilpatrick		
Lloyd McCormick		
Thomas Nelson		
Bruce Simon		
Clyde Smith		
Don Steppler		
Fred Thomas		
Norm Wallin		
TALLY	9	6

Sue Pennington
Secretary

Bob Pavlovich
Chairman

MOTION: Rep Blotkamp moved do pass as amended

ROLL CALL VOTE

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

DATE 3/20/82 BILL NO. SB 182 NUMBER

NAME	AYE	NAY
Bob Pavlovich	X	
Bob Bachini	X	
Rob Blotkamp	X	
Gene DeMars	X	
Bill Glaser		X
Stella Hansen	X	
John Johnson	X	
Vernon Keller		X
Tom Kilpatrick	X	
Lloyd McCormick	X	
Thomas Nelson		X
Bruce Simon	X	
Clyde Smith		X
Don Steppler	X	
Fred Thomas	X	
Norm Wallin		X
TALLY	11	5

Sue Pennington
Secretary

Bob Pavlovich
Chairman

MOTION: Rep. Simon moved be concurred in & moved the amendments.

ROLL CALL VOTE

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

DATE 3/20/89 BILL NO. SB 18 NUMBER

NAME	AYE	NAY
Bob Pavlovich		X
Bob Bachini		
Rob Blotkamp		
Gene DeMars		X
Bill Glaser		
Stella Hansen		X
John Johnson		
Vernon Keller		
Tom Kilpatrick		X
Lloyd McCormick		X
Thomas Nelson		
Bruce Simon		
Clyde Smith		
Don Steppler		
Fred Thomas		
Norm Wallin		
TALLY	11	5

Sue Pennington
Secretary

Bob Pavlovich
Chairman

MOTION: Rep. Nelson moved be concurred in

STANDING COMMITTEE REPORT

March 20, 1989

Mr. Speaker: We, the committee on Business and Economic Development report that SENATE BILL 87 (third reading copy -- blue), with statement of intent included, be concurred in .

Signed: _____
Robert Pavlovich, Chairman

[REP. _____ WILL CARRY THIS BILL ON THE HOUSE FLOOR]

STANDING COMMITTEE REPORT

March 20, 1989

Mr. Speaker: We, the committee on Business and Economic Development report that HOUSE BILL 746 (first reading copy -- white), with statement of intent included, do pass as amended .

Signed: _____
Robert Pavlovich, Chairman

And, that such amendments read:

1. Title, line 10.
Strike: "AN"
Insert: "A DELAYED"

2. Page 2, lines 9, 12, and 17.
Page 3, line 2, 16, and 20.
Page 4, line 2
Page 5, lines 18 and 24.
Page 6, lines 2, 4, and 25.
Page 7, lines 3, 7, and 25.
Page 8, lines 14, 21, 22, and 23.
Page 9, lines 3 and 15.
Page 10, line 6.
Page 12, lines 19 and 21.
Strike: "12"
Insert: "13"

3. Page 2.
Following: line 12.
Insert: "(1) "Adjusted gross proceeds" means all money collected or received from games authorized by [sections 1 through 13] minus prizes paid."
Renumber: subsequent subsections

4. Page 2, lines 18 and 19.
Strike: subsection (3) in its entirety
Renumber: subsequent subsections

5. Page 4, line 9.
Following: "manufacture"
Insert: "for sale in this state"

6. Page 4, line 14.
Strike: "manufacturer's or"
Following: "license"
Strike: "shall:"
Insert: "must"

7. Page 4, line 15.
Strike: "(a)"

8. Page 4, line 16.
Strike: ";"
Insert: "."

9. Page 4.
Following: line 16
Insert: "(3) An applicant for issuance or renewal of a manufacturer's or distributor's license shall:"

10. Page 4, line 17.
Strike: "(b)"
Insert: "(a)"

11. Page 4, line 19.
Strike: "(c)"
Insert: "(b)"

12. Page 4, line 21.
Strike: "(d)"
Insert: "(c)"

13. Page 5, line 5.
Strike: "(3)"
Insert: "(4)"

14. Page 6, line 9.
Following: "the"
Insert: "adjusted"

15. Page 6, lines 24 and 25.
Strike: "licensed under"
Insert: "who offer or make available games authorized by"

16. Page 7, line 4.
Strike: "$800"
Insert: "$500"

17. Page 7, line 7.
Strike: "be a random game"

Insert: "comply with standards promulgated by the department"

18. Page 7, line 8.
Strike: "80%"
Insert: "70%"

19. Page 7, line 10.
Strike: "Gross"
Insert: "Adjusted gross"

20. Page 7, line 14.
Strike: "a"
Insert: "an adjusted"
Strike: "3%"
Insert: "5%"

21. Page 8, line 14.
Following: "12]"
Insert: ","

22. Page 9.
Following: line 10
Insert: "NEW SECTION. Section 11. Tampering violation. A person who purposely or knowingly tampers with or conspires to tamper with any game or the play of any game to influence the outcome of the game is guilty of a misdemeanor."
Renumber: subsequent sections

23. Page 12, line 23.
Strike: "July 1, 1989"
Insert: "6 months after passage and approval"

STANDING COMMITTEE REPORT

March 20, 1989

Mr. Speaker: We, the committee on Business and Economic Development report that SENATE BILL 182 (third reading copy -- blue), be concurred in as amended .

Signed: _____
Robert Pavlovich, Chairman

[REP. SIMON WILL CARRY THIS BILL ON THE HOUSE FLOOR]

And, that such amendments read:

1. Title, lines 5 and 6.
Strike: "REDEFINING "MENTAL ILLNESS";"

2. Page 2, line 21 through 23.
Strike: lines 21 and 22 in their entirety and through "ASSOCIATION" on line 23
Insert: "neurosis, psychoneurosis, psychopathy, psychosis, or a personality disorder"

3. Page 4, line 2.
Page 5, line 5.
Strike: "$6,000"
Insert: "$5,000"

4. Page 4, line 17.
Following: "~~or~~"
Insert: "35% or"

5. Page 4, line 18.
Following: "~~greater,~~"
Insert: "whichever is greater,"

6. Page 4, line 21.
Strike: "$2,000"
Insert: "$1,500"

7. COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT STANDING COMMITTEE REPORT OF MARCH 9, 1989

Strike: Amendment No. 1 in its entirety

STANDING COMMITTEE REPORT

March 20, 1989

Mr. Speaker: We, the committee on Business and Economic Development report that SENATE BILL 18 (third reading copy -- blue) be concurred in .

Signed: _____
Robert Pavlovich, Chairman

[REP. THOMAS WILL CARRY THIS BILL ON THE HOUSE FLOOR]

ROLL CALL VOTE

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

DATE 3/20/89 BILL NO. SB 18 NUMBER

NAME	AYE	NAY
Bob Pavlovich		X
Bob Bachini		
Rob Blotkamp		
Gene DeMars		X
Bill Glaser		
Stella Hansen		X
John Johnson		
Vernon Keller		
Tom Kilpatrick		X
Lloyd McCormick		X
Thomas Nelson		
Bruce Simon		
Clyde Smith		
Don Steppler		
Fred Thomas		
Norm Wallin		
TALLY	11	5

Sue Pennington
Secretary

Bob Pavlovich
Chairman

MOTION: ~~Rep.~~ Nelson moved be concurred in

Amendments to Senate Bill No. 182
Third Reading Copy

For the Committee on Business and Economic Development

March 17, 1989

1. Title, lines 5 and 6.
Strike: "REDEFINING "MENTAL ILLNESS";"

2. Page 2, line 21 through 23.
Strike: lines 21 and 22 in their entirety and through "ASSOCIATION" on line 23
Insert: "neurosis, psychoneurosis, psychopathy, psychosis, or a personality disorder"

3. Page 4, line 2.
Page 5, line 5.
Strike: "$6,000"
Insert: "$5,000"

4. Page 4, line 17.
Following: "~~or~~"
Insert: "35% or"

5. Page 4, line 18.
Following: "~~greater,~~"
Insert: "whichever is greater,"

6. Page 4, line 21.
Strike: "$2,000"
Insert: "$1,500"

COMMITTEE ON BUSINESS AND ECONOMIC DEVELOPMENT
STANDING COMMITTEE REPORT OF MARCH 9, 1989

Strike: Amendment No. 1 in its entirety

EX 1
SB 18
3/20/84

SB 18

$$RR = [ROR(RB) + OE + T] - OR$$

RR	=	Revenue Requirement
ROR	=	Rate of Return
RB	=	Rate Base (Investment)
OE	=	Operating Expenses
T	=	Taxes
OR	=	Operating Revenue

EX 2
3/20
SB 18

MONTANA LOW-INCOME COALITION

P.O. BOX 1029
HELENA, MONTANA 59624
(406) 449-8801
(406) 443-0012

TESTIMONY OPPOSING SENATE BILL 18
Representative Pavlovich, Chair

Good morning Mr. Chair and Committee Members. My name is Pam Marshall, and I am here today representing the Montana Low Income Coalition. As an organization, we oppose Senate Bill 18.

We feel that the consumer is in no position to choose other communication utilities and therefore should not be forced to bear the cost of these utilities' advertising. The possession of a phone has become a necessity in this society, as it enables employers to reach those seeking employment. Further, as this bill is written, the consumer pays not only the cost of use, but also the cost of public relations. The consumer has no option but to purchase from the utility the services provided, and we feel there is no need to force us to purchase advertising that encourages further use.

We encourage your vote against Senate Bill 18. Thank you.

#3
SB 18
3/20/81

TESTIMONY OF BILL THOMAS FOR THE MONTANA RAINBOW COALITION

RE: Senate Bill 18

Mr. Chairman and Members of the Committee:

The Montana Rainbow Coaltion is opposed to Senate Bill 18. We think it is unfair and unwise to include regular advertising costs in the rate base.

The poor and the elderly in Montana are having a hard enough time making ends meet without socking them with a rate increase, not for better service, for new equipment, for special equipment for the handicapped, for safety, or some other clearly beneficial public purpose or increased benefit, but for regular advertising.

The provisions of this bill are clearly a radical departure from the type of expenses which are now excluded from the rate base in MCA 69-3-307 -- all of which do serve some larger public purpose or provide a clear consumer benefit.

Many people in this state are living hand to mouth every day and every month, right on the edge. For these people, paying increased monthly bills to cover regular advertising as a result of this bill might mean going without a meal, a warm coat or some other real necessity.

We urge you to consider these people in your deliberations. SB18 is bad public policy. We urge you to vote it down. Thank you.

EX #4
SB 18
3/20/89

COMMON CAUSE/MONTANA

P.O. Box 623
Helena, Montana 59624 (406) 442-9251

TESTIMONY OF COMMON CAUSE
AGAINST SENATE BILL 18

Mr. Chairman and members of the House Business and Economic Development Committee, for the record my name is Terri McBride, lobbyist for Common Cause/Montana. I am here on behalf of the members of Common Cause.

We would like to go on record in opposition to Senate Bill 18.

We believe this legislation, if passed, would harm telecommunications consumers. According to information provided by the Public Service Commission if SB 18 had been in effect in 1987 more than $450,000 in Montana telephone advertising expenses could have been considered by the PSC in rate making.

Already there are many individuals who have difficulties paying for their communications services. This legislation could harm these people by putting the burden of additional advertising expenses into their rates.

We understand the purpose of this legislation is that consumers could benefit by increased services and efficiency. However, we are concerned this legislation would impact most everyone's rates while only a portion of the consumers will be able to afford the promised increased services. Second, the proposed purpose of better efficiency is unsubstantiated. According to the PSC they know of no Montana studies or reports to support this argument.

We also believe this bill could set a precedent by opening the door to allow other utilities the opportunity to consider their increased-use-advertising expenses in the rate base. Once again this would benefit the utility rather than the consumer. In our opinion, as the cost of telephone services continues to rise we stray further and further away from the original goal of universal telephone services.

We urge a do not concur on Senate Bill 18.

Executive Summary

Alcoholism Treatment Impact on Total Health Care Utilization and Costs

Analysis of the Federal Employee Health Benefit Program with Aetna Life Insurance Company

February 1985

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute on Alcohol Abuse and Alcoholism
5600 Fishers Lane
Rockville, Maryland 20857

List of Figures

Overview

This project examined the impact of alcoholism treatment services on overall health care utilization and costs for individuals and families filing claims with the Aetna Life Insurance Company under the Federal Employees Health Benefit Program (FEHBP). Two study groups were used: (1) a treatment group consisting of families with at least one member filing a claim for alcoholism treatment during calendar years 1980–83, and (2) a comparison group consisting of a random sample of families who filed no alcoholism claims during the 1980–83 period.

The specific objectives and findings of the project are summarized below:

Objective: *Compare the health care utilization and costs for families with a member receiving alcoholism treatment with the utilization and costs of a random sample of families with no known alcoholic member.*

Finding: On the average, alcoholic families used health care services and incurred costs at a rate about twice that of similar families with no known alcoholic members. Average monthly costs for the two groups over the 1980–83 period were $210 per person and $107 per person, respectively.[1]

Objective: *Examine the utilization of alcoholism treatment services.*

Findings: The typical treated alcoholic in the Aetna population was a Federal employee or annuitant in his/her late forties or early fifties. Sixty-eight percent were male and 32 percent were female. All 50 States were represented, although the geographical distribution was not necessarily the same as the distribution of Federal employees.

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[1] Cost refers to charges as reflected in claims filed. All dollar figures [redacted]

A total of 2,934 persons filed claims for alcoholism treatment during the 4 years, an average of 7.6 persons per 10,000 covered individuals.

Alcoholism treatment costs totaled $9,168,617, of which $5.9 million (64.8 percent) was paid in benefits by Aetna. Costs per person receiving care averaged $3,125 over the 4 years of the study.

Seventy-seven percent of all alcoholics received inpatient care, which accounted for 95 percent of all alcoholism treatment costs. The average inpatient admission lasted 21.7 days and cost $3,157. Ambulatory care averaged $411 per person receiving such care.

Among the inpatient care facilities used were general hospitals (82 percent of all admissions), specialized alcoholism hospitals (9.5 percent), and hospital-affiliated inpatient/alcoholism care centers (5.6 percent).

The benefit cost of Aetna's alcoholism treatment coverage, i.e., costs spread over all Aetna subscribers, was $1.34 per covered individual per year.

Objective: *Determine if overall health care utilization and costs change for treated persons after they begin alcoholism treatment.*

Findings: There is a gradual rise in the overall health care costs and utilization for alcoholics during the 3 years preceding alcoholism treatment, with the most dramatic increase occurring in the 6 months before treatment. Total monthly costs increase from about $150 per month 2 years prior to treatment to an average of more than $450 per month during the 6 months prior to treatment and $1,370 in the final pretreatment month.

After alcoholics start treatment, their health care costs drop significantly and eventually reach approximately the level that existed several years prior to treatment. Their total monthly costs average $294 during the first 6 months after treatment and decline to an average of $190 per month by 2½ to 3 years after treatment.

The most significant drop in health care costs occurs for treated alcoholics under the age of 45. The least reduction occurs for those 65 years and older.

Objective: *Estimate the potential health care cost savings associated with alcoholism treatment.*

Finding: Using a variety of forecasting techniques, the project estimated that the average alcoholic's treatment cost could be offset by reductions in other health care costs within 2 to 3 years following the start of treatment. That is, the average alcoholism treatment costs can be recovered within 3 years after treatment initiation.

Study Background

Earlier studies established that alcoholics have lower life expectancies than nonalcoholic populations (Pell and D'Alonzo 1973; Room and Day 1974; Thaler 1977). Regular heavy ingestion of ethanol increases the chances of physical illness and early death from many causes, including liver problems such as cirrhosis; intestinal, gastrointestinal, and endocrine system problems; throat and esophagus problems; heart disease; neurological problems; and cancer. In addition, spouses and children who live with alcoholics incur an increased risk of abuse as well as increased anxiety (U.S. Department of Health and Human Services 1981).

As a result of heavy drinking, alcoholics covered under a health insurance plan often consume health care resources at a much higher rate than nonalcoholic persons of similar age and sex. The nonalcoholic members of the alcoholic's family are also higher than average consumers of health care (Holder and Hallan 1976; Hallan 1981; NIAAA 1983). The effect of alcoholism treatment on overall health care utilization and costs has become an important issue over the past decade as more insurance carriers, self-insured companies, and health maintenance organizations have financed alcoholism treatment.

A few studies have examined the impact of alcoholism treatment on health care costs and utilization using data from prepaid plans or health maintenance organizations. Brock and Boyaly (1978), in a study for the Group Health Association of America, observed a 40-percent reduction in overall outpatient visits resulting from alcoholism treatment. A study of Kaiser Permanente of Southern California found a 27-percent reduction in inpatient and outpatient medical care costs (Sherman, Reiff, and Forsythe 1979). Likewise, research on the Arizona Health Plan showed declines in postalcoholism treatment costs (Hunter 1978). Other alcoholism treatment studies have examined health care dollar savings per client. For example, a study in 1976 of various U.S. alcoholism treatment centers revealed savings of about $1,000 per client, and researchers estimated that a program in Oregon saved about 40¢ for every $1 spent on treatment (JWK International Corp. 1976; Hayami and Precobori 1981).

In another study, researchers examined 250 alcoholics enrolled under the Health Benefits Program, Public Employees Retirement System, the State of California, over a 2-year postalcoholism treatment period. They found an annual reduction of about $84 per person following the start of treatment for alcoholism (Holder and Hallan 1978). In a subsequent 5-year followup study of 90 families with an alcoholic member in the same health insurance program, researchers found an average monthly reduction in total health care costs of about $72 per person, as well as a decline in health care utilization to the same level as a matched comparison group of nonalcoholic families (Holder and Hallan 1981).

These studies establish the reasonableness of the hypothesis that total health care costs decline following treatment for alcoholism; however, most have important methodological limitations. The most significant limitations include small study groups (usually fewer than 500 cases), short pretreatment and posttreatment periods (usually 12 months), and lack of comparison groups.

In addition, researchers need to replicate these studies in a variety of enrolled populations to determine their applicability. No single health insurance population can be nationally generalizable because of differences in enrolled worker populations, types of insurance benefits, and health care availability. Although employers and health insurance carriers have moved to increase coverage for alcoholism treatment, additional research and experience should help remove the reluctance to cover alcoholism treatment due to fear of increased costs.

The U.S. Office of Personnel Management (OPM), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the U.S. Department of Health and Human Services, and the Aetna Life Insurance Company collaborated to develop data to examine the impact of alcoholism treatment on the overall health care costs and utilization of treated alcoholics and members of their families. Aetna was the second-largest carrier offering a plan under the FEHBP during the period covered by this study and is currently the third-largest carrier.[1] Aetna has specifically included coverage for alcoholism treatment since 1978.[2]

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[1]OPM currently offers over 100 health insurance "plans" to the Federal civil service workforce under the FEHBP. About 12 percent of the FEHBP population is covered by the Indemnity Benefit Plan of the Aetna Life Insurance Company. As of September 30, 1983, the Aetna plan covered some 390,000 enrollees and a total beneficiary population (including dependents) of about 980,000.

[2]Prior to 1978, treatment for alcoholism, while not specifically mentioned in the Aetna plan, was in all likelihood often covered under the rubric of mental disorders. Aetna currently offers Federal employees two benefit options for alcoholism treatment. The high-option benefit plan provides for annual inpatient and outpatient care for alcoholism up to $20,000 and $1,000, respectively. The low-option plan limits are $15,000 for inpatient and $750 for outpatient treatment.

Project Objectives and Approach

The specific objectives of this project, which covered calendar years 1980 through 1983, were as follows:

- Compare the health care costs[1] and utilization of families with a member receiving alcoholism treatment with the costs and utilization of a random sample of families with no known alcoholic member.
- Examine the utilization of alcoholism treatment services.
- Determine if overall health care utilization and costs change for treated persons after they begin alcoholism treatment.
- Estimate the potential health care cost savings associated with alcoholism treatment.

The data set available from Aetna included information on claims filed during the period January 1980 through December 1983[2] and contained over 20 million individual claim records. Claims from 462,162 families were represented, about 3,000 of which had a family member who filed at least one claim for alcoholism treatment. This proportion (0.7 percent of all families) is consistent with the proportion found in other insured populations (Hallan 1981; NIAAA 1983). The scope of Aetna's data set permitted analysis of a much larger number of families than in most other studies, longer pretreatment and posttreatment time periods, and a more comprehensive set of cost and utilization measures.

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[1]Throughout this report "cost" refers to charges submitted to Aetna in claims filed under the FEHBP. "Alcoholic" refers to individuals (families) filing claims for alcoholism treatment services during the term of the study. "Nonalcoholic" refers to individuals (families) who have filed no such claims. "Enrollee" refers to the Federal employee or retiree in whose name the health insurance contract is written.

[2]The only exception is for claims filed during March 1980. Aetna could not reconstruct these records, and thus no data on claims filed during this [illegible] discussed in detail in the full [illegible]

Two groups were studied:

1. A treatment group consisting of all families with at least one member beginning alcoholism treatment during 1980–83
2. A comparison group consisting of a random sample of all families filing no alcoholism claims during the period of the study, 1980–83.[3]

Most analyses included only those families and individuals who were continuously enrolled with Aetna over the 4 years, since unbiased analyses of health care trends can only be performed on individuals and families for whom complete data are available.[4]

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[3]While the ideal design would be one utilizing a comparison group of either untreated alcoholics randomly assigned from the same population as the treatment group, or diagnosed but untreated alcoholics matched with the treatment group on critical variables, no such group could be constituted from the Aetna data set. Random assignment is not possible in a post hoc study of this type, and ethical considerations would in all likelihood preclude it in any case. A group of diagnosed but untreated alcoholics could also not be used since alcoholics were "known" only when a claim for alcoholism treatment services was filed. The comparison group of nonalcoholic families was used only to make general comparisons with the alcoholic families, not to measure the impact of treatment. The random sample was stratified to obtain a group with a mean family age distribution similar to that of the treatment group. Gender was not used for stratification since it is not a family characteristic. In any case, the sex distribution of continuously enrolled alcoholics is not significantly different from the sex distribution of all Aetna enrollees. See final report for a detailed description of the Aetna data set and further discussion of the study design.

[4]No enrollment data were contained on the Aetna data files. It was therefore necessary to estimate continuity of coverage via an examination of claim-filing patterns. Families filing claims in both the first and [illegible]

Comparison of Alcoholic and Nonalcoholic Families

The two groups were quite similar demographically (see table 1). Mean family size was about 2½ persons, and in both groups, 22 to 23 percent were single-person families. The mean age of all family members averaged around 50 years.[1] In both groups about 80 percent of the families had high option coverage throughout the 4 years. Switching between options was quite infrequent. About 22 percent of the families in both groups consisted of the enrollee only, 34 to 35 percent comprised enrollee and spouse, and 28 to 31 percent comprised enrollee, spouse, and children.

The health care utilization and total cost of the two groups were examined by calendar year. Alcoholic families exhibited mean monthly per person costs (charges) well above those of nonalcoholic families—$210 vs. $107 over the 4-year period.[2] Statistically significant differences (.0001 level) between the alcoholic families and the comparison families were found for each year.[3] Within each group, no statistically significant calendar year trends were evident that might confound longitudinal analyses (see figure 1).

Similar patterns were found for inpatient care. Monthly per person inpatient days for alcoholic families (.68) were over three times the level found for nonalcoholic families over the 4 years.

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[1]This age similarity is the obvious result of drawing an age-stratified sample of nonalcoholic families. This age stratification probably served to minimize differences on other variables as well. On none of these demographic variables were differences statistically significant.

[2]Average monthly costs standardized on a per person basis.

[3]Note on statistical testing: Between group differences for each year were tested using t tests; within group differences across the 4 years were tested using analysis of variance (F test). Statistical controls were not used because demographic comparisons showed no significant differences for which adjustment was necessary. The only major change in the Aetna plan during the study period was the addition of comprehensive dental benefits (under the high option) in 1982. Dental claims were eliminated from the study file to control for this bias. See "Alcoholism Treatment Impact on Total Health Care Utilization and Costs: A Four-Year Longitudinal Analysis of the Federal Employees Health Benefit Program with Aetna Life Insurance Company," February 1, 1985, report prepared for [illegible]

Table 1. Demographic profile of alcoholic and nonalcoholic family study groups—all continuously enrolled, 1980–83

Family profile	Alcoholic group	Nonalcoholic group
Number of families	1,645	3,598
Average family size:		
Mean	2.6	2.5
Percent distribution		
1	21.8	23.0
2	38.2	39.2
3–4	30.7	30.0
5+	9.4	7.8
Total	100.1	100.0
Average family age:*		
Mean	49.7	50.3
Percent distribution		
< 18	1.2	1.2
18–20	1.9	1.9
21–24	3.7	3.7
25–34	18.7	18.7
35–44	15.9	15.9
45–54	12.1	12.1
55–64	22.2	22.2
65–70	13.6	9.4
71+	10.7	14.8
Total	100.0	99.9
Type of plan:		
Percent distribution		
High option only	79.9	78.0
Low option only	11.9	13.7
Both	8.1	8.3
Total	99.9	100.0
Type of family:		
Percent distribution		
Enrollee only	21.8	22.3
Enrollee and spouse	35.1	33.7
Enrollee and child(ren)	7.5	7.8
Enrollee, spouse, and child	31.2	28.3
Enrollee, spouse, child, and other	.5	.2
Enrollee and other	0	.1
No enrollee**	4.0	7.7
Total	100.1	100.1

*As of January 1, 1984.

**Refers to families in which no claims for enrollee were filed over the 4-year period.

Figure 1. Comparison of alcoholic and nonalcoholic study groups by calendar year: Average per capita monthly family health care cost

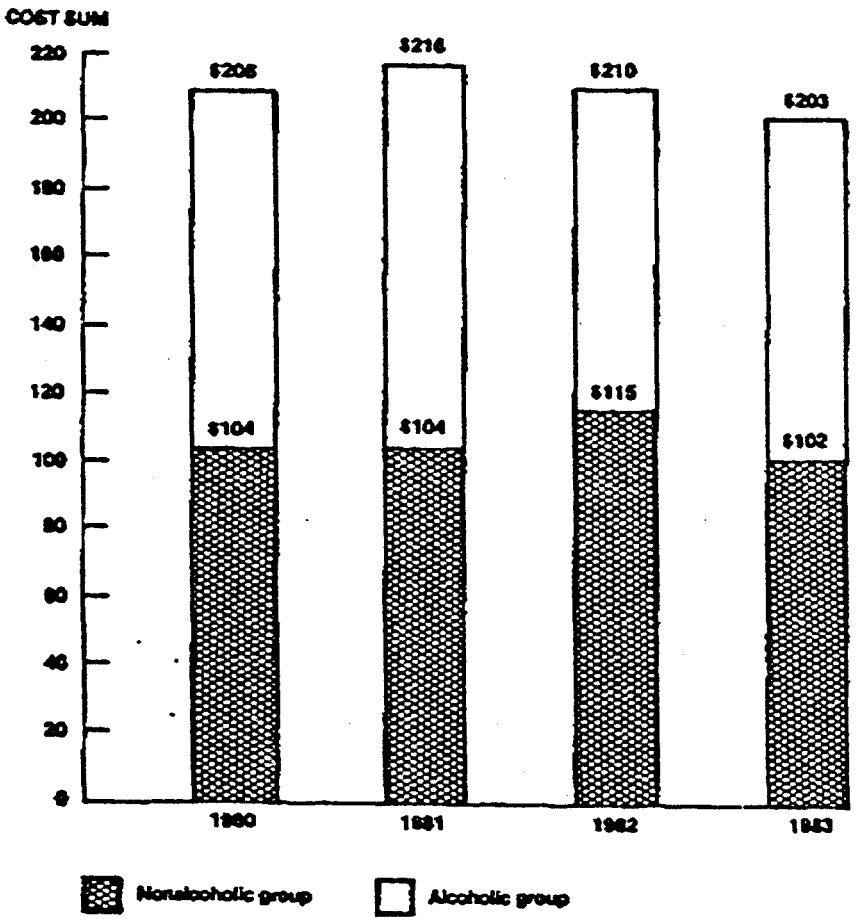
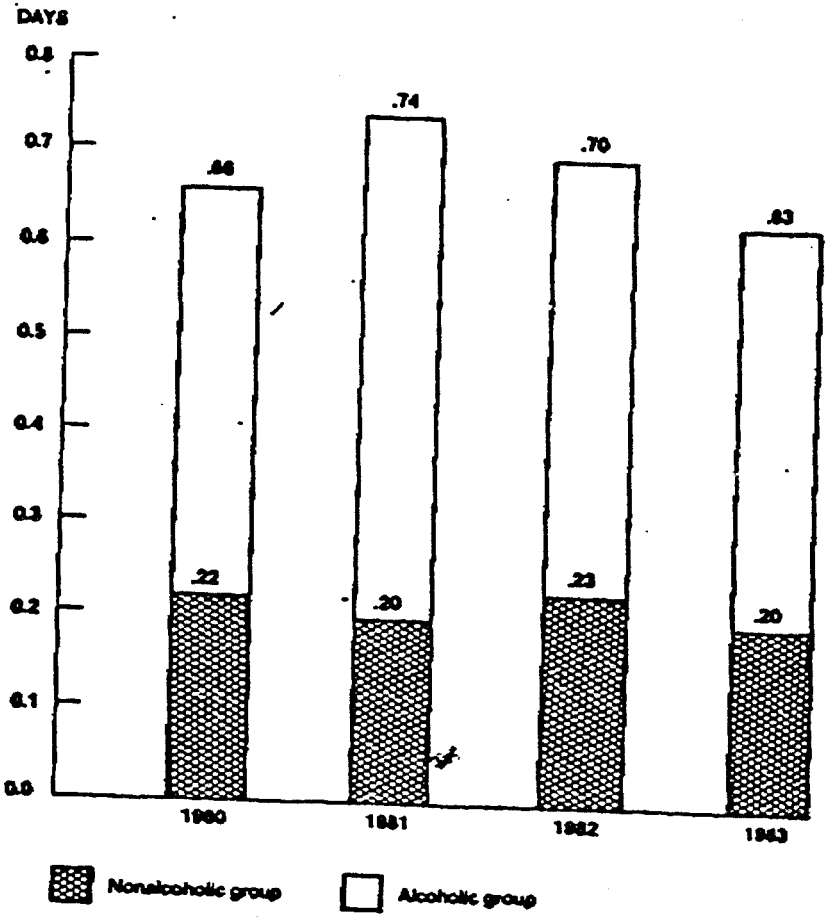


Figure 2. Comparison of alcoholic and nonalcoholic study groups by calendar year: Average per capita monthly family inpatient days



Again, statistically significant differences in use between groups were found for each year. However, within each group, no calendar year trends were found (see figure 2).

Ambulatory utilization did not differ between the two groups for any year; both groups averaged about .21 ambulatory treatment events per month per person. Ambulatory care costs made up only one-quarter or less of total health care costs.

Overall, these results [illegible] for research [illegible]

no known alcoholic members (Holder and Hallan 1981). Inpatient care costs accounted for most of this difference between alcoholic and nonalcoholic families; ambulatory utilization was similar for the two groups.

Characteristics of Individuals Receiving Alcoholism Treatment

Over the 4-year period of the study, 2,934 individuals filed claims for alcoholism treatment with Aetna under the Federal Employees Health Benefit Program. An average of about 735 persons began treatment each year. Of these, 58 percent were continuously enrolled with Aetna over the study period.[1] The average treated alcoholic was 51 years old. However, three distinct age groups can be identified: under 45 (32 percent), 45 to 64 years old (47 percent), and 65 and older (21 percent). Sixty-eight percent of those receiving alcoholism treatment were male.

Two-thirds of those receiving alcoholism treatment were enrollees (i.e., employees or annuitants), 23 percent were spouses of enrollees, and 10 percent were dependent children. Other dependents (including parents) comprised less than 1 percent of the treated group. All 50 States, Puerto Rico, and the District of Columbia were represented (see table 2).

Continuously enrolled and noncontinuously enrolled alcoholics differed very little in terms of the alcoholism treatment they used. Accordingly, the groups were combined for the analysis of alcoholism treatment services in order to provide a more complete picture of alcoholism treatment patterns.

[1]Note that there are more continuously enrolled alcoholics than continuously enrolled alcoholic families because a few had more than one alcoholic member.

Table 2. Characteristics of individuals receiving alcoholism treatment under the Aetna Federal Employees Benefit Program, 1980–83

Total number of persons receiving treatment	2,934
Average number of persons beginning treatment per year	734
Average age	50.7
Percent distribution	
Male	68
Female	32
Age	
Under 45	32
45 to 64	47
65 and older	21
Enrollees (Federal employees or annuitants)	67
Spouses of enrollees	23
Dependent children	10
Other dependents	Less than 1

Pattern of Alcoholism Treatment Services

Identifying the types of alcoholism treatment services and the patterns of use among the Aetna-insured populations is important for understanding changes in alcoholics' health care after they begin alcoholism treatment.

The total cost (charges) for alcoholism treatment services was $9,168,617 over the 4 years. Sixty-five percent of this amount was paid in benefits. This amounted to a mean cost of $3,125 per person receiving alcoholism treatment (see table 3). Mean per person benefit payments were $2,024. Seventy-seven percent of all alcoholics filing claims received some inpatient services, while 37 percent received some ambulatory services. The average number of inpatient admissions per person receiving inpatient care was 1.22, with an average length of stay of 21.7 days. Inpatient care accounted for 95 percent of all alcoholism treatment costs.

The utilization rate of the alcoholism benefit as a percentage of total covered individuals was quite low, less than 1 percent. The estimated benefit cost for Aetna's alcoholism treatment coverage was $1.34 per covered individual per year, or $3.43 per health insurance contract per year.[1]

Those receiving alcoholism treatment under the Aetna plan used a broad range of facilities and providers. Most inpatient care, however, was concentrated in general hospitals (82 percent of all inpatient alcoholism admissions). Specialized alcoholism hospitals (9.5 percent) and hospital-affiliated inpatient or alcoholism care centers (5.6 percent) were used less frequently. No other facility type had more than 1 percent of admissions (see table 4.)

Average inpatient days per admission varied. Some of this variation may well have been due to the very small number of admissions to some facility types. For those facilities that had 15 or more admissions, average lengths of stay were quite similar: 22.7 days for specialized alcoholism hospitals, 22.8 for hospital-affiliated care centers, 21.4 for general hospitals, and 22.9 for residential facilities with minimal medical involvement.

The mean cost per admission also varied. For facility types having at least 15 admissions, specialized alcoholism hospitals were the most expensive (averaging $193 per day) while hospital-affiliated care centers ($188 per day) were not far behind. Rates at general hospitals were much lower ($138 per day)[2], and facilities with minimal medical involvement (e.g., nonmedical rehabilitation centers) were least expensive ($83 per day). These four facility types had roughly similar proportions of their charges paid as benefits.

Table 3. Annual alcoholism treatment utilization and costs* for all individuals filing alcoholism treatment claims, 1980–83

Utilization and costs	4-Year annual average
Inpatient admissions per person*	1.22
Mean length of stay per admission	21.7 days
Total costs	$2,292,154
Total benefits paid	$1,484,950
Total benefits as a percent of cost	64.8%
Mean cost per person	$3,125
Mean benefits paid per person	$2,024
Utilization rate for total covered individuals	.076%
Estimated benefit cost	
Per contract (enrollee):	
Annually	$3.43
Monthly	$ .29
Per covered individual:	
Annually	$1.34
Monthly	$ .11

* Per person receiving inpatient care.

[1]The benefit cost represents the cost to Aetna (based on benefits paid) of providing alcoholism treatment services (i.e., benefits paid for alcoholism treatment divided by the number of persons insured). These figures represent annual averages over the 4-year period. Since enrollment and coverage data are available only on an annual basis, we do not know how many unique individuals were involved over the entire 4 years, [illegible] figures can be derived only by taking an average of the

[2]While these per diem rates are lower than the average for general health care, it is important to remember that for the most part this [illegible] patients [illegible] acute care, and the cost figures cited [illegible]

Table 4. Utilization of alcoholism treatment service by specific provider types—the Federal Employees Health Benefit Plan with Aetna, 1980–1983

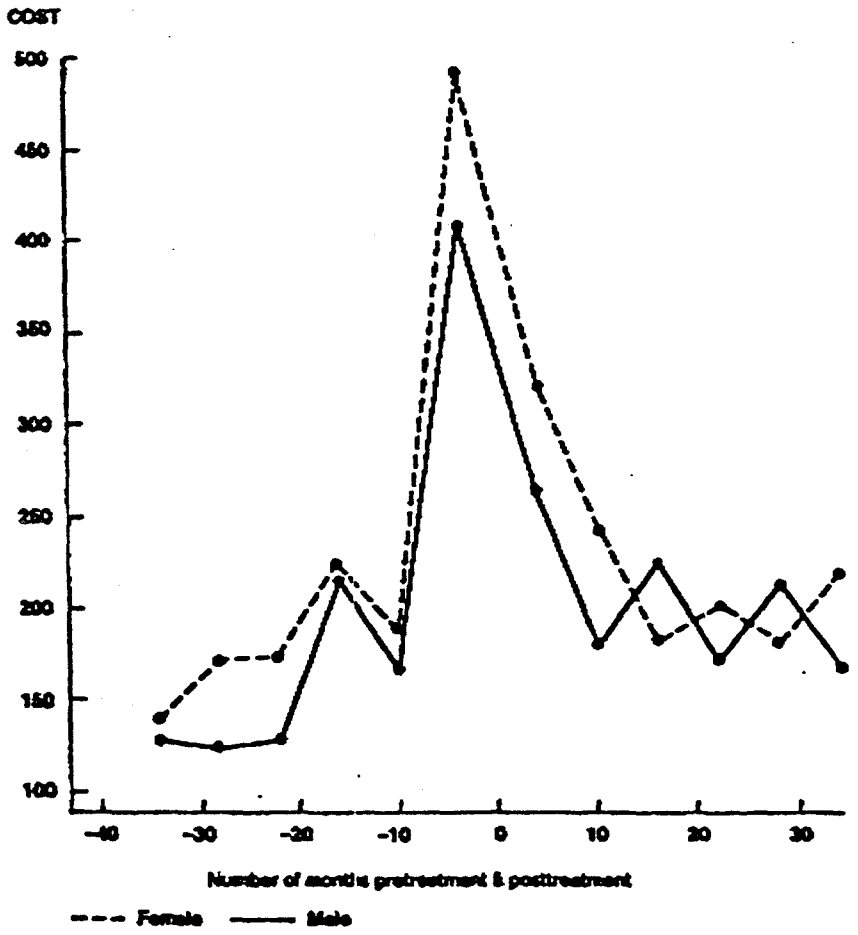
Type of provider	Inpatient treatment					Ambulatory care	
	Admissions (percent of total)	Mean length of stay (days)	Mean cost per admission	Mean cost per day	Benefits paid as percent of cost	Ambulatory visits (percent of total claims submitted)	Benefits paid as percent of total
Specialized alcoholism hospital	9.5	22.7	$4,380	$193	69.1	3.7	14.9
Psychiatric hospital	.2	13.0	$2,032	$156	26.2	NA	NA
General hospital	82.4	21.4	$2,958	$138	65.6	13.1	43.6
Hospital-affiliated inpatient or alcoholism care center	5.6	22.8	$4,290	$188	75.6	.7	48.7
Residential alcoholism treatment facility with minimal medical involvement	.7	22.9	$1,893	$83	74.6	.3	69.9
Drug abuse treatment facility	.1	30.0	$4,530	$151	28.2	NA	NA
Community mental health center	.3	22.6	$3,297	$146	69.1	2.1	40.7
Convalescent care facility	.1	16.0	$3,410	$213	53.2	NA	NA
Medical doctor	.2*	18.5	$2,689	$145	71.9	64.9	50.9
Osteopath	NA	NA	NA	NA	NA	.7	47.6
Psychologist	NA	NA	NA	NA	NA	6.6	44.4
Psychiatric social worker	NA	NA	NA	NA	NA	2.4	45.9
All other (unspecified)	1.0	24.1	$2,730	$113	43.1	5.5	10.3

NA = not applicable. No claims submitted during the study period.
*This is the provider type code given by Aetna. It is unclear why a physician would be submitting claims for inpatient room and board (part of the basis for defining an admission), but these few claims may reflect services provided in physician-owned or -operated inpatient facilities.

A variety of providers gave ambulatory alcoholism treatment, although most care was rendered by only a few types.[3] In 65 percent of all ambulatory claims, medical doctors (including psychiatrists) were listed as the service provider. General hospitals and psychologists account for 13.1 percent and 6.6 percent of ambulatory visits, respectively.

[3]The measure of ambulatory visits is limited by the data, i.e., the count of visits is actually based on the number of claims for professional services, and the number of visits included in any claim is unknown. Thus, some of the variability in visits across provider types may be the result of differences in billing practices.

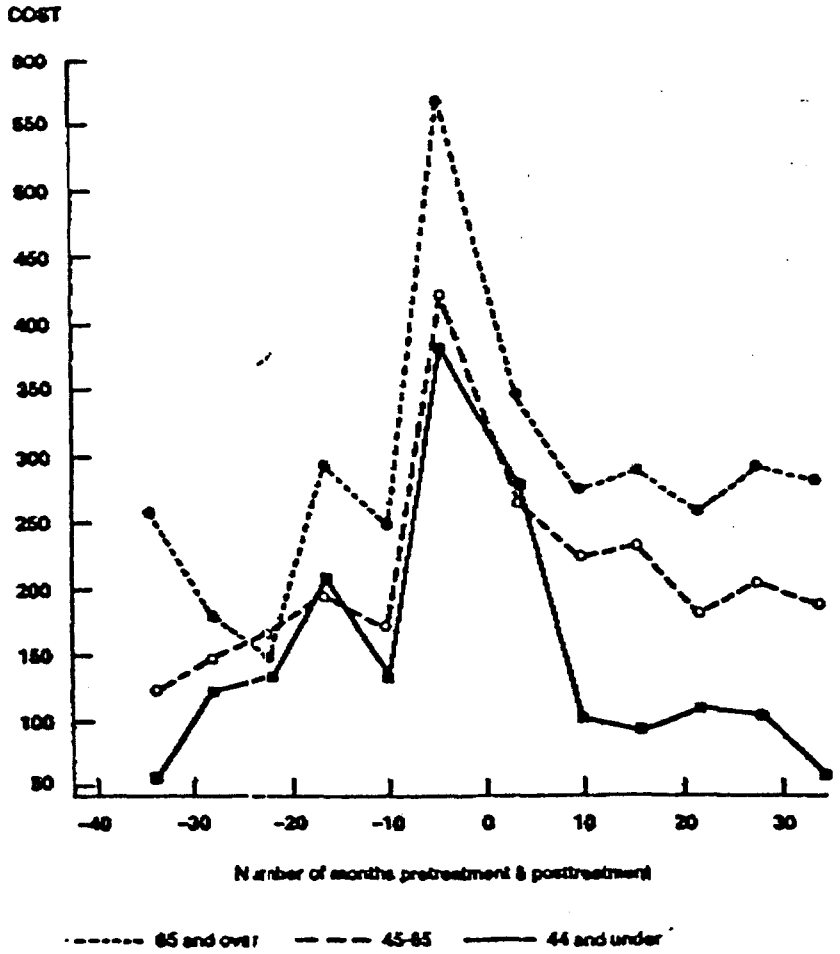
Figure 4. Average monthly health care costs: Alcoholic individuals by sex



dropped to levels comparable to those experienced 36 months prior to treatment. The modal age of this group is most like the modal age for study groups typically represented in previous studies of the health care costs of treated alcoholics.

The health care costs of the two older age groups also dropped significantly following the start of alcoholism treatment. Costs did not, however, reach levels as low as those existing several years prior to treatment. This finding is understandable for two reasons. First, the health care costs of persons who are past middle age—particularly those over 60—increase substantially as they become

Figure 5. Average monthly health care costs: Alcoholic individuals by age

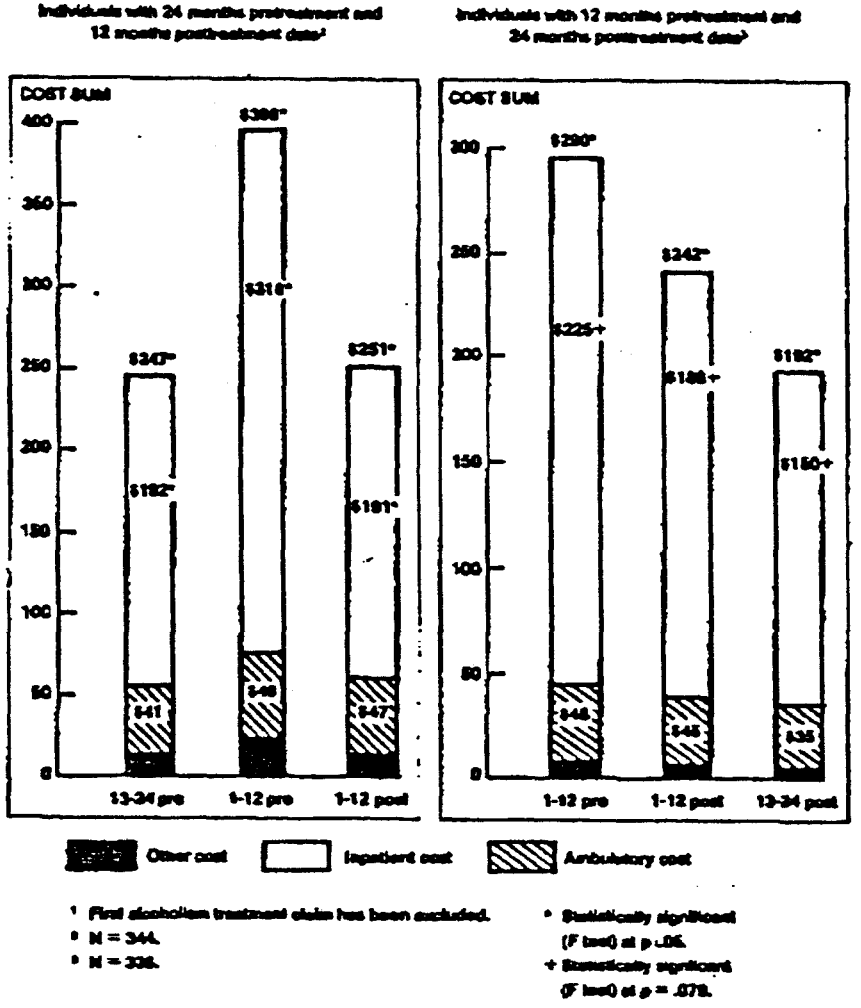


NOTE: First alcohol as treatment claim has been excluded.

and thus have developed more serious physical health problems than younger alcoholics. It is more difficult for alcoholism treatment to reverse the effects of this long-term chronic drinking (Maddox et al. 1984).

Statistical testing showed that the changes observed in the overall health care costs of alcoholics following the beginning of alcoholism treatment were indeed statistically significant. Figure 6

Figure 6. Average monthly health care costs for alcoholics over defined 12-month periods[1]



[1] First alcoholism treatment claim has been excluded.
[2] N = 344.
[3] N = 338.
* Statistically significant (F test) at p < .05.
+ Statistically significant (F test) at p = .078.

months of posttreatment data; and the 12/24 group, which included persons having 12 months of pretreatment and 24 months of posttreatment data. Alcoholics in the 24/12 group had average monthly total costs of $247 in the second year prior to beginning alcoholism treatment. Average costs for this group increased to $398 per month in the year immediately before treatment and then decreased to $251 per month in the year following treatment. The total costs of alcoholics in the 12/24 group were $290 per month in the year prior to treatment, dropping to $242 and $192 in the first and second posttreatment years. Both of these trends are statistically significant at the .05 level.

Health care utilization for the nonalcoholic members of families containing at least one treated alcoholic was also investigated. A rising and falling pattern similar to that of the alcoholic members did not clearly exist among the Aetna population. While the nonalcoholic members in the alcoholic families did show posttreatment decreases in their utilization and costs, these changes were not statistically significant.

Estimate of Offset Savings

Cost offset—the extent to which reduced medical care costs following the start of alcoholism treatment offset the cost of the treatment itself—very much interests those who provide and finance alcoholism treatment.

The empirical findings of this project do not establish a causal link between alcoholism treatment and the posttreatment decline in overall health care utilization.[1] Yet it is not unreasonable to believe that some portion of the decline results from that treatment and not entirely from other factors such as spontaneous remission. With this assumption, it then becomes reasonable to ask what the health care costs of these alcoholics might have been had they not undertaken treatment.

Lacking an appropriate control group, one way of estimating what the cost offset in this project might be is to use the pretreatment cost trends of the treated alcoholic population to estimate what "no treatment" costs might have been for those individuals.[2]

This approach has the limitation inherent in all forecasting—estimates will be believable only if the factors operating in the past are assumed to be operating in the future. Forecasts will therefore prove useful only under the assumption that the pattern of "no treatment" costs for alcoholics (who actually did receive treatment) would have been an extension of their historic pretreatment costs.

"No treatment" costs were forecast using several techniques. While these techniques required the assumption that past trends would continue into the future, they did allow alternative models that reflected some of the distinct ways in which this might occur. In particular, these techniques examined different assumptions about how much of the immediate pretreatment cost rise would be a permanent component of a "no treatment" condition.

Forecasts based on a *Markov chain* model are consistent with a belief that costs under a "no treatment" condition will stabilize, albeit at a fairly high level. Three distinct forecasts using ordinary least squares *regression analysis* all assume increasing costs. By using pretreatment periods of varying lengths (12, 24, or 36 months), however, models were developed that differed significantly in the extent of this cost increase.

For example, using a 12-month pretreatment period is consistent with a belief that most of the cost increase would be "permanent," that is, costs would continue to rise if treatment were not begun. Use of a 36-month pretreatment period deemphasizes the sharp rise immediately preceding treatment. The longer period is consistent with a belief that, while costs would continue to increase, much of the sharp increase immediately before treatment would reverse itself, at least for a time, and that the long-term rate of growth would not match the 12-month pretreatment rate even in the absence of treatment.

Once "no treatment" forecasts were obtained using each model, estimates of quarterly cost savings were obtained by subtracting the actual posttreatment cost values for each quarter from the corresponding projected values from each model. Estimated cost savings per person, i.e., the reduction in total health care costs after all alcoholism treatment costs have been considered, are summarized in table 5.[3] A positive net savings appears by the third year in all forecasting approaches, although the size of estimated savings varies. Under the most conservative model (linear regression using a 36-month prealcoholism treatment period), a positive net savings of $405 occurs by the end of the third year after the start of treatment. The largest savings after 3 years is $9,400 based on the linear regression model using a 12-month pretreatment period. These two models establish upper and lower boundaries for expected cost savings.

In all forecasting approaches, no net savings occur until at least the second year, due largely to the extensive use of inpatient alcoholism treatment by Aetna claimants, described earlier. As noted above, which estimate appears most plausible depends on the assumed relationship of pretreatment utilization patterns to "no treatment" trends. One key factor is how much of the immediate pretreatment ramp remains as a permanent component of the "no treatment" period. Regardless of forecasting technique, it appears

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[1] As noted earlier, a control group of untreated alcoholics would be required to make more definitive statements regarding causality.

[2] The most accurate way to measure cost savings is to take the difference between the total posttreatment health care costs incurred by the treated alcoholics and the health care costs that same group would have incurred had they not received alcoholism treatment. Using a true experimental study, this would be done by comparing the costs of alcoholism claimants to the costs of a group of untreated alcoholics randomly assigned from the same population. [illegible] acceptable approach would be [illegible]

[3] See main report for a more technical discussion of the derivation and [illegible]

Table 5. Estimates of potential cost savings resulting from reductions in health care costs for alcoholics following alcoholism treatment initiation

Estimated cost savings per person following initiation of alcoholism treatment	Estimates based on regression model using			Estimates based on Markov Chain model
	36-Month pretreatment period	24-Month pretreatment period	12-Month pretreatment period	
After 1 year	($2,159)	($1,501)	($ 671)	$(1,063)
After 2 years	($1,116)	$ 658	$3,372	$ 705
After 3 years	$ 405	$3,751	$9,400	$2,515

that over a 3-year time frame alcoholism treatment does produce a net savings. Savings may possibly begin sooner and probably increase with time.

Conclusion

This study found that alcoholism treatment is associated with statistically significant reductions in total health care costs. These reductions were largest for persons under 45 years of age. Alcoholics in this age group had posttreatment health care costs that eventually declined to a level as low as that experienced several years prior to alcoholism treatment. This is consistent with the findings of other studies for this age group.

FEHBP Aetna enrollees are older on the average than most health insurance populations; a large percentage of treated alcoholics was 65 and over. Persons in this age group also had lower costs after starting treatment. Their costs did not, however, decline to a point comparable to their lowest pretreatment levels, probably as a result of the group's older age and potentially longer period of chronic alcohol abuse (Shuckitt and Miller 1976; Blazer et al. 1984).

One of the unique features of this study is the long pretreatment time period used. This allowed a more thorough examination of the pretreatment health care cost patterns of alcoholics than had been possible in prior research. The study documented the rapid increase in the health care costs of untreated alcoholics that occurs in the year immediately preceding alcoholism treatment.

It is important to realize, however, that this sharp upward ramp is not unique to alcoholism but also occurs for other chronic diseases. Schlesinger et al. (1983), for example, examined the total health care cost of persons with chronic diseases in the hypertensive disease, the respiratory disease, the diabetic, and the ischemic heart disease groups. In all four disease groups medical care utilization and costs significantly increased during the 6 months prior to a diagnosis of the disease. Across all disease groups, costs rose by as much as 500 percent. As with alcoholism, most of the increased cost was the result of hospitalization.

Schlesinger et al. (1983) found that total health care costs dropped sharply within the first year following diagnosis and the start of treatment for persons with diseases in all four groups. But in no case did the postdiagnosis health care costs of individuals in any group decline to levels as low as those experienced a year prior to treatment.

No study utilizing a health care claims data base similar to the one available for this project (lacking an equivalent comparison group of untreated alcoholics and a description of the specific

method(s) of alcoholism treatment) can confidently attribute reductions in health care costs to specific causes. However, given the consistency of these findings with other research showing cost reduction following alcoholism treatment, it is not unreasonable to attribute some portion of the reduction to the alcoholism treatment itself (Brock and Boyajy 1978; Sherman, Reiff, and Forsythe 1979; Holder and Hallan 1981; Saxe et al. 1983). Further, these findings are also consistent with the previously cited reduced health care costs observed following diagnosis and treatment initiation for other chronic diseases (Schlesinger et al. 1983) and with research showing reductions in health care costs associated with mental health care (Schlesinger et al. 1983; Roweton 1983; Mumford et al. 1984).

No study of a particular enrolled population can be definitive given both the diversity of the alcoholic population and the diversity of populations enrolled under employee health benefit plans, as well as the variances in types of coverage and the services available in different regions of the country. Even this study, based on the Aetna Federal employee population in all 50 States, is not necessarily representative of all Federal employees, let alone the national population.

Nonetheless, this project makes an important contribution as one in a series of studies examining the relationship between treatment for alcoholism and utilization of overall health care and its accompanying cost. The study's significance derives from (a) a large alcoholic sample (about 3,000 treated alcoholics, 1,700 of whom were continuously enrolled with Aetna during the study period), (b) lengthy pretreatment and posttreatment time periods (up to 36 months), and (c) multiple health care cost and utilization measures to confirm observed patterns.

References

Blazer, D.; George, L.; Woodbury, M.; Manton, K.; and Jordon, K. The elderly alcoholic: a profile. In: Maddox, G.; Robins, L.N.; and Rosenberg, N., eds. *Nature and Extent of alcohol problems among the elderly.* Proceedings of a Workshop (December 3–4, 1983) Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1984. pp. 275–297.

Brock, C.B., and Boyajy, T.G. *Group Health Association of America Study: Alcoholism Within Prepaid Group Practice HMOs.* Report prepared for NIAAA, #5H84AA01745, Rockville, MD, 1978.

Hallan, J.B. Health insurance coverage for alcoholism: a review of costs and objectives. *Alcohol Health and Research World* 4:16–21, 1981.

Hayami, D.E., and Preobori, D.K. Effect of coverage on the use of an HMO alcoholism treatment program, outcome and medical care utilization. *American Journal of Public Health* 71:1133–44, 1981.

Holder, H.D., and Hallan, J.B. *A Study of Health Insurance Coverage for Alcoholism for California State Employees: Two Year Experience Summary* Raleigh, NC: H-2, Inc., December 1976.

Holder, H.D., and Hallan, J.B. *The California Pilot Program to Provide Health Insurance Coverage for Alcoholism Treatment—One Year After.* Chapel Hill, NC: H-2, Inc., December 1978.

Holder, H.D., and Hallan, J.B. *Medical Care and Alcoholism Treatment Costs and Utilization: A Five-Year Analysis of the California Pilot Project to Provide Health Insurance Coverage for Alcoholism.* Chapel Hill, NC: H-2, Inc., December 1981. Contract No. ADM 281-79-0008 for the National Institute on Alcohol Abuse and Alcoholism.

Hunter, H. *Arizona Health Plan Cost-Benefit Study.* Report to NIAAA, #5H84AA01745, Rockville, MD, 1978.

JWK International Corp. *Benefit-Cost Analysis of Alcoholism Treatment Centers.* Report to NIAAA, #AFM-281-75-0031, Rockville, MD, 1976.

Maddox, G.; Robins, L.N.; and Rosenberg, N., eds. *Nature and Extent of Alcohol Problems Among the Elderly.* Proceedings of a Workshop (December 3–4, 1983). Rockville, MD: NIAAA, 1984.

Mumford, E.; Schlesinger, H.J.; Glass, G.V.; Patrick, C.; and Cuerdon, T. A new look at evidence about reduced cost of medical utilization following mental health treatment. *American Journal of Psychiatry* 141: 1145-1158, October 1984.

National Center for Health Services Research. *National Health Care Expenditures Study—Household Data: United States, 1977.* U.S. Department of Health and Human Services, in press.

National Institute on Alcohol Abuse and Alcoholism. *Development of Cost Simulation Study of Alcoholism Insurance Benefit Packages: Project Description and Recommendations.* Rockville, MD: U.S. Department of Health and Human Services, May 1983.

Pell, S., and D'Alonzo, C.A. A 5-year mortality study of alcoholics. *Journal of Occupational Medicine* 15:120–25, 1973.

Room, R., and Day, N. *Alcohol and Mortality*. Special Report to National Institute on Alcohol Abuse and Alcoholism, U.S. Department of Health and Human Services, March 1974.

Rowston, W.E. *Reducing Medical Utilization with Psychotherapy*. Charlottesville, VA: Associated American Ltd., April 15, 1983.

Saxe, L.; Dougherty, D.; Esty, K.; and Fine, M. *The Effectiveness and Costs of Alcoholism Treatment*. Washington, DC: Office of Technology Assessment, Congress of the United States, 1983.

Schlesinger, H.J.; Mumford, E.; Glass, G. V.; Patrick, K.; and Sherfstein, S. Mental health treatment and medical care utilization in a fee-for-service system: outpatient mental health treatment following the onset of a chronic disease. *American Journal of Public Health*. 73:422-29, 1983.

Schuckitt, M.A., and Miller, P.L. Alcoholism in elderly men: a survey of a general medical ward. *Annals of the New York Academy of Sciences* 237:558-71, 1976.

Sherman, R.M.; Reiff, S.; and Forsythe, A.B. Utilization of medical services by alcoholics participating in an outpatient treatment program. *Alcoholism: Clinical and Experimental Research*, 3:115, 1979.

Thaler, H. Alcohol consumption and diseases of the liver. *Nutrition and Metabolism* 21:186-93, 1977.

U.S. Department of Health and Human Services. *Fourth Special Report to the U.S. Congress on Alcohol and Health*. DeLuca, J.R., ed. DHHS Pub. No. (ADM)81-1080. Washington, D.C.: Supt. of Documents, U.S. Government Printing Office, 1981.

Figure 1. Comparison of alcoholic and nonalcoholic study groups by calendar year: Average per capita monthly family health care cost

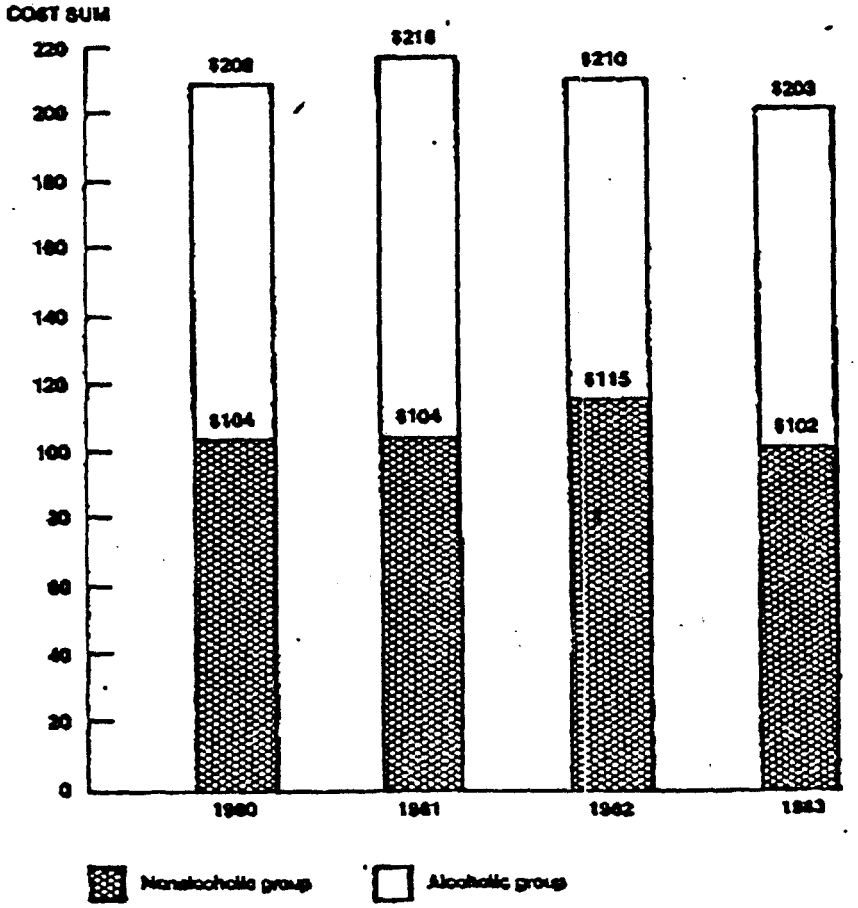


Figure 2. Comparison of alcoholic and nonalcoholic study groups by calendar year: Average per capita monthly family inpatient days

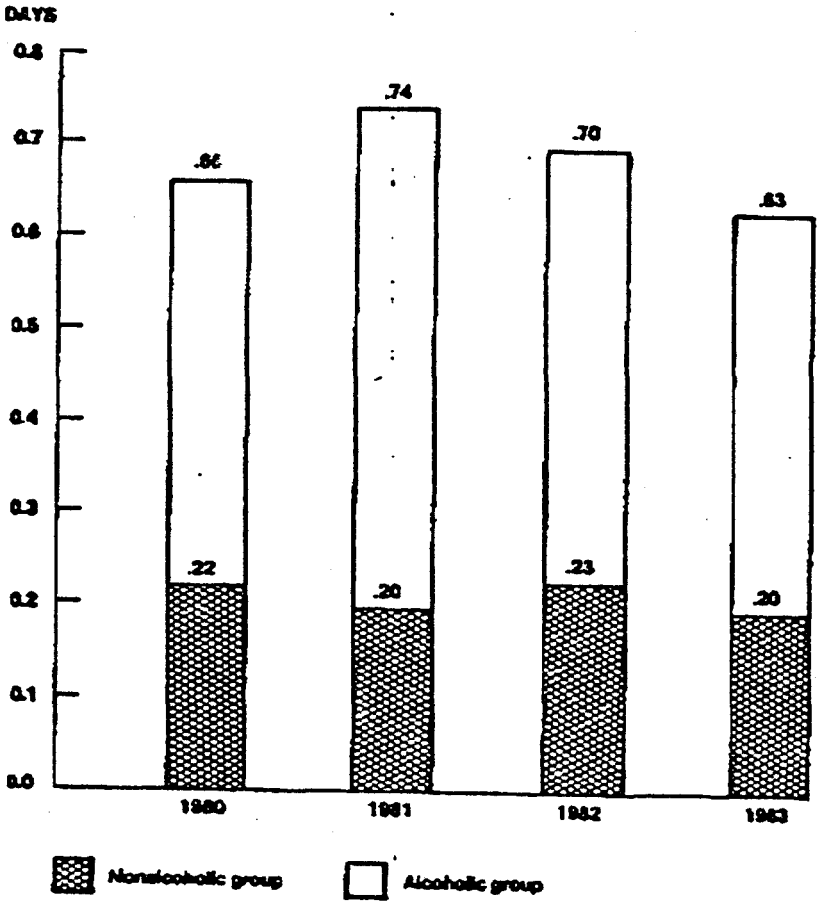
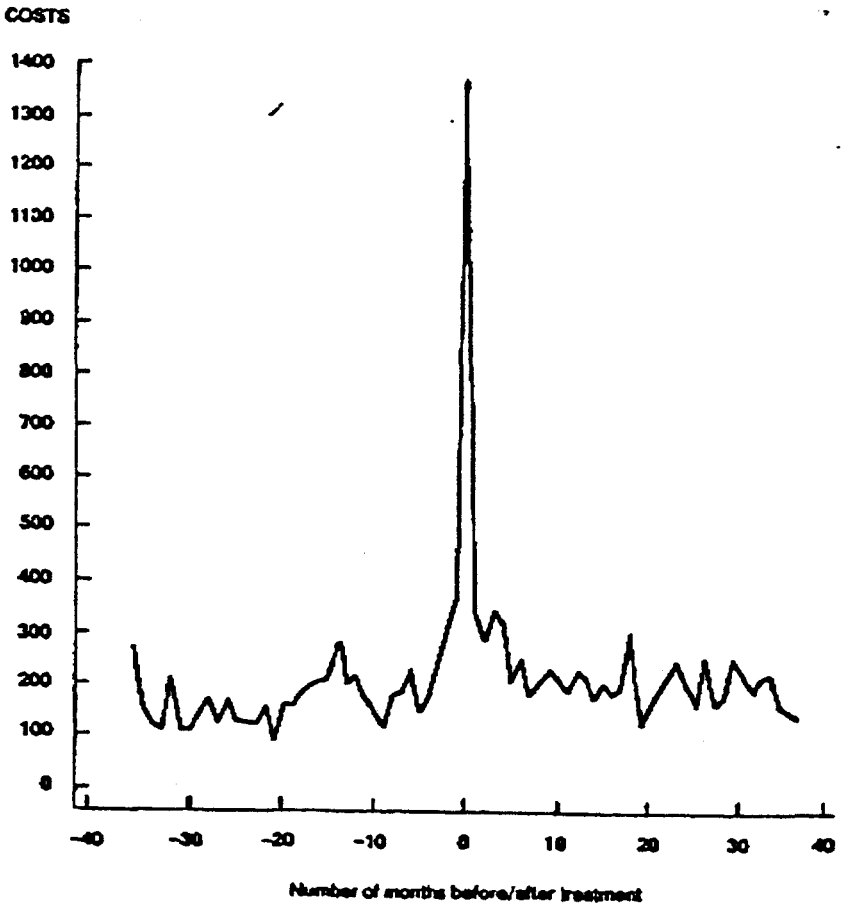


Figure 3. Average monthly total health care costs for treated alcoholics by month pretreatment and posttreatment



NOTE: First alcoholism treatment claim has been excluded.

Figure 4. Average monthly health care costs: Alcoholic individuals by sex

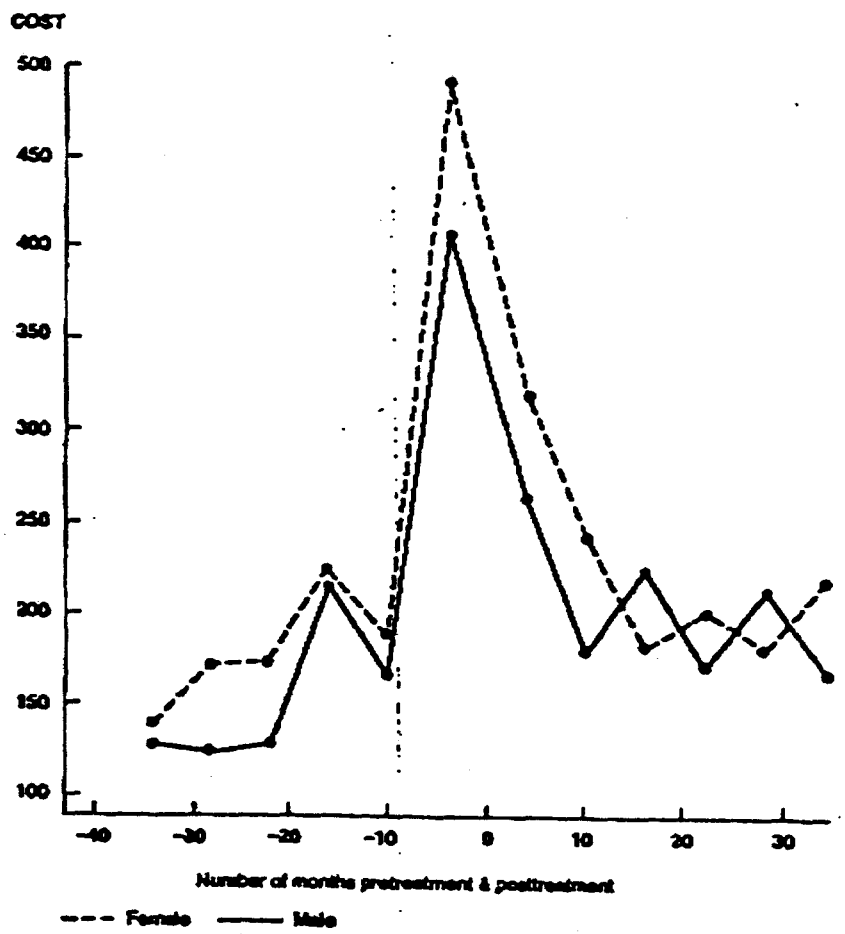
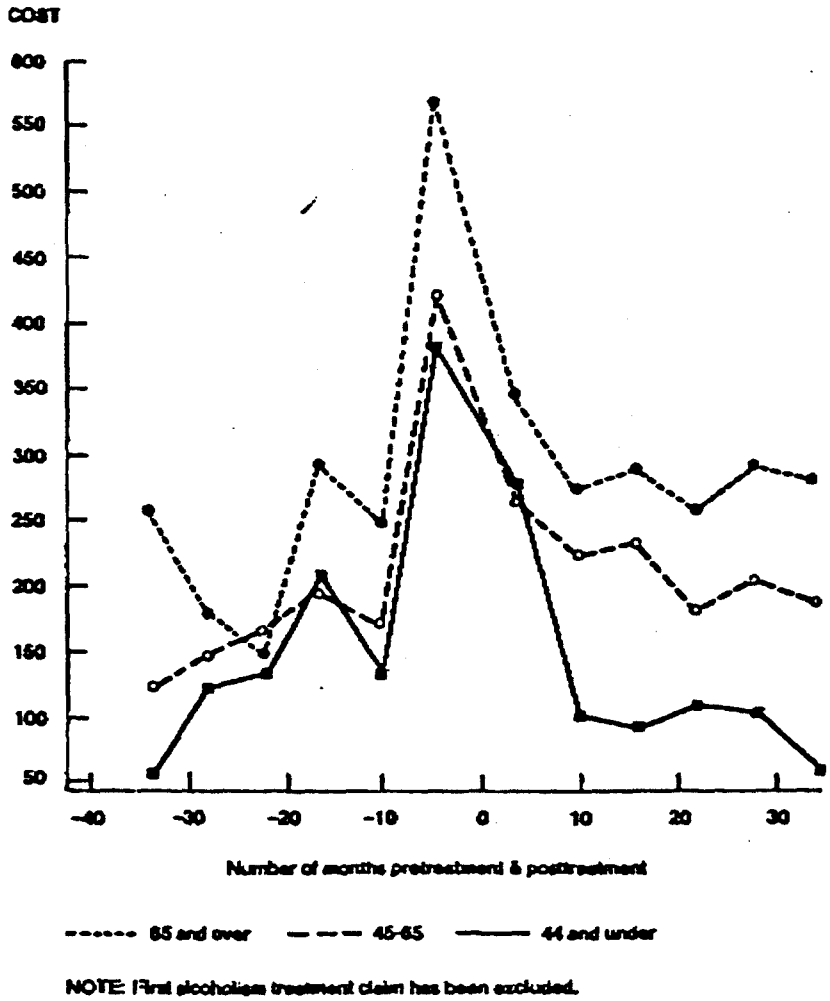


Figure 5. Average monthly health care costs: Alcoholic individuals by age



NOTE: First alcoholism treatment claim has been excluded.

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DATA

Brown University Digest of Addiction Theory and Application

ISSUE HIGHLIGHTS

Volume 6
Number 2

MANISSES
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COST BENEFIT OF ALCOHOLISM TREATMENT

Harold D. Holder, Ph.D., and James O. Blose, M.P.P.

In a study based upon a review of claims filed by 1697 treated alcoholics in the Federal Employees Health Benefit Program with the Aetna Insurance Company, it was found that, on the average, alcoholics incurred gradually increasing total health costs prior to treatment, but declined during several follow-up years.

In the several studies that have examined the impact of alcoholism treatment on medical care cost and utilization using data from prepaid plans or HMOs (H. Hunter, unpublished data, November 1978), there has been a consistent decrease in overall health care utilization following alcoholism treatment. Still, the general conclusion of the findings can be questioned because of the possibility of self-selection in enrollment with HMOs and the concentration of research in specific geographic areas.

The study reported herein has followed a diverse approach in covering: (1) a large, continuously enrolled treated alcoholic population (about 1700 subjects), (2) cases from all 50 states, (3) longer pretreatment and posttreatment time periods, (4) use of multiple cost and utilization measures to corroborate any observed effects, and (5) use of a comparison group.

Further, the research has the capacity to extend our knowledge in two directions: (1) exploratory analyses to be conducted on alcoholics of differing ages; and (2) a longer and more detailed picture of the pretreatment cost patterns of alcoholics than has been possible.

RESEARCH APPROACH

The data for this study were derived from a review of all claims filed with Aetna Life and Casualty Company during the

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calendar years 1980 through 1983 by all persons insured under the Federal Employees Health Benefit Program. The Aetna plan covered 390,000 enrollees, half of whom were aged 60 or older. A total of 2934 individuals filed claims for alcoholism treatment, each fitting the description of "a person who had received medical treatment under a primary diagnosis of alcoholism."

A randomly selected group of families that had filed no claims for alcoholism treatment were used only to make comparisons with the alcoholic families regarding general medical care utilization patterns. No statistically significant differences in demographic characteristics were found between the two family groups.

All medical care claims for both groups for services rendered during the four-year period were analyzed. Costs were defined as unique charges for services submitted to Aetna by medical care providers.

Under the Federal Employees Health Benefit Program with Aetna, alcoholism treatment is explicitly covered under the surgical and medical expenses for mental disorders. About 80% of the families in both the alcoholic and nonalcoholic study groups retained high-option coverage ($20,000) throughout the four years.

RESULTS

The four-year average per capita monthly health care costs for families with an alcoholic member were $209.60 (100% higher than those with a nonalcoholic member). The mean age for the 1697 treated alcoholics was 51 years, 65% being males. Primarily, the favored treatment was inpatient care, with an average length of stay of 21.7 days in a general hospital.

Costs associated with the first alcoholism claim have been excluded from these and all subsequent analyses reported herein. Since initial alcoholism treatment usually involved an expensive inpatient stay, including these costs in the analysis tended to obscure the pattern of general medical care utilization. All subsequent costs for alcoholism treatment were included, however.

Taken as a whole, results clearly indicate that mean monthly total medical care costs gradually increase before the initiation of

alcoholism treatment, decline immediately following treatment initiation, and continue to decline at least into the second year.

On the average, from 36 to 12 months before alcoholics begin alcoholism treatment their medical care costs gradually increase, with average monthly costs per person rising from approximately $130 to $179. During the year before treatment begins, however, total medical care costs rise much faster. The average monthly medical care cost rose to $452 in the six-month period before alcoholism treatment and to $1370 in the final month.

After treatment begins, total medical care costs drop fairly rapidly for about 12 months. This drop continues, though more slowly, during the next two years. Total health care costs averaged $294 per month during the six months following treatment initiation, but only $190 per month by the third post-treatment initiation year.

We examined three age groups: less than 45 years, 45 to 64 years, and 65 years and older. Alcoholics in each age group followed the general patterns of the total group. Yet there was a clear association between age and the extent of the drop in medical care costs following the start of alcoholism treatment. By 36 months after the start of treatment, the average monthly total costs of those less than 45 years (N=440) had dropped to a level comparable with that experienced 36 months prior to treatment.

The middle age group (45 to 64 years old, N=823) is most like the model age of groups typically represented in previous studies of treated alcoholics. The health care costs of this group also dropped significantly following the start of alcoholism treatment, although they did not reach levels as low as those existing several years prior to treatment. The oldest group (N=434), which consisted primarily of retirees, experienced the highest overall medical care costs and showed the least convergence to the levels that existed prior to initiation of alcoholism treatment.

COMMENT

Though no study of a single enrolled population can be definitive, given both the diversity of the alcoholic population and the diversity of populations enrolled under employee health benefit plans, the research is probably more generalizable than

many previous studies based on smaller regional samples. Also, the long term period available for analysis allowed for more thorough examinations of pretreatment medical care cost patterns of alcoholics.

This examination identified more clearly the nature of the rapid increase in costs that occurs in the year immediately preceding initial alcoholism treatment. It appears that within the six months prior to the start of alcoholism treatment, the emotional and physical problems of the average alcoholic escalate. These worsening problems manifest themselves in the use of additional health care services. This sharp upward ramp is not unique to alcoholism but also occurs for other chronic diseases.

Only for persons less than 45 years of age did posttreatment health care costs eventually decline to a level as low as that experienced several years prior to alcoholism treatment.

The health policy in question is whether alcoholism treatment as actually rendered to a large population that is motivated to seek care can result in reduced overall health care costs. The results of this study provide further evidence that this question should be answered affirmatively.

SUGGESTED READINGS

Hallan, J.B. Health insurance coverage for alcoholism: A review of costs and objectives. *Alcoholism Health and Research World* 4:16-21, 1981.

Hayami, D.E. and Freeborn, D.K. Effect of coverage on use of an HMO alcoholism treatment program, outcome, and medical care utilization. *American Journal of Public Health* 71:1113-1143, 1981.

Jones, K.R. and Vischi, T.R. Impact of alcohol, drug abuse and mental health treatment on medical care utilization. *Medical Care* 17:1-82, 1979.

Maddox, G., Robins, L.N., and Rosenberg, N. (eds.) *Nature and Extent of Alcohol Problems Among the Elderly*. Rockville, MD, National Institute on Alcohol Abuse and Alcoholism, 1984.

Saxe, L., Dougherty, D., Esty, K., et al. *The Effectiveness and Costs of Alcoholism Treatment*. Congress of the U.S., 1983.

SB 182
3/20

Office of the Legislative Auditor

MONTANA UNIVERSITY SYSTEM
MENTAL HEALTH BENEFIT INCREASE
Legislative Request (89L-82)

March 10, 1989

This memorandum details expected increases in benefit payments for the University System health insurance plan.

CALCULATION OF 50% TO 80% BENEFIT INCREASE

FY 1989-90

Actual FY88 charges less reductions	$276,956.46
X 15% inflation	41,543.47
Projected charges with inflation	$318,499.43
Less deductible	(39,405.92)
Projected FY90 Allowable claims	$280,093.51

Allowable claims X Benefit Payment

$280,093.51 X 50% =	$140,046.76	(current law)
$280,093.51 X 80% =	$224,074.81	(proposed law)
Difference	$ 84,028.05	(increase due to proposed law)

FY 1990-91

Projected FY90 charges less reductions	$318,499.43
X 15% inflation	47,774.91
Projected charges with inflation	$366,274.34
Less deductible	(39,405.92)
Projected FY91 Allowable claims	$327,868.42

Allowable claims X Benefit Payment

$327,868.42 X 50% =	$163,934.21	(current law)
$327,868.42 X 80% =	$262,294.74	(proposed law)
Difference	$ 98,360.53	(increase due to proposed law)

ASSUMPTIONS

1. This calculation includes costs for increasing benefit payments, at current claim level, from 50% to 80%.

2. A claims manager for an insurance company said mental health costs are rising 10-20% per year. The calculation was made assuming health care costs would rise 15% each year, and the 15% inflation factor was

added in before calculating increases in benefits from 50% to 80%.

3. Fiscal year 1987-88 actual costs were used to project future costs assuming the number of claims would remain constant.

4. We assumed the deductible amount would remain stable.

ADDITIONAL COSTS

Senate Bill 182 raises thresholds for maximum benefits in the following areas:

1. Inpatient benefits-the bill would raise aggregate maximum benefits for alcohol and drug addiction from $4,000 to $6,000 for any 24 month period. This would include basic inpatient expense policies and major medical policies.

2. Outpatient benefits-the bill would raise aggregate maximum benefits for mental illness, alcoholism, and drug addiction during a benefit period from $1,000 to $2,000.

These increased threshold amounts could increase costs for the University System health plan, but we are not able to estimate a dollar impact.

Amending the definition of "mental illness" to encompass all disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association could have a dollar impact. It appears this change in definition expands coverage of illnesses beyond those illnesses which the University System health plan currently covers. As a result, there could be significant increased costs.

The calculation on page 1 assumes caseload for mental illness benefits would remain the same. According to a claims manager from an insurance company we contacted, caseload would probably increase due to increased benefits. In other states, when group insurance plans have increased mental health benefits to the same level as physical illnesses (as in SB 182), mental health costs have almost doubled. An increase in caseload, due to expanded coverage and/or increased benefits could significantly affect costs for the University System health plan.

For example, current caseload data from the University System health plan indicates there were 4855 claims for mental health benefits in fiscal year 1987-88. Using the projected benefits payments (at 80%, with inflation included) as calculated on page 1, average payment

for benefits in fiscal year 1989-90 would be $46 ($224,074.81/4855), at current caseload level. The following chart shows projected benefit payments if caseload increases by various levels.

PROJECTED EXPENDITURES WITH CASELOAD INCREASE
FISCAL YEAR 1989-90

Caseload % Increases	Current Caseload	Projected Caseload	Average Payment	Projected Expenditure	Current Law	Increase Due to Proposed Law
10%	4855	5340	$46	$245,663	$140,046	$105,617
20%	4855	5826	46	267,996	140,046	127,950
30%	4855	6311	46	290,329	140,046	150,283
40%	4855	6797	46	312,662	140,046	172,616
50%	4855	7282	46	334,995	140,046	194,949
60%	4855	7768	46	357,328	140,046	217,282
70%	4855	8254	46	379,684	140,046	239,638
80%	4855	8739	46	401,994	140,046	261,948
90%	4855	9224	46	424,304	140,046	284,258
100%	4855	9710	46	446,660	140,046	306,614

v/u71r.mem

3/20/89

Axes I and II Categories and Codes

All official DSM-III-R codes are included in ICD-9-CM. Codes followed by a * are used for more than one DSM-III-R diagnosis or subtype in order to maintain compatibility with ICD-9-CM.

A long dash following a diagnostic term indicates the need for a fifth digit subtype or other qualifying term.

The term *specify* following the name of some diagnostic categories indicates qualifying terms that clinicians may wish to add in parentheses after the name of the disorder.

NOS = Not Otherwise Specified

The current severity of a disorder may be specified after the diagnosis as:

mild / moderate / severe — currently meets diagnostic criteria

in partial remission (or residual state)
in complete remission

DISORDERS USUALLY FIRST EVIDENT IN INFANCY, CHILDHOOD, OR ADOLESCENCE

DEVELOPMENTAL DISORDERS
Note: These are coded on Axis II.

Mental Retardation
317.00 Mild mental retardation
318.00 Moderate mental retardation
318.10 Severe mental retardation
318.20 Profound mental retardation
319.00 Unspecified mental retardation

Pervasive Developmental Disorders
299.00 Autistic disorder
Specify if childhood onset
299.80 Pervasive developmental disorder NOS

Specific Developmental Disorders
Academic skills disorders
315.10 Developmental arithmetic disorder
315.80 Developmental expressive writing disorder
315.00 Developmental reading disorder
Language and speech disorders
315.39 Developmental articulation disorder
315.31* Developmental expressive language disorder
315.31* Developmental receptive language disorder
Motor skills disorder
315.40 Developmental coordination disorder
315.90* Specific developmental disorder NOS

Other Developmental Disorders
315.90* Developmental disorder NOS

Disruptive Behavior Disorders
314.01 Attention-deficit hyperactivity disorder
Conduct disorder,
312.20 group type
312.00 solitary aggressive type
312.90 undifferentiated type
313.81 Oppositional defiant disorder

Anxiety Disorders of Childhood or Adolescence
309.21 Separation anxiety disorder
313.21 Avoidant disorder of childhood or adolescence
313.00 Overanxious disorder

Eating Disorders
307.10 Anorexia nervosa
307.51 Bulimia nervosa
307.52 Pica
307.53 Rumination disorder of infancy
307.50 Eating disorder NOS

Gender Identity Disorders
302.60 Gender identity disorder of childhood
302.50 Transsexualism
Specify sexual history: asexual, homosexual, heterosexual, unspecified
302.85* Gender identity disorder of adolescence or adulthood, nontranssexual type
Specify sexual history: asexual, homosexual, heterosexual, unspecified
302.85* Gender identity disorder NOS

Tic Disorders
307.23 Tourette's disorder
307.22 Chronic motor or vocal tic disorder
307.21 Transient tic disorder
Specify: single episode or recurrent
307.20 Tic disorder NOS

Elimination Disorders
307.70 Functional encopresis
Specify: primary or secondary type
307.60 Functional enuresis
Specify: primary or secondary type
Specify: nocturnal only, diurnal only, nocturnal and diurnal

Speech Disorders Not Elsewhere Classified
307.00* Cluttering
307.00* Stuttering

Other Disorders of Infancy, Childhood, or Adolescence
313.23 Elective mutism
313.82 Identity disorder
313.89 Reactive attachment disorder of infancy or early childhood
307.30 Stereotypy habit disorder
314.00 Undifferentiated attention-deficit disorder

ORGANIC MENTAL DISORDERS

Dementias Arising in the Senium and Presenium
Primary degenerative dementia of the Alzheimer type, senile onset
290.30 with delirium
290.20 with delusions
290.21 with depression
290.00* uncomplicated
(Note: code 331.00 Alzheimer's disease on Axis III)

Code in fifth digit: 1 = with delirium, 2 = with delusions, 3 = with depression, 0* = uncomplicated.
290.1x Primary degenerative dementia of the Alzheimer type, presenile onset, ________
(Note: code 331.00 Alzheimer's disease on Axis III)
290.4x Multi-infarct dementia, ________
290.00* Senile dementia NOS
Specify etiology on Axis III if known
290.10* Presenile dementia NOS
Specify etiology on Axis III if known (e.g., Pick's disease, Jakob-Creutzfeldt disease)

Psychoactive Substance-Induced Organic Mental Disorders
Alcohol
303.00 intoxication
291.40 idiosyncratic intoxication
291.80 Uncomplicated alcohol withdrawal
291.00 withdrawal delirium
291.30 hallucinosis
291.10 amnestic disorder
291.[illegible]0 Dementia associated with alcoholism
Amphetamine or similarly acting sympathomimetic
305.70* intoxication
292.00* withdrawal
292.81* delirium
292.11* delusional disorder
Caffeine
305.90* intoxication
292.84* mood disorder
292.89* Posthallucinogen perception disorder
Inhalant
305.90* intoxication
Nicotine
292.00* withdrawal
Opioid
305.50* intoxication
292.00* withdrawal
Phencyclidine (PCP) or similarly acting arylcyclohexylamine
305.90* intoxication
292.81* delirium
292.11* delusional disorder
292.84* mood disorder
292.90* organic mental disorder NOS
Sedative, hypnotic, or anxiolytic
305.40* intoxication
292.00* Uncomplicated sedative, hypnotic, or anxiolytic withdrawal
292.00* withdrawal delirium
292.83* amnestic disorder
Other or unspecified psychoactive substance
305.90* intoxication
292.00* withdrawal
292.81* delirium
292.82* dementia
292.83* amnestic disorder
292.11* delusional disorder
292.12 hallucinosis
292.84* mood disorder
292.89* anxiety disorder
292.89* personality disorder
292.90* organic mental disorder NOS

Organic Mental Disorders associated with Axis III physical disorders or conditions, or whose etiology is unknown.
293.00 Delirium
294.10 Dementia
294.00 Amnestic disorder
293.81 Organic delusional disorder
293.82 Organic hallucinosis
293.83 Organic mood disorder
Specify: manic, depressed, mixed
294.80* Organic anxiety disorder
310.10 Organic personality disorder
Specify if explosive type
294.80* Organic mental disorder NOS

PSYCHOACTIVE SUBSTANCE USE DISORDERS

Alcohol
303.90 dependence
305.00 abuse
Amphetamine or similarly acting sympathomimetic
304.40 dependence
305.70* abuse
Cannabis
304.30 dependence
305.20* abuse
Cocaine
304.20 dependence
305.60* abuse
Hallucinogen
304.50* dependence
305.30* abuse
Inhalant
304.60 dependence
305.90* abuse
Nicotine
305.10 dependence
Opioid
304.00 dependence
305.50* abuse
Phencyclidine (PCP) or similarly acting arylcyclohexylamine
304.50* dependence
305.90* abuse
Sedative, hypnotic, or anxiolytic
304.10 dependence
305.40* abuse
304.90* Polysubstance dependence
304.90* Psychoactive substance dependence NOS
305.90* Psychoactive substance abuse NOS

SCHIZOPHRENIA

Code in fifth digit: 1 = subchronic, 2 = chronic, 3 = subchronic with acute exacerbation, 4 = chronic with acute exacerbation, 5 = in remission, 0 = unspecified.

Schizophrenia
295.2x catatonic, ________
295.1x disorganized, ________
295.3x paranoid, ________
Specify if stable type
295.9x undifferentiated, ________
295.6x residual, ________
Specify if late onset

DELUSIONAL (PARANOID) DISORDER

297.10 Delusional (Paranoid) disorder
Specify type: erotomanic, grandiose, jealous, persecutory, somatic, unspecified

PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED

298.80 Brief reactive psychosis
295.40 Schizophreniform disorder
Specify: without good prognostic features or with good prognostic features
295.70 Schizoaffective disorder
Specify: bipolar type or depressive type
297.30 Induced psychotic disorder
298.90 Psychotic disorder NOS (Atypical psychosis)

MOOD DISORDERS

Code current state of Major Depression and Bipolar Disorder in fifth digit:
1 = mild
2 = moderate
3 = severe, without psychotic features
4 = with psychotic features (*specify* mood-congruent or mood-incongruent)
5 = in partial remission
6 = in full remission
0 = unspecified

For major depressive episodes, *specify* if chronic and *specify* if melancholic type.

For Bipolar Disorder, Bipolar Disorder NOS, Recurrent Major Depression, and Depressive Disorder NOS, *specify* if seasonal pattern.

Bipolar Disorders
Bipolar disorder
296.6x mixed, ________
296.4x manic, ________
296.5x depressed, ________
301.13 Cyclothymia
296.70 Bipolar disorder NOS

Depressive Disorders
Major Depression
296.2x single episode, ________
296.3x recurrent, ________
300.40 Dysthymia (or Depressive neurosis)
Specify: primary or secondary type
Specify: early or late onset
311.00 Depressive disorder NOS

ANXIETY DISORDERS (or Anxiety and Phobic Neuroses)

Panic disorder
300.21 with agoraphobia
Specify current severity of agoraphobic avoidance
Specify current severity of panic attacks
300.01 without agoraphobia
Specify current severity of panic attacks
300.22 Agoraphobia without history of panic disorder
Specify with or without limited symptom attacks

SOMATOFORM DISORDERS

300.70* Body dysmorphic disorder
300.11 Conversion disorder (or Hysterical neurosis, conversion type)
Specify: single episode or recurrent
300.70* Hypochondriasis (or Hypochondriacal neurosis)
300.81 Somatization disorder
307.80 Somatoform pain disorder
300.70* Undifferentiated somatoform disorder
300.70* Somatoform disorder NOS

DISSOCIATIVE DISORDERS (or Hysterical Neuroses, Dissociative Type)

300.14 Multiple personality disorder
300.13 Psychogenic fugue
300.12 Psychogenic amnesia
300.60 Depersonalization disorder (or Depersonalization neurosis)
300.15 Dissociative disorder NOS

SEXUAL DISORDERS

Paraphilias
302.40 Exhibitionism
302.81 Fetishism
302.89 Frotteurism
302.20 Pedophilia
Specify: same sex, opposite sex, same and opposite sex
Specify if limited to incest
Specify: exclusive type or nonexclusive type
302.83 Sexual masochism
302.84 Sexual sadism
302.30 Transvestic fetishism
302.82 Voyeurism
302.90* Paraphilia NOS

Sexual Dysfunctions
Specify: psychogenic only, or psychogenic and biogenic (Note: If biogenic only, code on Axis III)
Specify: lifelong or acquired
Specify: generalized or situational
Sexual desire disorders
302.71 Hypoactive sexual desire disorder
302.79 Sexual aversion disorder
Sexual arousal disorders
302.72* Female sexual arousal disorder
302.72* Male erectile disorder
Orgasm disorders
302.73 Inhibited female orgasm
302.74 Inhibited male orgasm
302.75 Premature ejaculation
Sexual pain disorders
302.76 Dyspareunia
306.51 Vaginismus
302.70 Sexual dysfunction NOS

Other Sexual Disorders
302.90* Sexual disorder NOS

SLEEP DISORDERS

Dyssomnias
Insomnia disorder
307.42* related to another mental disorder (nonorganic)
780.50* related to known organic factor
307.42* Primary insomnia
Hypersomnia disorder
307.44 related to another mental disorder (nonorganic)
780.50* related to a known organic factor
780.54 Primary hypersomnia
307.45 Sleep-wake schedule disorder
Specify: advanced or delayed phase type, disorganized type, frequently changing type
Other dyssomnias
307.40* Dyssomnia NOS

Parasomnias
307.47 Dream anxiety disorder (Nightmare disorder)
307.46* Sleep terror disorder
307.46* Sleepwalking disorder
307.40* Parasomnia NOS

FACTITIOUS DISORDERS

Factitious disorder
301.51 with physical symptoms
300.16 with psychological symptoms
300.19 Factitious disorder NOS

IMPULSE CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED

312.34 Intermittent explosive disorder
312.32 Kleptomania
312.31 Pathological gambling
312.33 Pyromania
312.39* Trichotillomania
312.39* Impulse control disorder NOS

ADJUSTMENT DISORDER

Adjustment disorder
309.24 with anxious mood
309.00 with depressed mood
309.30 with disturbance of conduct
309.40 with mixed disturbance of emotions and conduct
309.28 with mixed emotional features
309.82 with physical complaints
309.83 with withdrawal
309.23 with work (or academic) inhibition
309.90 Adjustment disorder NOS

PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION

316.00 Psychological factors affecting physical condition
Specify physical condition on Axis III

PERSONALITY DISORDERS
Note: These are coded on Axis II.

Cluster A
301.00 Paranoid
301.20 Schizoid
301.22 Schizotypal

Cluster B
301.70 Antisocial
301.83 Borderline
301.50 Histrionic
301.81 Narcissistic

Cluster C
301.82 Avoidant
301.60 Dependent
301.40 Obsessive compulsive
301.84 Passive aggressive
301.90 Personality disorder NOS

V CODES FOR CONDITIONS NOT ATTRIBUTABLE TO A MENTAL DISORDER THAT ARE A FOCUS OF ATTENTION OR TREATMENT

V62.30 Academic problem
V71.01 Adult antisocial behavior

V40.00 Borderline intellectual functioning (Note: This is coded on Axis II.)

V71.02 Childhood or adolescent antisocial behavior
V65.20 Malingering
V61.10 Marital problem
V15.81 Noncompliance with medical treatment
V62.20 Occupational problem
V61.20 Parent-child problem
V62.81 Other interpersonal problem
V61.80 Other specified family circumstances
V62.89 Phase of life problem or other life circumstance problem
V62.82 Uncomplicated bereavement

ADDITIONAL CODES

300.90 Unspecified mental disorder (nonpsychotic)
V71.09* No diagnosis or condition on Axis I
799.90* Diagnosis or condition deferred on Axis I

V71.09* No diagnosis or condition on Axis II
799.90* Diagnosis or condition deferred on Axis II

MULTIAXIAL SYSTEM

Axis I Clinical Syndromes
V Codes

F4
S/B 182
3/20/89

Health Insurance

STATE-MANDATED COVERAGES ADD TO COSTS, MAKE POLICIES UNAFFORDABLE BY UNINSURED

A major reason so many people lack health insurance in the United States is that state-mandated health coverages are increasing the costs of insurance and pricing millions of people out of the health insurance market, according to a study by the National Center for Policy Analysis.

John C. Goodman, president of NCPA, a public policy research organization based in Dallas, Texas; and Gerald L. Musgrave, president of Economics America Inc., a consulting firm in Ann Arbor, Mich., are authors of the study.

Using an econometric model of the health insurance marketplace, the authors estimated that as many as one out of every four uninsured people lack health insurance coverage because state laws mandating specific coverages have increased the price of health insurance. This means up to 9.3 million people lack health coverage because of current government policies, the authors said.

The model produces statistical estimates of the factors causing people to be without health insurance. Although certain information about the market for health insurance is not available to researchers, the model explains 94 percent of the variation in the percent of the U.S. population without health insurance, according to the authors.

The study defines mandated health insurance benefit laws as state laws that require health insurance policies to cover specific diseases and specific health care services. There has been an explosion of these laws—the number has grown from 30 laws in 1970 to 686 such laws in 1988, the study said. Collectively, these state mandates have made no-frills insurance at reasonable rates unavailable to individuals, the study said.

Freedom Of Choice

Freedom of choice in health insurance—being able to buy a policy tailored to individual and family needs—is rapidly vanishing from the health insurance marketplace, the authors concluded.

The number of mandated health insurance benefit laws varies considerably by state—from a low of four in Delaware to a high of 32 in Maryland, the study found. States where mandates are having the greatest impact include Connecticut, Maryland, and Minnesota—where people who lack coverage because of state mandates exceeds 60 percent of the uninsured, according to the model's estimates.

For example, the study said 37 states require health insurance coverage for the services of chiropractors, three states mandate coverage for acupuncture, 13 states limit the ability of insurers to avoid covering people who have acquired immune deficiency syndrome or are at high risk for getting AIDS, 40 states mandate coverage for alcoholism, 20 states mandate coverage for drug addiction, and 30 states require coverage for mental illness. Additionally, five states mandate coverage for in vitro fertilization.

As a result of special interest lobbies that represent virtually every disease and disability, and important group of health care providers, the health insurance marketplace is being shaped and molded by political pressures, rather than by competition and consumer choice in a free market, the authors stated.

Self-Insured Plans

Almost all large employers and probably a majority of medium-sized employers have turned to self-insured health benefit plans, according to the authors. While one reason is that companies are better able to manage their own health care costs, the most important reason may be that employers with self-insured health plans have the freedom to bypass state mandates and to provide insurance tailored to the wants and needs of their employees, the study said.

The burden of state-mandated health insurance benefit laws falls heavily on employees of small firms and on people who purchase individual and family policies because many employers and individuals are exempt from the state laws. Under federal law, companies with self-insured health care plans are exempted from state mandates. Plans covering federal employees, the Medicare program, and many state government employee health plans and Medicaid programs also are exempt from the state mandates, the study said.

The study discusses the Massachusetts' universal health insurance law—which, beginning in 1992, will require the state's employers to pay a payroll tax of 12 percent on each employee's first $14,000 of wages, but would allow them to deduct the cost of employer-provided health insurance from the tax.

The law will force employers to spend (either in taxes or on health insurance) $840 for an employee earning $7,000 per year and $1,680 for employees earning $14,000 or more per year. These amounts are considerably lower than the expected premiums for individual and family policies, according to the authors.

Under Massachusetts' universal health care system, strong incentives will exist for employers to choose to pay the optional tax and turn the obligation of providing health insurance over to the government, the study said.

The state will offer a health insurance policy to all uninsured residents with subsidies for low-income people. However, because people will not be obligated to purchase the state's health insurance policy, it seems likely that the number of uninsured people will rise, instead of decrease, according to the authors.

In the 100th Congress, Sen. Edward Kennedy (D-Mass) introduced a bill to require employers to provide a specific package of health insurance benefits to employees (S 1265).

It differs from the Massachusetts plan because the cost of the health insurance would be determined by the market, and it would not allow workers to be without coverage, the authors stated. Since the required package of benefits is more generous than policies provided by most employers, the cost of the Kennedy proposal for private industry is much higher than for the Massachusetts plan, they added.

While the Kennedy proposal would override all state mandated benefit laws, the effect of this would be offset by the fact that special interest groups would turn their lobbying efforts from the state to the federal level, they further maintained, suggesting that if a federal health insurance law were enacted, costs would eventually increase as the initial package of benefits was expanded.

Copies of the study, *Freedom of Choice in Health Insurance* (NCPA Policy Report No. 134), are available for $10 each from NCPA, 7701 N. Stemmons, Suite 800, Dallas, Texas 75247; telephone (214 951-0306. □

PART THREE
STATE MANDATED BENEFITS

State governments are already familiar with the issue of mandated benefits, particularly for health insurance coverage. Every state in recent years has enacted legislation requiring either that specific diseases or treatments be covered or that specific health care providers be allowed to receive reimbursement.

State mandates have not extended, however, to businesses that self-fund their health insurance plans because of federal preemption under the Employee Retirement Income Security Act. As the number of mandates increase, it appears that more employers self-fund. The trend toward self-insuring is particularly evident in medium to large companies. Seventy percent of employers with a work force from 10,000 to 19,999 employees maintain self-insured health plans; as do 85 percent of employers with more than 40,000 employees.

At the state level, about 645 mandated health care provisions are in effect today, a majority of which have been enacted since 1980. However, proposals for mandates are now facing tougher scrutiny in state legislatures. The year 1986 saw the fewest number of state-enacted mandates (26) since 1972.

Part Three provides a review of state activity pertaining to mandated benefits. Greg Scandlen explains in chapter IX why mandated benefits suddenly have become a major concern in the business community. In an article that appeared in the June 1987 EBRI *Employee Benefit Notes*, Scandlen points to two major developments that have led to the current focus on the issue: the June 1985 Supreme Court decision in *Metropolitan Life Insurance Company v. the Commonwealth of Massachusetts*, which had the effect of leaving insured health plans still subject to state mandates; and the enactment of the 1985 Consolidated Omnibus Budget Reconciliation Act, which required continuation of health care coverage for terminated workers and dependents whether they are covered by self-funded or insured plans.

Scandlen describes four categories of mandated coverage laws: benefits, provider, continuation/conversion, and dependents. Since the expansion of all four categories must increase costs, Scandlen argues, the question that must be answered is whether the social need justifies the potential cost. Since state legislatures are increasingly asking that

question, Scandlen predicts that future proposals for mandates at the state level are less likely to be enacted.

In chapter X, Linda L. Lanam describes the types of mandates that states have recently adopted, noting as an example that 45 states now require newborn care to be included in both group and individual health insurance policies.

Pressures for mandates are difficult for state legislators to resist, Lanam says, partially because interest groups try to portray the proposed benefits as having little cost or even as helping to reduce costs. Lanam contends, however, that increasing the number of benefits available for reimbursement cannot help reduce total health care costs unless the new benefits are a substitute for other benefits.

State cost-containment efforts are leading, Lanam adds, to efforts to evaluate new mandated-benefit proposals more cautiously.

Next, we turn in chapter XI to an examination of a 1984 law enacted in the state of Washington that requires a review process before passage of mandated third-party benefits. A senior staff member of a Washington State legislative committee, John B. Welsh, Jr., explains the state law, which requires an assessment of the social and financial impacts of the proposed coverage on the basis of 12 guidelines or questions. A mandated coverage proposal must also be analyzed by the State Health Coordinating Council. Such a review, Welsh suggests, puts the burden of proof on those proposing the mandated coverage.

The legislature and a governor's task force recommended the legislation, Welsh explains, because they saw that interest groups would continue to petition for additional mandates, and those mandates would increase rather than help control health care costs. Although the requirement for the State Health Coordinating Council review was added to the law in 1987 and is not yet in effect, Welsh says that since 1983 groups proposing mandated benefits have had difficulty justifying the recommendations to the legislature.

IX. The Changing Environment of Mandated Benefits*

PAPER BY GREG SCANDLEN

Over the past year there has been a meteoric rise in concern by employer and business organizations over the topic of mandated employer-paid health benefits.

- The Employee Benefit Research Institute (EBRI) in late 1985 began planning for a day-long policy forum on mandated benefits held in April 1987.
- The White House Conference on Small Business has named elimination of mandated benefits as the second most important priority out of 60 recommendations sent to the president in November 1986.
- The National Association of Manufacturers, in conjunction with the Washington Business Group on Health, made mandated benefits a primary topic at their third annual Health Agenda Conference in January 1987.
- The National Chamber Foundation commissioned a major study for 1987 of mandated benefits and mental health and substance abuse benefits.
- The National Federation of Independent Business has become increasingly concerned about mandates, devoting most of one newsletter edition to it and lobbying vigorously against certain mandated proposals.

Two events have sparked this sudden increase of interest over an issue that has existed for over 20 years.

Supreme Court Decision

First was the U.S. Supreme Court Decision *Metropolitan Life Insurance Company v. the Commonwealth of Massachusetts*, June 3, 1985. This decision dashed the hopes of many in the business community that the Employee Retirement Income Security Act meant what it said when it preempted state laws relating to employee benefits plans—that the content of such a plan could not be regulated by the states. Unfortunately for those in the business community, the Court placed more emphasis on the "saving clause" which allowed the states to continue to regulate insurance, while prohibiting them from regu-

* Editor's note: The following article appeared in the June 1987 *Employee Benefit Notes*.

lating employee benefits plans. The upshot of this decision is that insured health benefits would remain subject to state mandates, while self-funded health benefits would not.

Enactment of COBRA

The second event was enactment of the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1985, with its federal continuation-of-coverage mandate. Unlike previous state mandates on the same topic, the federal mandate made no exception for self-funded health benefits, but included all health programs. Buried in a congressional omnibus budget bill [now P.L. 99-272], this provision did not cause a great stir until after it became law and employers were faced with first trying to understand it, and then with trying to comply with it. Employers demanded to know how this was allowed to happen. And their Washington representatives have answered: "Never again."

It is ironic that this heightened awareness is coming at a time when the popularity of mandating health insurance benefits appears to be tapering off at the state level. In fact, in 1986, there were fewer mandate laws enacted by the states (26) than any year since 1972, when only six were enacted. Several states have passed legislation to require that mandating proposals be subject to an objective evaluation. It remains to be seen how effective these evaluations, based on the social and financial impact of the new benefits, will be. But the fact that they have become law indicates a new skepticism on the part of state legislatures.

Categories of Mandated Benefit Laws

Mandated coverage laws fall into four categories roughly equivalent to "who, what, when, and where." These may be explained as follows:

Benefits (what)—These mandates expand the kind of services covered under a health insurance contract. Examples would be alcoholism treatment or in vitro fertilization.

Provider (where)—These expand the numbers and types of providers eligible to perform and be reimbursed for the covered services. Examples are requirements that birthing centers be covered as are hospital maternity units, or that social workers be reimbursed for covered services that are within the scope of their license.

Continuation/Conversion (when)—These expand the length of time the coverage will be in effect. Like COBRA, these may require that a worker may continue participating in the group contract for a certain period after termination.

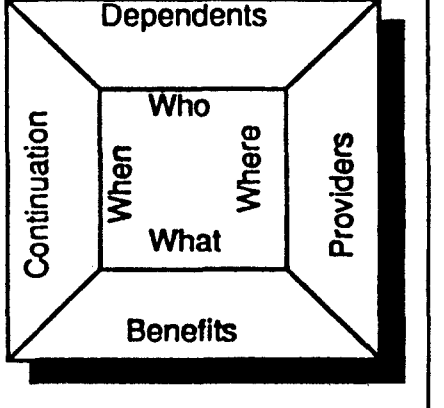
Dependents (who)—Not always applicable to actual dependents, these mandates expand the numbers of people to be covered under a contract. Typically, these may be applied to handicapped children upon reaching the age of majority or to adopted children and newborns.

Like a square balloon (chart IX.1), these four kinds of mandates result in an exponential enlargement of the exposure to risk for a health insurance contract.

The actual increase in claims cost is the subject of vitriolic debate. Insurance companies and employer groups maintain the costs of mandates are high and getting higher. Providers and advocates for certain disease victims argue that the costs are not high, and that in any event, the money spent on one service is offset by eventual savings in the cost of traditional services.

Whatever the actual cost in terms of claims submitted, there can be little doubt that if one expands the services covered, *and* the number of people providing the services, *and* the number of people receiving the services, *and* the length of time in which they are eligible to receive them, the exposure to cost increases *must* be large.

CHART IX.1
The Square Balloon of Mandated Coverage Laws



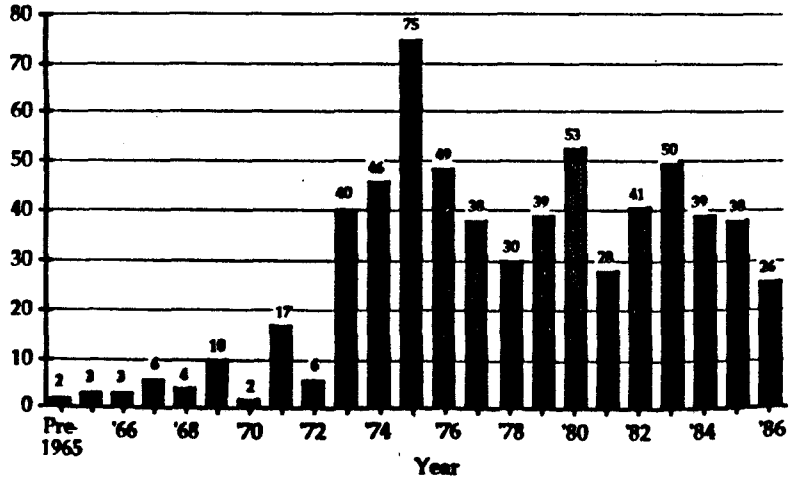
Social Need Versus Potential Cost

The argument then becomes a question of whether the social need justifies the potential cost—precisely the question that increasing numbers of state legislatures are asking. Indeed, the most recent trends with respect to mandates in the states, have been a slowing down of further enactments, and interest in developing objective criteria to measure the social and financial impact of new mandates.

Chart IX.2 illustrates the number of mandates enacted by all the states for each year since 1965. Prior to 1965, only two such laws existed. 1975 was the peak year, with 75 mandated coverage laws being enacted in that year alone. In 1986, only 26 new laws were enacted—fewer than any year since 1972.

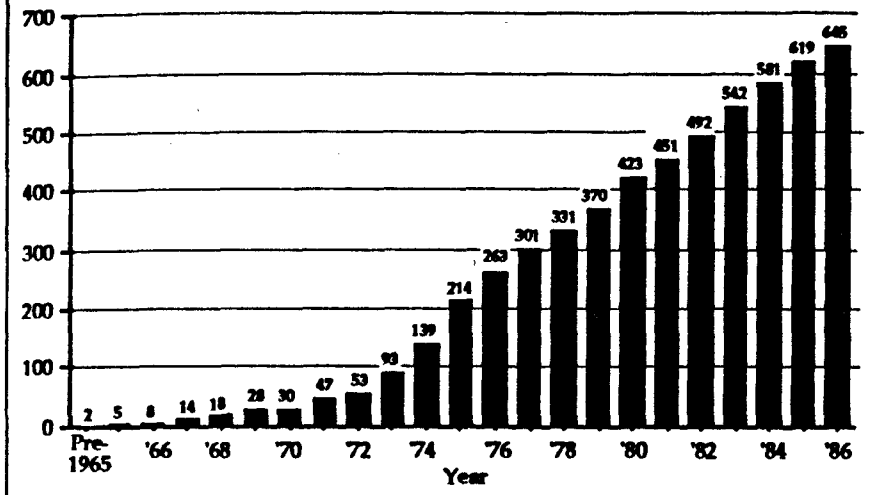
The chart is remarkably similar to the traditional product life cycle as taught in basic marketing courses. There is an introduction period (1965–1970) in which the product is just becoming known; a market acceptance period (1971–1975) characterized by a large growth in "sales;" a maturity period (1976–1983) in which sales level off; and a period of decline (1984–1986) in which the market has become saturated and new customers are hard to find. This type of cycle

CHART IX.2
Number of Health Mandates Enacted by 50 States Each Year Since 1965



Source: Blue Cross and Blue Shield Association

CHART IX.3
Cumulative Number of Health Mandates Enacted by 50 States Each Year Since 1965



Source: Blue Cross and Blue Shield Association

applies to everything from Hula Hoops and Wacky Wall Walkers to video cassette recorders and compact discs. Unfortunately, unlike Wacky Wall Walkers, when the "customers" become bored with these products (state mandates) they cannot toss them in the back of the closet. They are laws and continue as laws until they are repealed. Thus we get a situation like that demonstrated in chart IX.3, which shows the aggregate number of mandating laws throughout the country. The total has climbed from two prior to 1965 to 645 at the end of 1986.

It remains to be seen whether the decline in mandates will continue. It is possible there could be a resurgence as there has been in other years. In fact, during 1987 there have been as many or more mandate bills introduced as other years. The 70th session of the Texas legislature, for instance, is considering 36 separate pieces of legislation mandating some form of expanded coverage on employer-based health insurance.

There are numerous reasons, however, for believing these bills will not be successful.

The Future of State Mandated Benefit Proposals

- States appear to be less enamored of mandates than they used to be. One indicator is the decreasing numbers of laws enacted for three years in a row. More significant, however, may be the "mandate evaluation" laws enacted in six states and being considered by several others. These laws were inspired by criteria developed by the NAIC [National Association of Insurance Commissioners] in 1983 and recommended for adoption by state legislators and insurance commissioners. To date, Hawaii, Florida, Washington, Oregon, Arizona, and Pennsylvania have enacted some form of the criteria, which amount to a social and financial impact statement.

- The growth in self-funding and the concomitant escape from state regulation has made mandating benefits ever less effective in securing services for the general population. A recent Johnson & Higgins Health Group survey of more than 1,300 employers reported 46 percent were self-funding their health benefits (Johnson & Higgins. *Corporate Health Care Benefits Survey*. Princeton, New Jersey: Johnson & Higgins HealthGroup, 1986). The larger the group, the more likely they were to self fund. Seventy percent of the employers with 10,000–19,999 employees self-funded, as did 85 percent of those with more than 40,000 employees. [Nationally, 42 percent of health plan participants in medium and large establishments had all or part of their plans self-funded by their employers. See November 1986 *EBRI Issue Brief*]. Given the usual variation between states, there may be some states in which 70–75 percent of the population escapes mandated coverages. Thus, even the most desirable of mandates may have very little effect.

- Recognizing the diminished effect of state-level mandates and increasing resistance from state legislators, provider groups have begun turning to Congress to achieve their purposes. Congressional action has the very attractive advantage of one-stop shopping for lobbying new mandates. Not only will one law affect all 50 states, but one law will also cover all employer health plans, not just insured ones. Congress has a traditional reluctance to tamper with insurance issues, but like state legislators, members of Congress may be drawn to the possibility of achieving some social good without spending any taxpayer money. Mandates make that easy. If substance abuse is a national problem, congress can require that all employers provide benefits for the treatment of substance abuse. A noble purpose is served, without spending a penny of direct federal revenues.

Proponents of mandates like this approach so much that some have begun to believe they are wasting time attempting to enact mandates at the state level. This may be particularly true of certain patient advocacy organizations with limited budgets and national constituencies.

- The fourth reason state mandates are less likely to become law is the sudden interest by employers. The COBRA continuation law shocked employer organizations into heeding the threat posed by mandates, both to those still insured (at the state level) and to all employers providing health benefits (at the federal level). Suddenly, like minimum wage increases and unemployment compensation hikes, mandates have become a red flag for all employers. Business coalitions have been developing a marketplace model for health care throughout the country, and "let the market decide" is a slogan easily applied to mandates as well as to hospital rate-setting or cumbersome health planning regulations.

The primary arena for discussion of mandates has clearly shifted from the state to the federal level. It remains to be seen whether Congress will heed the lessons learned at the state level—that mandates never end. Once one is enacted, other provider groups are encouraged to seek more. Possibly the product life cycle will be replicated by Congress, until they, too, become saturated and decide to evaluate these proposals objectively. Meanwhile, however, employer and business groups are on the alert and will strive to dissuade Congress from continuing very far along this path.

X. Mandated Benefits—Who Is Protected?

PAPER BY LINDA L. LANAM

More than 600 state-mandated health benefits statutes exist today in various combinations across the 50 states, over 350 of them enacted since 1980. Every state has at least one mandated benefit and hundreds of new proposals are introduced in state legislatures each session. And yet, more than 30 years after the first one was enacted in Massachusetts, mandated benefits remain something of a mystery.

Proponents of mandates (whether of coverage to be provided or providers to be reimbursed) argue that they:

1. assure the general availability of at least a minimum level of health benefits to the insured population; and
2. encourage the inclusion of lower-cost health care providers within the health care delivery system.

Opponents of mandates contend that such statutes:

1. increase the overall cost of the health care system; and
2. encourage the growth of self-funded (and unregulated) health benefit programs.

Despite decades of debating, neither side has been particularly successful in substantiating their claims with any generally accepted data. As a result, much of this paper must be based on what are, hopefully, logical deductions rather than on desirable but unavailable statistical studies or other documentation of what purposes mandated benefits actually serve or what costs they really involve.

Political and Philosophical Problem for State Legislators

One thing that is relatively easily understood is why mandated benefits are so difficult to defeat in the legislative arena. Mandated benefits pose both a political and a philosophical problem for many state legislators. The purported goals of the supporters of each and every mandate appear to be in the public interest. The advocates, usually locally based, are increasingly well-organized and prepared for dealing with the technical aspects of the legislative process. The opponents are generally insurers, employers, and doctors—in other

words, "the establishment." They often lack a true state base or adequate local staff and time for consistent lobbying.

The proponents generally represent a single-issue group who may be prepared to promise or withhold votes on election day based on that issue. The opponents generally have a number of concerns that may be considered by the legislature in any one session and cannot deliver a significant voting block based on any one of them.

However, perhaps the biggest single force behind enactment of many of the state mandated benefits laws in existence today (and the federal ones tomorrow) is the perception that there is little or no cost connected to them. In the beginning, in fact, that was almost true. In the 1950s and 1960s as the economy grew, so did employee wage and benefit packages. No one individual increment was sufficient in and of itself to be a cause for alarm and so legislators (and labor negotiators) were lulled into a state of almost blissful ignorance. Mandated benefits were seen by many as a means to assure that employees without union-negotiated contracts and persons purchasing individual health insurance policies could obtain similar coverage.

Coverage and Provider Reimbursement

The growth of mandates in those early years occurred in both the areas of coverage—newborn baby care for example—and provider reimbursement—chiropractors and psychologists in particular. Today 45 states require that newborn care be included in both group and individual health insurance policies, 34 require payment to psychologists, and 26 require that chiropractors be reimbursed for covered services. In addition, the current availability of benefits and providers now ranges from *in vitro* fertilization in Maryland to acupuncturists in California.

Perhaps original momentum at the state level came from social policy considerations and a desire for something close to a risk-free society. However, in the decades of the 1970s and 1980s two things occurred that had an indelible impact on the development status of mandated benefits and the people they were intended to protect: (1) the Employee Retirement Income Security Act (ERISA) became law, and (2) the seemingly unending upward spiral of health care costs began to be recognized.

ERISA, enacted in 1974 as the culmination of an effort began under President John F. Kennedy to provide some form of comprehensive protection for participants in employee benefits plans, is generally thought of as a pension law. However, it also contains provisions

specifically dealing with "welfare benefit plans." Among those provisions is section 514, which provides in part that "the provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . except . . . nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." The result of this rather convoluted preemption combined with an exemption from preemption was to create the framework for distinctly different regulatory approaches to insured and self-funded employee benefit plans.

Transfer or Spread the Risks?

As a general rule, employers can either transfer the risks involved in making benefit payments or retain the risks and spread them over a large group of employees. If the decision is to transfer the risks, the two principal techniques are the purchase of group insurance or the use of a prepaid service program. Under a group insurance contract, the economies of a large volume of insureds serve to decrease administrative costs and agent commissions so that the premium charged to the employer-policyholder is less than that for equivalent individual insurance. The most common prepaid service plan is the health maintenance organization (HMO). However, other alternative delivery systems are developing which, like HMOs, can offer significant advantages over the conventional fee for service programs from the standpoint of utilization control and quality of service.

Employers may choose not to transfer the risk of loss associated with employee benefit payments but to either retain the risk or self-insure it. The relatively narrow distinction between these two approaches relates to whether or not an actual claims reserve is established to fund the future payment of benefits. Most such employer-established plans are self-insured, often with some form of reinsurance or stop-loss coverage as additional protection.

The 1985 Supreme Court decision in *Metropolitan Life Insurance Co. and Travelers Insurance Co. vs. Massachusetts* served to reinforce the fact that states have the power and prerogative to regulate the contents of the group insurance policies through which many employee health benefit plans are provided. Self-funded benefit plans, even those that are the subject of stop-loss or reinsurance coverage, are subject only to regulation under ERISA and cannot be made subject to such state regulation as mandated benefits or participation in state risk pools or guaranty associations. This discrepancy in reg-

ulation alone creates some incentive for employers to fund their own benefit plans. An additional incentive to self-funding is that of the buzz phrase of the early 1980s: "health care cost containment."

Cost containment, in fact, has had a wide-ranging impact on both the health care delivery and reimbursement systems, in both the public and private sectors, and at both the state and federal level. The efforts to gain some control over rising health care costs, which have been attempted in recent years, necessitate a relatively high degree of flexibility in benefit design, reimbursement patterns, and delivery systems to achieve real long-term success. Mandated benefits, in effect, freeze into place a set of benefits that will require legislation to alter and that may not be appropriate to today's, let alone tomorrow's conditions. The legislative process can be stimulated by a variety of factors and can achieve a variety of results, but the ability to respond quickly and appropriately is not generally characteristic of the process and certainly cannot be depended upon.

Impact on Cost Containment Efforts

One effect of the public pressure brought to bear regarding cost containment has been to cause a growing number of state legislatures to evaluate new mandate proposals more cautiously. The states of Washington, Arizona, and Oregon, for example, have adopted requirements for social and financial impact studies on all proposed mandated coverages. The Virginia legislature even passed a resolution placing itself in general opposition to all mandates. These actions may have somewhat slowed their success, but advocates of mandates have also adapted to the new cost-conscious environment. Arguments presented on behalf of such provider groups as nurses, psychiatric social workers, and such benefits as substance abuse treatment are couched in terms of savings, if not in health care costs then in terms of lower absenteeism or greater productivity. Supporters claim that costs are minimal on a per person basis or that the services or providers will actually reduce overall costs.

As an aside, I would point out that the cost of any benefit relates to two factors: price and frequency of utilization. Only when benefits are substituted is there likely to be any real savings. Adding benefits without qualification only increases the universe eligible for reimbursement and does little or nothing to reduce total health care costs. This the is the dilemma that faces state legislators—limit access or increase costs.

Most recently, "catastrophic coverage" has become the primary focus of the discussion about health care. Yet it was the earliest mandates, maternity and newborn coverage, continuation and conversion privileges, which were those that came closest to meeting the "new" goal of assuring the availability of health benefits intended to protect beneficiaries from losses due to gaps in or complete lack of coverage. Current state efforts to deal with the uninsurable population are concentrated in the area of adopting risk pools for those who cannot otherwise obtain private insurance and are not eligible for Medicaid, rather than enacting or evaluating proposed mandated benefits in light of their impact on the availability of private insurance coverage for the uninsured population. However, pool coverage may provide a new area for experimentation with mandates since it requires the availability of a set benefit package. Here any increase in costs could have an even more devastating impact than in standard insurance products because of the vulnerable population involved.

Both sides of the debate on mandated benefits can be said to be motivated by concern for the public interest. But it must be recognized that the concept of public interest is anything but a static one. In fact, there may be more than one public and their interests may, at times, be in direct conflict.

XI. Legislative Review of Third-Party Mandated Benefits and Offerings in the State of Washington

PAPER BY JOHN B. WELSH, JR.

Introduction

In 1984, the legislature of the state of Washington passed a "sunrise" law for reviewing legislative proposals for mandating third-party benefits prior to their enactment. The new law was occasioned by the introduction of a growing number of bills that would require insurance carriers, including health care service contractors such as Blue Cross and Blue Shield, and health maintenance organizations (HMOs), to include in all accident and sickness policies sold in the state some form of specific benefit or coverage. The trend toward mandating benefits in the 1970s, continuing unabated to date in virtually every state of the nation, has resulted in growing concerns about the cost ramifications of these mandates as well as the social utility of the benefits themselves.

The philosopher Santayana said it is more important to have some of the questions than all of the answers. On the subject of mandated benefits, or coverages as they are termed here, we do not pretend to have either all of the questions or all of the answers.

But we do have one answer at least, and a number of questions for the perennial bills are being introduced yearly that seek to mandate health coverage, or offer health coverage, by virtue of law.

The recent law[1] requires every person or organization seeking sponsorship of a legislative proposal that would require a mandated benefit to submit a report to the legislative committees of reference, assessing both social and financial impacts of the coverage according to 12 enumerated criteria. The mandated coverage proposal is then referred by the legislative committee to the State Health Coordinating Council for an independent review, analysis, and recommendation. The State Health Coordinating Council is an advisory body composed of a majority of consumers whose mission is to develop a biennial

[1] RCW 48.42.060–080

state health plan for assessing needs and guiding budgetary expenditures in the health area.

The history of the legislation goes back to 1983 when the governor appointed a health cost containment task force that initiated the idea in its report to the governor and legislature, recommending that the legislature conduct a systematic review of any proposed mandated health coverage under specified guidelines to determine whether the benefit is in the public interest. The state presently has about 14 such mandates.

Effect of Insurance

By way of introduction, I would like to touch briefly on the effect health care insurance has on health care costs in general, of which mandated benefits are but a part.

Most families in the United States today have insurance, either through commercial insurers, HMOs, or health care service contractors (Blue Cross and Blue Shield). In the state of Washington, 80 percent of the population are covered by HMOs and "the Blues."

One often-cited reason for the increase in health care costs is the widespread reliance on insurance as a way of financing and prepaying health expenditures. About half of consumer health expenditures are paid through public and private insurance. There is general agreement that reliance on health insurance encourages the use of health services, and health insurance shields both patients and providers from the awareness of costs.

There are strong indications that the fee-for-service form of reimbursement, which is the most prominent system for reimbursing health providers, creates incentives for health practitioners to increase both the price and volume of services. It reimburses the provider for each service rendered: the more services that are provided, the higher the reimbursement. In addition, as insured patients are not paying the cost, they are not likely to question the number of services or the cost. On the contrary, they may prefer, even demand the maximum in available services. Consequently, the fee-for-service system has not encouraged efficiency or provided appropriate incentives to restrain increases in the costs of health care.

The health provider's role consists of a number of elements: technical, professional, and entrepreneurial. These elements vary between physicians and other practitioners depending on their practice setting, style, and associated economic incentives. Due to the significant control physicians and other health providers have over the medical

care process, and the lack of incentives inherent in the fee-for-service system for controlling the utilization of services, the entrepreneurial element has been a major factor in health cost inflation.

Physicians generate about 70 percent of all health care expenditures. The fees of physicians and other health providers make up 22 percent of the health care dollar and hospitals almost 50 percent.

Mandating coverage of health benefits provided by health insurers has exacerbated the problem, because these increased benefits will be reimbursed largely through fee-for-service, and control over their utilization is minimal. Copayments and deductibles may abate some of the problem, however, as the insured patient is at risk for some of the costs of care.

Rationale for Mandated Coverages

Constitutionally, the legislature may indeed interfere with contractual relationships with insurance carriers by mandating benefits consistent with its authority to regulate insurance. There never has been a successful legal challenge to these mandates, as courts will rely on legislative findings of what constitutes the best interests of public health, welfare, and safety. Beyond the question of whether lawmakers can interfere in the health insurance marketplace, there remains the open question of whether they should.

In consideration of the legislation, both the legislature and governor's task force were motivated to act principally for two reasons:

1) interest groups will continue to petition the legislature for additional mandates; and

2) these mandates may be cost inflating, rather than cost containing and provide little benefit to the public.

The factors that underlie the efforts to mandate are numerous and varied, but let me mention six principal reasons why we see mandated-coverage proposals:

1) Incomplete health insurance coverage—access to health insurance for a given condition may be difficult to find for a person with a special need.

2) Expanding definitions of health care and new services and treatments because of the new technology.

3) Anti-physician sentiment—physicians are the core of the health care delivery system, but the medical establishment is seen by many as too monopolistic and overpaid; and physicians are getting competition from other nonmainstream health providers.

4) Expansion of the number and types of health practitioners—there are today 142 separate health-related professions with 240 occupational job classifications.

5) Changing values and expectations of society—health care is increasingly considered a right these days without which those of "life, liberty, and the pursuit of happiness" could not exist.

6) Perceived discrimination against certain practitioners by the "established" professions, e.g., naturopaths, chiropractors, acupuncturists, midwives, and other nonmainstream professions.

There are generally three distinct types of mandated coverage proposals, depending on who is proposing them:

1) Those that are provider generated—this is by far the most numerous. Health provider groups want to get coverage to increase their clientele, to assure a steady flow of fees.

2) Those that provide coverage for a very limited number of people, e.g., reconstructive breast surgery resulting from mastectomies, newborn infants with congenital anomalies, etc.

3) Those that attempt to use insurance to address social problems as a means of increasing access of people to health care services, such as alcoholism and mental health benefits.

Problems

Despite the motives for mandating health coverages, there are a number of problems associated with these coverages. An Oregon study concluded that mandated coverages account for about 3 percent of total health care expenditures.[2] That is not insignificant, though, when we consider that health expenditures are fast approaching 12 percent of the gross national product, and are outstripping inflation threefold. In effect, however, cost impacts of different mandates do vary considerably. The largest fiscal impacts are those related to large-scale services: obstetrical care, newborn infant care, mental health, and alcoholism.

Coverage by insurance tends to increase utilization of particular services, as we have seen, and therefore the total cost of health care. In fact, the third-party reimbursement system is the biggest culprit of the health cost spiral: the patient is insulated from the true costs;

[2]Oregon State Health Planning and Development Agency, *Mandated Health Insurance Benefits in Oregon.* March 1983.

and the provider is given an economic incentive to provide maximum services regardless of costs/benefit considerations in the fee-for-service reimbursement system.

In consideration of all these problems, the decision to legislatively impose a health insurance mandate therefore represents a complex policy judgment. A systematic review of all the ramifications of these proposals will assist the policymakers in determining whether the mandate is truly in the public interest.

Legislative Guidelines

There are a total of 12 guidelines or questions mentioned in the law, divided according to social and financial impacts, as follows.

The Social Impact

(a) To what extent is the treatment or service generally utilized by a significant portion of the population? (b) To what extent is the insurance coverage already generally available? (c) If coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatments? (d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship? (e) What is the level of public demand for the treatment or services? (f) What is the level of public demand for insurance coverage of treatment or services? (g) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?

The Financial Impact

(a) To what extent will the coverage increase or decrease the cost of treatment or service? (b) To what extent will the coverage increase the appropriate use of the treatment or service? (c) To what extent will the mandated treatment or service be a substitute for more expensive treatment or service? (d) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders? (e) What will be the impact of this coverage on the total cost of health care?

These guidelines represent a framework for analysis. The process should involve consumers, insurers, health planning groups, and labor and business groups interested not only in employee benefits but

containing costs. Analysis should be as objective as possible in a legislative forum, where "politics is the art of the possible," as was noted by Bismark a century ago. And the process should be deliberative and take time during the interim to study. A summary report should be fashioned that responds to all the questions in the statute.

Conclusion

In sum, the legislature of the state of Washington has now required a set of guidelines to assist the members in assessing whether proposed mandated coverages are truly in the public interest. Under certain circumstances, mandated coverages may be very appropriate. This legislation then is not so much of an answer after all, but a process for getting at the answer.

In the final analysis, the main benefit of the legislation is to place the burden of proof squarely on the groups proposing the mandated coverage. Testimony on this subject can get emotional at times, but for those wishing to judge these proposals on their merits, this sort of analysis may be very useful.

Listed below are the actual citations referenced in this chapter by John Welsh.

RCW 48.42.060 MANDATED HEALTH COVERAGE—LEGISLATIVE FINDING. The legislature takes notice of the increasing number of proposals for the mandating of certain health coverages or offering of health coverages by insurance carriers, health care service contractors, and health maintenance organizations as a component of individual or group policies. Improved access to these health care services to segments of the population which desire them can provide beneficial social and health consequences which may be in the public interest.

However, the cost ramifications of expanding health coverages is resulting in a growing concern. The way that such coverages are structured and the steps taken to create incentives to provide cost-effective services or to take advantage of cost off-setting features of services can significantly influence the cost impact of mandating particular coverages.

The merits of a particular coverage mandate must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage. The legislature hereby finds and declares that a systematic review of proposed mandated or mandatorily offered health coverage, which explores all the ramifications of such proposed legislation, will assist the legislature in determining whether mandating a particular coverage or offering is in the public interest. This chapter provides for a set of guidelines which should be addressed in the consideration of all such mandated coverage proposals coming before the legislature. [1984 c 56 | 1.]

48.42.070 MANDATED HEALTH COVERAGE—REPORT TO LEGISLATIVE COMMITTEES. Every person or organization which seeks sponsorship of a legislative proposal which 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 committees having jurisdiction, assessing both the social and financial impacts of such coverage, including the efficacy of the treatment or service proposed, according to the guidelines enumerated in RCW 48.42.080. [1984 c 56 | 2.] *Copies of the report shall be sent to the state health coordinating council for review and comment. The state health coordinating council, in addition to the duties specified in RCW 70.38.065, shall make recommendations based on the report to the extent requested by the legislative committees.* [C 150 L 87]

48.42.080 MANDATED HEALTH COVERAGE—GUIDELINES FOR ASSESSING IMPACT. Guidelines for assessing the impact of proposed mandated or mandatorily offered health coverage to the extent that information is available, shall include, but not be limited to, the following:

(1) The social impact: (a) To what extent is the treatment or service generally utilized by a significant portion of the population? (b) To what extent is the insurance coverage already generally available? (c) If coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatments? (d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship? (e) What is the level of public demand for the treatment or service? (f) What is the level of public demand for insurance coverage of treatment or service? (g) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?

(2) The financial impact: (a) To what extent will the coverage increase or decrease the cost of treatment or service? (b) To what extent will the coverage increase the appropriate use of the treatment or service? (c) To what extent will the mandated treatment or service

be a substitute for more expensive treatment or service? (d) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders? (e) What will be the impact of this coverage on the total cost of health care? [1984 c 56 | 3.]

XII. Part Three Policy Forum Discussion

Congressional Tools for Fiscal Analysis

MR. SALISBURY: Could I ask whether any of the people present from the government would like to comment on the feasibility of Congress adopting a fiscal impact statement approach or a preadoption study approach as has been established in the state of Washington? One could argue that the Congressional Budget Office (CBO) in some ways performs a function similar to that.

MR. LINDEMAN: We at CBO have been getting these kinds of proposals already, particularly in the international competitiveness area, and I really should defer to Paul Cullinan since I would hope that it would end up on his side of the building rather than my side of the building. But one of the problems we have is the lack of very good models as to where these costs fall and how they affect larger issues like trade balances. Congress sometimes thinks that the models and the information are better than they in fact are. I think it was alluded to earlier about how little information you sometimes have even to begin one of these analyses.

In the trade area, we concluded that we could give some kind of qualitative assessment, although we were not, I suspect, terribly enthusiastic about even that. But hard, quantitative assessments are hard to come by.

MR. CULLINAN: I will follow up on Dave Lindeman's comments on the difficulty of doing the actual estimates. While I was putting together a list of the costs of the various bills that are going to be wrapped up in the omnibus trade legislation in the House, I was struck with the number of estimates that we had that really were not estimates. They were letters saying the costs were uncertain because of X, Y, and Z.

Now trade estimates are perhaps a little more complicated than some of the mandating benefits ones, but I do not think that fundamentally it is that different. The data really are not very good, and the good data tend to be good because people have spent a lot of time and investment in them, and that usually means they are out of date. So it is really very difficult for us. If we are going to start to get into this area, I guess I would suggest that we start to budget for a few more people in the Congressional Budget Office, but I am not sure

that would get us very far, even if we tap the resources of the Congressional budget committees a little better.

MS. PHILLIPS: Let me turn this idea around and come at it the other way. There already is a procedure under which CBO produces cost estimates. There are some excellent people at CBO working on cost estimates for programs such as Medicare and Medicaid or Aid to Families with Dependent Children (AFDC) or Social Security, to name some that I am particularly familiar with. They produce very careful estimates. If the long write-up of how they got their final number does not satisfy you, they are happy to sit down and tell you what assumptions they used. So I would say that most of the *financial* impact issues mentioned in John Welsh's paper are already dealt with by the federal Congressional Budget Office estimates of fiscal impact of proposed legislation.

They have to define what is going to be the take-up of this new benefit, what is going to be the cost, what are some of the tradeoffs, what are the offsets, what benefits will people not use. Now admittedly, it gets a little hairy, because often the data just does not exist to help you make even more than an educated guess. But much does already exist, so that we are not operating in a complete vacuum.

Where I have real problems is with assessing the *social* impact of proposed policies as mentioned by John Welsh. When you get into behaviorial impact analysis and then try to project it out into what it will do to the economy at large, you may run into major difficulties.

There have been pushes for more analysis over the years—for family impact statements, environmental impact statements, fiscal impact statements, and as David Lindeman mentioned, the new push for a trade competitiveness impact statement. There comes a point when the system clogs up with all of these analyses.

MR. CULLINAN: At present, the CBO is required to give an assessment of federal budget costs and assessment of the impact this legislation might have on state and local government. It is not required to make any assessment of the financial cost being imposed on the private sector.

MR. LINDEMAN: If you get into order of magnitude difficulties, I think we could say as an example what the take-up rate of a new matching proposal for AFDC would be. You are dealing with state behavior. You have some historical trends. You have some information you can be tapping, although that can get "iffy" as well. But when you are talking about mandating a particular thing in a health insurance package on a nationwide scale, it becomes a very different kind of analysis.

As Paul Culinan said, we already have to get into the business of measuring the impact on the states. A colleague of mine was complaining the other day that he was having some problem determining what the effect would be of raising the age for drinking from 18 to 21—whether it was going to be more costly to enforce the law at the state level, or whether it was going to decrease the number of accidents and lessen the burden on public hospitals. It is that kind of analysis you get into. It gets awfully speculative. While I do not want to discourage Martha Phillips and others giving more resources to CBO, some caution should be exercised.

MS. LANAM: It is true, from both the insurance perspective and the employer perspective, that what the state reviews have helped to do to some extent in the states that have developed them, is to get employers and insurers to try to develop some of this data and come up with the kinds of studies they never had to do before. The one positive thing about the growth of these laws is that it forces us to study what the impact is.

However, it is somewhat easier, for example, for a Blue Cross and Blue Shield Plan, with identified participating providers, to gauge an increase in the total number of participating providers after a new mandate than it may be for a company like mine to gauge an increase in claims when we just pay a claim that comes in with an identifiable person on it. We do not have a defined universe. However, we can do administrative cost studies and that kind of thing.

The move to create a need for this data—for somebody saying, "we have to have it, therefore, you have to come up with it"—is a positive point, to some extent, regardless of whether we are right or wrong about costs.

MR. UGORETZ: If Congress or a state—as the state of Washington has admirably indicated—is going to require somebody else to pick up the tab for some specific benefit or even a range of benefits, then it is not too much to ask those who are supposed to pay for the benefit that there be some very careful and detailed analysis of the costs of those benefits. The burden is on those who are asking for the benefit, to show what those costs are going to be. If they cannot, then I do not think that the benefits should be requested until they can come up with the data. What we have seen in the states with almost 700 mandated-benefit provisions, is that, by and large, the decision to require those specific benefits has been made, not with careful and

detailed analysis, but on some warm and fuzzy belief that it would be very nice if everybody in the state had access to a particular benefit.

The question is: In light of the kinds of expenses that we are seeing in the health area, can we afford all of it? I think that probably we cannot, that at some point individuals are going to have to pick up a greater share of the health burden; and it may be that they have to pick up more in the area of noncore benefits.

Coordination of Mandates between Federal and State Governments

MR. KILLEEN: Does this not raise the issue of whether the whole focus of the debate has gone from the state level to the federal level? What I heard described is a very fine state law in the state of Washington, at least with the issues as they have been confronted by the state legislatures. But with the Employee Retirement Income Security Act (ERISA) preemption of self-insured plans and the increasing move to self-insurance, debate is beginning in Congress now about a federally mandated program. And I suspect if that happens, part of that will replace any existing state mandate. Has the debate not now moved to the Congress and away from the state legislatures?

MS. LANAM: What it has done is open a debate in Washington. The difficulty is that it has not replaced the debate at the state level, and perhaps one of the best examples of this is the Consolidated Omnibus Reconciliation Act (COBRA).

There was specific discussion during enactment of the continuation requirements that there be no specific preemption of state laws. Now in effect what happens is that if a state had a continuation requirement of less than the COBRA requirement, it is superceded; but if a state wanted to take the position, for example that six months of continuation occurs after the three-year COBRA requirement, it could do that. There is no preemption of additional state requirements on top of COBRA.

The discussions so far of the minimum benefits at the federal level have tended, along that same line, to be minimums that would, in effect, preempt state requirements that were equal to or less than. There has not yet been a specific discussion about replacing state legislation and state requirements above that minimum level.

Given the rather strong state's rights approach that a lot of insurance regulators take, most insurance companies think we are going to get the worst of both worlds.

MS. DILLEY: I wanted to make a comment on the earlier discussion about impact statements. Many of the complaints people have had about the budget process and many of the complaints many people had about the tax bill last year are that the budget and the tax bill tended to get wrapped up in numbers and in questions about whether there was enough money for this or that right down to the dollar level. Getting as much data as possible is fine, but the policy discussion should precede that, and we should not fool ourselves that collecting enough data is going to answer the questions as to what we ought to be doing. As a former budget analyst, I can attest that numbers mean what people want them to mean, and they are as good as today's newspaper and do not last much longer than that.

It is good to get as much data as possible. But the policy decisions are going to precede that and we should not expect the data to answer the questions.

What Do the Data Mean?

MR. KLEIN: It was suggested that it might be difficult for the federal government to go through this data analysis. Has the Council in the state of Washington had much difficulty doing the necessary data review work or going through the policy questions that are put before it to evaluate what should be mandated?

MR. WELSH: The requirement that the State Health Coordinating Council do this review was just added to the law this year. It was signed by the governor last week. It is not even in effect yet. But to address your question anyway, between 1983 and now the persons who are proposing these mandated benefits have had difficulty in justifying their requests for consideration of legislation.

The basic question is how much information does a member of the legislature or a member of the Congress need to make the policy decision. Some will make that decision right now without the data, on an emotional, heartfelt level perhaps, and automatically be in favor of a benefit. Others will be automatically opposed to the benefit.

The primary advantage of the statute is at least to lay out a framework of the right questions, if we do not have all the right data, at least a framework for addressing it—for those members who are in the middle and who have not initially committed to either being for or against the proposal. Yes, there is a paucity of data around, but at least the burden of proof is now squarely on people that are proposing the mandate, and it is up to them to come up with the ar-

guments for the mandate so it can at least be considered in a rational as opposed to an emotional or political setting.

MR. SCANDLEN: I think it is also true that most of these laws require a social impact statement as well as a financial impact statement. So it is not just a matter of counting money.

The biggest effect is whether there is really a sentinel effect to these laws. It is sort of putting the legislature on record as having a certain sentiment that is skeptical of mandated benefits. The state of Nebraska passed a law that required any mandates that passed to be applicable only if they also applied to self-funded groups, which is, of course, impossible without congressional action.

It remains to be seen if the statute passed by one legislature in Nebraska will be effective in succeeding legislatures. It may very well not be. These laws are indicative, however, of a trend that is perhaps best shown by the number of mandates that have actually been enacted. The year 1986 saw the fewest number of enacted health benefit mandatory laws since 1972. There were only 26 passed in 1986, which is a significant dropoff from the previous 14 years. It remains to be seen if that decline will continue. The state of Texas right now is considering 36 different mandating laws. They are currently just proposals.

The issue of self-funding is a real key one, and somebody made the point that it looks like more attention is being paid to Congress getting some of these benefits put into employee health benefit packages. I think that is in part because even the most desirable mandate on the state level can only apply to, in most states, about half of the group health market. If you switch your attention to Congress, then you can affect all states, all covered employees, with one law.

State-Mandated Group Health Insurance Coverages

Mark Power and August Ralston

The number of state-mandated group health insurance coverages have more than tripled since 1975. The most common coverages are for newborns, alcoholism, chiropractors, psychologists, mentally/physically handicapped, conversion privilege and optometrists. A significant research question is whether or not mandating health insurance coverages by a state is likely to be an effective approach for assuring that particular benefits are made available to employees.

The general conclusions of this study are: (1) mandating health insurance coverages will adversely affect health care costs, especially for smaller employers; (2) state mandatory health benefits legislation does not apply equitably to the universe of employers that sponsor health care coverage; and (3) state mandatory health benefits legislation does not improve the gaps in health care coverages for private or public employees.

The authors cannot support the statement that mandating health insurance coverages by a state is likely to be an effective approach for assuring that particular benefits are made available to employees.

Introduction

Every state in the United States has enacted at least one law that mandates a particular coverage in each group health insurance policy that is sold or offered for sale within the state. The fundamental argument for mandating a coverage is that employees/consumers, by virtue of having the benefit, will avail themselves of services they would not seek otherwise and/or share the cost of the services with their employer through the group insurance mechanism. A primary argument against a mandated health insurance benefit is that the mandate will increase health insurance costs unnecessarily.

The purpose of this article is to assess whether or not mandating health insurance coverages by a state is likely to be an effective approach for assuring that particular benefits are in fact made available to employees.

Although many of the data for the analysis are drawn from the State of Iowa, results presented appear to have general applicability.

The discussion that follows includes the status of state-mandated health insurance coverages, a study of group health insurance coverages in Iowa in relation to the mandates issue, an analysis of the cost of mandated benefits and conclusions and recommendations.

The Status of State Mandates

A mandated health insurance coverage law is one that requires insurers and/or health care services plans either to include or offer a particular benefit in their policies or plans or requires the right of direct payment. The *right of direct payment* refers to payment to providers, such as marriage and family counselors, social workers, midwives and skilled nursing or home health aides, for services provided independent of referral from a licensed physician or psychiatrist. Statutes that require benefits for specific

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Table I

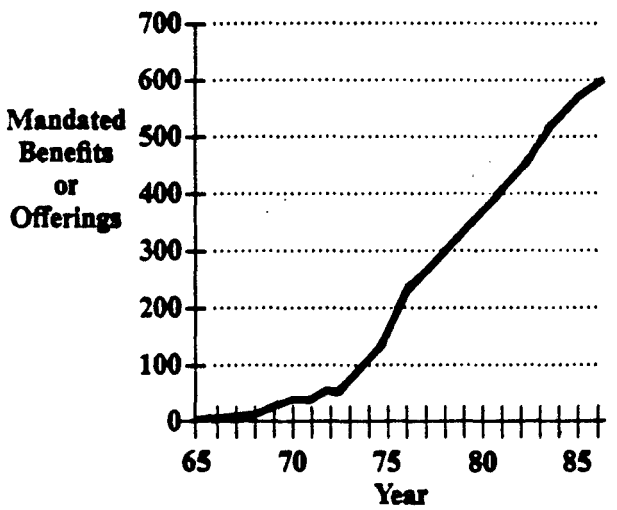
NUMBER OF MANDATED BENEFITS PER STATE

Number of Mandates	Number of States
1 to 5	3
6 to 10	21
11 to 15	14
16 to 20	7
21 to 29	5
Total	50

Source: BCBSA Report.

Figure 1

CUMULATIVE TOTAL OF STATE HEALTH BENEFIT MANDATES 1965-86



Source: State Mandated Benefits, Working Paper No. 5, Subcommittee on Labor-Management Relations of the Committee on Education and Labor, U.S. House of Representatives, January 21, 1987. Prepared by Blue Cross and Blue Shield Association.

services, categories of insureds or users, certain diseases or conditions or types of health care providers are coverage mandate laws. A comprehensive identification of the number of states mandating specific benefits or offerings of benefits in laws enacted through 1986 was completed recently by the Blue Cross and Blue Shield Association (BCBSA).[1]

BCBSA Report

The BCBSA reports the existence of 604 state-mandated health benefits. Approximately 50 of these are mandated offerings. The number of benefits mandated per state is summarized in Table I. The most common mandates—those occurring in 30 or more states—are coverage for newborns, alcoholism, chiropractors, psychologists, mentally or physically handicapped, conversion privilege and optometrists. A variety of coverages, including psychiatric nurses, physical and occupational therapists, second opinion, diabetic education, long term care and catastrophic coverage, were mandated by five or fewer states.

Delaware and Idaho each has legislated four health coverage mandates, and Vermont has enacted five. California, Connecticut, Maryland, Minnesota and New York each has more than 21 mandates or mandated offerings. Maryland has the most with 29. The largest group of states, 21, has enacted six to ten mandates or mandated offerings for health coverages.

The number of state health benefit mandates, which has increased dramatically over the past two decades, is illustrated in Figure 1. The number of mandates enacted increased from zero in 1965 to approximately 200 by 1975 and then tripled to 604 through 1986. More mandates were enacted in 1987, and legislative interest in state-mandated health insurance coverages remains high. For example, in the fall of 1987, the State of Iowa had seven items of proposed mandatory benefits coverage pending for the 1988 legislative session.

Insurance Department Questionnaire Results

In order to determine in greater detail the nature of benefit mandates and the insurers and health care plans to which the mandates apply, the authors of this paper surveyed state insurance commissioners.[2] The insurance departments in 35 states and the District of Columbia responded to the inquiry. Three of the states were unable to complete the questionnaire because of personnel shortages or provided responses that were not usable. Thus, the summary below is based on 33 completed questionnaires.

The commissioners were asked for each benefit mandated if their statutes require mandated coverage, mandated offer or right of direct payment. The responses to this question are reported in Table II. Of the 252 total mandates identified by the commissioners, over one-half, 149, fall in the mandated coverage category. In 61 cases, a mandated offer is required. For 42 benefits, the mandate is in the form of the right of direct payment.

Table II

NUMBER OF STATE MANDATES BY TYPE

Category	Number of Mandates
Mandated coverage	149
Mandated offer	61
Right of direct payment	42
Total	252

Table III

CONTRACTS AND PLANS AFFECTED BY MANDATES

Contracts or Plan Type	Number of Mandates
Commercial group only	36
Commercial group and prepaid	23
Commercial group and individual	40
Commercial group, individual and prepaid	52
Individual only	6
All	5
Other	14
Total	176

It is important to note, however, that for alcohol, chemical dependency/drug abuse and mental health, a mandated offer is as frequent as mandated coverage. Also, with respect to providers—dentists, chiropractors and podiatrists—the right of direct payment is often the form of the mandate.

The commissioners were asked if each benefit mandated is applicable to commercial insured group contracts, employer self-funded plans, individual insured contracts or prepaid plans (e.g., HMOs, TPAs, PPOs, etc.). The total of 176 in Table III is less than the 252 total in Table II because all of the respondents did not indicate the type of contract or plan to which the mandates applied.

For the mandated benefits in aggregate, the most common practice—52 incidents—is to require the benefit for commercial group and individual contracts and prepaid plans. Commercial group and individual contracts are next most common at 40.

In 36 combinations of benefits and states, only commercial group insurers are required to provide or offer the stated benefit. Commercial group insurers and prepaid plans are combined in 23 incidents. In six cases, a particular mandate is limited to individual contracts. And in five cases, the mandates apply to all insurance contracts and plans, including self-insured plans. The legal basis for the application of state mandates to self-insured plans is not clear in light of the preemption in the Employee Retirement Income Security Act (ERISA) of 1974 for self-insured plans.

Disease benefits, such as alcohol and chemical dependency/drug abuse, have not been mandated to be included only in individual contracts. It is about equally common to require these benefits in commercial group insured contracts only, in group contracts and prepaid plans or in group, individual and prepaid plans. Mandates that relate to providers, such as dentists, chiropractors and podiatrists, on the other hand, tend to be required in the commercial group insured contract and prepaid plan combination.

Group Health Insurance Coverage in Iowa and the Mandates Issue

In order to profile the scope and nature of health coverage in Iowa, a questionnaire was designed and mailed to Iowa and non-Iowa insurers and prepaid plans. These insurers and plans represent approximately 97% of the group health care premiums written in Iowa for 1986.[3]

The insurers and plans were asked to provide data on the number of group contracts and employees and dependents covered, premiums and claims, and benefits that are the subject of current or potential legislative mandates. The prepaid plans were not able to respond because the format was not compatible with their data collecting and reporting systems. A number of the non-Iowa insurers either did not respond, were not able to provide the information requested or indicated they prefer to "not participate in such studies."

The insurers, in the letter transmitting the questionnaire, were promised that all information would be aggregated, and responses by individual firms would not be identified. Thus, the usable data from the insurers that did respond are aggregated in the following analysis of group health insurance coverages in Iowa.

Basic Data

Contract, employee and dependents data gathered from the questionnaires are presented in Table IV.

The insurers for the July 1, 1986 through June 30, 1987 year had 11,323 group contracts in effect.

Table IV

IOWA GROUP CONTRACTS, EMPLOYEES AND DEPENDENTS

Employee Group Sizes	Number of Group Contracts	Number of Covered Employees	Number of Insureds Covered*
1,000 or more	52	145,047	339,859
500-999	57	39,834	87,974
250-499	88	31,712	78,275
100-249	270	39,577	93,154
10-99	2,781	74,566	174,312
Less than 10	8,075	28,545	64,432
Totals	11,323	359,281	838,006

*Employee and dependents.

Table V

INSURED GROUPS BY SIZE AND EMPLOYEES BY FIRM SIZE FOR IOWA IN 1986

Group or Firm Size	Number of Covered Employees	Number of Employees	Covered Employees as Percentage of Total Employees
1,000 or more	145,047	217,513	66.7%
500-999	39,834	88,203	45.2
250-499	31,712	102,569	30.9
100-249	39,577	138,154	28.6
10-99	74,566	325,245	23.0
Less than 10	28,545	142,400	20.0
Totals	359,281	1,014,084*	

*Excludes all self-employed. Employment in March 1986.
Source: Iowa Department of Employment Services, Research and Analysis Department.

The contracts covered 359,281 employees in Iowa and 838,006 employees and dependents. The 359,281 employees covered by the insurers that responded are approximately 26.7% of the total workforce and 33% of the employed workforce with health insurance coverage. The 838,006 insureds account for 29.7% of the Iowa population.

A comparison of the employees by group size in Table IV to the distribution of employees by firm size within Iowa demonstrates an important relationship. The data for this comparison are presented in Table V.

As shown in Table V, the Iowa Department of Employment Services reported 217,513 persons employed in March 1986 in firms with employment of 1,000 or more. The number of employees covered by the insurers in this study for that size of employee group is 145,047, as taken from Table IV. The comparison is not for the identical time period, but the July 1, 1986 to June 30, 1987 contract year would not produce any significantly different data from a somewhat earlier time period, nor would the March 1986 employment data be significantly different for a more recent month.

For the 1,000 or more category, the number of employees covered by the group health plans is 66.7% of the number employed. The percentage declines for each lower size of firm or group of insureds. For firms and employee groups of less than ten, the employees in the group contracts for the insureds in Table V represent only 20% of the employees of the relatively smaller employers.

Table VI

IOWA GROUPS, EMPLOYEES AND INSUREDS DISTRIBUTED BY SUBJECT TO AND EXEMPT FROM MANDATES

Employee Group Size	Subject to Mandates			Exempt From Mandates			Exempt Insureds as % of All Insureds
	No. of Group Contracts	No. of Covered Employees	No. of Insureds	No. of Group Contracts	No. of Covered Employees	No. of Insureds	
1,000 or more	18	66,461	150,814	34	78,586	189,045	55.6%
500-999	22	15,550	31,079	35	24,284	56,895	64.7
250-499	44	15,414	36,079	44	16,298	42,196	53.9
100-249	155	22,265	51,336	115	17,312	41,818	44.9
10-99	2,194	56,636	131,323	587	17,930	42,989	24.7
Less than 10	7,662	26,935	60,705	413	1,610	3,727	5.8
Totals	10,095	203,261	461,336	1,228	156,020	376,670	44.9%

The comparison and declining percentages suggest that any mandate for the inclusion of a benefit in group contracts will affect employees in greater numbers on a relative basis in larger firms. It also suggests that, to the extent that group contracts of larger employers already include a benefit that becomes mandated, relatively more group plans and employees of smaller firms will be affected by the new mandate.

The contract, employee and insureds data in Table IV are separated and presented in Table VI under the headings *subject to mandates* and *exempt from mandates*. The division reflects the impact of ERISA and the U.S. Supreme Court decision in *Metropolitan v. Massachusetts* (1985). ERISA regulates qualified employee welfare plans and preempts the right of the states to regulate employee welfare plans that fall within the scope of ERISA.

The states, on the other hand, clearly have the right to regulate insurance. The U.S. Supreme Court in *Metropolitan v. Massachusetts* upheld the right of states by holding that ERISA did not preempt a Massachusetts law that mandates that employers that purchase group health care insurance or plans provide certain minimum mental health benefits. It is important to note that ERISA regulates employee benefit plans directly, whereas state mandate laws regulate employee benefit plans indirectly by regulating the insurance coverage or plan that is purchased to fund life or health benefits. ERISA and state mandates, in effect, coexist. Consequently: (1) if a public or private employer self-insures a health care plan, the plan is subject to ERISA regulation and state regulation of the plan is preempted; (2) if the plan is insured, it is subject to state mandates. Thus, in Table VI, the groups under the *subject to* heading are affected directly by Iowa's mandates and the groups under the *exempt from* heading are not.

As shown in Table VI, 44.9% of the insureds in the group plans of the insurers that provided usable data in the questionnaire are in plans exempted from the State of Iowa mandates by virtue of being subject to ERISA regulation and not purchasing insurance. That percentage is significant because it suggests that state mandates that involve group life and health insurance coverages have or will have no effect on about 45% of group insureds. Because of market forces and employer and employee preferences, the benefits in the *subject to* and *exempt from* categories may be essentially the same. Group size may have a greater influence on the benefits package than the mandates and exemption issues. The larger the firm, the more exhaustive the plan coverage.

The distribution of insureds in Table VI generally is skewed in the same manner as the distribution of employees is skewed in Table V. That is, although 44.9% of all insureds are in exempt plans, 55.6% of those insureds in plans of 1,000 or more and 64.7% of those in plans of 500 to 999 are in exempt plans as compared to only 5.8% of insureds in small plans in the exempt category. The percentage declines from 64.7% to 5.8% consistently as the group size falls from 500 to 999 to groups of less than ten. Thus, state mandates could have a differential effect, with a disproportionate number of small group plans and their insureds being affected as compared to large group self-insured plans.

Table VII

TYPE OF IOWA CLAIMS PAID AS PERCENTAGE OF TOTAL CLAIMS PAID BY GROUP SIZE

Employee Group Size	Claims Paid (Mil. $)	In-patient Mental Health	Out-patient Psycho-therapy	In-patient Alco-holism	Out-patient Alco-holism	In-patient Chemical Depend.	Out-patient Chemical Depend.	Total % of Clms.
1,000 or more	$126.70	3.54%	0.15%	0.94%	0.04%	0.50%	0.03%	5.19%
500-999	39.19	4.37	0.11	1.17	0.05	0.35	0.04	6.08
250-499	37.59	3.58	0.14	1.33	0.04	0.38	0.01	5.49
100-249	48.80	4.26	0.11	1.24	0.02	0.44	0.01	6.07
10-99	95.80	3.10	0.08	1.37	0.03	0.46	0.02	5.06
Less than 10	41.19	3.17	0.10	1.07	0.02	0.49	0.01	4.87
Total	$389.28	3.57%	0.12%	1.16%	0.03%	0.45%	0.02%	5.35%

Claims Analysis

An understanding of group health insurance in Iowa is enhanced by analyzing the claims data provided by the insurers that responded to the questionnaire. The total claims paid by these insureds for the period from July 1, 1986 through June 30, 1987 are shown in Table VII with the percentage of the total claims accounted for by each benefit. The claims also are distributed by employee group size.

The claims-paid total of $389.28 million was at least 50% of claims paid under all group health insurance contracts and prepaid plans in Iowa during the claims period.[4] The benefits for which percentages are shown in Table VII are among those that are of current interest for potential legislative mandates in Iowa. Other benefits, such as podiatry, optometry, registered nurse and physical therapy, are not shown because each represents considerably less than 1% of claims paid. Chiropractor coverage was not included because the insurers providing the data felt they did not have sufficient experience with this mandated benefit in Iowa for the claims rate to be meaningful.

The data in Table VII indicate that the benefits that are being considered for mandates represent a measurable portion of the claims paid under group health insurance contracts covering a substantial segment of insured employees and their dependents in Iowa. Inpatient mental health claims, in particular, are a significant portion of all claims paid. The generally declining percentages for mental health and for the total of the rows in Table VII from the larger groups to the smaller groups do suggest that more extensive coverage is provided for these benefits in larger groups than in smaller groups.

The claims data in Table VII are separated in Table VIII in accord with insured or *subject to* and self-insured or *exempt from* status. Outpatient and inpatient are combined under each of the two types of plans for ease of presentation. The generally higher percentages for claims paid under the self-insured or exempt plans than under the insured or subject-to-mandate plans are not sufficiently significant to conclude that mental health, alcoholism and chemical dependency benefits are more extensive under self-insured than under insured plans. The higher percentages, however, do suggest that possibility.

The claims data presented above will be considered further in the section that follows.

Cost of Mandated Benefits

Conceptually, the measurement of the cost of a mandated benefit is straightforward. The cost would be the increase in premium required to cover claims and expenses that result from the mandated benefit. Practically, however, measurement is difficult for a variety of reasons. Among the reasons are: (1) insurers and prepaid plans may not record and monitor claims and expenses according to mandated benefit categories; (2) procedure descriptions and codings of diagnoses used by providers, prepaid plans and insurers may vary and are often imprecise or incorrectly applied; and (3) the benefit mandated may have been provided previous to the mandate and, thus, the premium associated with a new man-

Table VIII

PERCENTAGE OF CLAIMS DISTRIBUTED BY GROUP SIZE, TYPE OF BENEFIT AND EXEMPTION STATUS

	Subject to Mandates			Exempt From Mandates		
Employee Group Size	Mental Health	Alcoholism	Chemical Dependency	Mental Health	Alcoholism	Chemical Dependency
1,000 or more	2.72%	0.63%	0.28%	4.44%	1.19%	0.70%
500-999	5.06	1.26	0.17	4.21	1.19	0.50
250-499	2.79	1.10	0.43	4.49	1.59	0.37
100-249	3.83	1.03	0.52	5.01	1.53	0.36
10-99	3.26	1.47	0.50	2.96	1.15	0.41
Less than 10	3.13	1.12	0.53	6.02	0.56	0.02
Total	3.25%	1.12%	0.43%	4.30%	1.27%	.54%

Table IX

MARYLAND BLUE CROSS AND BLUE SHIELD CLAIMS EXPENDITURES AS A PERCENTAGE OF ALL CLAIMS FOR GROUP CONTRACTS 1984

		Coverage		
Benefit Category	Hospital	Med./Surg.	Major Med.	Total
Nervous/mental*	5.33%	1.58%	19.86%	6.49%
Prosthetic device	0.16	0.08	4.64	0.84
Alcohol rehab.	1.38	0.00	0.00	0.76
Cleft lip/palate	0.03	0.02	0.00	0.02
Podiatrist	0.00	3.36	0.57	1.07
Social worker	0.00	0.04	2.05	0.33
Chiropractor	0.00	0.01	2.30	0.36
Psychologist	0.00	0.10	5.32	0.86
Optometrist	0.00	0.00	0.00	0.00**
Licensed pract.	0.00	0.05	0.02	0.02
Home health	0.45	0.00	0.12	0.26
Nurse anesthetist	0.00	0.00	0.00	0.00**
Total	7.33%	5.23%	34.87%	11.01%

*Includes inpatient and outpatient.
**Less than 0.001%.

date may not represent its cost. Although costs are difficult to measure accurately, a well-defined study of the costs of mandated benefits in Maryland is a good starting point for an understanding of the magnitude of costs.[5]

Maryland

The Blue Cross and Blue Shield plans serving Maryland developed claims and administrative expense data for 1984 for the mandated benefits in that state for mental illness—inpatient, mental illness—outpatient, prosthetic devices, alcohol rehabilitation, cleft lip and palate, podiatrist, social worker, chiropractor, psychologist, optometrist, licensed practitioner, home health care and nurse anesthetist. The study did not include maternity benefits, benefits that are mandated to be offered and mandated conversion privileges.

The claims and administrative expenses for the mandated benefits in Maryland covered by Blue Cross and Blue Shield for 1984 under group contracts are summarized in Table IX. The claims and

Table X

COST OF MARYLAND MANDATES AS ESTIMATED BY HIAA

Benefit Category	Employee Premium	Family Premium
Mandated	$11.05	$ 46.10
Nonmandated	83.95	223.90
Total	$95.00	$270.00
Percentage of mandated to total	12%	17%

expenses are shown as a percentage of the total for all group hospital, medical/surgical and major medical. The administrative expenses included in costs are approximately 10% of the claims paid.[6]

The data indicate that the cost for all mandated benefits represents 11% of the total benefit cost of Blue Cross and Blue Shield enrollees in Maryland. The costliest mandated benefit is mental health at 6.5% of the claims total. The alcohol rehabilitation benefit accounts for only 0.8% of claims. Many of the mandated benefits, such as cleft lip/palate, optometrist, licensed practitioner and nurse anesthetist, clearly had a minimal impact on claims costs.

At the same time that Blue Cross/Blue Shield of Maryland was conducting its study, the Health Insurance Association of America (HIAA) created a task force to study the cost of mandated benefits in Maryland. The HIAA is the national trade association of the private health insurance industry. Its members include more than 330 companies writing over 85% of the health insurance policies sold by private insurers. Blue Cross and Blue Shield plans are not HIAA members.[7]

The benefits mandated by Maryland law were priced by an actuarial subcommittee of the HIAA task force. The subcommittee used empirical methods similar to those used to price any health insurance benefit. The estimate of cost as developed by the task force's subcommittee was illustrated for a typical group plan as shown in Table X.[8]

The monthly insurance premium is split between mandated benefits and nonmandated benefits. The *employee premium* column shows the premium for an employee without dependents. The *family premium* column represents the combined premium for an employee with one or more dependents. As reported in Table X, the cost of mandated benefits was estimated by HIAA to be 12-17% of the typical total health insurance premium. Thus, the HIAA result and the Blue Cross/Blue Shield estimate of the cost of mandated benefits for Maryland were similar.

Consultants' Findings

A group of insurance and health care consultants recently completed a study of health insurance expenses in six states that had mandated mental health, alcohol and drug benefits.[9] The states studied—Arkansas, Connecticut, Maryland, Massachusetts, Oregon and Wisconsin—had diverse characteristics (e.g., region, population, economy and social attitudes). The researchers contacted 31 sources that have been actively involved in the pricing, administration and marketing of large numbers of group health insurance plans during pre- and postmandate periods. No individual coverage expenses were studied. The study covered 84,500 plans and 8,822,100 insureds in the six states.[10]

In the first 36 months following the enactment of a mandate, most employers experienced moderate premium increases due to the mandates. Few moved to self-insurance, and no plans were terminated. Thirty-five percent of the sources experienced premium increases in the plans they covered of 10-15% attributable to mandates; 50% reported premium increases of 5-10%. Eleven percent reported increases of 1-5%. Approximately 35% of the sources found no measurable increase in premiums as a result of mandates. The two reasons for the limited premium increases were: (1) although individual claims for these mandated benefits may be extensive, the claims represent a small percentage of total claims; and (2) many plans already included coverage that approached, equaled or exceeded the mandates.

Ninety-eight percent of the sources indicated no movement from insured to self-insured plans solely because of mandates. Fourteen percent of the sources reported measurable cost reductions in other areas of their plans because the implementation of mandates for plans that previously offered little or no coverage in the mandated areas shifted claims within the plan; 43% reported no offsetting

cost reductions in other areas; 43% said it was too early to determine if there were savings in other areas.

The results of the study by the consulting group did not support the chemical dependency and mental health providers' assertions that increased use of their services would be offset by savings from decreased use of general medical and hospital services. The study did note increased use and cost of outpatient services, decreased inpatient costs and decreases in the total outpatient and inpatient costs.

Iowa Claims Data

The claims data, exclusive of administrative costs, provided by the insurers that issue group health contracts in Iowa support the findings in the Maryland study and in the consultants' report. The Iowa claims experience for one claims year was presented in Table VII for mental health, alcoholism and chemical dependency. Even though these benefits are not mandated in Iowa, the data do represent useful cost information.

Both inpatient and outpatient mental health coverage provided in the group contracts produced claims of 3.69% of total claims. (See Table VII.) This is a significant cost component of premiums, which is comparable to Maryland and the states included in the consultants' study. The inpatient and outpatient alcoholism and chemical dependency percentages totaled 1.19 and 0.47, respectively, for the Iowa insurers in Table VII. These percentages are similar to the percentages in the other studies and suggest that these benefits produce noticeable costs, but not ones as significant as for mental health. The percentage of claims in the Iowa data for podiatrist, optometry, registered nurse and physical therapy each accounted for less than 1% of total claims paid. The same result was experienced in Maryland and the other states studied by the consultants.

Conclusions

The purpose of this study was to determine whether mandating health insurance coverages by a state is likely to be an effective approach for assuring that particular benefits are made available to employees. In order to answer this research question, the authors examined the status of state-mandated health insurance coverages, health insurance coverages in Iowa in relation to the mandates issue and the cost of mandated benefits.

The research undertaken allows for the following conclusions to be drawn:

- State mandatory health benefit legislation contributes to the already rising cost of providing health care to employees and will be especially burdensome to small employers whose plans are most likely not to include the mandated benefit. Additionally, employers with ten or fewer employees are most likely not to cover their employees under a qualified welfare benefit plan. Although this analysis does not directly support the following, the cost impact of mandatory health benefits legislation could result in fewer plan starts or increased plan terminations for this category of insured plans.
- State mandatory health benefit legislation does not apply equitably to all employers that provide health care benefits to their employees. This is evident from the data on plans exempted from mandates by virtue of being subject to ERISA regulation because of not purchasing insurance. This means that self-funded plans, in which a majority of covered employees participate, are not subject to state mandatory benefits legislation.

  This finding in and of itself is not alarming, because it is typically the larger employer that offers a self-funded comprehensive health care plan. This statement is defensible only if the comprehensive nature of the plan would include benefits that are mandated. Unfortunately, the data analyzed in this study do not directly support the correlation between plan size and comprehensive coverage.
- State mandatory health benefits legislation does not improve the gaps in health care coverages for private or public employees. This statement is supported by the fact that many small employers do not currently offer insurance company-guaranteed health care coverage and that a majority of larger employers have self-funded plans that are ERISA plans and exempt from state mandatory health benefits legislation.

In summary, the facts presented in this analysis of state mandatory health benefits legislation do not support the statement that the mandating of health insurance coverages by a state is likely to be an effective approach for assuring that particular benefits are made available to employees.

Endnotes

1. G. Scandlen and B. Larsen, "Mandated Coverage Laws Enacted Through December, 1986," prepared for Office of Government Relations, State Services, Blue Cross and Blue Shield Association, February 10, 1987.
2. A. Ralston, M. Power and S. McGinnis, "State Legislatively Mandated Life and Health Insurance Coverages." The Legislative Extended Assistance Group of the Iowa General Assembly, Oakdale, Iowa, January 1988.
3. *Annual Report of the Insurance Division of Iowa* (Des Moines, Iowa: Iowa Department of Commerce, 1987).
4. *Ibid.*
5. Z. Dyckman and J. Anderson, *Mandated Health Benefits in Maryland: A Research Report on Relevant Public Polic Issues* (Columbia, Maryland: Center for Health Policy Studie 1985).
6. *Ibid.*, p. 12.
7. R. J. Mellman, *Maryland Mandated Benefits Repo* (Washington, D.C.: Health Insurance Association of Americ 1985).
8. *Ibid.*, p. 11.
9. B. Browne, A. F. Browne, B. T. McLaughlin and C. I Wagner, "Effect of Mandated Drug, Alcohol, and Ment Health Benefits on Group Health Insurance Premiums," *Jou nal of the American Society of CLU and ChFC* (January 1987 74-78.
10. *Ibid.*, p. 75.

The Economics and Politics of Mandated Health Benefits: A Pennsylvania Case Study

Charles P. Hall Jr.

In this article, the author discusses some political and economic considerations surrounding proposed legislation that would mandate certain health care benefits in Pennsylvania. One major conclusion is that proponents of mandated benefits often are special interest groups that have been left out of all or most of the commonly found benefit packages in a particular state. In addition, the need for certain mandated benefits often is insufficiently documented by supporters of the legislation.

Introduction

The rapid and continuing escalation of health care costs has been a major national concern for most of the last decade. Responses have been generated at the federal, state and local levels of government as well as throughout the private sector, but no one seems yet to have found a totally satisfying solution. The purpose of this paper is to examine, in political and economic terms, just one relatively specific effort to deal with a portion of the problem. Recent legislation enacted in the State of Massachusetts and the Kennedy bill that was proposed in Congress dealt with general mandations of an overall package of health insurance benefits. The focus of this article is, instead, on mandating either a single benefit or a narrow spectrum of benefits that are seen by some special interest group as having been left out of all or most of the commonly found benefit packages in a particular state.

One might view the distinction as the rifle approach to mandated benefits as opposed to the shotgun approach. In one sense, it could be stated that the Massachusetts law and the Kennedy bill are designed to address a broad social problem, and they both advocate a government-mandated package of privately sponsored benefits to solve it. By contrast, one recent study reports a total of 604 state-mandated health benefits of the single benefit variety.[1] The majority of these mandates require that a specific coverage be *provided*, while some take other forms, such as requiring that a particular benefit be *offered*.

Arguably, the Massachusetts package approach makes more sense, in that it theoretically should produce a set of benefits that are designed to serve the interests of the entire community. The single benefit legislation, on the other hand, is designed to meet special interests. Indeed, in some cases it has been suggested that the special interests that are served are those of a particular provider group seeking to have its services reimbursed on a par with more traditional providers (typically physicians and/or hospitals) rather than the interests of citizens in general. Their argument would be that they can provide needed services either better and/or more economically than can traditional medical professionals.

Against this backdrop, in 1986 the General Assembly of the Commonwealth of Pennsylvania

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The original research for this paper was sponsored by the Pennsylvania Health Care Cost Containment Council while the author served as a member of its first mandated benefits review panel. Responsibility for views presented in this paper, however, rests solely with the author.

passed Act 1986-89, the Health Care Cost Containment Act. As stated in the act:

> . . . there exists in this Commonwealth a major crisis because of the continuing escalation of costs for health care services. Because of the continuing escalation of costs, an increasingly large number of Pennsylvania citizens have severely limited access to appropriate and timely health care. Increasing costs are also undermining the quality of health care services currently being provided. Further, the continuing escalation is negatively affecting the economy of this Commonwealth, is restricting new economic growth and is impeding the creation of new job opportunities in this Commonwealth.

The act went on to attribute the escalating costs to a number of factors such as inefficiency of health service systems, the system of third party reimbursement, cost shifting resulting from a growing indigent population and the lack of adequate effort by the health care industry to contain costs.

Having identified the problem, Act 89 went on to declare that the policy of the Commonwealth was to "promote health care cost containment by creating an independent council to be known as the Health Care Cost Containment Council" (HCCCC). Other stated purposes of the act were to promote development of competitive health care services, assure access to services for all citizens and to facilitate the entire effort "by providing data and information to the purchasers and consumers of health care on both cost and quality of health services. . . ."

The composition of the HCCCC was, perhaps inevitably, highly political. It consists of 21 members: the secretary of health, the secretary of public welfare, the insurance commissioner, six representatives of the business community who are purchasers of health care, six representatives of organized labor (the president pro tempore of the Senate and the speaker of the House of Representatives each names half of the business and labor representatives) and one representative each of consumers, hospitals, physicians, Blue Cross and Blue Shield, commercial insurers and HMOs, all appointed by the governor.

While the duties and responsibilities of the HCCCC are wide ranging, the focus here is on the single issue of mandated health benefits, which, as noted above, has been a growing phenomenon across the country over the past 15 years.

Mandated Health Benefits

The history of mandated health benefit legislation across the country has been characterized by intensive lobbying efforts by single interest groups. The efforts usually are associated with what many would identify as a good cause, but the arguments often have been based on emotional appeals to a sense of social responsibility and what is right that have been presented with an almost evangelical zeal. In many instances, the campaign is led by victims of a particular illness and/or members of their families, and they present poignant evidence of their own suffering and how it would be alleviated by the benefit in question. In a number of cases, though, the most vocal proponents of mandated benefits have been health care practitioners who might profit directly by having their fees covered by the new insurance. Rightly or wrongly, such individuals inevitably have their motives questioned. Seldom, if ever, have definitive cost/benefit studies of the economic impact of such legislation been conducted prior to its passage.

The General Assembly tried to insulate itself from similar pressures by stating (Act 89, Section 931.1 (a)) "that proposals for mandated health benefits or mandated health insurance coverage should be accompanied by adequate, independently certified documentation defining the social and financial impact and medical efficacy of the proposal." To this end, the HCCCC is required to create a mandated benefits review panel (MBRP) whenever such legislation is presented. The panel consists of three senior researchers, one each from the fields of biostatistics, economic research and health research. The MBRP is responsible for the careful review of all supporting documentation, both pro and con, that is submitted in connection with any proposed mandate. (It specifically is directed not to conduct its own research on the matter.) When the review is completed, the MBRP submits its findings to the HCCCC.

In addition to the input from the MBRP, the HCCCC also must solicit the opinions of the secretary of health and the insurance commissioner regarding mandated benefit proposals. Upon receipt of the comments and findings of these three sources, the HCCCC must forward that material, along with its own recommendations respecting the proposed legislation, to the governor, the president pro tempore of the Senate, the speaker of the House of Representatives, the secretary of health, the insur-

ance commissioner and all persons who submitted material pertaining to the bill.

Although on the surface the provisions pertaining to the review of mandated benefit proposals seem reasonable and rational, a careful review of the detailed directions provided for the MBRP suggests that an extremely heavy burden has been placed on the shoulders of anyone sponsoring such legislation. Section 931.3(c) directs the MBRP to report to the council the following: (1) whether or not the documentation is complete as defined in paragraph 931.3 (b); (2) whether or not the research cited in the documentation meets professional standards; (3) whether or not all relevant research respecting the proposed mandated benefit has been cited in the documentation; and (4) whether or not the conclusions and interpretations in the documentation are consistent with the data submitted.

In paragraph 931.3(b), proponents/opponents of any mandated benefit legislation are required to submit documentation that demonstrates the following:

1. The extent to which the proposed benefit and the services it would provide are needed by, available to and utilized by the population of the Commonwealth
2. The extent to which insurance coverage for the proposed benefit already exists or, if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the Commonwealth
3. The demand for the proposed benefit from the public and the source and extent of opposition to mandating the benefit
4. All relevant findings bearing on the social impact of the lack of the proposed benefit
5. Where the proposed benefit would mandate coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapy and no therapy
6. Where the proposed benefit would mandate coverage of an additional class of practitioners, the results of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits
7. The results of any other relevant research
8. The impact of the proposed coverage on the general availability of health insurance in Pennsylvania
9. Evidence of the financial impact of the proposed legislation, including at least:
   A. The extent to which the proposed benefit would increase or decrease cost for treatment or service
   B. The extent to which similar mandated benefits in other states have affected charges, costs and payments for services
   C. The extent to which the proposed benefit would increase the appropriate use of the treatment or service
   D. The impact of the proposed benefit on administrative expenses of health care insurers
   E. The impact of the proposed benefits on benefit costs of purchasers
   F. The impact of the proposed benefits on the total cost of health care within the Commonwealth.

Mandated Mental Health— House Bill 1987-364

The first bill to be reviewed under the provisions of Act 1986-89 was HB 1987-364, to provide certain mental health benefits. The author and his two colleagues on the first MBRP did not have the luxury of a standard pattern to follow in reviewing the documentation relating to HB 364 and submitting findings. After meeting with staff and some members of the HCCCC, it was decided that each member of the panel would prepare and submit an independent evaluation of the materials sent to the council in support of or opposition to the proposed legislation. In the end, the conclusions of the three panel members were amazingly consistent.

Of particular interest is the fact that all three MBRP panelists felt that both the proponents and opponents of HB 364 consistently failed to meet the rigidly stipulated data requirements of Act 1986-89. This was true despite the fact that there are more mandated mental health benefits laws in force across the country than for any other single benefit, and there had been at least four similar bills introduced to the Pennsylvania legislature since 1983.

On the surface, at least, this made it reasonable to expect that the documentation requested could be provided and would lead to some definitive recommendations. Indeed, voluminous materials were supplied to the MBRP (over 1,000 pages of opinions, articles, consulting reports and several books).

A total of six statements were received by the HCCCC in response to its call for comments on HB 364. Five of the statements opposed the legislation, while the remaining one, which was prepared by the Mental Illness Insurance Coalition (MIIC), a consortium of several provider and advocacy groups, supported it with great zeal. It became apparent in the course of the review that in many instances the differences between advocates and opponents were based primarily on different values, definitions and perceptions. That being the case, they sometimes observed and reported the same facts while drawing different conclusions about what those facts mean. As a reviewer, it was possible to call this to the attention of the HCCCC, but it may not be much help in resolving the dilemma.

The following is a summary of this reviewer's findings regarding the submitted evidence, presented in the same order as the provisions stipulated in Section 931.3(b) of Act 1986-89.

1. None of the opponents to the legislation addressed the basic question of the extent to which the mental health (MH) services that the proposed benefits would cover are needed, available or utilized. All, in one way or another, felt that adequate benefits are available, though none claimed an identity between the specifics of HB 364 and existing coverage. Indeed, the emphasis was on availability, with less said about coverage actually in existence and utilization.

The advocates presented some good documentation on the supply of MH facilities and professional specialists in the state. General NIMH data on mental health service needs were also presented. Nothing definitive was said about whether the available services could fulfill adequately the needs of state residents.

The implication that MH services must be delivered only by MH specialists was inconsistent with reality. A major concern of the reviewer throughout was that absolutely no clinical evidence was cited by anyone to show that patients, once diagnosed as having MH needs, are necessarily better off seeing an MH professional rather than a "regular" doctor who recognizes the problem. It is a well-known fact that many persons with minor psychiatric problems have been successfully served by their family doctor, whether a general practitioner or a family medicine specialist.

The proponents' response revealed a lack of understanding of the economists' distinction between *need* and *demand*, and some of their assumptions raised significant questions in this regard. Naturally, they felt that the proposed benefits are needed and not available. Opponents again argued that benefits were available, and the fact that they are not purchased widely suggests the absence of an effective demand, as opposed to a wish list. They also suggested that mandating this benefit could force some groups to give up other preferred benefits because of cost constraints.

2. In the aggregate, the opponents presented strong evidence on the availability of a variety of MH coverages. It was claimed that there "is no evidence that employers cannot get what they want." Several insuring groups described what they make available in MH benefits, but no information was given on the amount of coverage actually in existence.

The proponents of the legislation start with some underlying assumptions that are not accepted universally. If their assumptions are granted, they make a strong case. Example: They feel that anything less than identical coverage for MH is deficient. But there are other areas, such as dental benefits, that also get different coverage. Is that necessarily bad? Should private insurance cover MH catastrophes? The proponents say yes, but that has not been the historical view either in the U.S., where the state has had that responsibility for over a century, or elsewhere. Further, the proponents fail to note that HB 364 does not assure increased use of benefits. Several studies have demonstrated that the existence of insurance alone is not the problem. They do not document inadequate care but make their arguments about inadequate insurance. Also included are some emotional, but irrelevant, data about uninsured children; HB 364 does not address this issue. Both sides noted that more research is needed.

3. The most cogent objection voiced by insurers was the fear of the use of *diagnostic clusters* in defining benefits under the bill. The uncertainty of the relationships between diagnosis, treatment and costs in the MH field was cited. It was noted that this was precisely the reason that Medicare's DRG program waivered MH, and the opponents commented on the inconsistency of the proponents in supporting the DRG waiver while lobbying in favor of HB 364. Insurers also objected because self-insured benefit plans would be exempt from the provisions of the bill.

Advocates acknowledged that there is less demand for MH benefits but rested their case on the argument, essentially, that they are better qualified than the public to know what the public needs, so

the benefits should be mandated. They attempted a detailed, point by point refutation of other objections that was not convincing. They also put an enormous amount of faith in the utilization controls written into the legislation, even though they are unproven. The opponents did not accept this position, having seen similar controls fail in the past.

4. The proponents feared that, without HB 364, there would be a continued erosion of existing coverage that, in turn, will discourage utilization.

5. This point is not applicable, because HB 364 does not specify particular therapies. One opponent, however, expressed a fear that that would be the next step.

6. N/A.

7. Having responded so extensively to other questions posed in the legislation, no specific citations were presented in this section. While members of the MBRP were aware of other statements, they were directed not to do anything other than to respond to the remarks of the commission on this point.

8. Fairly brief responses to this section were made by some of the opponents. They presented no documentation, but logic suggests some concerns may be valid. Four possible consequences include: (1) Some employers may drop their health insurance to avoid the mandate (not very likely); (2) some employers may reduce the limits on their other coverage in order to lower exposure to MH costs or simply to control premiums under the mandate (more likely); (3) some will change to self-insurance, which is exempt from mandates (a real possibility); (4) some firms will move to avoid the mandate (far-fetched, unless the firm were already at the breaking point). Another opponent (Blue Cross) expressed fears that continued loss of its competitive position to self-insurance may undermine its ability to continue its commitment to insure all comers, because their premium base will be too small. Though possible, this argument was not overly convincing.

9A. All seemed to agree that hard data were in short supply on this point. Much of the discussion was general. Some opponents noted the insurance effect—lower out-of-pocket costs lead to an increase in demand, which in turn can have an effect on cost, depending on supply conditions. A cogent argument to support an expected rise in unit costs per patient (not per unit of service) was presented by one opponent, citing data showing that partial hospitalization may be used as an additional rather than a substitute service.

The advocates again put their faith in the belief that partial hospitalization and better outpatient benefits might lower inpatient costs. Though no good studies were available, the weight of existing evidence suggests that the insurance effect is more likely to dominate.

The so-called offset effect—that better MH services will result in lower costs for other medical services—came up here and elsewhere in the responses. All of the many studies that have looked at this issue have had flaws, mostly methodological, so a definitive conclusion is still in the future. The weight of authority at this time, however, suggests that total costs will rise (MH plus other medical) even though there might be some reduction in other medical costs. This reduction in other medical costs is attributed by most observers to a combination of two factors: (1) Availability of MH benefits removes the need for medical practitioners to disguise the diagnosis in order to be reimbursed, thus producing more honest reporting of costs; (2) adequate treatment for certain mental problems may result in a reduction in consequential medical symptoms, e.g., timely treatment for stress may preclude later treatment for ulcers. No data, unfortunately, were presented to indicate the relative clinical effects on patients.[2]

9B. What little evidence that does exist suggests that costs will rise,[3,4] but no other state has benefits identical to those in HB 364, and the differences in supply and demand of services, practice patterns and demographics make any such comparisons questionable at best. Furthermore, because of varying insurer procedures for tracking claims and the aforementioned widespread practice of masking the diagnoses for social as well as insurance reasons, it is difficult precisely to document cost increases, some of which simply may reflect changes in reporting rather than new costs.

9C. Virtually no comments were made on this point. One opponent expected a 25% increase, "not all appropriate," but gave no supporting data.

9D. Only one respondent mentioned administrative costs, stating that they would rise proportionately. No evidence to support this was presented. All other statements on this point were unconvincing.

9E. One opponent and the sole proponent each came up with precise estimates of costs. Neither showed their calculations. One detailed the underlying assumptions, but they were, in this reviewer's opinion, very questionable.

9F. The consensus seems to be that the answer

cannot be responsibly addressed, given available data. Several of the opponents, though, clearly expect an increase.

At least three of the opponents expressed concern about the lack of clarity in the definition of *maximum liability* under Section 603B of HB 364. The concern is real, and the confusion was justified. Several other minor questions about wording were mentioned.

Conclusions

This reviewer concluded that the decision on whether or not to recommend passage of HB 364 must rest on criteria other than economic issues, even in the event that more definitive economic data become available. The controlling issues seem to be more philosophical/political in nature. Although there is clearly the potential for a fairly significant impact of HB 364 on both the cost and quality of MH in the Commonwealth, available data simply do not permit precise predictions.

There, of course, would be some shift from the public to the private sector of financial responsibility for covered benefits. The weight of evidence, however, suggests that much of the needed MH care in this or any other state will not find expression in actual demand whether or not insurance benefits are available.

The quality of economic research that was available to answer the questions posed by Act 1986-89 was disappointing and may account in part for the heavy reliance of the proponents on more emotional arguments. It is also distressing that so little has been done to document outcomes of MH care, either by site of treatment or by type of provider. This fault rests with MH professionals, who long since should have recognized the need for such research.

Despite passionate attempts by the proponents to deny it, the MH field is still different in many respects from other medical fields. The relationships between diagnoses, treatment regimens and costs remain soft from an insurer's point of view. Although HB 364 specifically does contain provision for utilization review, there is no available history of its successful application under coverages such as those provided in the legislation.

It was the unanimous conclusion of the MBRP panel that neither the proponents nor the opponents of HB 364 presented a scientifically supportable case for their position. In reaching this conclusion, however, the panel was unanimous in the belief that the question of whether or not to mandate any health insurance benefit is a matter of such complexity that it is unlikely that this kind of policy decision can or should ever be made solely on the basis of scientific evidence as requested in Sections 931.3(b) and 931.3(c) of Act 1986-89. Nevertheless, the data requested could be of assistance in policy making, at least to the extent that evidence is available.

The panel members believe that, given the explicit requirements of Act 1986-89, it is unlikely that the proponents or opponents of any health benefits legislation ever will be able completely to fulfill its requirements. In the present instance, the quality of the evidence available to support the proposed mental health benefits under HB 364 varied considerably. For example, the evidence on the supply of facilities and personnel was far stronger than the data that were provided on projected costs. No evidence at all was presented on the clinical outcomes of treatment by mental health professionals versus that of regular doctors.

In one sense, it is difficult to criticize those who submitted position papers on the proposed legislation for the deficiencies in their presentations since in some of the areas specified there is no existing, valid research available; indeed, in some areas, it is probably not possible to conduct the indicated research because of ethical or moral constraints. Humans cannot always be researched as if they were laboratory rats. In other cases, although a valid scientific experiment might be designed, the cost of performing it would be prohibitive.

Clearly, the legislature made it difficult for sponsors of mandated health benefits legislation to meet all of the informational requirements of the law. It is not entirely clear whether this was done in a deliberate effort to discourage any such legislation or whether, in setting forth the requirements, the legislature did not realize the weight of the burden they were imposing. The suspicion is that the legislature knew exactly what would happen. The primary goal was to hold the line on costs. Act 1986-89 provides a convenient vehicle for accomplishing this, while permitting the legislature to assume the high ground of protecting the public purse by requiring the logical process of cost/benefit analysis prior to acting. In theory, of course, the legislature could enact a particular new benefit even if satisfactory answers to the questions posed by the law were not available, but that seems unlikely under current circumstances.

Regardless of intent, if future mandated benefits

legislation in Pennsylvania rests on satisfactory answers to all of the requirements spelled out above, there will be little if any new legislation passed. This could be good news for benefits managers, at least in the short run, but it theoretically could backfire if and when a sufficient number of frustrated advocacy groups mount a concerted campaign for more radical reform.

Postscript

In its final report to the legislature, submitted on November 20, 1987, the HCCCC, basing its position on the findings of the MBRP and the comments received from the secretary of health and the commissioner of insurance, stated that "... there was not sufficient documented evidence presented to support a conclusion that near-term health insurance cost increases due to mandated insurance benefits for the treatment of mental disorders would be offset by cost savings over the longer term." While noting that the opponents also had failed sufficiently to document the negative consequences that they projected, the HCCCC agreed with the position of the MBRP that, "In advocating a change in public policy that would impose new governmental mandates on business and on consumers, the burden of proof fairly rests on the proponents of change." Because the proponents failed to meet this test with respect to cost effectiveness, the HCCCC admonished the legislature to recognize in considering the legislation that "no satisfactory basis has been established for the position that such a mandate will be cost neutral or cost containing." In light of the clear legislative history that shows that cost containment is currently of paramount importance to the legislature, it should not be surprising that the bill was not enacted into law.

Endnotes

1. G. Scandlen and B. Larsen, "Mandated Coverage Laws Enacted Through December, 1986," prepared for Office of Government Relations, State Services, Blue Cross and Blue Shield Association, Chicago (February 10, 1987).

2. In a recent conversation with Anthony F. Panzetta, M.D., president and CEO of TAO, Inc., a Philadelphia-based mental health managed care organization, the author was told that studies now underway strongly suggest that over extended periods net savings can be demonstrated in the total of both regular and mental health costs. Previous studies used too short a time period to reflect this.

3. Z. Dyckman and J. Anderson, *Mandated Health Benefits in Maryland: A Research Report on Relevant Public Policy Issues* (Columbia, MD: Center for Health Policy Studies, 1985).

4. R. J. Mellman, *Maryland Mandated Benefits Report* (Washington, DC: HIAA, 1985).

EX 1
HB

MONTANA MTA Tavern Association

Affiliated and Associated with the NLBA

PROFESSIONAL PLAZA - SUITE AB-2
900 N. MONTANA AVENUE - P.O. BOX 851
Helena, MT 59624 / PHONE 406-442-5040

March 19, 1989

TO: Rep. Bob Pavlovich, Chairman, and Members of the House Business and Economic Development Committee

RE: HB 743

We have been informed that still another series of amendments will be proposed to your Committee on subject bill.

The position of the Montana Tavern Association, as stated in our previous written testimony, remains in total opposition to HB743 and to any amendments that may be proposed for the purpose of taking the bill from the table.

We found no reason to support the bill before and we find less now.

Very truly yours,

Steve Wilken

SW/d

STEVE WILKEN, President

HB 627
3/20/89
#1

AMENDMENTS TO HOUSE BILL NO. 627

1. Page 53, line 17.
Following "."
Strike: "The"
Insert: "Subject to [section 43], the"

2. Page 54, line 9.
Following: line 8
Insert: "NEW SECTION. Provisions protecting employees. (1) The department shall give a 3% preference to qualified bidders who agree to retain state liquor store employees at existing or higher wage and benefit levels. The agreement must be part of the contract of sale.

(2) A successful bidder who does not make the agreement referred to in subsection (1) shall offer the displaced state employees the right of first refusal for employment in the package store. This condition must be a part of the contract for sale.

(3) A state liquor store employee has preference in employment for another state position when the employee's qualifications are substantially equal to other applicants. The preference shall be effective upon passage and approval and shall remain in effect for one year following the effective date of termination.

(4) Pay for a state liquor store employee who is reemployed during the one-year preference period shall be set according to the pay plan rules promulgated by the department of administration.

(5) An employee who is reemployed during the preference period shall not serve the qualifying period for use of annual vacation and sick leave.

(6) As part of the sale contract, a successful bidder must agree to recognize the collective bargaining agent in service areas covered by a collective bargaining agreement."

WITNESS STATEMENT

NAME Mary Jane Fox BILL NO. SB 18

ADDRESS 1204 N. Oakes

WHOM DO YOU REPRESENT? Self + Mt. Rainbow Coalition

SUPPORT _____ OPPOSE X AMEND _____

COMMENTS: As a consumer, I strongly oppose advertising costs being included in Rate calculations. Advertising for increased usage (ie: profits) is not an appropriate expense to be incurred by consumers.

Please vote DO NOT PASS!

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

VISITORS' REGISTER

Business COMMITTEE

BILL NO. SB 18 182 DATE 3/20/89

SPONSOR Williams Keating

Please put the bill number. Thanks

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Bill Thomas	Helena Montana Rainbow Coalition		X
EARL REILLY	M.S.C.A (Helena)		X
Pam Marshall	Montana Low Income Coalition		X
Mary Jane Fox	Helena, Mt. Rainbow Coalition		X SB18
Nancy Griffin	Madison Lumber Co. Ennis, MT		X SB18
Terri L. McBride	Common Cause		X SB 18
GENE PHILLIPS	KALISPELL	SB18	
Brant Quick	Northern Plains Resource Council		SB18 ✓
Judy Griffith	Helena Sch Dist 816 Harrison	182	
Mike [illegible]	CDPM	182	
[illegible]	2117 Townsend	182	
[illegible]	400 [illegible]	182	
[illegible]	MFOTA HEALTH Assoc.	182	
Pat [illegible]	Rimrock Foundation	SB182	
Jim Powell	Box 3776 Msla, MT	182	X
[illegible] Jamison	RMTC	182	
Craig Campbell	4 Wood Court	182	
Tom Hopgood	Health Ins. Assoc. Amer.		✓ 182
Wm [illegible]	Rimrock Foundation	SB182	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

VISITORS' REGISTER

_____ COMMITTEE

BILL NO. _____ DATE _____

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Jani Stone	Helena	182 ✓	
Steve Waldron	Helena	182 ✓	
George Washington	Chopped down the Apple tree		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

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