New York State

Mandated Health Insurance Benefits

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Mandated Benefits in New York

EXECUTIVE SUMMARY

Mandated benefit efforts started in the 1970s were accelerated as part of the anti-managed care push back in the 1990s. Many of the original mandated benefits were ones that any reasonable person would expect to be covered by their health insurance. Next, mandated benefits focused on providers such as chiropractors and fertility specialists who lobbied state legislatures to require health entities to pay for their services. The most recent wave of proposed mandates results from tight state budgets. State programs are requesting mandated reimbursement from health insurers for services they are required to provide, thus moving the cost of these services from public programs to the privately insured population.

Many health policy experts believe that some benefits are appropriate to mandate while others may not be appropriate. It is not easy to tell when laws have gone from forcing health insurers to provide services that premium payors believe they have paid for, to forcing premium payors to purchase services they do not want. Also, virtual "first-dollar" coverage characteristic of HMOs, has caused many of us to forget what insurance is really for. Insurance is for unpredictable events with a financial impact that would be hard to budget for.

Mandated benefits are a problem because they:

- Increase the utilization of the services covered,
- Give the perception that the mandated benefit is effective even if there are no scientific studies showing sufficient effectiveness,
- Create the impression that health insurance is not a commodity offered in a free market but rather that health insurance coverage of all benefits is a right,
- Increase the cost of insurance leading to more uninsured, and
- Increase the tendency of groups to self-insure in order to avoid mandates.

In recognition of the problems created by mandated benefits, 22 states have mandate reviews. Some states have legislated mandatory reviews of all proposed mandates before they can be considered by the legislature. The reviews include the efficacy of the mandate, the ability of an individual to pay for the service in the absence of insurance, and the premium impact of the mandate in different market segments. Many states do periodic reviews of all state mandates and the cumulative effect on current health insurance premiums. New York State has no such requirement.

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Currently in New York, it is estimated that mandated benefits increase health insurance premiums by a net amount of 12.2% or an increase in single coverage of $444.57 a year and in family premiums of $1,066.37 a year *(based on estimates done in other state for similar mandated benefits)*. There are over 100 new mandates being proposed every year that would further increase the cost of health insurance resulting in more individuals and employers dropping coverage that they consider unaffordable. In addition to the cost of mandated benefits recent budgetary actions will result in $132 million in assessments, taxes, and fees that will be passed on to the insured population.

The state of New York has implemented programs to reduce the number of uninsured. Currently, about 500,000 are enrolled in the Child Health Plus, 85,000 in the Family Health Plus, and 15,000 are enrolled in Health New York. However, even after extensive state initiatives to reduce the uninsured there is a large uninsured population in New York. Most of the uninsured are working poor who cannot afford health insurance premiums or whose employers cannot afford health insurance. Currently, 15% to 17.7% of New Yorkers are uninsured or 2,800,390 to 3,263,721 individuals. This is compared to a nationwide uninsured percentage of 16.5%.

Mandated benefits do not affect everyone. They are typically not applicable to public programs or self-insured groups. They only affect the insured population purchasing individual and small group health insurance. Groups can avoid the cost of mandated benefits by self-insuring, which may pass more of the cost to groups too small to self-insure or those with individual coverage. In 2000, 38.7% of the employees covered by insurance in New York were covered by self-insured plans. Also, 422,460 firms or 21% of all New York firms are self-insured.[1]

There is a paradox concerning mandated benefits in that low cost services individually may not overburden the insured population, and could often be budgeted for by the individuals using the services. On the other hand, higher cost services that would be an excessive financial burden to individuals yield a larger increase in premiums for the insured population. Also, it is becoming apparent that lower cost services do have a significant financial effect when they are aggregated together. This is the public policy trade off between cost and benefit with which legislators have to struggle. It is estimated that for every 1% increase in private insurance premiums nationally, 400,000 more people will become uninsured. This equates to approximately 30,000 people in New York.

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PROBLEMS CREATED BY MANDATED BENEFITS

Mandated benefits put added pressure on the already critical situation of increasing health insurance costs that are becoming less affordable for more individuals and companies each year.

The latest Kaiser Health Poll Report found that more Americans (38%) are worried that their income will not keep up with rising health care costs and health insurance premiums than are worried about losing money in the stock market (22%), not being able to pay their rent or mortgage (19%), being a victim of a terrorist attack (19%), or losing their job (15%). About one in four (26%) say they are very worried they might not be able to afford the prescription drugs they need in the next six months, and almost one in five (18%) report being very worried that they might lose their health insurance coverage.

Kaiser concludes that worries about health care are at the forefront of the economic concerns Americans have.

Locally, a Federal Reserve Bank of New York survey released in January 2002 indicates that 63% of small business owners in upstate New York cite health insurance premiums as a barrier to growth.[2] This top rated concern exceeded concerns about workers' compensation costs, energy costs and federal taxes.

Mandates cause several problems:

1 – *Mandates increase health insurance utilization*. Mandates encourage individuals to use their insurance for therapies not covered before – insulating people from the cost of that care. When people perceive they are getting care for little or nothing, they have an incentive to use more services. The New York State Employees Health Plan experience with hearing aid coverage showed that when maximum benefits were increased from $600 to $1,000 claims increased from 3,400 to 6,000 and the average claim increased from $513 to $843. New York State is particularly vulnerable to increased utilization due to its large proportion of physicians to citizens. New York is third in the nation after the District of Colombia and Massachusetts with 395 physicians per 100,000 citizens. The national average is 269 physicians per 100,000.[3]

2 – *Mandates give the impression that the benefits are effective.* If a benefit is mandated by insurance, there is an implication that the treatment is effective in treating the problem. This could lead individuals to receive services that are not shown to be effective or have been shown to be ineffective leading to wasted health care dollars and false hope.

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3 – *Mandates create the impression that health insurance coverage is a right.* Since the advent of employer based health insurance, employees and labor unions have increasingly called for "first-dollar" health insurance coverage. As a result, most working Americans look to insurance to pay for procedures they could already easily afford. Mandated benefits intensify the view that health insurance coverage is a right and that health insurance is no longer a commodity in a free market.

4– *Mandates raise the cost of insurance*. Because most workers are insulated from the cost of health insurance, they do not shop for the best value. This along with increased utilization drives up total health care costs, and health insurance premiums rise to meet the costs. This cost is often passed onto employees in increased premium sharing and/or out-of-packet cost, which decrease the real wages workers receive.

5 – *Employers and individuals cancel their policies*. As employers and people with individual policies face increasing premiums that they cannot afford, they begin to cancel their coverage. Healthy people conclude that the risk they bear is less than the premiums they pay and they decide to take their chances without insurance.

6 – *More Uninsured*. As a result of individuals and employers dropping their health insurance more people become uninsured. Additionally, mandates that require insurers to accept applicants without regard to their health status encourage people to go without health insurance while they are healthy by making it easy to get insurance once they need it.

7– *More Self-Insured.* Since self-insured groups are not subject to mandated benefits, smaller and smaller groups decide to self-insure to avoid mandates and keep premiums lower. In New York in 2000, 422,460 firms or 21% of all firms self-insured.[4]

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Health Insurance Cost Drivers

Health insurance costs are primarily a function of the underlying utilization of medical services and the unit cost of each service. The use of services is related to the benefit plan design (coverage under the health insurance product, managed care techniques including preauthorization of services, and member cost sharing), and the health characteristics of the covered population. Unit costs are a function of the provider reimbursement mechanism (fee-for-service charges, discounts from charges, fixed or varying fee schedules, etc.).

Health care costs increase over time as either the underlying unit costs change or the use of services change. The unit costs change as providers change their charge levels to account for general inflation or changes in costs associated with their business, including increased malpractice costs. The use of services change over time as the population ages and as consumer demand for services increases as a reaction to advertising of new services, such as prescription drugs. New technology impacts both the use and cost of services.

Health insurers are pressured by market competition and state regulators to control the rates charged for their product. Insurers must manage the forces that increase the costs of the health care products, but the insurance market has additional pressures above the increasing underlying health care cost including:

- Insured individuals tend to use health care services more when they are covered under the insurance plan than when they are paid for out-of-pocket;
- Individuals are able to self-select benefit plans that maximize their benefits and minimize their out-of-pocket expense;
- Providers charge insured patients more to make up for uncompensated care and lower public program reimbursements (cost shifting);
- Mandated benefits increase the scope of coverage and costs of health plan.

An Insurable Event

In its simplest sense, insurance is a group of people agreeing to share the cost of a random event that could cause financial hardship to any one of them. If the probability of the event or the financial loss is not equal among them, individuals with higher probability of a higher loss would contribute more. If the financial loss amount and timing are predictable, saving for such an event is a more financially effective funding mechanism than insurance because of the administrative overhead of insurance. For example, it would not be financially

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efficient to pay the overhead of insurance administration to cover oil changes, replacement tires or even for the costly replacement of an aging vehicle under auto insurance policies.

Not all health services are considered insurable just as not all automobile maintenance is considered insurable by auto insurance. The purpose of insurance is to share the cost of financial losses that cannot be predicted and are outside of an individual's ability to budget or save for. Day-to-day items of normal living are not insurable. There are exceptions, such as health insurers and managed care products providing coverage for preventive care services that can be budgeted for. These are covered because they increase the perceived value for healthy individuals and provide early detection and treatment of conditions that would otherwise develop into major health problems.

Each insurance company defines an insurable event, unless the service is mandated by law, based on the following criteria:

- Medically necessary;
- Non-cosmetic;
- Non-experimental.

A medically necessary service is one that is needed to preserve life, reduce pain, or improve the quality of life and ability to function. Generally, the evaluation of health care services to determine medical necessity includes:

- Medically appropriate and necessary to meet basic health needs;
- Consistent with the diagnosis or condition and rendered in a cost-efficient manner; and
- Consistent with national medical practice guidelines regarding type, frequency, and duration of treatment.

Another aspect of medical necessity is the efficacy of the service. Services that are not effective in solving the medical problem are commonly not covered by health insurance.

External review is used as a safety measure to ensure that medically necessary services are provided. This system allows the medical profession to be the final arbitrator when a medical decision is being made. In this way, inappropriate over utilization of services and inappropriate denial of coverage are both reduced. New York has had independent external appeals legislation since 1998.

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Cosmetic services are not typically covered under health insurance products. These services involve changes to physical appearance without correction or material improvement in physiological function.

Medical research is funded by many sources throughout the United States. Health insurance products pay for medically necessary proven treatments that are not experimental, investigational, or unproven. Health care supplies, treatments, procedures, drug therapies or devices are considered experimental if they are:

- Not generally accepted by informed health care professionals in the United States as effective in treating the condition, illness, or diagnosis for which their use is proposed;
- Not proven by scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed; or
- Undergoing scientific study to determine safety and efficacy.

The Uninsured

It is estimated that up to 17.7% of New Yorkers were uninsured in 2001 compared to 16.5% nationwide. A September 2002 United Hospital Fund analysis found that one in four people under age 65 in New York City are uninsured and 90% of the uninsured workers do not have insurance offered to them.[4] Most of the uninsured are working poor. These individuals cannot afford to pay for insurance that is offered to them by their employers or their employers cannot afford to pay for health insurance premiums. In 2001, 16% of New York State's uninsured had at least one full time working family member and 26% had at least one part-time working family member.[5] The same data shows that 63% of the 2001 New York uninsured earned less than 200% of the federal poverty level.

In general, individuals do not want to pay for benefits they think they will never use or subsidize others who will use health benefits to a much larger extent than they will. They only want to pay as much in premium as they expect to use. However, people are willing to pay for benefit packages that include benefits that they will not use (e.g. maternity benefits), as long as there are sufficient benefits that they believe they may use. Because no one really knows exactly how much their health care costs will be and people are risk adverse, they are willing to pay for health insurance in case of an unforeseen event even if they believe that they are very healthy. That said, there is a limit to how much people are willing or able to pay for benefits that they will never use.

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The number of uninsured is related to the income and/or available resources of individuals and/or employers to afford the high cost of health insurance. A Lewin Group study in 1997 estimated that for every 1% increase in private insurance premiums nationally, 400,000 more people will become uninsured. This equates to approximately 30,000 people in New York.

Most insured individuals receive their health insurance from employment. As healthcare costs increase with each incremental cost, some employers will choose not to offer coverage. This is especially true of small employers, as a majority of small employers who do not offer health insurance cite affordability as a major issue. A survey released in February 2001 by the New York chapter of the National Federation of Independent Business revealed that 63% of small business owners say the cost of health care is one of the three most serious problems they face.[6] This was reinforced in January 2002 when a Federal Reserve Bank of New York survey showed that 63% of small business owners in upstate New York cite health insurance premiums as a barrier to growth.[7]

The article entitled "Explaining the Decline in Health Insurance Coverage, 1979-1995"[8] examines the relationship of the "premium cost-to-income ratio". The findings suggest that a 10% increase in the premium cost-to-income ratios results in a 1.2% increase in the number of uninsured. This statement implies that as long as the increases in per capita health insurance premiums outpace the increases in personal income, the uninsured population will continue to increase.

Using an analysis done by Sloan and Conover, Jensen and Morrisey estimated that 20-25% of the uninsured problem is caused by state mandated benefits.[9]

Another study sponsored by the Health Insurance Association of America in 1999 found that nearly one out of four uninsured Americans, or 10 million consumers, blame their lack of coverage on state mandates. As the number of benefit mandates increases, the cost of insurance rises and employers, particularly small employers, are less likely to offer coverage to their employees. The problem of the uninsured is growing and is exacerbated by the steadily increasing number of benefit mandates. When premiums raise employers drop coverage or pass more of the cost to employees who then may not be able to afford the increased cost sharing.

Mandates and the Movement to Self-Insure

In 2000, 38.7% of the employees covered by insurance in New York were covered by self-insured plans.[10] The percent varied by employer size from 11.8%

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for employers with 25-99 employees to 60.1% of employers with over 1,000 employees.

A concern often raised about insurance mandates is that they encourage firms to self-insure in order to avoid the mandates. Companies operating under ERISA have almost complete freedom to provide the type and amount of insurance they choose, since they are not impacted by state mandated benefit, rather are governed by ERISA and federal regulations. This allows employers to be flexible and put their own benefit plan together. Even with this level of freedom, many large self-insured employers do include some mandated benefits in their health benefits packages. In 1997 when chiropractic services were mandated to be included in health benefit plans, Kodak stated publicly that its decision to become self-insured was due in part to the chiropractic mandate.

Smaller companies also seek ways to self-insure, avoid state health insurance restrictions such as mandates, and thus create plans that meet their financial and personal needs. Nationally in 2000, 11% of firms with fewer than 100 employees self-insure.[11]

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CURRENT NEW YORK MANDATED BENEFITS

The state of New York has more than 30 mandated benefits for health insurance products. Following is a list of the mandated benefits, the year they were enacted, and the estimated cost of these benefits. The cost of mandated benefits can be presented as the direct cost, claims associated with the mandated benefit, or the indirect cost where the direct costs are adjusted for the elimination or reduction of other services or claims. For example, follow-up testing related to additional screenings and cost reductions due to early detection and treatment of disease. These estimates are based on studies done in other states on similar mandated benefits.

We did not estimate the associated economic and social consequences of not providing treatment or care associated with the mandated benefits, such as loss of productivity, assistance costs for families, and housing support.

	Cost as a Percent of Premium	
Mandated Benefit	**Direct Cost**	**Net Cost**
Breast Cancer Length of Stay (1997)	*	*
Cancer Second Opinion (1997)	*	*
Cervical Cytology Screening (1992)	0.3%	*
Chiropractic (1997)	2.5%	2.5%
Contraceptives (2002)	0.3%	0.3%
Diabetes /Equipment (1993)	0.5%	0.2%
EMS coverage (1976)	*	*
Enteral Formulas (1997)	0.1%	0.1%
Home Health Care (1972)	0.1%	0.1%
Infertility Coverage (1990 & 2002)	0.7%	0.7%
Licensed Nurse Midwife (1982/1998)	*	*
Mammography (1988 & 2002)	0.4%	0.2%
Mastectomy (1997)	0.2%	0.2%
Maternity Care (1976)	3.6%	3.6%
Maternity Length of Stay (1996)	1.0%	0.3%
Off-Label Cancer Drug (1990)	0.2%	0.2%
Osteoporosis (2002)	0.4%	0.4%
Outpatient Alcohol/Substance Abuse (1983)	1.0%	1.0%
Pre-Admission Testing (1976)	*	*
Preventive and Primary Care (1993)	0.8%	0.2%
Prostate Coverage (2000)	0.7%	0.3%
Second Surgical Opinion (1976)	*	*
Social Workers (1984)	1%	1%
Total	14.7%	12.2%

* means less than 0.1% of premium

None of the mandated benefits alone constitute a significant percentage of the premium for group insurance in New York. However, the combined cost of all

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mandated benefits is significant. The net premium costs associated the mandates are estimated to account for 12.2% of health insurance premiums.

Mandated Benefit	Annual Net Dollar Increase in Premium	
	Single	Family
Breast Cancer Length of Stay (1997)	*	*
Cancer Second Opinion (1997)	*	*
Cervical Cytology Screening (1992)	*	*
Chiropractic (1997)	$98.36	$235.93
Contraceptives (2002)	$11.8	$28.31
Diabetes /Equipment (1993)	$7.87	$18.87
EMS coverage (1976)	*	*
Enteral Formulas (1997)	$3.93	$9.44
Home Health Care (1972)	$3.93	$9.44
Infertility Coverage (1990 & 2002)	$27.54	$66.06
Licensed Nurse Midwife (1982/1998)	*	*
Mammography (1988 & 2002)	$7.87	$18.87
Mastectomy (1997)	$7.87	$18.87
Maternity Care (1976)	$141.64	$339.73
Maternity Length of Stay (1996)	$11.8	$28.31
Off-Label Cancer Drug (1990)	$7.87	$18.87
Osteoporosis (2002)	$15.74	$37.75
Outpatient Alcohol/Substance Abuse (1983)	$39.34	$94.37
Pre-Admission Testing (1976)	*	*
Preventive and Primary Care (1993)	$7.87	$18.87
Prostate Coverage (2000)	$11.8	$28.31
Second Surgical Opinion (1976)	*	*
Social Workers (1984)	$39.34	$94.37
Total	$444.57	$1,066.37

* means less than 0.1% of premium

The total net cost of mandates increases single coverage $444.57 a year and family premiums $1066.37 a year.

New York is one of the most heavily mandated states in the nation. It is also a leading state in costs - ranking third in cost for individual coverage and ninth for family coverage as compared to the other forty-nine states. The impact of these costs is now apparent in the business community, as health insurance costs have moved to the forefront of employer concerns. New York policy makers need to move slowly in the area of mandating additional benefits or risk further deterioration of employer based health insurance.

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Donna Novak has over 30 years of experience and is the leader of her own consulting firm. She specializes in health care cost reduction, predicting the cost of health care insurance reform, as well as measuring the financial health of insurers, HMOs, and provider health care risk takers. She has worked with state regulators, the NAIC, and Congressional staff to implement new insurance reform regulations. She has also assisted state insurance regulators develop solutions to their uninsured problems.

Donna has held a number of leadership positions with the Academy of Actuaries (AAA). In her role at the AAA, Donna worked with the congressional staff designing the Health Insurance Portability and Accountability Act (HIPAA), advised the Medicare Commission, and reviewed the Health Care Financing Administration's new risk-adjuster mechanism for Medicare. Donna played a key role in the AAA's effort to develop a Managed-Care Organization Risk-Based Capital (MCORBC) formula for the NAIC and led the group responsible for drafting the initial NAIC Health Reserving Guidance Manual. She is frequently asked to speak to industry and professional groups on health insurance risks and the capital needs associated with health risk taking.

Prior to founding her own firm, Donna worked for three major insurance carriers, the Blue Cross and Blue Shield Association (BCBSA), two of the major accounting firms and a major benefits consulting firm. At BCBSA she was responsible for financial monitoring of Plans and for communicating to Plans about emerging regulatory issues from an actuarial and financial perspective. As a consultant she worked with state insurance departments advising them on the effect of proposed insurance regulations and the appropriateness of insurance company transactions under review in the state.

Donna is a Fellow of the Conference of Consulting Actuaries (FCA), Associate of the Academy of Actuaries (ASA) and Member of the American Academy of Actuaries (MAAA). She received a BA in mathematics from DePaul University with post-graduate study in Mathematics at Illinois Institute of Technology and completed an MBA in Health Care Management and Finance at Northwestern's Kellogg School of Management.

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[2] Small Business: Big Challenge; Buffalo Branch of the Federal Reserve Bank of New York – www.newyoudfed.org/buffalo

[3] Kaiser Family Foundation – www.kff.org

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