Infertility Benefits:

A $200 Million
Tax On New York's Businesses

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INTRODUCTION

Legislation under consideration in New York would expand the state's existing mandated infertility services to include insurance coverage of assisted reproductive technologies (ARTs). Debate on this proposal has raged the past three years, pitting employers, insurers and the New York State Catholic Conference against impacted individuals, certain pharmaceutical companies, medical providers and other religious interests. It is likely that this debate will intensify in 2002 — a statewide election year. The ***Employer Alliance for Affordable Health Care,*** a broad-based business coalition dedicated to the goal of keeping health care affordable, believes that the September 11 attacks and subsequent economic downturn provide an opportunity for New York lawmakers to reassess the state's health care priorities — including the appropriateness of mandating expanded infertility services at this time.

Unlike twenty-two other states, New York has no formal process of evaluating the costs or medical efficacy of proposed health insurance mandates prior to their consideration. Mandate benefit reviews aid legislative deliberations by providing lawmakers with timely, objective and scientifically based data on pending health insurance mandates.

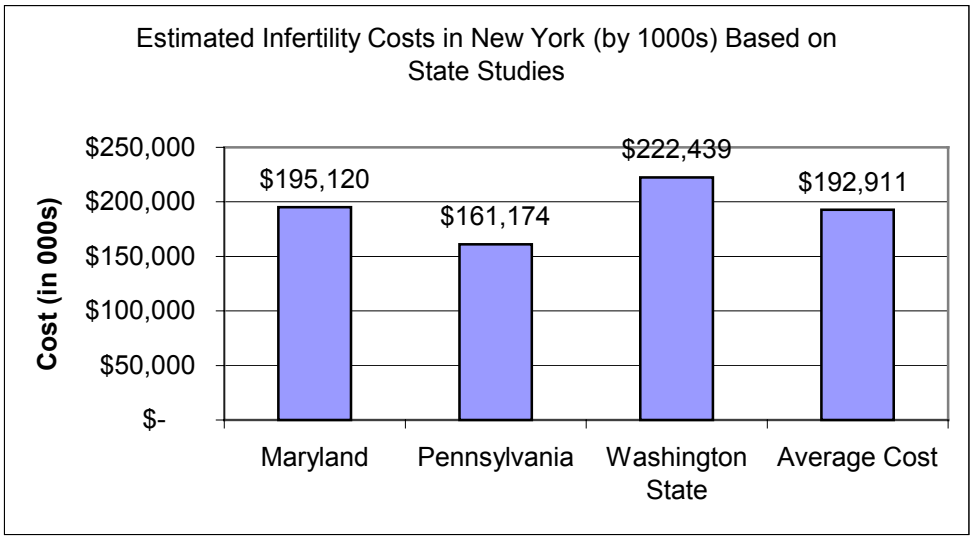
Total cost of this mandate in New York is estimated at nearly $193 million annually.

In lieu of a formal state study, the ***Employer Alliance*** sought to determine the potential financial impact of expanding infertility benefits in New York. To achieve this, the ***Alliance*** utilizes data from the three most recent infertility mandate reviews issued by other states:

- The Maryland Health Care Access and Cost Commission (1997),
- The Pennsylvania Health Care Cost Containment Council (1998)
- The Washington State Department of Health (2001).

Based on these studies and averaging the statistical calculations to New York's population, the total cost of this mandate in New York is estimated to be nearly $193 million annually (see chart #1).

(Chart# 1)



BACKGROUND – INFERTILITY COVERAGE IN NEW YORK

New York is one of fifteen states that already mandate some level of infertility coverage. Chapter 897 of the Laws of 1990 prohibits policies sold in New York from excluding coverage for the diagnosis and treatment of correctable medical conditions solely because the medical condition results in infertility. In practice, these provisions require every fully insured policy to cover treatments for such maladies as endometriosis and blocked fallopian tubes — conditions that may result in infertility. Legislation expanding this benefit to include ARTs has been introduced in every legislative session since 1990. However, in recent years interest in expanding this mandate has increased.

New York is one of fifteen states that already mandate some level of infertility coverage.

Although there have been no cost/benefit studies performed on current legislative infertility proposals in New York, in 1998 the New York State Task Force on Life and the Law issued an exhaustive (474 pages) report on ARTs titled **"*Assisted Reproductive Technologies – Analysis and Recommendations for Public Policy*."** In addition to outlining the many ethical, clinical and legal challenges related to ARTs, the Task Force also examined the appropriateness of mandating insurance coverage and concluded:

> "*The question for public policy in New York today is not whether assisted reproduction should be included in a basic package of benefits under a hypothetical system of universal access to health care. Instead the question is whether New York should mandate coverage for assisted reproduction when insurance policies routinely excluded coverage for a broad range of basic health care services and when many New Yorkers have no health insurance coverage at all. While we are sympathetic to the need for broader access to insurance coverage for assisted reproduction, we can find no persuasive reason for giving assisted reproduction special priority as a matter of state law."* [1]

In 2001, each house of the New York Legislature passed differing proposals to expand insurance coverage of infertility treatment. The primary disagreement between the houses has been over the inclusion of a "conscience clause." The Senate has insisted on the inclusion of such a clause to exempt employers with religious objections from having to purchase the mandated coverage. The Assembly has been vehement in its opposition to this provision. Besides the conscience clause, both bills provide a similar level of benefits. The Senate proposal, however, strives to be more cost effective in its benefit design. This is done through express age limitations to access these benefits, the express prohibition of extending these services to cover reversals of sterilization and placing a dollar expenditure ceiling on total infertility expenditures.

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[1] "*Assisted Reproductive Technologies – Analysis and Recommendations for Public Policy*"**;** The New York State Task Force on Life and the Law; April 1998; Pg. 443.

Below is a review of current infertility proposals in each house.

Bill / Provisions	A. 2002/Silver	S.5627/LaValle
Scope of Coverage	All ARTs *and* any other medical service that treats infertility; no age restrictions	Restricts benefits to patients ages 21-44, in accordance with clinical guidelines to be promulgated by the Department of Health
Coverage Limitations	Four ARTs. If successful (defined as "live birth"), an additional two attempts would be allowable; no cap on cost of services	$60,000 lifetime cap on services
Pharmacy Limitations	None	None
Conscience Clause	No	Yes
Other Provisions	Conformance to guidelines issued by American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine	Prohibits coverage for reversals of sterilization, sex change procedures and cloning

The ***Employer Alliance*** would argue that both bills have significant loopholes that weaken efforts to mitigate costs and improve outcomes. For instance, even though both bills call for lifetime limits on services, these provisions can be easily undermined. A motivated individual who exhausted their current benefits could simply opt-in to another plan and commence another round of treatments. Furthermore, confidentiality laws would facilitate the ability of patients to move from plan to plan undetected.

Both bills have significant loopholes weakening efforts to mitigate costs and improve outcomes.

INFERTILITY STUDIES FROM OTHER STATES – CLOSE-UP

In the past five years, three states — Maryland (1997), Pennsylvania (1999) and Washington (2001) — have undertaken studies to determine the cost of providing infertility coverage. The Maryland study is strictly a cost analysis of claims data from that state's existing mandate. In Pennsylvania and Washington, in addition to analyzing pending legislative proposals, both state reviews offer recommendations on the proposals to the Legislature. In each case, the studies concluded that mandating infertility benefits was inappropriate.

In both Pennsylvania and Washington, studies concluded that mandating infertility benefits was inappropriate.

The following offers a synopsis of each study, including its strengths and weaknesses as a comparative model to pending New York legislation, and a calculation of New York State costs based on data provided in these studies.

Maryland (1997)

Maryland enacted legislation in 1996 charging the Health Care Access and Cost Commission (HCACC) to conduct evaluations of existing state mandated benefits on the total cost of health care in that state. In 1997 the commission issued a report, written with the assistance of William Mercer Inc., studying the impact of existing mandated benefits. Part of that study included a cost estimate of Maryland's infertility mandate.

COMPARE AND CONTRAST WITH NEW YORK PROPOSALS

Maryland's infertility mandate was enacted in 1994 (Md. Code 15-814). The scope of the law is narrower than current proposals pending in New York. Some of the critical differences in the Maryland law include:

1. Maryland law provides only outpatient in-vitro fertilization services (IVF).
2. Maryland law requires recipients have a two-year history of infertility before the benefit can be accessed unless other medical conditions are documented (both New York proposals require only a one-year history).
3. Maryland law requires spousal relationship for recipient of services.
4. Maryland law exempts businesses with fifty or fewer employees.

The exemption of small businesses (1-50 employees) from this mandate is the most significant departure from the New York proposals. Eliminating the small group market exempts nearly 85% of all New York businesses and 41% of all covered employees from this mandate, reducing its overall cost.[2,3] Furthermore, New York's Assembly bill (A.2003) requires coverage of IVF ***in addition*** to eleven other enumerated procedures and "any other medically indicated service or procedure…" Mandating coverage of only a single (albeit one of

Relieving the small group market from this mandate would exempt nearly 85% of all businesses in New York.

[2] *Medical Expenditure Panel Survey Insurance Component (MEPS-IC) Survey*, Agency for Healthcare Research and Quality (1999)

[3] *Employer Sponsored Health Insurance*, US Department of Health and Human Services, Pub # 98-1017 p. 36

the most popular) assisted reproductive techniques would also reduce the overall cost of this benefit.

MARYLAND COST ESTIMATE

The Maryland Health Care Access and Cost Commission concluded that the "marginal cost" of mandating IVF in that state was $18 per member annually[4]. "Marginal cost" is defined as the cost of providing the service less the costs that would have been incurred by the policy even if the coverage were not mandated.

NEW YORK COST ESTIMATE

To determine the estimated cost of expanding infertility treatments in New York, the ***Employer Alliance*** used the Maryland per member cost and applied it to those New Yorkers that would be impacted by the new benefit. Those who would benefit include:

Individuals covered by employer-sponsored health insurance	9.68 million[5]
Less federal ERISA plans exempted from state mandates (23%)	-2.23 million[6]
Direct Pay Policy Holders (Individual market)	+ .66 million[7]
Medicaid Recipients	+ 2.73 million[8]
Total number of New Yorkers impacted	10.84 million

Utilizing this data we can calculate the cost of this benefit in New York:
10.84 million New Yorkers with coverage X $18/year = $195,120,000 annually.

NEW YORK ESTIMATE ASSUMPTIONS

The following assumptions were used in calculating New York's costs:

1. The IVF benefit extends to all insured New Yorkers regardless of the size of the employer (unlike Maryland, no proposal in New York calls for an exemption of small group markets).
2. Does not include any costs related to non-IVF treatments, including the cost of drug therapies.
3. Benefit extends to Medicaid recipients. In this case costing taxpayers nearly $50 million annually.
4. Costs associated with multiple births and low birth weight babies are not included.

[4] *Mandated Health Insurance Services Evaluation (1998)* Maryland Health Care Access and Cost Commission
[5] Kaiser Family Foundation, State Health Facts Online: Population Distribution by Insurance Status 1997-1999
[6] Rutgers Center for State Health Policy, Employer-Sponsored Health Insurance in New Jersey, 2001
[7] Kaiser Family Foundation, State Health Facts Online: Population Distribution by Insurance Status 1997-1999
[8] Kaiser Family Foundation, State Health Facts Online: Population Distribution by Insurance Status 1997-1999

Pennsylvania (1998)

The Pennsylvania Health Care Cost Containment Council (PHC4) was established in 1986, becoming the second state in the country to establish a process for reviewing proposed state mandated health benefits.[9] In December 1998, the PHC4 released a report titled ***"Senate Bill 1183 – Infertility Diagnosis and Treatment Legislation"***, which analyzed pending legislation that sought to required every health insurance policy with pregnancy-related benefits to also provide coverage for the diagnosis and treatment of infertility. The PHC4 recommendation on this proposal was definitive:

> *"Mandating insurance coverage of costly treatments which benefit comparatively few Pennsylvania residents is not a cost effective means of utilizing limited health care resources. With many health care needs not covered and with 12 percent of the adult population in Pennsylvania without even basic coverage, there is no persuasive reason to give infertility treatment special priority under law."*[10]

COMPARE & CONTRAST WITH NEW YORK PROPOSALS

It appears that Pennsylvania's SB1183 served as a prototype to New York's Assembly bill (A.2003). The language pertaining to the types of procedures mandated, the number of attempts permitted and the definition of infertility are similar. One point of departure in the Pennsylvania proposal is the inclusion of a conscience clause. However, on balance, SB1183 provides a sound comparative basis on which to estimate the cost of the Assembly's proposal in New York not only because of the similarity of provisions in each bill, but also due to the regional proximity of the two states.

Pennsylvania's SB1183 served as a prototype for New York's A.2003.

PENNSYLVANIA COST ESTIMATE

To perfect a baseline estimate of the total costs of SB 1183, the PHC4 staff utilized existing U.S. Census and other data on the cost and utilization of ARTs. The report cited a common problem with mandates — they increase the total utilization of health care. After reviewing utilization data in Massachusetts, the commission concluded that "in a five year span from the time of the mandate's passage, assisted reproductive technology utilization in Massachusetts rose to a level that was approximately five times higher than the rest of the United States and Canada."[11] Increasing utilization of infertility treatments continues as a national trend. The New York Times recently reported that between 1995 and 1998, in-vitro fertilization procedures increased by 37% to about 81,000 annually.[12] Anticipated utilization increases are reflected by PHC4s decision to double its estimated utilization rates.

After mandating infertility coverage in Massachusetts, utilization of ARTs increased to nearly 500% of the national average.

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[9] Blue Cross/Blue Shield Website:http://bcbshealthissues.com; State Mandated Benefit Evaluation Laws
[10] Pennsylvania Health Care Cost Containment Council Review of SB1183 – Infertility Coverage (1998)
[11] The Pennsylvania Health Care Cost Containment Council study on SB 1183 – April, 2000
[12] "Fertility Inc.: Clinics Race to Lure Clients", New York Times, January 1, 2002

NEW YORK COST ESTIMATE

Using PHC4 methodologies, the cost for infertility coverage in New York is calculated as follows:

NYS population of females 2000 (21-44)[13]	3,460,108
Less uninsured (17%)[14]	- 588,218
	2,871,890
Less federal ERISA plans exempted from state mandates (23%)[15]	- 660,535
Population eligible for mandated benefits	2,211,355
ART Utilization Rate (0.2% of eligible population)[16]	4,423

According to PHC4, average ART costs are $18,000 (two attempts averaging $9,000/attempt): **$18,000 X 4,423 = $79,613,000.**

According to PHC4, 11% of the recipients require an additional $2,000 in costs for intracytoplasmic **487 X $2,000 = $ 974,000.**

Total New York estimated costs:
$79,613,000 + $974,000 = $ X 2 (increase in utilization) = $161,174,000.

NEW YORK ESTIMATE ASSUMPTIONS:

The following assumptions were used in calculating New York's costs:

1. Costs of drug therapies are ***not*** included.
2. Benefit extends to Medicaid recipients.
3. Costs associated with multiple births and low birth weight babies are not included.
4. Does not factor out "marginal costs" for services that may already be covered under New York's existing mandate.

[13] NYS Data Center, 2000 Census of Population and Housing – summary file #1
[14] Kaiser Family Foundation, State Health Facts Online: Population Distribution by Insurance Status 1997-1999
[15] Rutgers Center for State Health Policy, Employer-Sponsored Health Insurance in New Jersey, 2001
[16] William M. Mercer "Infertility as a Covered Benefit" 1997

Washington State (2001)

Chapter 412 of the laws of 1987 established a process in Washington State for health insurance mandates to undergo a "sunrise review process." The law requires the Department of Health, upon legislative request, to provide lawmakers with an analysis of the social and financial impact of any insurance mandate. The Department is bound to provide the Legislature with this report thirty days prior to the start of the legislative session.

In January 2001, the Department released ***SB6735 Infertility Mandated Benefits Sunrise Review.*** This intensive study concluded:

> *"The Legislature should not enact legislation mandating insurance carriers to cover infertility services for all state-regulated health plans.*
>
> - *Increased utilization can increase the cost of insurance coverage. While savings could be assumed for psychological and productivity costs, it is not measurable. Additional costs for multiple births resulting from infertility treatment needs to be considered. Overall, coverage will result in additional insurance premiums which would be borne by all plan members without offsetting benefits."*[17]

COMPARE AND CONTRAST WITH NEW YORK PROPOSALS

Similar to proposals in New York, SB6735 requires all insurers to include coverage for infertility diagnoses and treatment, including drugs and ARTs. Other provisions include:

1. Requirement that covered person first utilize less costly treatments before resorting to ARTs.
2. Limitation on oocyte retrievals to a lifetime cap of six – unless successful – then a covered individual can receive two more attempts (similar, to the Assembly bill).
3. Requirement that treatments conform to standards established by the American Society for Reproductive Medicine, the Society for Assisted Reproductive Technology and the American College of Obstetricians and Gynecologists (similar to Assembly bill).

WASHINGTON STATE COST ESTIMATE

To calculate a cost estimate, the Washington State report reviewed cost studies from Great Britain, New Zealand and the United States. The report relied primarily on a study from Massachusetts calling it "the most complete analysis of costs" available.[18] In 1989, Massachusetts became one of the first states to pass an infertility law. In 1998, Professor Martha Griffin and Dr. William Panak examined infertility claims data with the Massachusetts Department of Insurance for the period 1986 – 1993. This study, widely touted by infertility advocates, concluded that infertility services in that state cost $1.71 per member per month.

[17] Washington State Dept. of Health; *Infertility Mandated Benefits Sunrise Review,* January 2001
[18] Ibid.

NEW YORK COST ESTIMATE

Infertility advocates have embraced the $1.71 per monthly contract costs as affordable. When factored across the insured population of New York, however, it is a costly mandate.

$1.71 X 12 = **$20.52 annual cost per member**

Individuals covered by employer-sponsored health insurance	9.68 million[19]
Less federal ERISA plans exempted from state mandates (23%)	-2.23 million[20]
Direct Pay Policy Holders (Individual market)	+ .66 million[21]
Medicaid Recipients	+ 2.73 million[22]
Total number of New Yorkers impacted	10.84 million

Total New York estimated costs:
10.84 million fully insured New Yorkers X $20.52 = $222,439,000 total annual costs

NEW YORK ESTIMATE ASSUMPTIONS:

The following assumptions were used in calculating New York's costs:

1. Costs of drug therapies are ***not*** included.
2. Benefits will be extended to Medicaid recipients.
3. Costs associated with multiple births and low birth weight babies are not included.
4. Does not factor out "marginal costs" for services that may already be covered under New York's existing mandate.

[19] Kaiser Family Foundation, State Health Facts Online: Population Distribution by Insurance Status 1997-1999
[20] Rutgers Center for State Health Policy, Employer-Sponsored Health Insurance in New Jersey, 2001
[21] Kaiser Family Foundation, State Health Facts Online: Population Distribution by Insurance Status 1997-1999
[22] Kaiser Family Foundation, State Health Facts Online: Population Distribution by Insurance Status 1997-1999

THE PROBLEM WITH HEALTH INSURANCE MANDATES

Each proposed health insurance mandate is accompanied by compelling stories of needy individuals unable to access health services they desire because their insurance policy does not cover the service. The expansion of infertility benefits is a good example of a proposal that most legislators would want to support. Indeed, providing struggling couples an opportunity to conceive a child in a more cost-effective manner is a worthy goal. However, there is another side of mandates that must be considered — one that suggests mandating these services can be counterproductive to the goal of providing people with even basic coverage. Below we outline some of the problems with mandating health coverage.

MANDATES INCREASE HEALTH CARE COSTS

Mandates are a double-edged sword. They make health insurance more comprehensive, but they also increase premiums. While mandates are typically sold to legislators as "cost cutters," they nearly always cause the cost of health insurance to rise. Both the Washington and Pennsylvania studies cautioned lawmakers about the implications of rising costs when considering mandating infertility service in their respective states. A 1998 Maryland study concluded that the 34 benefits mandated in that state added as much as $785 to each health insurance policy annually, accounting for 15% of the health premium.[23] In Virginia, mandates constituted more than 21% of claims.[24] The ***Employer Alliance*** assumes the 31 mandated benefits in New York have a similar impact on premiums.

In a slowing economy, an employer can handle increased health care costs two ways:
First, they can share a greater portion of the burden with their employees, requiring employees to pay a larger share of their health premiums — in effect reducing employees' salaries to pay for benefits. This approach is already widely used in the administration of pharmacy benefits. As the labor market continues to soften, the ***Employer Alliance*** would expect to see more cost shifting to other portions of the health insurance package as well. Secondly, increased costs cause certain employers to curtail existing non-mandated benefits or drop health insurance coverage for employees altogether. A study by health policy and analysis consultants, The Lewin Group, concluded that for every 1% increase in health care costs, 30,000 New Yorkers lose health insurance coverage. New York's stubborn uninsured problem is not an idle concern. Today 3 million New Yorkers (18%) lack any insurance even though studies indicate that 60% of them are fully employed.[25]

For every 1% increase in premium, 30,000 New Yorkers lose health care coverage.

HEALTH INSURANCE MANDATES HIT SMALL BUSINESSES HARDEST

Many of New York's largest employers are exempt from state health insurance mandates because they are self-insured. Employers that have the capital to underwrite their own health insurance benefits program are exempt from state mandate laws under the federal Employee Retirement Income Security Act (ERISA). It is estimated that at least half the New Yorkers with employer-sponsored health insurance are enrolled in self-insured plans. When surveyed, many

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[23] Maryland Health Care Commission, Mandated Health Insurance Services Evaluation, December 1999
[24] Jensen, Morrissey "Employer-Sponsored Health Insurance and Mandated Benefit Laws, Millbank Quarterly Vol. 77 No. 4 1999.
[25] United Hospital Fund, *Current Population Survey,* March 2000.

employers report they self-fund to save money and have more control of plan benefits. An analysis of self-funded Texas employers showed that approximately 15% of employers that self-insure did so specifically to avoid certain mandated benefits.[26]

The result of an increase in self-insured employers is that the cost of mandates falls predominately on small employers. This triggers premium increases in the small group market at a much faster rate than in the large group market. Unfortunately, small businesses are the least capable of affording premium hikes. According to a 1998 study by Gail Jensen and Michael Morrissey, "in the absence of state mandates, 18% of small businesses without health coverage would buy it."[27] The ***Employer Alliance*** finds it ironic that while lawmakers have devoted considerable attention to the plight of sole proprietors and improving access to small business insurance through programs like Healthy New York, they have failed to address the compelling nexus between health insurance mandates and their impact on small businesses.

HEALTH INSURANCE MANDATES CAN PROMOTE BAD MEDICINE

Health insurance mandates that lack medical efficacy have passed legislatures because of the emotional nature of a disease state. As an example, over the past decade, five states (not New York) enacted measures mandating coverage for autologous bone marrow transplants to treat breast cancer. Clearly, these measures were passed as acts of compassion and hope - but not necessarily in recognition of the science surrounding the procedure. We know today that this mandate was a mistake. These treatments have since been proven ineffective in treating breast cancer and, in fact, were responsible for the needless, painful death of thousands of women who undertook these treatments with the confidence and expectation that the treatment would extend their lives. Despite this history and the science we know today, legislation covering autologous bone marrow transplants to treat breast cancer is one of the hundred mandates still in introduction in New York (A.4845).

Passing mandates that are not medically efficacious is not just a concern for other states. In 2000, New York enacted its 31st mandate — a requirement that called for broad screening of men for prostate cancer through use of the PSA test starting at the age of 40. This was passed even though more than a dozen organizations, including the American Cancer Society, the National Cancer Institute, the U.S. Preventive Services Task Force and the American College of Physicians were on record in opposing indiscriminate mass prostate screening as promoted by New York's law. Data has been uncovered and reexamined that has raised the debate on the efficacy of several screening tests. A recent article in the New York Times stated, "Pap tests for cervical cancer and tests for colon cancer show clear benefits. But evidence for others, like mammography and a blood test for early signs of prostate cancer, is less clear."[28] Medical protocols change on an almost daily basis. We would urge legislators to consider measures to promote physician knowledge and adherence to existing and emerging evidence-based guidelines as opposed to seeking to micro-legislate mandates on dynamic medical protocols.

Infertility treatment efficacy remains elusive. According to the Washington State study, 35% of individuals who seek infertility treatment will unfortunately never have a baby. By our

[26] Texas Dept of Insurance Health Insurance Regulation in Texas Dec. 1998

[27] Jensen, Morrissey "Employer-Sponsored Health Insurance and Mandated Benefit Laws, Milbank Quarterly Vol 77 No. 4 1999.

[28] NYT "Questions Grow over the Usefulness of Some Routine Cancer Tests", Gina Kolata 12.30.2001

estimates, that would mean expenditures of nearly $70 million spent on these services annually would be in vain. Some states that have mandated infertility services have sought to mitigate these concerns by demanding these services be provided solely through Centers of Excellence. New York lawmakers have not embraced this concept – making efficacy of such a measure in this state further suspect.

The Washington report also points out that that 25 to 37 percent of ART deliveries involve multiple births. In 1998, the Managed Care Interface determined that the average cost per low birth weight case (based on national charges) was $87,000. Multiple-births not only increase the immediate cost of health care, they are also tied to later costs often borne by taxpayers related to increased utilization of special medical and educational services.

CONCLUSIONS

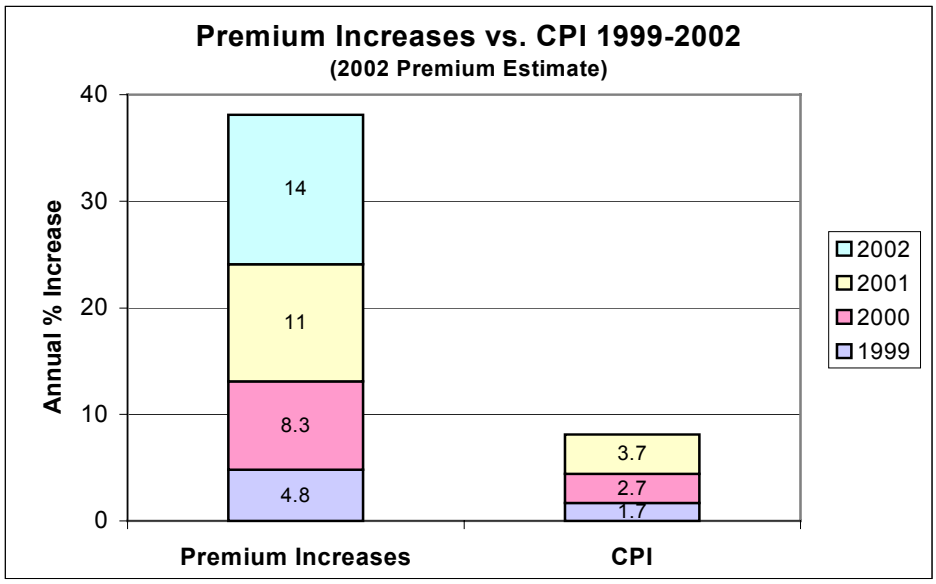
REASSESSING PRIORITIES

The data presented in this report are conclusive — expanding infertility coverage in New York State will conservatively cost some employers and all taxpayers between $161 million - $222 million annually. As a state mandate, the cost of this legislation will fall primarily on the shoulders of those least able to afford it — small employers, sole proprietors and other employers not large enough to self-insure. For ***Employer Alliance*** members, never has there been a worse time to consider such a measure. It is simply unconscionable that during this deepening recession the Legislature would want to levy what amounts to a $100 million + premium tax on employers to fund these services. **The *Employer Alliance* opposes the passage of expanded infertility benefits and calls for a moratorium on all health insurance mandates.**

Without the benefit of a state sanctioned study, many lawmakers are swayed by well intended but often misleading advocates who passionately emphasize that ***making insurance companies pay*** for infertility treatments will have ***little bearing on the overall cost of health insurance***. Unfortunately, these assertions are incorrect. The experience of ***Alliance*** members is that insurers pass these increases along to payers in the form of higher premiums, making New York's health care costs — already among the highest in the nation — climb higher. **The *Employer Alliance* supports New York joining with twenty-two other states in establishing a process to evaluate all health insurance mandates prior to legislative consideration.**

The acceleration of health care costs is not mere speculation. A new report by the National Health Statistics Group states, "spending growth in 1999 and 2000 slightly outpaced growth in gross domestic product (GDP) the first sign that the nine-year stability in health spending share of GDP may be coming to an end." Health care costs have increased precipitously (in excess of 24%) for the past three years and are predicted to climb an additional 14% in 2002 (Chart #2).

(Chart #2) [29]



[29] Job-Based Health Insurance in 2001: Inflation Hits Double Digit, Managed Care Retreats, Health Affairs 2001 (Vol 20 No.5) - CPI data provided by US Department of Labor, Bureau of Statistics

Employers, particularly small employers, are looking to government to find relief from these costs so that they can continue to provide effective comprehensive coverage for their employees. Achieving that goal becomes more difficult as each mandate is passed. New York's costs are already too high. **The *Employer Alliance* believes that mandates should be capped at no more than 10% of entire premium.**

The attacks of September 11 and the subsequent softening of New York's economy provide lawmakers with an opportunity to reassess our state's health care priorities. ***We can make health insurance more affordable and accessible***. To achieve this goal, the ***Employer Alliance for Affordable Health Care*** urges the following:

1. **A moratorium on all health insurance mandates until a process is put in place that will require a study to understand the impact of proposed mandates on premium payers.**
2. **A study of New York's existing 31 mandates to understand their costs and any barriers to access to coverage they may have created.**
3. **A cap on the total cost of mandates to no more than 10% of the total annual premium.**
4. **Pass legislation that will encourage greater provider adherence to current and changing medical protocols.**

* * *

The ***Employer Alliance for Affordable Health Care*** is a coalition of 1,200 businesses and business organizations employing more than 90,000 New Yorkers statewide. ***Alliance*** members are dedicated to maintaining affordable quality health care that is accessible to all New Yorkers. Skyrocketing health care costs are taking a toll on business owners throughout the state and the ***Employer Alliance*** is increasingly concerned about the growing cost of health care, the state's rising number of uninsured and the appropriateness of passing health insurance mandates during economic recessions.