STATE OF MAINE
118TH LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSIONS

Final Report of the

BLUE RIBBON COMMISSION TO STUDY THE EFFECTS OF GOVERNMENT REGULATION AND HEALTH INSURANCE COSTS ON SMALL BUSINESSES IN MAINE

January 1998

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EXECUTIVE SUMMARY

The Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine was established by Resolve 1997, chapter 85. The Commission was chaired by Rep. Arthur F. Mayo III and included members representing the Legislative and Executive branches of state government, state employees, employee unions and the business sector.

Because the Commission was affected by a delay in the appointment of members, it directed its primary efforts on addressing the effects of health insurance costs on small businesses. The Commission conducted a cursory review of the effects of government regulation on small businesses and recommends that additional time and resources be devoted to this issue in the future. The Commission's study of health insurance costs focused on four areas: 1) identifying and defining the small group health insurance market; 2) mandated health insurance benefits; 3) private purchasing alliances; and 4) tax incentives. In the area of government regulation, the Commission focused on three areas: 1) the laws and rules that affect small businesses; 2) the ways in which businesses receive notice of changes in laws and rules; and 3) the efforts of state government to streamline its rules and coordinate its regulatory framework.

The Commission makes the following recommendations.

1. The Commission recommends that the review process for mandated benefits be amended by adding the following criteria:

- **cumulative impact of mandates with addition of a proposed mandate**
- **impact of requiring a mandate to apply to state employee health insurance program**
- **applicability of a mandate to health maintenance organizations and its effect on concept of managed care**
- **extent to which provisions of a mandate are available under self-insured ERISA plans and collectively bargained plans**
- **prohibit proposed mandated benefits from being introduced in the Second Regular Session**
- **require the joint standing committee having jurisdiction over insurance matters to hold a public meeting for the presentation of review and evaluation by the Bureau of Insurance**
- **require the joint standing committee having jurisdiction over insurance matters to determine if proponents of mandate have demonstrated need for review and evaluation of proposal by Bureau of Insurance**

2. The Commission recommends that the Joint Standing Committee on Taxation and the Legislature consider enacting legislation that contains tax incentives aimed at individuals and small businesses. The Commission will forward a copy of the report to the Taxation Committee and work with Committee toward enactment of legislation. The purpose of the incentives would be to lower employee health insurance costs; encourage small businesses

to provide their employees health insurance; and encourage employees to participate in workplace health insurance plans.

3. The Commission recommends that the Maine Congressional delegation consider improving access to medical savings accounts and stepping up the phasing-in of the self-employment health insurance deduction. The Commission will communicate with the delegation and forward a copy of the report.

4. The Commission recommends that the private purchasing alliance laws be amended to encourage the establishment of alliances by removing the restriction on participation of insurance producers, independent producers and producer agencies in a purchasing alliance and by removing the requirement that a purchasing alliance be a nonprofit entity.

5. The Commission recommends that the Governor issue an Executive Order requiring each state agency to annually summarize statutory changes from the most recent Legislative Session, post summaries on the Internet and distribute the summaries to key constituencies.

6. The Commission recommends that the joint standing committee of the Legislature having jurisdiction over economic development matters periodically review the operation of the One-Stop permit center within the Department of Economic and Community Development. The purpose of the review would be to ensure DECD has adequate staff and resources to provide this service.

7. The Commission recommends that the Legislature's Presiding Officers write the chairs of each joint standing committee of the Legislature reminding the chairs of their committees' responsibilities under Title 5, section 8060 of the Maine statutes for reviewing regulatory agendas.

8. The Commission recommends that the Commission be reestablished to continue its study of the effects of government regulation on small businesses and report back to the Legislature by November 1, 1998.

INTRODUCTION

The Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine was established in the First Special Session of the 118th Legislature by Resolve 1997, chapter 85. The legislation creating the Commission, LD 1905, was introduced by Senator Bruce MacKinnon and was presented before the Joint Standing Committee on Business and Economic Development.

The Blue Ribbon Commission consisted of 12 members: six members appointed by the Governor; three members appointed by the Speaker of the House; and three members appointed by the President of the Senate. The Commission was comprised of individuals that represented the Legislative and Executive branches of Maine State Government, the business sector, employee unions, and state employees. The Commission members were as follows:

- Representative Arthur F. Mayo III, Chair
- Senator Bruce W. MacKinnon
- Representative Jane W. Saxl
- Timothy Agnew, CEO, Finance Authority of Maine
- Douglas S. Carr, Esquire, Perkins, Thompson, Hinkley & Keddy
- Thomas J. Giordano, Maine Revenue Service
- Edward Gorham, Maine AFL-CIO
- Commissioner S. Catherine Longley, Department of Professional & Financial Regulation
- Commissioner Thomas D. McBrierty, Department of Community & Economic Development
- James McGregor, Maine Merchants Association
- Patrick Murphy, Pan Atlantic Consultants
- Peter Sassano, Hahnel Bros. Co.

Although the legislation which created the Commission had an effective date of September 19, 1997, due to a delay in the appointment process, the Commission was not convened until December 1, 1997. The members selected Rep. Arthur F. Mayo III to chair the Commission.

In addition to this first meeting, the Commission held four other meetings. These meetings occurred on December 10, 1997, December 17, 1997, December 31, 1997 and January 6, 1998. The first two meetings of the Commission focused on fact finding and information gathering in the areas of government regulation and health insurance and their effects on small businesses in Maine. Several parties were invited to present to the Commission. These included individuals from the Bureau of Insurance, the National Federation of Independent Business, the private insurance industry, the Governor's office, and the Maine Department of Economic and Community Development. The last two meetings were devoted to Commission discussions of recommendations and review of the final report. Meeting summaries are included in Appendix F.

Resolve 1997, chapter 85 established January 1, 1998 as the reporting date of the Commission. Due to the relatively short time frame that the Commission was given to complete its work, December 1, 1997 - January 1, 1998, the Commission decided to request a reporting deadline extension to January 16, 1998. The extension request was approved by the Legislative Council.

COMMISSION'S CHARGE AND FOCUS

The Commission's first matter of business was to discuss its charge. The charge given to the Commission in Resolve 1997, chapter 85, addressed two areas and was very broad: To study the effects of: 1) government regulation; and 2) health insurance costs on small businesses throughout the State. Because the Commission had only a short time to complete its work, it decided to focus much of its effort on the effects of health insurance costs on small businesses. Members decided that the health insurance field provided defined issues that could be examined in a timely manner. In contrast, members decided that an examination of government regulation would require a significant amount of time in order to thoroughly survey problems and define solutions. Therefore, the Commission decided to take a cursory review of government regulation relative to small businesses and make recommendations regarding further review in this area.

Health Insurance: Areas Of Focus

The Commission began its study of health insurance by identifying and defining the small group business market. In its findings and recommendations on health insurance, the Commission focused on four major areas: 1) the small business group market; 2) mandated health benefits; and 3) incentives for employers to provide health insurance; and 4) private purchasing alliances.

Small business group market: The Commission decided that its study of health insurance costs on small businesses would benefit from an examination of the current small group market in Maine. Among the issues the members decided to look at were:

- the types of insurance plans being utilized in the small group market;
- the pricing of insurance plans;
- the availability of insurance plans to small group employers and employees;
- private purchasing alliances; and
- the effect of community rating on the small group health insurance market.

Mandated health benefits: The Commission decided that there were several issues within mandated health benefits that they wanted to examine. These included:

- the Legislature's process for reviewing requests for mandated benefits;
- Maine's enactment of mandated benefits relative to other states;
- the application of mandated health benefits to various types of insured groups;

- the impact of mandated benefits on health insurance costs; and
- the impact of mandated benefits on the ability of small businesses to provide their employees health insurance.

Incentives for employers: The Commission members decided that they would examine the realm of existing and potential incentives available to encourage small businesses to provide health insurance, while at the same time relieving small businesses from the high costs of providing health insurance to their employees. These incentives included:

- income tax credits
- income tax deductions
- medical savings accounts

Private Purchasing Alliances: The Commission decided that it would examine the private purchasing alliance statutory provision and explore the reasons why a private purchasing alliance has not been established in the State.

Government Regulation: Areas Of Focus

Although the Commission decided early on that it would not have enough time to do a thorough study of government regulation effects on small businesses in Maine, it agreed that a cursory review of government regulation would be plausible. To accomplish this task, the Commission decided to examine the spectrum of regulations to which a small business is currently subject. The Commission focused on three areas: 1) the laws and rules that affect small businesses; 2) the ways in which businesses receive notices of changes in laws and rules; and 3) the efforts of state government to streamline its rules and coordinate its regulatory framework.

SMALL BUSINESSES IN MAINE

Based on statistics provided by the Maine Department of Labor, the number of private businesses (excluding government) in Maine as of March 1996 was 37,286. 96 percent of these private businesses employed 50 or fewer employees. Please refer to Figure I below.

As of March 1996, the total number of employees in Maine was 419,575. 49.1 percent of the total number of employees in Maine worked for private employers with 50 or fewer employees. Please refer to Figure 2 below.

Figure I: Number of Private Employers in Maine Based on Number of Employees

Number of Employees	Number of Private Employers (excluding government)	Percent of Total Private Employers (excluding government)
0-4	22,363	59.9%
5-9	6,892	18.5%
10-19	4,225	11.3%
20-49	2,385	6.3%
50-99	831	2.2%
100-249	446	1.2%
250-499	87	.02%
500-999	38	.01%
1000 and over	19	.005%

Total number of private employers = 37,286
Source: Table B from the 1996 Maine Employment and Earnings Statistical Handbook, March 1996

Figure 2: Number of Employees in Maine Based on Employer Size

Number of Employees	Number of Private Employees (excluding government)	Percent of Total Private Employees (excluding government)
0-4	33,221	7.9%
5-9	45,493	10.8%
10-19	56,628	13.4%
20-49	71,527	17%
50-99	56,871	13.5%
100-249	65,746	15.6%
250-499	30,463	7.2%
500-999	24,604	5.8%
1000 and over	35,215	8.3%

Total number of employees = 419,575
Source: Table B from the 1996, Maine Employment and Earnings Statistical Handbook, March 1996

Although Maine does have a high concentration of its private employers within the 50 or fewer employees range, Maine is not unique compared with the rest of the nation in this regard. Maine does, however, have a slightly higher percentage (40.8%) of its employees working in firms which employ 50 or fewer employees than the national average (36.8%).

THE EFFECTS OF HEALTH INSURANCE COSTS ON SMALL BUSINESSES

One of the primary charges of the Commission was to address the effects of health insurance costs on small businesses in Maine. The Commission received testimony from representatives of small businesses that health insurance costs are a significant concern for employers. Based on the U.S. Census Bureau's Current Population Survey of March 1997, the percentage of Maine's

employees under 65 without health insurance coverage is 14 percent. Of those Maine employees covered by health insurance, 76.2 percent are covered by employment based plans.

The size of the employer had an impact on whether or not an employee had health insurance. Among Maine workers in firms with 1,000 or more workers, 72.1 percent have coverage through their employer in their own name and are not covered under a spouse's policy, compared with 28.4 percent of workers in firms with fewer than 10 employees.

A recent study published in *Health Affairs* based on findings from the Medical Expenditure Panel Survey indicates that employment-based insurance coverage has fallen in recent years. The study found that coverage has declined because fewer numbers of employees are opting for the benefit. During the same period, the rate of employers offering health insurance to employees has increased . One reason cited for the decline is the rising costs of health insurance premiums. Insurance premiums for health insurance increased 90% between 1987 and 1993 while wages and salaries increased only 28% during that same period. Another reason cited for the decline is that employees are being asked to pay a greater portion of their health insurance coverage by employers. A copy of the study is included in Appendix J.

Under current law, the small group health insurance market operates under a system of community rating and other requirements. In its work, the Commission did not address the overall regulation of the small group health insurance market. Instead, the Commission focused on issues that directly impact the question of access to health insurance (and hopefully, indirectly impact the question of cost) for small employers and their employees. In its discussions, the Commission highlighted several factors that may impact the decision of small businesses to provide health insurance as a benefit to its employees: mandated health insurance benefits, tax incentives and the establishment of private purchasing alliances. While some of these factors do not directly impact the bottom-line costs of health insurance coverage, the Commission felt the issues were relevant to increasing access and competition in the small group health insurance market.

Small Group Health Insurance

Currently, there is no state or federal law that requires employers, large or small, to provide health insurance as a benefit to employees. In fact, the federal Employee Retirement Income Security Act's (ERISA) preemption clause has long been interpreted as prohibiting the enactment of any state law that imposes a mandate on employers to provide health insurance, in whole or in part, to employees. The preemption clause states that "any state law relating to an employee welfare benefit plan is preempted." However, federal law does grant states the authority to regulate the "business of insurance." As such, states may regulate the health insurance policies and contracts sold in their states by insurance companies and other licensed health carriers like health maintenance organizations.

Using its authority to regulate the insurance industry, Maine has enacted several laws in the 1990's that impact the health insurance policies sold to individuals and to small groups, namely small employers. These requirements must be met by every small group insurance policy or

contract issued or renewed in the State. The following provides a brief overview of the statutory requirements applicable to small group insurance policies.

Definition of Small Group

Until recently, Maine law defined a small group for insurance purposes as any type of business with fewer than 25 employees. However, as of July 1, 1997, a small group is one with 50 or fewer employees. This change in the definition maintains parity with how federal law defines a small group health insurance plan. Eligible employees are those who work 30 or more hours a week. At the employer's option, part-time employees working as few as 10 hours a week or retired employees may be treated as eligible employees. Self-employed individuals with no other employees may be considered an eligible small group, but insurers have the option of offering self-employed individuals an individual policy instead of a small group policy.

Elsewhere in Maine statutes, there are inconsistencies in the definition of small group or small employer. For example, some mandated health insurance benefits exempt groups of 20 or fewer members or 12 or fewer members from the applicability of the statute. And in the labor laws, small employers of 15 or fewer employees are exempted from the requirements of the Family Medical Leave Act. Although the Commission does not make any recommendation on this issue, it noted these inconsistencies and believes that uniformity in the definition of small business throughout Maine law is important.

Community Rating

Community rating refers to the rate to be charged to all eligible groups for small group health insurance plans prior to any adjustments in the rate. The community rate is determined by the insurance carrier or HMO and differs among each insurer and for each health insurance plan. The rate may not take into consideration individual characteristics like gender, health status, claims experience or policy duration. The rate must be applicable to all eligible members of a small group. For example, there may be one rate for an individual employee, one rate for an employee with children, another rate for an employee and spouse and another rate for an employee, spouse and children. Rates may also vary based on the size of the group.

Under current law, the rates for small group health insurance may not vary based on gender, health status, claims experience or policy duration. For groups with fewer than 25 employees, rates may vary based on age, tobacco use, industry and geographic area but the variation may not be more than 20% above or below the "community rate" for all of these factors combined. For small groups between 25 and 50 employees, the rates may not vary by more than 40% above or below the "community rate" in 1998; by more than 30% above or below the "community rate" in 1999; and after January 1, 2000, the rates may not vary by more than 20% above or below the "community rate."

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Guaranteed Issuance

maintenance organization that sell insurance to the small group market must provide coverage to any small employer who applies for coverage that meets the carrier's participation requirements.

and their dependents who do not have other coverage.

Guarantee Renewal

employees and their dependents except in cases of nonpayment of premium; fraud or material misrepresentation by the policy holder, employer or eligible individuals; noncompliance with the

group market.

Continuity of Coverage

they change to another group or individual insurance policy if they had prior coverage at any time during the 90 days before the discontinuance of the replaced contract or policy or within 180 days

insurers waive any medical underwriting or preexisting condition exclusion to the extent that benefits would have been payable under the prior policy or contract. The requirements also

continuity of coverage.

Preexisting Condition Exclusion

coverage takes effect may be subject to a preexisting condition exclusion of not more than 12 months. In large and small group contracts, a preexisting condition exclusion may relate only to

during the six months immediately preceding the effective date
of coverage. A preexisting condition exclusion relating to pregnancy may not be imposed. And

the absence of a diagnosis of the condition relating to that information.

It is important to note that the reforms enacted in Maine relating to small group insurance plans including guaranteed issuance, guaranteed renewal, preexisting condition exclusions continuity of predated the adoption of similar
these reforms in 1993, the federal law was not enacted until the passage of the Health Insurance Portability and Accountability Act of 1996. The federal law makes the requirements applicable to

many of the substantive provisions of the federal law, the Legislature needed to enact only

conforming legislation in the 118th Legislature's First Regular and First Special Session. The Commission noted that the enactment of these requirements at the federal level makes any changes in state law regarding small group health insurance unlikely without a corresponding change in federal law.

Standard and Basic Plans

All carriers selling small group health plans in Maine must offer 2 standardized plans defined by rule by the Bureau of Insurance. These plans called the basic and standard plan must meet the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services that are applicable to small group plans. The basic and standard plan differ in the benefit plan design and the premium rates. The premium rates charged by carriers for the basic plan may not exceed 80% of the corresponding rate charged by that carrier for the standard plan.

The effect of the small group (and individual) insurance market reforms described above have been evaluated in a recent report to the Maine Bureau of Insurance conducted by Towers Perrin Integrated Health Systems Consulting, a national actuarial and consulting firm. The report was completed in December 1997 and is now available from the Bureau of Insurance.

Mandated Health Insurance Benefits

Mandated health insurance benefits refer to state laws requiring insurers and health maintenance organizations (and indirectly, employers) to provide certain benefits as part of health insurance policies and contracts. These types of laws were first enacted thirty years ago by state legislatures. A mandated insurance benefit is a statutory requirement that health insurance coverage be provided for specific health services, specific diseases or physical conditions or for services rendered by certain providers of health care services. Mandated benefits must be included as part of the overall benefit package provided to policyholders. A mandated offer is a statutory requirement that health insurance coverage for specific health services, specific diseases or physical conditions or for services rendered by certain providers of health care services be offered to policyholders as part of insurance policies. With mandatory offers, the policyholder has the option of purchasing insurance coverage for a specific benefit. While policyholders are not required to purchase coverage for the benefit, providers of health insurance are required to offer the specific coverage to policyholders at the policyholders' expense.

Mandated Insurance Benefits Required Under Maine Law

Under Maine law, there are more than 20 different mandated insurance benefits and 7 mandated offers of health insurance benefits that require coverage for certain health care services and certain health care providers under insurance policies sold in the State. While some mandated benefits exclude small groups of 20 or fewer employees, there are mandated insurance benefits that apply to both individual and small group policies as well as large group policies and contracts. A chart of mandated benefits required under Maine law is included in Appendix G.

In Maine, health insurance coverage is mandated for specific health services and specific diseases like:

- maternity, newborn and child coverage;
- mental health and substance abuse treatment;
- biologically-based mental illnesses;
- screening mammograms;
- breast cancer treatment, including inpatient hospital care, breast surgery and reconstruction after mastectomy surgery;
- metabolic formula and modified low-protein food for persons with inborn errors of metabolism; and
- medical supplies, equipment and self-management training for diabetics.

Mandated offers of health insurance coverage include:

- home health services; and
- cardiac rehabilitation services.

Health insurance coverage is also mandated for certain providers of health care services through requirements that the services of the providers be reimbursed by insurers. These providers include:

- dentists;
- psychologists;
- clinical social workers;
- certified nurse specialists in psychiatric and mental health nursing; and
- chiropractors.

Mandated offers of coverage and reimbursement for health care services are required for the services of:

- optometrists; and
- licensed counselors.

As noted above, the standard and basic plans required to be offered in the small group insurance market are also subject to any mandated insurance benefits made applicable to small groups. The main concern about mandated health insurance benefits is the impact of these mandates on the overall costs of health insurance premiums. Many insurers, health maintenance organizations and employers believe mandates have a significant impact on health insurance premiums, especially in the small group market. Another concern often raised is the effect mandates have on the flexibility of both insurers and employers to design the health insurance coverage offered to small groups and employees.

Applicability of Mandated Insurance Benefits Laws

Maine's insurance laws are contained in Title 24 and Title 24-A of the statutes and regulate entities licensed to sell insurance in this State. There are three types of regulated entities that are authorized to sell health insurance and health care plan contracts: nonprofit hospital and medical

service organizations, for-profit insurance companies and health maintenance organizations. Title 24 regulates nonprofit hospital and medical service organizations, e.g. Blue Cross Blue Shield, and Title 24-A regulates for-profit insurers and health maintenance organizations.

Maine laws relating to mandated health insurance benefits and mandatory offers of such benefits require that certain health care services, certain health conditions and diseases, or certain providers of health care services be included as standard benefits in insurance policies and contracts sold in the State. Depending on the particular benefit and the decision of lawmakers, these laws have been applied to all individual contracts, to all group contracts, to group contracts according to group size and to one, some or all of the types of regulated entities.

Recently, the scope of mandated benefits have been extended to health maintenance organizations as the operation of health maintenance organizations has grown throughout the State. While this has been the trend, it is important to note the dichotomy between the principles of managed care with its emphasis on preventive care and management of health care services and costs through a primary care physician and mandated health insurance benefits which legislate certain health care services and allow self-referrals without prior authorization of primary care physicians.

Maine's mandated insurance benefits laws do not apply to self-insured employer health benefit plans, to coverage provided through federal programs like Medicaid and Medicare and to coverage provided to federal employees. Self-insured plans are exempted from state regulation by the federal Employee Retirement Income Security Act (ERISA). ERISA preempts any State laws relating to employee benefit plans, including health plans. However, ERISA does contain a provision which preserves a State's authority to regulate insurance. Since ERISA's enactment in 1974, the courts have interpreted these provisions to remove self-insured employer health plans from the application of state laws regulating insurance companies and insurance contracts, including mandated insurance benefit laws. Nationally, it is estimated that more than 40% of all employer health benefit plans are self-insured. It is important to note that while Maine law requiring coverage for certain health care services does not apply to these types of programs there are provisions in federal law that require self-insured plans, Medicare and Medicaid to provide coverage for certain benefits and health care providers.

Generally, mandated health insurance benefits do apply to the State Employee Health Insurance Program. Because the State Employee plan is not a self-insured plan, the requirements of mandated benefits will apply to the state plan like all other group health insurance contracts. In one instance, however, the State Employee Health Insurance Program was exempted from the requirements of the mandated insurance benefit for self-referred chiropractic services.

Review and Evaluation of Proposed Mandated Insurance Benefits

Under current law, proposed legislation relating to a mandated health insurance benefit must be reviewed and evaluated by the Bureau of Insurance before being enacted into law. 24-A MRSA §2752. A copy of the provision is included as Appendix H. The statute requires that the joint standing committee of the Legislature having jurisdiction over the proposal hold a public hearing and determine the level of support for the proposal among the committee members. If there is

substantial support for the proposed mandate in the committee, the committee may request review and evaluation of the proposal by the Bureau of Insurance. In conducting the review and evaluation of the proposed mandated health insurance benefit, the Bureau of Insurance must address a number of criteria outlines in the statute that focus on the social impact, financial impact and medical efficacy of mandating the benefit as well as the effects of balancing those considerations. After review and evaluation has been completed by the Bureau of Insurance, a proposed mandated health insurance benefit may or may not be enacted by the Legislature. However, review and evaluation of the proposal is required before a mandated benefit may be enacted. A mandated offer (or option) is not considered a mandated health insurance benefit and does not require a review and evaluation.

Because of this statutorily required procedure, legislation proposing mandated health insurance benefits is somewhat unique as part of the committee process. After scheduling and holding a public hearing on a mandated health insurance benefit proposal, the committee generally discusses the proposal or holds a straw vote to determine the level of support for the proposal and to determine whether or not a request for a review and evaluation should be made to the Bureau of Insurance. If a review and evaluation is requested, the committee delays any further consideration of the proposal in work session until the review has been completed. While the review and evaluation must be completed in a timely manner, the bureau often needs a few months or more to gather the necessary information and conduct its review of the proposed mandate. Very often, the committee will carry over a proposed mandate bill from the First Session to the Second to allow the Bureau additional time to complete the review. The most recent reviews and evaluations of proposed mandates have been conducted for the Bureau of Insurance by a consulting firm, William M. Mercer, Inc. The Bureau of Insurance expects that it will continue to contract with a consultant for the preparation of reviews and evaluations requested by the committee.

Proposed mandates introduced in the Second Regular Session present a particular challenge for the Bureau of Insurance because bills cannot be carried over to the next elected Legislature and the review and evaluation must be completed before the end of the Second Regular Session. Once the review is complete, the committee begins work sessions on the proposed bill and reports its recommendation on the proposal to the Legislature.

Although review and evaluation is required by the statute, the Legislature is not bound to follow this procedure and may amend or even repeal the statute. As such, the procedures outlined in the statute reflect a policy decision more than a legal requirement. The process allows the Legislature to make determinations on mandated benefit proposals with the benefit of time and informed input from the Bureau of Insurance on the proposal's medical efficacy and social and financial impact.

Findings of Commission

With regard to mandated insurance benefits, the Commission finds that mandates do have a direct impact on health insurance costs, especially if the cumulative impact of mandates are considered. The Commission notes that actuarial estimates are difficult to make about the individual and cumulative impact of mandated health insurance benefits. However, a recent study from the

National Center for Policy Analysis done by Milliman & Robertson, an actuarial firm, estimated the costs of 12 of the most common mandated insurance benefits nationally and found that cumulatively the mandates can increase costs by as much as 15%-30%. A copy of the study is included as Appendix K. And in a cost analysis conducted in late 1995, Rick Diamond, Life and Health Actuary with the Bureau of Insurance estimated that 7 mandated benefits required under Maine law have a cost impact. The cost impact was measured by determining if the benefit would be likely reduced or eliminated in the absence of a mandate. These mandates included mental health and substance abuse treatment, screening mammography, breast reconstruction surgery, treatment for metabolic errors and services provided by chiropractors and, possibly, dentists. Based on tracking the amount of health claims paid for mandated benefits and the total amount of health claims paid, the total cost of mandates was estimated to be 6% or less. However, this estimate does not reflect any cost impact of mandated benefits that became effective or were enacted after January 1, 1996. A copy of the memo prepared by Rick Diamond is included as Appendix I.

While the costs of mandated insurance benefits are considered by lawmakers, the Commission notes that mandated health insurance benefits often present a very compelling interest to the Legislature. In every legislative session, the Legislature is confronted with new proposed mandates or the reintroduction of mandate proposals not approved in past sessions. The Commission also notes the recent interest of Congress in enacting mandated health insurance benefits at the federal level that apply to health insurers and self-insured ERISA plans alike. These mandates address hospital coverage for maternity stays and mental health parity coverage.

The Commission finds that the current process for reviewing and evaluating proposed mandated insurance benefits should be improved so that the Legislature will have the benefit of useful information before making the policy decision about whether or not to enact future mandated health insurance benefits.

Private Purchasing Alliances

Maine law authorizes the voluntary establishment of a private purchasing alliance. An alliance is a nonprofit corporation licensed under the Insurance Code to provide health insurance to its members through multiple unaffiliated carriers. Alliances are authorized to set their own standards for membership in the alliance. These entities are designed to provide additional options for the purchase of insurance by small employers. Although the law became effective in July 1996 and the rules governing alliances were finally adopted in March 1997, there are no licensed purchasing alliances in the State.

Purchasing Alliance for Small Group Market

The Commission highlighted the benefits of a purchasing alliance for small businesses as:

- the ability of small businesses to combine purchasing power and influence to spread the insurance risk across a larger group; and
- the opportunity to provide more employee choice through an offering of multiple plans through the alliance.

The Commission also discussed the reasons that a purchasing alliance has not been established in the State despite continued interest in the business community. The Maine Chamber and Business Alliance has explored the possibility of sponsoring a purchasing alliance but does not feel that it has the membership among small businesses to achieve the critical mass of enrollees needed to make an alliance viable. The Chamber's membership includes more large business among its members than small businesses, many of which have self-insured plans and are exempt from state law requirements under ERISA. Other organizations that represent small employers, like the Maine Merchants Association and the NFIB-Maine Chapter, also lack the critical mass of enrollees. The Commission was told that a minimum of 10,000 lives are needed to make a purchasing alliance viable.

At its third meeting, John Benoit of the Holden Insurance Agency in Portland, Maine made a presentation to the Commission of a purchasing alliance model for small employers. This model utilizes the normal brokerage network for distribution of the alliance plan along with a common enrollment form and marketing material for carriers and health plans offered through the alliance. This would ensure that carriers belonging to the alliance are potentially presented and marketed to every employer in the State. While the participation of carriers and the offering of multiple plans is similar to purchasing alliances developed in other states, Mr. Benoit's model is unique because it envisions the use of some sort of mechanism, either stop loss insurance or reinsurance, to help minimize the impact of large losses on participating carriers. It is the opinion of the Bureau of Insurance that the purchase of stop loss or reinsurance by participating carriers would not be prohibited under the current statute.

At this point, Mr. Benoit's model is a concept although it has been presented to the Bureau of Insurance, the Maine Chamber and Business Alliance, the Greater Portland Chamber of Commerce and the Maine Health Management Coalition ("MHMC"). The MHMC endorses the concept but is not interested in being the plan's sponsor because their members are large businesses.

The barriers to developing such a purchasing alliance noted by Mr. Benoit include: the restriction on insurance agents and industry members to participate in the organization of the alliance; the risk adjustment provisions may need to be more detailed as to what types of arrangements are permissible; and requirement that the alliance be nonprofit which prohibits private entrepreneurship. The funding for the start up costs of an alliance (estimated to be between $250,000 and $500,000) is also a significant barrier. Currently, there are no provisions allowing state funding for the alliance.

Findings of Commission

The Commission finds that the legislative barriers to the establishment of a private purchasing alliance should be removed. The Commission does not believe there is any significant interest for the state to sponsor a purchasing alliance, especially one including state employees, but believes that the private sector should not be overly restricted by the licensing and regulatory requirements for a purchasing alliance. The interests of government in maintaining the proper oversight of the alliance for the protection of the enrollees and the interests of the private sector must be balanced. The Commission notes that the presence of a purchasing alliance for the small group market can increase access and competition in the market.

Tax Incentives

The Commission discussed three tax-related issues that impact health insurance costs for small business: state tax incentives; medical savings accounts; and the deductibility of health insurance costs for self-employed individuals for federal income tax purposes.

Tax Credits and Deductions for Small Employers and Employees

During the First Session of the 118th Legislature, the Legislature's Taxation Committee considered three bills related to tax incentives for small employers and employees to have health insurance. LD 18, An Act to Give Small Business Employer Health Benefit Tax Relief, proposed a tax credit to employers of 50 or fewer employees for the lowest of: $5000; 20% of the costs incurred by the taxpayer in providing insurance; or $100 for each employee covered by the employer-provided health insurance. LD 70, An Act to Provide a State Income Tax Credit for the Costs of Health Insurance Paid by Individuals, proposed a tax credit equal to 50% of the health insurance premiums paid by individuals whether or not the individual paid the full premium or contributed toward the costs. The credit was limited to $4000 per year. LD 164, An Act to Provide Tax Credits for Small Businesses Providing Health Insurance Benefits for Employees, proposed to provide a tax credit equal to 25% of the health insurance costs incurred by an employer of fewer than 25 employees. Although all of these proposals were voted out by the Taxation Committee "Ought Not To Pass", Commission members noted that there was interest in the proposals. The primary reason these proposals and other tax incentives were not fully considered was the decision by the Taxation Committee not to pursue individual tax reform proposals piecemeal but if possible to address overall tax reform. Members also noted that changes in the State's revenues and the available surplus in the upcoming session may be factors that will may positively influence the consideration of tax incentive proposals this session.

This session, the Legislature will consider two pieces of legislation addressing tax incentives in some manner. LD 1931, An Act to Create Incentives for Employers to Contribute toward the Costs of Comprehensive Health Insurance for Families. LD 1931 provides a credit to employers providing health insurance equal to the excess of health insurance costs over 7.5% of gross payroll; a deduction for individuals equal to 20% of the health insurance premium paid by the taxpayer; and a reduction in the calculation of income for the purposes of eligibility for the

Property Tax and Rent Rebate Program equal to the amount of insurance premium paid for preventive care. LD 1945, An Act to Minimize State Revenue Loss Due to Ineffective Health Coverage, provides a tax credit for any employee that pays at least 60% of the costs of an employee health benefit plan that meets the minimum requirements for a small group health plan. The credit is equal to the lowest of: $5000; 20% of the costs incurred by the taxpayer in providing insurance; or $100 for each employee covered by the employer-provided health insurance.

Medical Savings Accounts

Under federal law, a pilot program has been established for medical savings accounts, The program is limited to 750,000 individuals and available to employees of small businesses (50 or fewer employees) and to self-employed individuals. Medical savings accounts (MSA) are tax free accounts that can be used to pay for medical expenditures. Under the federal pilot program, individuals must be covered by a high deductible catastrophic plan and have no other health insurance coverage. The deductibles must range between $1500 -$2250 for individuals and $3000-$4000 for families. Contributions of up to 65% of the cost of the deductible for individuals and up to 75% of the deductible for families may be made to the MSA by either the employer or the individual. Money in the MSA may be used tax free for medical expenses or is subject to a 15% penalty for individuals under age 65. Individuals 65 or older can withdraw the money for any purpose but the withdrawals will be taxed.

Medical savings accounts became available through the federal program on January 1, 1997 and enrollments began then. According to a recent Internal Revenue Service report, only 22,051 medical savings accounts were established as of June 30, 1997. The Commission received information from the Bureau of Insurance that it is aware of two carriers offering the product in Maine.

Under state law, Maine does not have any statutory provisions allowing the establishment of medical savings accounts which would extend particular state tax benefits. The first state to enact a MSA law was Colorado in 1986. Based on information from the National Conference of State Legislatures, there are currently 23 states with laws addressing medical savings accounts in some manner.

Deductibility of Health Insurance Costs for Self-Employed Individuals

Under prior law, self-employed individuals were eligible for a federal income tax deduction of 30% from gross income for the costs of health insurance for themselves, their spouses and dependents. Recently, Congress increased the deduction beginning in tax years beginning after December 31, 1996. The deduction is phased in according to the following schedule: 40% in 1997; 45% in 1998 and 1999; 50% in 2000 and 2001; 60% in 2002; 80% in 2003, 2004 and 2005; 90% in 2006; and 100% in 2007. There is no equivalent deduction for state income tax purposes, although the state income tax is calculated on the basis of federal adjusted gross income which includes the deduction for health insurance costs.

Findings of Commission

The Commission is very supportive of the concepts included in the tax incentive proposals but declines to recommend a specific proposal for the Legislatures' consideration. The Commission believes that a tax credit or deduction for small employers who provide health insurance and employees who contribute toward the costs of their employer-provided health insurance or provide their own insurance may increase the numbers of employers who provide insurance and the number of employees who take advantage of the benefit. In that regard, the Commission will share the report with the Joint Standing Committee on Taxation and work with them toward the enactment of legislation. Because it is likely that health insurance costs will continue to rise in Maine and throughout the United States, the Commission believes there should be a corresponding tax incentive for employers and individuals to maintain health insurance coverage. Further, the Commission does not recommend any specific state proposals addressing medical savings accounts or the deductibility of health insurance costs for self-employed individuals. With regard to the deductibility of premiums, the Commission notes that the federal tax deduction is carried through for state income tax purposes.

RECOMMENDATIONS

1. The Commission recommends that the review process for mandated benefits be amended by adding the following criteria:

- **cumulative impact of mandates with addition of a proposed mandate**
- **impact of requiring a mandate to apply to state employee health insurance program**
- **applicability of a mandate to health maintenance organizations and its effect on concept of managed care**
- **extent to which provisions of a mandate are available under self-insured ERISA plans and collectively bargained plans**
- **prohibit proposed mandated benefits from being introduced in the Second Regular Session**
- **require the joint standing committee having jurisdiction over insurance matters to hold a public meeting for the presentation of review and evaluation by the Bureau of Insurance**
- **require the joint standing committee having jurisdiction over insurance matters to determine if proponents of a mandate have demonstrated need for review and evaluation of proposal by Bureau of Insurance**

Under Title 24-A Section 2752, proposed mandated health benefits legislation must undergo review and evaluation by the Bureau of Insurance before it can be enacted into law. While this procedure is not binding on the Legislature, the joint standing committee having jurisdiction over insurance matters has followed the procedures in Section 2752 when considering proposed mandates. The Commission found that the current process of review and evaluation of the social

and financial impact and medical efficacy of a proposed mandate could be improved by adding additional criteria.

2. The Commission recommends that the Joint Standing Committee on Taxation and the Legislature consider enacting legislation that contains tax incentives aimed at individuals and small businesses. The Commission will forward a copy of the report to the Taxation Committee and work with Committee toward enactment of legislation. The purpose of the incentives would be to lower employee health insurance costs; encourage small businesses to provide their employees health insurance; and encourage employees to participate in workplace health insurance plans.

During the Second Regular Session of the Legislature, the Joint Standing Committee on Taxation will be considering at least two legislative proposals relating to tax incentives for individuals and small businesses providing health insurance. While the Commission does not support one specific proposal over another, it believes that the Taxation Committee and the Legislature should carefully consider these legislative proposals.

3. The Commission recommends that the Maine Congressional delegation consider improving access to medical savings accounts and stepping up the phasing-in of the self-employment health insurance deduction. The Commission will communicate with the delegation and forward a copy of the report.

Representatives of small businesses raised concerns about the availability of medical savings accounts and stepping up the phasing-in of the federal income tax deduction for health insurance costs of self-employed individuals. Because these two issues are regulated under federal law, the Commission hopes that the Maine Congressional delegation will consider the concerns raised by the State's small businesses.

4. The Commission recommends that the private purchasing alliance laws be amended to encourage the establishment of alliances by removing the restriction on participation of insurance producers, independent producers and producer agencies in a purchasing alliance and by removing the requirement that a purchasing alliance be a nonprofit entity.

Although the Legislature has recently enacted legislation authorizing the establishment of private purchasing alliances, no private purchasing alliances have been established in Maine. The Commission found that there is interest in the business community in establishing an alliance, but that the current statute has restricted the development of an alliance. The Commission hopes that several changes in the statutory provisions will encourage the creation of private purchasing alliances in the State.

THE EFFECTS OF GOVERNMENT REGULATION ON SMALL BUSINESSES

Findings of Commission

The impact of state regulations on Maine's small business raises a host of complex questions. To name just a few: What is the extent of regulations placed upon Maine's small businesses? What regulations are necessary to protect the public safety and welfare? Where do problems occur in the regulatory process? How do state regulations affect small business operations?

The Commission found that these and other regulatory questions merit a detailed study which would require far more time and research than was available in the short 6-week study period available to the Commission. In light of time limitations, the Commission sought input on state regulations from affected parties and state officials with an eye toward identifying immediate steps that could be taken to improve the interaction of small business owners and employees with Maine's regulatory system. The Commission encourages the Maine Legislature to continue examining questions relating to the regulation of Maine's small businesses.

The Commission discussed an important deficiency in the current process of regulating businesses: A lack of notice to the public when the Legislature passes laws affecting businesses. Each session the Maine Legislature enacts a variety of new laws that alter the existing requirements for small businesses or provide new requirements. Although Commission members are quite familiar with the premise that ignorance is not a defense for violating a law, the Commission finds that state authorities can greatly improve communication with small businesses about the new requirements of laws. The majority of small business owners do not have the time or resources to monitor statutory changes.

The Commission also finds that potential agency regulations can receive prospective Legislative review through better use of the Legislature's biennial regulatory agenda review mechanism. Title 5, section 8060 of the Maine Statutes requires each state agency to submit a regulatory agenda for each biennium to the appropriate legislative committee of jurisdiction. Each committee is required by statute to review the regulatory agenda at a meeting. The regulatory agenda lists all rules expected to be adopted in the legislative biennium, an explanation of the statutory basis of the rules, the purpose of the rules and the potentially benefited and regulated parties. The Commission finds that few Legislative committees utilize the regulatory agenda review process to provide agencies input on the direction and potential impacts of upcoming regulations.

RECOMMENDATIONS

1. The Commission recommends that the Governor issue an Executive Order requiring each state agency to annually summarize statutory changes from the most recent Legislative Session, post summaries on the Internet and distribute the summaries to key constituencies.

The Commission found that many state agencies periodically develop summaries of changes or additions to laws which they administer. Summaries developed by all state agencies would provide vehicles to notify affected parties of these changes and additions. The Commission recommends that the Governor issue an Executive Order requiring each agency to develop such a summary following the conclusion of each Legislative Session. The Commission further recommends the summary be posted on each agencies' web site and be sent to key organizations with which the agency interacts. The organizations could then notify their memberships and assist in educating the business community, the public and others. The Commission recommends the Executive Order also include the following requirements:

- That summaries include 1) A title that clearly identifies the nature of the statute; 2) A simple, consumer-oriented summary of the statute and what is required of an affected party; 3) Either the exact language of the statute or information on how to obtain the language; and 4) Agency contacts for additional information on the statute.
- That an advertisement be run annually in the state's major newspapers informing the public about the summaries and how to obtain copies. The Department of Economic and Community Development should be charged with placing the advertisement. The Commissioner of the Economic and Community Development estimates that the advertising costs will be $10,000 annually. This amount should be specifically dedicated to the Department in the Executive Order.
- That the Department of Economic and Community Development should annually notify all state agencies of their responsibilities under the Executive Order.

2. The Commission recommends that the joint standing committee of the Legislature having jurisdiction over economic development matters periodically review the operation of the One-Stop permit center within the Department of Economic and Community Development. The purpose of the review would be to ensure DECD has adequate staff and resources to provide this service.

Title 5, Section 13063 of the Maine Revised Statutes requires the Department of Economic and Community Development to operate a service whereby a person can obtain in one place information on all permits needed to operate a business in Maine. The Commission reviewed the service DECD has in place and finds that it is well operated and provides an invaluable service to the business community and Maine residents. The law requires DECD to report by January 1 of every even-numbered year to the Legislature on the benefits of expanding the program. The Commission finds that businesses and residents will benefit from these reviews and a

determination of whether the program's staffing and technical support are commensurate with the demands for information.

3. The Commission recommends that the Legislature's Presiding Officers write the chairs of each joint standing committee of the Legislature reminding the chairs of their committees' responsibilities under Title 5, section 8060 of the Maine statutes for reviewing regulatory agendas.

Maine law requires that agencies submit regulatory agendas for each legislative biennium. The agendas must be submitted between the beginning of a regular session and 100 days after adjournment. The Legislature's role in overseeing state agencies and monitoring rules would be greatly enhanced if legislative committees fulfilled their statutory requirement to review agencies' regulatory agendas. Because of the somewhat flexible deadline, it is possible that the review by the legislative committees could take place between sessions or in the Second Regular Session. A letter from the Presiding Officers to committee chairs at the start of each First Regular Session of the Legislature would ensure this review process is observed.

4. The Commission recommends that the Commission be reestablished to continue its study of the effects of government regulation on small businesses and report back to the Legislature by November 1, 1998.

The Commission found that time constraints affected its ability to fully study the issue of how government regulation impacts small businesses. The Commission believes that questions relating to the impact of regulations are complex and require additional study. The Commission has drafted a joint order reestablishing the Commission for the purpose of studying the effects of government regulation on small businesses. The Commission's chair will seek introduction and approval of the joint order by the Legislature during the Second Regular Session. A copy of the draft joint order is included as Appendix D.

APPENDIX A

Legislation establishing the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

CHAPTER 85

S.P. 679 - L.D. 1905

Resolve, Establishing a Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

Sec. 1. Commission established. Resolved: That the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses, referred to in this resolve as the "commission," is established; and be it further

Sec. 2. Commission membership. Resolved: That the commission consists of 12 members appointed as follows: The Governor shall appoint 6 members, to include at least 2 members from the Governor's cabinet, one member representing the business sector, one member representing employee unions and one state employee; the Speaker of the House shall appoint 3 members, to include at least one Representative and one member representing the public sector; and the President of the Senate shall appoint 3 members, to include at least one Senator and one member representing the private sector; and be it further

Sec. 3. Appointments; meetings. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The Executive Director of the Legislative Council must be notified by all appointing authorities once the selections have been made. Within 15 days after appointment of all members, the Chair of the Legislative Council shall call and convene the first meeting of the commission. The commission shall select a chair from among its members; and be it further

Sec. 4. Duties. Resolved: That the commission shall study the effects of government regulation and health insurance costs on small businesses throughout the State; and be it further

Sec. 5. Staff assistance. Resolved: That the commission may request staffing assistance from the Legislative Council; and be it further

Sec. 6. Expenses. Resolved: That the members of the commission who are Legislators are entitled to receive the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2 and reimbursement for travel and other necessary expenses for attendance at meetings of the commission. Other members are not entitled to compensation or reimbursement of expenses; and be it further

Sec. 7. Report. Resolved: That no later than January 1, 1998, the commission shall submit its report, together with any necessary implementing legislation, to the Joint Standing Committee on Business and Economic Development and the Executive Director of the Legislative Council. The Joint Standing Committee on Business and Economic Development is authorized to

authorized to report out any legislation during the Second Regular Session of the 118th Legislature concerning the findings and recommendations of the commission.

If the commission requires an extension, it may apply to the Legislative Council, which may grant the extension; and be it further

Sec. 8. Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

	1997-98
LEGISLATURE	
Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses	
Personal Services	$880
All Other	1,300
TOTAL	$2,180

Provides funds for the per diem and expenses of legislative members and miscellaneous costs, including printing, of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses.

APPENDIX B

Members of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

Members of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

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Mr. Patrick Murphy
Pan Atlantic Consultants
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Representative Jane W. Saxl
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35 State House Station
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Mr. Thomas D. McBrierty
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Mr. Edward Gorham
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APPENDIX C

Draft Legislation Implementing the Recommendations of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

Title: **An Act to Implement the Recommendations of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine**

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA § 1951, sub-§ 2 is amended to read:

2. Private purchasing alliance. "Private purchasing alliance" or "alliance" means a ~~nonprofit~~ corporation licensed pursuant to this section established under Title 13-A or Title 13-B to provide health insurance to its members through multiple unaffiliated participating carriers.

Sec. 2. 24-A MRSA § 1953, first ¶ is amended to read:

In addition to the powers granted in Title 13-A or Title 13-B, an alliance may do any of the following:

Sec. 3. 24-A MRSA § 1955, sub-§ 1 is amended to read:

24A § 1955. Restrictions

1. Restricted activities. An alliance may not purchase health care services, assume risk for the cost or provision of health services or otherwise contract with health care providers for the provision of health care services to enrollees without the prior approval of the superintendent.

Sec. 4. 24-A MRSA § 1955, sub-§ 3 is amended to read:

3. Conflict of interest. A person may not be a board member, officer or employee of an alliance if that person is employed as or by, is a member of the board of directors of, is an officer of, or has a material direct or indirect ownership interest in a carrier or health care provider ~~or insurance agency or brokerage~~. A person may not be a board member or officer of an alliance if a member of that person's household is a member of the board of directors of, is an officer of or has a material direct or indirect ownership interest in a carrier or health care provider ~~or insurance agency or brokerage~~. An ~~A board member, officer or~~ employee of an alliance who is licensed as an agent, broker or consultant may act under that license only on behalf of the alliance and only within the scope of that person's duties as ~~a board member, officer or~~ an employee.

Sec. 5. 24-A MRSA § 2752, sub-§ 1-A is enacted to read:

1-A. Introduction of proposals. A mandated health benefit proposal may not be introduced in a Second Regular Session or a Special Session of the Legislature.

Sec. 6. 24-A § 2752, sub-§ 2 and § 3 are amended to read:

2. Procedures before legislative committees. Whenever a legislative measure containing a mandated health benefit is proposed, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is ~~substantial~~ support for the proposed mandate among members of the committee based upon testimony from the public or providers and the committee has determined that the proponents of the proposal have demonstrated a need for the proposed mandate, the committee may refer the proposal to the Bureau of Insurance for review and evaluation pursuant to subsection 3. Once a review and evaluation has been completed, the committee shall hold a meeting for the purpose of presenting the findings of the Bureau of Insurance in conducting the review and evaluation. A proposed mandate may not be enacted into law unless review and evaluation pursuant to subsection 3 has been completed.

3. Review and evaluation. Upon referral of a mandated health benefit proposal from the joint standing committee of the Legislature having jurisdiction over the proposal, the Bureau of Insurance shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report must include, at the minimum and to the extent that information is available, the following:

A. The social impact of mandating the benefit, including:

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

(2) The extent to which the treatment or service is available to the population;

(3) The extent to which insurance coverage for this treatment or service is already available;

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

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

(6) The level of public demand and the level of demand from providers for the treatment or service;

(7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(8) The level of interest ~~of~~ and extent to which collective bargaining organizations ~~in~~ are negotiating privately for inclusion of this coverage in group contracts;

(9) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(10) The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(11) The alternatives to meeting the identified need;

(12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(13) The impact of any social stigma attached to the benefit upon the market;

(14) The impact of this benefit on the availability of other benefits currently being offered; ~~and~~

(15) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

(16) The impact of making the benefit applicable to the State Employee Health Insurance Program.

B. The financial impact of mandating the benefit, including:

(1) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(2) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

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

(4) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

(5) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years;

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

(7) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(8) The impact of this coverage on the total cost of health care; and

(9) The effects on the cost of health care to employers and employees, including the financial impact on small employers, medium-sized employers and large employers;

C. The medical efficacy of mandating the benefit, including:

(1) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(2) If the legislation seeks to mandate coverage of an additional class of practitioners:

(a) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

(b) The methods of the appropriate professional organization that assure clinical proficiency; and

D. The effects of balancing the social, economic and medical efficacy considerations, including:

(1) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders; ~~and~~

(2) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders~~.~~ ; and

(3) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage.

Summary

This bill implements the recommendations of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine.

APPENDIX D

Draft Joint Order Reestablishing Commission

JOINT ORDER ESTABLISHING THE
BLUE RIBBON COMMISSION TO STUDY THE EFFECTS
OF GOVERNMENT REGULATION ON SMALL BUSINESSES IN MAINE

ORDERED, that the Blue Ribbon Commission To Study the Effects of Government Regulation on Small Businesses in Maine is established as follows:

1. Establishment. The Blue Ribbon Commission To Study the Effects of Government Regulation on Small Businesses in Maine, referred to in this order as the commission, is established.

2. Membership. A member of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine who was appointed pursuant to Resolve 1997, chapter 85 is appointed to the commission if that person agrees to serve on the commission. If a person appointed to the commission under Resolve 1997, chapter 85 does not agree to serve on the commission, a member must be appointed from the following list, by the appointing authority so noted, so that the commission has the following composition:

A. One Senator, appointed by the President of the Senate;

B. Two Representatives, appointed by the Speaker of the House;

C. One member with expertise in state financial and professional regulation, appointed by the President of the Senate;

D. One member with expertise in state economic and community development, appointed by the President of the Senate;

E. One member with expertise in employee unions, appointed by the President of the Senate;

F. One member who is a representative of an association of small business owners, appointed by the President of the Senate;

G. One member who is an employee of a small business, appointed by the President of the Senate;

H. One member with expertise in state financing of small business ventures, appointed by the Speaker of the House;

I. Two members who represent the private sector, appointed by the Speaker of the House; and

J. One member who is a State employee, appointed by the Speaker of the House.

3. Appointments. Appointments to the commission must be made no later than April 30, 1998. The appointing authorities shall notify the Executive Director of the Legislative Council upon making their appointments. When the appointment of all members is complete, the Chair of the Legislative Council shall call and convene the first meeting of the commission no later than May 15, 1998. The commission must select a chair from among its members.

4. Meetings. In conducting its duties, the commission may meet as often as necessary, within available budget resources, with any individuals, departments, organizations or institutions it considers appropriate.

5. Duties. The commission must study the effect of state regulations on small business operations, problems that occur in the regulatory process, the extent of regulations placed upon small business and solutions to ease regulatory burdens on small businesses.

6. Staff assistance. The commission shall request staffing and clerical assistance from the Legislative Council, which must be provided from within available resources.

7. Compensation. Legislative members of the commission are entitled to receive legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2 and reimbursement for travel and other necessary expenses for attendance at meetings of the commission occurring after the adjournment of the Second Regular Session of the 118th Legislature. Members who are not legislators serve without compensation.

8. Report. The commission shall submit its findings, along with any necessary implementing legislation, to the Legislative Council and the joint standing committee of the Legislature with jurisdiction over business and economic development matters by November 1, 1998.

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APPENDIX E

Draft Recommendations Considered by the Blue Ribbon Commission

Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

Potential areas for recommendations from 12/1/97, 12/10/97 and 12/17/97 meetings

Health care related

Mandated benefits:

Finding: Acknowledge the recent, independent studies which conclude that state health care mandates increase costs and reduce coverage in the private sector. The final report of the Commission should include information based on the recent survey reported in Health Tracking Trends; the Milliman and Robertson study for the National Center for Policy Analysis; and GAO reports.

Preliminary Discussion: This proposed finding was included in the written recommendations prepared by Commission member Jim McGregor, Maine Merchants Association. In its discussion, commission members noted that the information included in the report related to mandates should also include recognition of the recent activities of the federal government in enacting mandates and that mandates represent a compelling interest for the Legislature that indicates the general public is asking for mandates.

Recommendation: Amend the review process for mandated benefits by developing a higher standard for review of future mandates (or directing the Bureau of Insurance to develop) by adding criteria such as evidence that a procedure or service is not being covered in Maine on a voluntary basis, that absence of a mandate is creating a problem, and that burden of proof is on providers and proponents that a mandate is needed and cost-effective.

Questions: Amend in what way? What is lacking in current process and criteria addressing social and financial impact and medical efficacy of mandates?
Are there aspects or concerns about managed care that are not examined under the current process?

Preliminary discussion: This proposed recommendation was included in the written recommendations prepared by Commission member Jim McGregor, Maine Merchants Association. The commission indicated support for such a recommendation.

Recommendation: Impose a two year moratorium on the enactment of mandated health benefits by the Legislature.

Preliminary discussion: This proposed recommendation was included in the written recommendations prepared by Commission member Jim McGregor, Maine Merchants Association. Commission members indicated they would not support a moratorium on the Legislature and noted that the Legislature would certainly not be bound by such a recommendation in the future.

Tax incentives:

Recommendation: Report out legislation that contains tax incentives aimed at individuals and small businesses. The purpose of the incentives would be to lower employee health insurance costs; encourage small businesses to provide their employees health insurance; and encourage employees to participate in workplace health insurance plans.

Questions: Include incentives similar to those attempted in past legislation? What is the individual income threshold for a truly effective tax incentive? How best to reach individuals and businesses with the highest needs for health insurance participation?

Preliminary discussion: This proposed recommendation was included in the written recommendations prepared by Commission member Jim McGregor, Maine Merchants Association. Commission members indicated support for such legislation and suggested piggybacking upon Senator Longley's proposed bill, LD 1931.

Recommendation: Report out legislation that asks Congress to improve access to medical savings accounts and step-up the phasing-in of the self-employment health insurance deduction, or address medical savings accounts and self-employed health insurance deduction at the state level.

Community rating:

Recommendation: Require the Bureau of Insurance to continue its survey of small employers to monitor the effects of the 1993 health insurance reforms.

Questions: Funding for the survey?

Data on medical costs

Recommendation: Create a statewide data base on the costs of medical treatments and services and a develop system of unrestricted distribution of that data. Report out legislation that provides the framework for collection, reporting and processing of the data. (Purpose: Collect data from all types of groups; provide the best data on costs with an eye toward reducing costs and increasing availability and use of health insurance.)

Questions: How does this relate to the purpose and scope of the Maine Health Data Organization? Would such an effort be duplicative at the state level? Should a data initiative like this be left to the private sector?

Employee empowerment:

Recommendation: Empower employees to make choices or participate in the choice of health insurance plans made available at a workplace. Accomplish this by making changes in the private purchasing alliance laws to make establishment of alliances more attractive.

Private purchasing alliances:

Recommendation: Encourage the establishment of private purchasing alliances by reporting out legislation that amends the alliance laws to allow brokers to participate in the development and management of alliances.

Renewal information for small groups:

Recommendation: Provide a holder of a small group policy the authority to request loss information at least 60 days prior to the renewal of the policy. Under current law, large group policyholders may make a written request to an insurer for loss information to be provided at least 60 days before renewal and 6 months after the issuance or renewal of a policy. Loss information is the aggregate claims experience of the group, including the amount of premiums received, the amount of claims paid and the loss ratio. Insurers are not required to provide this information to small groups.

Questions: In smaller groups, is there an ability to identify individuals through the nature and the amount of the claim despite the aggregate form of the information? Would there be an incentive to "dump" higher risks from the small group?

<u>Regulation</u>

Cost of regulation:

Recommendation: Report out legislation that requires all bills include a fiscal note that quantifies the bills' cost impacts on small businesses.

Public notice of law changes:

Recommendation: Report out legislation that requires any change in laws that affect business licensing or regulation be communicated to affected business communities and funded for each department or agency if necessary.

Contract/leased employees:

Recommendation: Study the use of provisions in laws under which employers utilize part-time employees, contract services or employee leasing companies to avoid health insurance costs, workers compensation costs and the certain administrative costs.

Market existing small business assistance:

Recommendation: Report out legislation that provides the Department of Economic and Community Development to market the many DECD and non-DECD services available to assist start-up and existing businesses.

Questions: Is this relevant to the Commission's charge?

Improve small business management:

Recommendation: Report out legislation that establishes a program for improving the management skills of small business owners and managers. (Reason: Business success is most highly correlated to the quality of management - not to the availability of funding)

Questions: Is this relevant to the Commission's charge?

DECD follow-up survey of assisted people:

Recommendation: Encourage or require the Department of Economic and Community Development to conduct follow-up surveys of people who have received assistance through the agency's one-stop permit/regulation center to monitor customer satisfaction and receive input on improvements.

Questions: Is this relevant to Commission's charge?

APPENDIX F

Summaries of Meetings on December 1st, 10th and 17th

Summary of December 1, 1997 meeting of The Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

Commission members attending:

* Rep. Arthur F. Mayo
* Sen. Bruce W. MacKinnon
* Timothy Agnew
* Douglas S. Carr
* Thomas J. Giordano
* Catherine Longley
* Edward Gorham
* Jim McGregor
* Peter Sassano

Election of chair: Rep. Mayo was elected chair of the commission.

Focus of study and timeframe: The commission first discussed its general charge and its reporting date of January 1, 1998. The charge, spelled out in the law creating the commission, addresses two areas and is quite broad: To study the effects of : 1) government regulation and 2) health insurance costs on small businesses throughout the state. The commission decided that, considering its short timeframe, it would focus its study on health insurance costs. Members said the health insurance field provides defined issues that can be examined in a timely manner. In contrast, members said an examination of government regulation would require a great deal of time to survey problems and define solutions. Members decided to take a cursory review of government regulation relative to small businesses and make recommendations regarding further review. The commission decided to request a reporting deadline extension to January 15, 1998.

Health insurance - areas of focus: The commission's discussions regarding health insurance focused on three major areas: 1) mandated benefits; 2) incentives for employers to provide health care; and 3) identifying and defining the small business group market.

Mandated benefits: Members suggested the commission examine the Legislature's process for reviewing requests for mandated benefits; Maine's enactment of mandated benefits relative to other states; the application of mandated benefits to various types of insured groups; and the impact of mandated benefits on insurance costs and the ability of small businesses to provide their employees health insurance.

Incentives for providing insurance: Members suggested the commission examine the universe of available and potential incentives to encourage small businesses to provide health insurance and relieve small businesses from the high costs unique to small business health insurance. Incentives include tax credits, tax deductions and the provision of medical savings accounts.

The small business group market: Members heard input from an interested party that the commission would benefit from painting a portrait of the current small group market

- trends in types of plans utilized, pricing, availability, the effect of community rating, etc. Members discussed the need to develop a solid definition of "small business."

To facilitate the commission's discussion, it was agreed staff would compile a mailing consisting of background material on mandated benefits, small group health insurance and recent legislation proposing tax incentives for employer-provided health insurance.

Regulation of small businesses: Members agreed that for an initial review of government regulation it would be helpful to understand the spectrum of regulations to which a small business is subject. Staff will be working with the Department of Economic and Community Development to develop examples.

Additional meetings: The commission set the following five meeting dates:

* December 10, 9 a.m.-Noon, Room 221 of the State House
* December 17, 9 a.m. -Noon, Room 134 of the State House
* December 31, 9 a.m. -Noon, Room 334 of the State House
* January 6, 9 a.m. -Noon, Room 334 of the State House
* January 14 (tentative), 9 a.m. -Noon, Room 334 of the State House

Summary of December 10, 1997 meeting of The Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

Commission members attending:

* Rep. Arthur F. Mayo
* Sen. Bruce W. MacKinnon
* Rep. Jane Saxl
* Douglas S. Carr
* Catherine Longley
* Jim McGregor
* Peter Sassano

Commission members absent:

* Commissioner McBrierty
* Timothy Agnew
* Thomas Giordano
* Edward Gorham
* Patrick Murphy

Extension letter: Commission members reviewed the letter sent to the Legislative Council requesting an extension of the reporting date from January 1 to January 16. The Legislative Council will consider the extension request at its December 18th meeting.

Review of Summary from December 1st meeting: Commission members reviewed and accepted the summary of the first meeting prepared by staff.

Overview of background material: Staff provided a brief overview of mandated health benefits. Members discussed the differences between a mandated health benefit and mandated offer. Under current law, mandated health benefit proposals must undergo a review and evaluation by the Bureau of Insurance before being enacted into law. Mandated offers are not subject to these statutory procedures. Although the Legislature has followed these procedures, the Legislature cannot bind future Legislatures and is not constitutionally required to follow these procedures. However, to date, the Legislature has not exempted any mandated health benefit proposal from this process.

Staff reviewed the most recently enacted mandated health benefits and noted the expansion of the applicability of the mandates to health maintenance organizations. Staff also noted that one mandate proposal has been carried over to the Second Regular Session - LD 307, An Act to Allow Self-Referral for Obstetrical Care in Managed Care Plans. In addition, two titles have been accepted for consideration in the Second Regular Session that propose mandated health benefits: LR 2790, An Act to Require Health Insurance Coverage for InVitro Fertilization Procedures, sponsored by Rep. Jane Saxl; and LR 2902, An Act to Permit Off-Label Drug Use of Prescription Drugs for Cancer, HIV and AIDS, sponsored by Sen. Mark Lawrence.

Tax incentives: Staff also reviewed the legislative proposals from the 118th Legislature relating to tax incentives for small employers to provide health insurance to their employees. Although all of these proposals were voted out by the Taxation Committee "ONTP", Commission members noted that there was interest in the proposals. The primary reason these proposals and other tax incentives were not fully considered was the decision by the Taxation Committee not to pursue individual tax reform proposals piecemeal but to address overall tax reform if possible. Members also noted that changes in the State's revenues and the available surplus in the upcoming session may be factors that will may positively influence the consideration of tax incentive proposals this session. Members asked staff for information at the next meeting related to tax incentive legislation in the next session.

Small businesses in Maine: Staff presented statistics on the number of small employers in the State based on data from the Maine Department of Labor. 96% of Maine's private employers (excluding government) employ 50 or fewer employees. These businesses employ 49.1% of the total number of employees that work for Maine's private employers.

Small group presentation: Rick Diamond of the Maine Bureau of Insurance spoke to the Commission about the status of the small group health insurance market. He noted that the small group market is more highly regulated than the large group market. One of the reasons he cited was the previous abuses by insurers who avoided insuring high-risk groups in favor of insuring only healthier risks. As a result of the small group reforms of guaranteed issuance, guaranteed renewal and community rating, small groups have gained increased access to health insurance. Mr. Diamond also reported that the small group market has about 20 indemnity insurers and five HMO's offering insurance in this market. He noted, however, that costs of health insurance, especially for small employers, continues to be a factor in the decision of whether or not to offer insurance to employers as a benefit. Employers have tried to control costs through offering managed care plans, utilizing higher deductible plans and requiring higher percentages of employee contributions. Commission members noted that the Bureau of Insurance has a great source of data on small group market from previous surveys and encouraged the Bureau to continue to survey small employers as was done in 1993 and 1995.

Small Business Issues - NFIB/Maine perspective:

David Clough spoke briefly and provided materials to the Commission relating to issues facing small business. He noted that health insurance is second only to workers' compensation as an area of concern to NFIB members in Maine. Mr. Clough addressed the shift in health insurance regulation that has taken place from state legislatures to Congress with the passage of HIPPA (Health Insurance Portability and Accountability Act). He told Commission members that NFIB is working for legislation in Congress to allow multi-state purchasing alliances. It is hoped that this type of legislation may combat the opinions of some that a voluntary purchasing alliance has not been established in Maine to date because of a lack of critical mass. Mr. Clough also noted the effect of ERISA on mandated health benefits and the exemption ERISA provides for large self-insured businesses. He also noted NFIB's support for "bare bones" insurance policies;

accelerated deductions of health insurance premiums for self-employed individuals; and stronger malpractice laws.

Small Business Regulation: Staff provided an overview of three examples of the state licenses/regulations applicable to different businesses. The information was produced by the Department of Economic and Community Development's Business Answers program. Staff noted the cumulative effect of regulations on small business, not any one segment of regulation. However, staff noted the intricacies and complexities of DEP permitting and licensing for small businesses compared with other licensing requirements.

Brian Dancause and Dora Dostie of DECD provided an overview of the Business Answers program. The program is a point and click system data base that provides information and referrals for a large number of business activities in the State. The program has been in operation for three years and includes information relating to approximately 100 of the most common business activities in the State. They noted that increased access to business information through an internet webpage is under development by DECD. Commission members asked Brian and Dora what additional steps could be taken to assist small business. They noted several factors including: (1) increased resources for the one stop business licensing program and the Business Answers program; and (2) increased management-savvy through education of small business people. Commission members noted that DECD may want to follow up with individuals that have been assisted by the Business Answers program to determine their experience with state government regulation.

Members also noted that small businesses are often unaware of newly enacted laws and regulations. Members suggested that better notice to businesses is needed. Members also discussed the proposed legislation from the last legislative session requiring a measurement of the fiscal impact of legislation on the business community. Staff will provide additional information on that proposal at the next meeting.

Small Group Health Insurance Issues - John Benoit, Holden Insurance Agency:

John Benoit provided the Commission with his thoughts on the issues facing the small group health insurance marketplace. The biggest issues for small business are cost and access. However, because community rating has stabilized the costs in the market, the deciding factor for most small businesses is increasingly related to access. He gave the Commission an overview of the Maine Health Management Coalition, a private sector data initiative among employers seeking to impact the cost of the health care encounter. He noted the lack of such an initiative for small employers. Mr. Benoit noted the stabilization of the costs and the maturing of the risk that has taken place in the small group market since the enactment of community rating and other reforms. Other issues in the small group market include the inability of small employers to get information on experience more than 30 days before renewal of a policy and the lack of a purchasing alliance for small employers. Commission members invited Mr. Benoit to the next meeting to make a presentation on his private purchasing alliance model.

Preliminary findings and recommendations: Commission members deferred discussion of preliminary findings and recommendations to the next meeting. Staff will prepare a list of possible recommendations based on the discussion and presentations for the next meeting.

Summary of December 17, 1997 meeting of The Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine

Commission members attending:

* Rep. Arthur F. Mayo
* Sen. Bruce W. MacKinnon
* Rep. Jane Saxl
* Timothy Agnew
* Douglas S. Carr
* Thomas Giordano
* Edward Gorham
* Tom McBrierty
* Jim McGregor
* Peter Sassano

Commission members absent:

* Patrick Murphy
* Catherine Longley

Request for Extension: The Legislative Council approved the Commission's request to extend the reporting date from January 1 to January 16.

Review of Summary from December 10th meeting: Commission members reviewed and accepted the summary of the December 10th meeting prepared by staff.

Overview of background material: Staff distributed an overview of the tax incentive proposals considered in the 118th Legislature's first session and noted that two titles will be considered in the next session that may relate to tax incentives for health insurance. One title - An Act to Create Incentives for Employers to Contribute toward the Costs of Comprehensive Health Insurance for Families - has been printed as LD 1931 and referred to the Taxation Committee. Commission member Tom Giordano distributed an overview of LD 1931 which provides a credit to employers providing health insurance equal to the excess of health insurance costs over 7.5% of gross payroll; a deduction for individuals equal to 20% of the health insurance premium paid by the taxpayer; and a reduction in the calculation of income for the purposes of eligibility for the Property Tax and Rent Rebate Program equal to the amount of insurance premium paid for preventive care. Member Giordano will bring information on the proposed fiscal note on LD 1931 to the next meeting.

Staff also briefly outlined LD 249, An Act to Require That All Legislative Documents Contain a Citizen and Business Impact Statement. This bill was considered last session but not enacted. The bill was modeled on the requirement that all legislation favorably reported out of committee have a fiscal note attached that estimates the financial impact of the legislation on state government and municipalities and counties. LD 249 would have required a similar statement on

legislation that addressed the impact on Maine citizens and businesses. The primary reasons for not enacting the bill were (1) the lack of staff resources in the Legislature; and (2) the belief that the public hearing process was the best forum for citizens and business to raise concerns about the impact of legislation.

Staff also highlighted the current statutory provisions governing private purchasing alliances in Maine. Although the law became effective in July 1996 and the rules governing alliances were finally adopted in March 1997, there are no licensed purchasing alliances in the State.

Presentation on Purchasing Alliance for Small Group Market: John Benoit, Holden Insurance Agency, spoke to the Commission for the second time on the status of the small group market and his concept for a small group purchasing alliance. He outlined the reasons he thinks a purchasing alliance is needed. Some of these reasons include the ability of small businesses to combine purchasing power and influence to spread the insurance risk across a larger group and the opportunity to provide more employee choice through an offering of multiple plans through the alliance. Mr. Benoit's purchasing alliance model utilizes the distribution of the alliance plan through the normal brokerage network with a common enrollment form and marketing material for carriers and health plans offered through the alliance. This would ensure that carriers belonging to the alliance are potentially presented and marketed to every employer in the State. While the participation of carriers and offering of multiple plans is similar to purchasing alliances developed in other states, Mr. Benoit's model is unique in the inclusion of a risk adjustment mechanism. The risk adjustment mechanism would combine the community rate requirements in the small group market with a reinsurance or stop loss insurance arrangement to minimize large losses for participating carriers.

At this point, Mr. Benoit's model is a concept although it has been presented to the Bureau of Insurance, the Maine Chamber and Business Alliance, the Greater Portland Chamber of Commerce and the Maine Health Management Coalition. The MHMC endorses the concept but is not interested in being the plan's sponsor because their members are large businesses. The Maine Chamber has explored the possibility of sponsoring a purchasing alliance but does not feel that it has the membership among small businesses to achieve the critical mass of enrollees needed to make an alliance viable. The Chamber's membership includes more large business among its members than small businesses.

The barriers to developing a purchasing alliance noted by Mr. Benoit include: the restriction on insurance agents and industry members to participate in the organization of the alliance; the risk adjustment provisions may need to more detailed as to what types of arrangements are permissible; and the restrictive nature of the rules. The requirement that the alliance be nonprofit also removes the ability of private entrepreneurial efforts and the Commission may want to address that provision as well. The funding for the start up costs of an alliance (estimated to be between $250,000 and $500,000) are also a significant barrier. Currently, there are no provisions allowing state funding for the alliance.

Preliminary Findings and Recommendations: The Commission discussed preliminary findings and recommendations before the end of the meeting. Commission member, James McGregor,

offered a list of suggested recommendations. In its discussions, Commission members generally accepted all of Jim's suggestions but indicated it would not support a recommendation that the Legislature impose a moratorium on enacting mandated health insurance benefits for two years. Commission members will continue the discussion of findings and recommendations at the next meeting.

APPENDIX G

History of Mandated Benefits

HISTORY OF MANDATED HEALTH INSURANCE BENEFITS

Year Enacted/ Effective Date	Benefits	Type of Mandate	Type of Contract Affected	Statutory Reference
1975	Maternity benefits provided to married women must also be provided to unmarried women	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2318 24-A MRSA §2741 24-A MRSA §2832
1975	Coverage of children must be made available to unmarried women on the same basis as married women	Mandated Offer	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2318 24-A MRSA §2742 24-A MRSA §2833
1975	Benefits for dentists' services must be covered to the extent that the same services would be covered if performed by a physician	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2303-A 24-A MRSA §2437
1975	Family coverage must cover any children born while coverage is in force from the moment of birth, including treatment of congenital defects	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2319 24-A MRSA §2743 24-A MRSA §2834
1975	Benefits for psychologists' services must be covered to extent that same services would be covered if performed by a physician	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2303 24-A MRSA §2744 24-A MRSA §2835

HISTORY OF MANDATED HEALTH INSURANCE BENEFITS

Year Enacted/ Effective Date	Benefits	Type of Mandate	Type of Contract Affected	Statutory Reference
1977	Benefits must be made available for home health care services	Mandated Offer	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2320 24-A MRSA §2745 24-A MRSA §2837
1979	Benefits must be made available for outpatient health care services of certified rural clinics	Mandated Offer	Nonprofit Insurers only: All individual and group contracts Commercial Insurers: Not applicable HMO's: Not applicable	24 MRSA §2324
1981	Benefits must be made available for optometrists' services to the extent same services would be covered if performed by a physician	Mandated Offer	Nonprofit and Commercial Insurers: All group contracts HMO's: Not applicable	24 MRSA §2331 24-A MRSA §2841
1983	Benefits must include coverage for treatment of alcoholism and drug dependency, subject to "reasonable limitations"	Mandated Coverage	Nonprofit and Commercial Insurers: All group contracts of more than 20 HMO's: Not applicable	24 MRSA §2329 24-A MRSA §2842
1983	Benefits must be included for licensed clinical social workers' and certified psychiatric nurses' services to extent same services would be covered if performed by a physician	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2303 24-A MRSA §2744 24-A MRSA §2835

HISTORY OF MANDATED HEALTH INSURANCE BENEFITS

Year Enacted/ Effective Date	Benefits	Type of Mandate	Type of Contract Affected	Statutory Reference
1983	Benefits must be included for mental health services, subject to "reasonable limitations"	Mandated Coverage	Nonprofit and Commercial Insurers: All group contracts of more than 20 HMO's: Not applicable	24 MRSA §2325-A 24-A MRSA §2843
1986	Benefits must be included for chiropractors' services to the extent that same services would be covered if performed by a physician. Benefits must be included for therapeutic, manipulative and adjustive services.	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2303-C 24-A MRSA §2748 24-A MRSA §2840-A
1987	Benefits must be made available for cardiac rehabilitation services	Mandated Offer	Nonprofit and Commercial Insurers: All group contracts of more than 20 HMO's: Not applicable	24 MRSA §2333-A 24-A MRSA §2845
1987 *(Amended 1997)*	Benefits must be provided for screening mammography at least once every 2 years for women age 40-49 and at least once annually for women age 50 and over	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2320-A 24-A MRSA §2745-A 24-A MRSA §2837-A
1997/ Effective Jan.1, 1998	Benefits must be provided for screening mammography at least once annually for women over age 40	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: All individual and group contracts	24 MRSA §2320-A 24-A MRSA §2745-A 24-A MRSA §2837-A 24-A MRSA § 4237-A

HISTORY OF MANDATED HEALTH INSURANCE BENEFITS

Year Enacted/ Effective Date	Benefits	Type of Mandate	Type of Contract Affected	Statutory Reference
1992	Benefits must be made available for acupuncturist's services to the extent comparable services would be covered if performed by a physician	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable	24 MRSA §2320-B 24-A MRSA §2745-B 24-A MRSA §2837-B
1994	Benefits must be provided for chiropractic care at least equal to benefits paid to other providers treating similar neuro-musculo-skeletal conditions	Mandated Coverage	Nonprofit and Commercial Insurers: Not applicable HMO's: All individual and group contracts	24-A MRSA §4236
1995	Benefits must be provided for surgery and reconstruction of both breasts following mastectomy surgery in the manner chosen by patient and physician	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: All individual and group contracts	24 MRSA §2320-C 24-A MRSA §2745-C 24-A MRSA §2837-C 24-A MRSA §4237
1995/ Effective Jan. 1, 1996 until Mar. 1, 1998 *(Amended 1997)* 1997/ Removed repeal date of Mar. 1, 1998	Benefits must be provided for acute care services of a chiropractic provider within HMO network for up to 36 visits per year without prior approval of primary care physician	Mandated Coverage	Nonprofit and Commercial Insurers: Not applicable HMO's: All individual and group contracts, except State Employee Health Insurance Program	24-A MRSA §4236
1995/ Effective Jan. 1, 1996	Benefits must be provided for metabolic formula and up to $3000 per year for modified low-protein food products prescribed by a physician for persons with inborn errors of metabolism	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: All individual and group contracts	24 MRSA §2320-D 24-A MRSA §2745-D 24-A MRSA §2837-D 24-A MRSA §4238

HISTORY OF MANDATED HEALTH INSURANCE BENEFITS

Year Enacted/ Effective Date	Benefits	Type of Mandate	Type of Contract Affected	Statutory Reference
1995/ Effective July 1, 1996	Benefits must be provided for coverage of biologically-based mental illness under same terms and conditions as coverage for physical illness	Mandated Coverage	Nonprofit and Commercial Insurers: All group contracts of more than 20 HMO's: All group contracts of more than 20	24 MRSA §2325-A, sub-§5-C 24-A MRSA §2843, sub-§5-C 24-A MRSA §4234-A, sub-§6
1995/ Effective July 1, 1996	Benefits must be provided for coverage of biologically-based mental illness under same terms and conditions as coverage for physical illness	Mandated Offer	Nonprofit and Commercial Insurers: All individual and group contracts of 20 or less HMO's: All individual and group contracts of 20 or less	24 MRSA §2325-A, sub-§5-D 24-A MRSA §2749-C 24-A MRSA §2843, sub-§5-D 24-A MRSA §4234-A, sub-§7
1996	Benefits must be provided for maternity and newborn care, including hospital stay, in accordance with "Guidelines for Perinatal Care" as determined by attending physician or certified nurse midwife and mother	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: All individual and group contracts	24 MRSA §2318-A 24-A MRSA §2743-A 24-A MRSA §2834-A 24-A MRSA §4234-B
1996	Benefits must be provided for medically necessary equipment and supplies used to treat diabetes (insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets) and approved self-management and education training	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: All individual and group contracts	24 MRSA §2332-F 24-A MRSA §2754 24-A MRSA §2847-E 24-A MRSA §4240
1996/ Effective Jan. 1, 1997	Benefits must be provided for screening Pap tests recommended by a physician	Mandated Coverage	Nonprofit and Commercial Insurers: All group contracts HMO's: All contracts	24 MRSA §2320-E 24-A MRSA §2837-E 24-A MRSA §4240

HISTORY OF MANDATED HEALTH INSURANCE BENEFITS

Year Enacted/ Effective Date	Benefits	Type of Mandate	Type of Contract Affected	Statutory Reference
1996/ Effective Jan. 1, 1997	Benefits must be provided for annual gynecological exam without prior approval of primary care physician	Mandated Coverage	Nonprofit and Commercial Insurers: All group contracts of managed care plans HMO's: All group contracts of managed care plans	24 MRSA §2322-F 24-A MRSA §2850-A 24-A MRSA §4241
1996/ Effective Jan. 1, 1997 1997/ Effective Jan. 1, 1998	Benefits must be made available for mental health services provided by licensed counselors	Mandated Offer	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: Not applicable HMO's: Made applicable to individual and group contracts	24 MRSA §2303, sub-§5 24-A MRSA §2744, sub-§3 24-A MRSA §2835, sub-§3 24-A MRSA §4234-A, sub-§8-A
1997/ Effective Jan. 1, 1998	Benefits must be provided for inpatient coverage with respect to breast cancer treatment for a medically appropriate period of time determined by the physician in consultation with the patient following a mastectomy, lumpectomy or lymph node dissection	Mandated Coverage	Nonprofit and Commercial Insurers: All individual and group contracts HMO's: All individual and group contracts	24 MRSA §2320-C 24-A MRSA §2745-C 24-A MRSA §2837-C 24-A MRSA §4237

Appendix H

Mandated Health Benefits Procedures

24A § 2752. Mandated health legislation procedures

1. Mandated health benefits proposals. For purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services as part of individual or group health insurance policies. A mandated option is not a mandated benefit for purposes of this section.

2. Procedures before legislative committees. Whenever a legislative measure containing a mandated health benefit is proposed, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is substantial support for the proposed mandate among members of the committee, the committee may refer the proposal to the Bureau of Insurance for review and evaluation pursuant to subsection 3. A proposed mandate may not be enacted into law unless review and evaluation pursuant to subsection 3 has been completed.

3. Review and evaluation. Upon referral of a mandated health benefit proposal from the joint standing committee of the Legislature having jurisdiction over the proposal, the Bureau of Insurance shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report must include, at the minimum and to the extent that information is available, the following:

A. The social impact of mandating the benefit, including:

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

(2) The extent to which the treatment or service is available to the population;

(3) The extent to which insurance coverage for this treatment or service is already available;

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

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

(6) The level of public demand and the level of demand from providers for the treatment or service;

(7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(8) The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;

(9) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(10) The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(11) The alternatives to meeting the identified need;

(12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance;

(13) The impact of any social stigma attached to the benefit upon the market;

(14) The impact of this benefit on the availability of other benefits currently being offered; and

(15) The impact of the benefit as it relates to employers shifting to self-insured plans;

B. The financial impact of mandating the benefit, including:

(1) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(2) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

(3) The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service;
(4) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

(5) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years;

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

(7) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(8) The impact of this coverage on the total cost of health care; and

the financial impact on small employers, medium-sized employers and large employers;

(1) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the

providing the treatment or service; and

(2) If the legislation seeks to mandate coverage of an additional class of

(a) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to

(b) The methods of the appropriate professional organization that assure clinical proficiency; and

including:

(1) The extent to which the need for coverage outweighs the costs of mandating

(2) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders.

APPENDIX I

Memo from Rick Diamond, Life and Health Actuary, Maine Bureau of Insurance on Cost of Mandated Benefits, March 1996

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ANGUS S. KING, JR.
GOVERNOR

BRIAN K. ATCHINSON
SUPERINTENDENT

RICHARD H. DIAMOND, FSA, MAAA
LIFE & HEALTH ACTUARY
Direct Dial (207) 624-8428

March 12, 1996

To: Rep. Art Mayo

From: Rick Diamond RHD

Subject: Cost of Mandated Benefits

You have asked for information on the cost impact of mandated health insurance benefits. Opponents of mandates frequently create the impression that mandates add tremendously to the cost of health insurance and are therefore a significant financial barrier for employers wanting to offer a health plan. This is generally not the case. The true cost of mandates is the difference between the cost of a health plan including the mandates and the cost of the plan that would be offered in absence of the mandate. In many cases the benefit mandated would be included anyway. These are benefits which, while not universal at the time the mandate was enacted, have become standard practice even in states where they are not mandated. Mandates in this category include:

- Maternity benefits and coverage of children may not be conditioned on marriage.
- Coverage of newborns from the moment of birth.
- Psychologists and optometrists covered to the extent that the same services would be covered if performed by a physician.

Cost Analysis

The mandates which have a cost impact, in that the benefit would likely be reduced or eliminated in absence of a mandate, are as follows:

- **Mental Health** - This mandate applies only to groups of more than 20. We track the amount of claims paid, which have been in the range of 3% to 4% of total group health claims. The true cost would be something less than this because (a) some mental health

benefits would likely be provided even in absence of a mandate, and (b) it has been asserted (and some studies confirm) that providing mental health benefits will reduce claims for physical conditions. Therefore 3% should be seen as the upper bound on the cost of the mandate.

- **Substance Abuse** - This mandate applies only to groups of more than 20. We track the amount of claims paid, which have been in the range of 1% of total group health claims. This percentage has decreased each year from 1.8% in 1988 to 0.5% in 1994. (This is probably due to utilization review, which has reduced the incidence of inpatient care. Inpatient claims have decreased from about 90% of the total to about 70%.) The true cost would be something less than this because (a) some substance abuse benefits would likely be provided even in absence of a mandate, and (b) it has been asserted (and some studies confirm) that providing substance abuse benefits will reduce claims for physical conditions. Therefore 1% should be seen as the upper bound on the cost of the mandate.

- **Chiropractic** - We track the amount of claims paid, which have been in the range of 1% of total health claims. Again, this should be seen as an upper limit.

- **Screening Mammography** - We track the amount of claims paid, which were 0.15% of total health claims in 1994. Again, this should be seen as an upper limit.

- **Dentists** (possibly) - This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It is not clear whether this benefit would be provided in absence of a mandate. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight."

- **Breast Reconstruction** - This is a new mandate enacted last year. Blue Cross estimates the cost at $.20 per month per individual.

- **Errors of Metabolism** - This is a new mandate enacted last year. Blue Cross estimates the cost at $.10 per month per individual.

Based on the above, the total cost of mandates is less than 6% (possibly much less).

APPENDIX J

Health Affairs Study: More Offers, Fewer Takers for Employment-Based Health Insurance: 1987-1996

More Offers, Fewer Takers For Employment-Based Health Insurance: 1987 And 1996

With more firms offering health insurance to workers, why aren't more workers covered? These first findings from the Medical Expenditure Panel Survey may hold the answer.

BY PHILIP F. COOPER AND BARBARA STEINBERG SCHONE

THE VAST MAJORITY of Americans with private health insurance obtain their coverage through the workplace—either directly through their own employment or indirectly through a family member. However, employment does not guarantee health insurance coverage, and recent studies show that employment-based insurance coverage is falling.[1]

One compelling explanation for this decline is the increasing cost of employment-related insurance. The 90 percent increase in health insurance premiums observed between 1987 and 1993 far exceeded the rise in wages and salaries (28 percent) during that period.[2] Employees' contributions to health insurance premiums also increased.[3] Rising premiums may discourage firms from offering insurance, and higher employee contribution rates may cause some workers to decline coverage when it is offered.

The past ten years also have been a time of profound change in health insurance markets. Many states have adopted legislation that mandated specific types of insurance benefits, allowed for purchasing alliances designed to spread risk across larger populations, and enacted small-group market reforms to increase the availability (and, in some states, control the cost) of health insurance for persons working in small firms.[4] Much of this legislation was designed to enhance insurance coverage and improve health plan generosity, but it may have contributed to the rise in health insurance costs.[5]

The Medicaid program also has changed significantly over the past decade. Medicaid eligibility was enhanced for children and pregnant women, and coverage for some low-income working persons was improved to discourage welfare dependency.[6] These expansions may also have contributed to the decline in employment-related coverage, since Medicaid serves as a potential substitute for private insurance.[7]

PREVIOUS RESEARCH

Many of the changes noted above were designed to enhance access to insurance, especially for particular segments of the population, so understanding the impact of these policies and their relationship to declining employment-based insurance coverage is of considerable interest.

Many researchers have focused on the correlates of employers' decisions to offer health insurance to their workers.[8] Paul Fronstin and Sara Snider compared Current Population

Philip Cooper and Barbara Schone are economists at the Agency for Health Care Policy and Research in Rockville, Maryland.

Survey (CPS) data from 1988 and 1993 and found a small (1.6 percent) decline in the proportion of persons who work for a firm that sponsors a health insurance plan.[9] Jon Gabel and colleagues, using Health Insurance Association of America (HIAA) and KPMG Peat Marwick surveys of small firms (fewer than 200 workers), found a 6.5 percent increase in the proportion of small firms that offered insurance between 1989 and 1996.[10]

Researchers have increasingly recognized that demand factors, as well as supply factors, may be responsible for the decline in employment-based coverage. Using 1988 CPS data, Stephen Long and Susan Marquis found that a significant fraction of workers are not offered health insurance. However, they argue that low coverage among workers may also reflect weak preferences for insurance.[11] Gabel and colleagues found that the importance of cost in a small employer's decision to offer coverage decreased over time, although it remains an important consideration. Two other reasons for not offering coverage—"lack of employee interest" and "health insurance not necessary to attract labor"—increased in importance from 1989 to 1996.

"Access to employment-related insurance did not decline between 1987 and 1996, but take-up rates fell."

The literature suggests that changes in the demand for and access to coverage may be responsible for the decline in employment-based insurance. However, with the exception of Long and Marquis, these researchers have not accounted for access to insurance through other family members; nor have they described the characteristics of workers who reject and accept coverage when it is offered. In this paper we investigate how employment-related insurance availability has changed over time and whether workers were accepting coverage at the same rate in 1996 as they were in 1987.

Data And Methods

The data for this study come from two sources: the 1996 panel of the Medical Expenditure Panel Survey (MEPS) and the 1987 National Medical Expenditure Survey (NMES). We focus on initial data from the first round of the household component of the 1996 MEPS and corresponding first-round data from 1987.[12] Our samples consist of persons between the ages of twenty-one and sixty-four who are employed but not self-employed.[13]

The main variables of interest for our analysis are offer rates and take-up rates of employment-related health insurance.[14] The offer rate, defined as the proportion of workers offered employment-related coverage, is based on the availability of health insurance from a person's main job. Since the offer rates we report are worker-specific, they reflect both offers of insurance from employers and workers' eligibility for insurance. Thus, a worker is classified as being offered health insurance if he or she works for a firm that provides insurance and is also eligible for the plan.[15] The take-up rate measures the proportion of those workers offered coverage who are policyholders of a health insurance plan from their main job.

We also account for the availability of employment-related health insurance through other family members. For all of the workers in our sample, we determine whether health insurance was available through a spouse or a parent (for those workers who are under age twenty-four and full-time students). We define the access rate to employment-based insurance as the proportion of workers who could have obtained insurance either through the worker's own job or through the job of a family member. We use the term *family take-up rate* to refer to the proportion of workers with access to employment-based insurance who are actually covered by it.

Findings

Based on our tabulations of offer rates, access rates, and take-up rates, we found that the

proportion of workers holding a health insurance plan from their main job fell between 1987 and 1996 (Exhibit 1).[16] On the other hand, the number of workers offered health insurance from their jobs grew between 1987 and 1996.[17] Taken together, these findings suggest that the decline in the proportion of workers holding employment-related coverage is attributable to changes in the proportion of workers who accept coverage, which is reflected in the 8.2-percentage-point fall in the take-up rate of insurance.[18]

Although the fraction of workers who are policyholders of an employment-sponsored plan has declined, this does not necessarily mean that there are more uninsured workers. Since many workers have access to employment-related insurance through other family members, these trends could simply reflect a change in dependent coverage patterns between 1987 and 1996. To investigate this possibility, we looked at access and coverage rates of employment-related health insurance that was available through family members. We found that more workers had access to employment-based insurance than were offered it: For example, 82.2 percent of workers had access to employment-sponsored insurance in 1996, compared with 75.4 percent of workers who actually were offered coverage that year (Exhibit 1). Also, roughly the same percentage of workers had access to health insurance in each year—81.8 percent in 1987 versus 82.2 percent in 1996. Thus, although more workers were offered insurance from their employers in 1996, the increase did not represent improved access to employment-related health insurance.

Among workers with access to employment-based insurance, approximately 93 percent were covered by such a plan in 1987; by 1996 this proportion had fallen to 89 percent (Exhibit 1). Thus, accounting for family coverage results in more modest changes between 1987 and 1996 than if insurance from the worker's own job alone were considered. Nevertheless, both sets of results paint a similar picture: Access to employment-related insurance did not decline between 1987 and 1996, but take-up rates fell.

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EXHIBIT 1
Employment-Related Health Insurance, 1987 And 1996

	1987		1996	
	Total (millions)	Percentage	Total (millions)	Percentage
All workers[a]	86.8	100.0%	100.0	100.0%
Workers holding coverage	55.5	63.9	60.4	60.4
Workers offered insurance	62.9	72.4	75.5	75.4
Take-up rate[b]	–[c]	88.3	–[c]	80.1
Workers with employment-based insurance coverage[d]	66.2	76.2	73.2	73.2
Workers with access to employment-based insurance[e]	71.0	81.8	82.2	82.2
Family take-up rate[f]	–[c]	93.2	–[c]	89.1

SOURCES: Medical Expenditure Panel Survey, 1996; and National Medical Expenditure Survey, 1987.
[a] Includes workers ages twenty-one through sixty-four who are not self-employed.
[b] Percentage of workers who hold insurance of those who are offered.
[c] Not applicable.
[d] Workers covered by an employment-based health insurance policy either from their own job or from the job of a family member (not including coverage from a union).
[e] Workers offered insurance from their main job or who have access through a spouse or, for workers under the age of twenty-four who are full-time students, through a parent.
[f] Percentage of workers who are covered by the employment-related health insurance of those who have access.

Worker Characteristics

We found significant variation in offers of insurance, access rates, and take-up rates by employee characteristics and important differences between the two years studied. The observed patterns suggest increasing disparity across workers in these rates over time.

■ AGE. In both years workers under age twenty-five were least likely and workers between the ages of thirty-five and fifty-four were most likely to be offered and have access to insurance (Exhibit 2). Workers under age twenty-five also faced lower offer rates and access rates in 1996 than they did in 1987. The fact that the youngest workers were less likely to be offered insurance in 1996 is especially significant since the overall rate of being offered insurance increased across the two time periods (and for all other age groups). In addition, access rates remained essentially unchanged for workers over age twenty-five but dropped quite significantly for the youngest workers.

Significant changes occurred in take-up rates over the time period. In 1987 there were no statistically significant differences in take-up rates by age; in 1996, however, workers under age twenty-five were significantly less likely than those in other age groups to have coverage (either from their own job or the job of a family member). These patterns suggest

EXHIBIT 2
Rates Of Employment-Related Health Insurance, By Worker Characteristics, 1987 And 1996

	1987					1996				
Worker characteristic	Total (millions)	Offer rate	Take-up rate	Access rate[a]	Family take-up rate[b]	Total (millions)	Offer rate	Take-up rate	Access rate[a]	Family take-up rate[b]
Age										
Younger than 25	10.6	55.6%	86.5%	67.0%	91.3%	9.6	51.0%	70.1%	58.9%	78.0%
25–34	27.9	72.7	89.0	81.6	93.1	29.3	75.5	80.2	82.1	87.7
35–54	39.2	76.8	88.1	86.9	93.7	52.1	79.9	80.9	87.0	90.9
55–64	6.9	72.8	88.2	78.5	92.8	9.0	75.5	81.7	80.4	90.4
Sex										
Male	46.0	78.1	91.1	83.0	92.6	51.4	76.9	84.0	81.9	88.8
Female	40.8	66.0	84.5	80.5	93.8	48.7	73.8	75.7	82.6	89.4
Race/ethnicity										
Hispanic	6.2	62.6	84.5	71.1	85.8	9.5	61.1	77.5	67.0	82.6
Black[c]	9.2	71.4	86.8	77.4	90.3	11.5	74.5	79.5	77.8	84.9
Other	71.4	73.4	88.7	83.3	94.1	79.1	77.3	80.4	84.7	90.2
Wage[d]										
$7.00 per hour or less	18.0	43.4	79.7	60.3	89.4	19.1	42.7	63.2	55.4	75.8
$7.01–$10.00 per hour	16.5	67.9	88.0	79.4	93.5	17.6	70.0	74.2	78.0	88.1
$10.01–$15.00 per hour	23.8	80.0	88.8	87.5	93.8	29.4	84.8	82.2	90.3	90.9
More than $15.00 per hour	28.4	87.1	90.7	92.2	94.1	28.6	93.4	85.7	96.1	93.9
Establishment size										
Fewer than 10 workers	15.6	45.0	82.6	62.4	90.1	17.1	48.1	73.8	62.7	84.6
10–25 workers	13.8	63.2	87.7	76.0	92.1	15.8	68.0	74.5	76.7	85.4
26–100 workers	20.0	77.9	87.4	85.8	92.4	25.3	80.8	79.2	86.2	88.2
More than 100 workers	33.1	86.9	90.4	92.1	95.4	36.7	89.6	84.4	92.9	92.8

SOURCES: Medical Expenditure Panel Survey, 1996; and National Medical Expenditure Survey, 1987.
NOTE: Information on workers with unknown characteristics is excluded from the relevant rows.
[a] Percentage of workers who were offered health insurance from their main job or had access through another family member.
[b] Percentage of workers covered by an employment-based plan, among those workers with access.
[c] Denotes persons who are black and non-Hispanic.
[d] In 1996 dollars.

that young workers have become increasingly less likely to be covered under an employer-sponsored insurance policy.

■ SEX. Gender differences in offers of insurance have diminished over time (Exhibit 2). The narrowing of the difference in offer rates reflects growth in the proportion of women offered health insurance at a time when offer rates for men remained relatively constant. Although offer rates for women improved over the time period, they are still significantly lower than offer rates for men. However, while men had significantly higher access rates in 1987, by 1996 their access rates were quite similar to those of women (81.9 percent for men, 82.6 percent for women). Men and women experienced similar declines in take-up rates across the time period, and although women remain less likely to hold offered insurance, their actual coverage rates are similar to those of men.

"Differences in offer and access rates by actual insurance status suggest substantial changes in the insurance market between 1987 and 1996."

■ RACE/ETHNICITY. Workers of "other" race/ethnicity (mainly white Americans) saw significant increases in offers of health insurance over the time period, but offer rates for Hispanics remained unchanged (the increase in offer rates for black Americans was not statistically significant) (Exhibit 2). Access rates remained virtually the same for all workers except Hispanics, for whom access rates fell.[19] In terms of take-up rates by race/ethnicity, there is more dispersion in rates of coverage (family take-up rates) than in the proportion of workers holding coverage (the take-up rate from the worker's main job). For example, family take-up rates for Hispanics were significantly lower than those of workers of "other" race/ethnicity in both years; however, in 1996 the rate at which Hispanics held coverage was not significantly different than those rates observed for non-Hispanic workers.

■ WAGES. Our findings indicate a strong positive relationship between offer rates, access rates, take-up rates, and wages, and the relationships intensify over the time period. For workers earning less than seven dollars per hour (in 1996 dollars), offer rates were virtually the same in both years, but access rates declined significantly. Offer rates and access rates for higher-wage workers (those earning more than ten dollars per hour) increased over the time period. The disparity in both individual and family take-up rates by wages was also greater in 1996, with workers earning ten dollars or less per hour having greater declines in take-up rates over the time period than higher-wage workers had.

■ SIZE OF EMPLOYER. Finally, the well-known positive relationship between establishment size and offer rates was evident in both 1987 and 1996.[20] We also observed this positive relationship with respect to access rates. Between 1987 and 1996, take-up rates for workers in smaller establishments (fewer than twenty-five employees) declined significantly more than did rates for workers in larger establishments.

INSURANCE STATUS

To investigate the disparity between offer rates and access rates, we looked at the distribution of workers and their associated offer and access rates by actual insurance status (Exhibit 3). For all workers, even those without employment-based coverage, offer rates increased significantly; access rates also increased, except among those with employment-based or union coverage.[21] The workers that experienced the greatest rise in access to employment-based insurance were those covered by a public plan: In 1987 workers with public insurance were significantly less likely than other workers to be offered insurance. In 1996, however, offer rates grew proportionately more for publicly insured workers than for other groups (from 5.3 percent to 24.7 per-

EXHIBIT 3
Employment-Related Health Insurance Availability And Insurance Status Of Workers, 1987 And 1996

	1987				1996			
	Total (millions)	Percent of all workers	Offer rate	Access rate	Total (millions)	Percent of all workers	Offer rate	Access rate
Total	86.8	100.0%	72.4%	81.8%	100.0	100.0%	75.4%	82.2%
Insurance status[a]								
Employment-related policy	68.2	78.6	86.6	97.0	75.8	75.8	89.7	97.0
Union policy	2.5	2.9	78.5	90.4	2.6	2.6	85.0	92.1
Other private insurance	3.3	3.8	12.4	16.8	3.0	3.0	26.0	32.9
Public insurance	0.7	0.8	5.3	8.2	2.9	2.9	24.7	28.4
Uninsured	12.1	13.9	11.2	16.3	15.7	15.7	24.0	29.1

SOURCES: Medical Expenditure Panel Survey, 1996; and National Medical Expenditure Survey, 1987.
[a] Insurance status is a hierarchical measure that classifies individuals' insurance status (as a policyholder or dependent) in the following order: (1) any employment-related coverage, (2) union coverage, (3) other private health insurance, (4) any public coverage, (5) no insurance.

cent). We observed no significant difference in offer rates between publicly insured workers (24.7 percent), workers with other private, non-employment-related coverage (26 percent), and workers who were uninsured (24 percent). Similar changes also occurred with respect to access rates.

These differences in offer and access rates by actual insurance status suggest substantial changes in the insurance market between 1987 and 1996. By 1996 roughly one-quarter of workers without employment-related or union insurance—approximately 5.3 million workers—had been offered a policy by their employers. An additional one million workers without employment-related coverage had access to it through other family members. These findings suggest that more workers are declining coverage now, even if it means forgoing insurance. Moreover, workers who decline insurance and are uninsured are more likely to be young, Hispanic or black, or unmarried or have low wages or low education levels.[22]

DISCUSSION

Our findings provide evidence of a decline in employment-related insurance coverage. The decline appears to be the result of falling take-up rates, since offer rates have increased and access rates have been stable over time.[21] Since take-up rates appear to be the driving force behind decreases in employment-based insurance coverage, understanding the factors that affect the demand for employment-based insurance is crucial. The falling take-up rates we observed may be attributable to a variety of factors: declining real incomes, especially among workers who are the least likely to have coverage; increasing costs of insurance; rising employee contributions to health insurance premiums; and expansions in Medicaid.[24] Declining take-up rates also may reflect increased price-consciousness among workers, as a result of more intense health insurance market competition and greater media attention to health care issues. Workers also may be responding to a decrease in the generosity of insurance offered by employers. In 1996 almost one-third of workers with other private insurance (for example, nongroup coverage) had access to employment-based insurance, compared with 16.8 percent in 1987 (Exhibit 3). This suggests that a larger proportion of workers with nongroup coverage may have forgone the cost advantages of an employment-based group policy.

Our results also indicate that certain subgroups of the population—young workers and workers with low wages—are particularly likely to lack employment-based insurance and that their situation has worsened

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over time. Workers with low wages (less than seven dollars per hour) and those under age twenty-five have faced relatively large declines in their access to employment-based insurance since 1987. These workers also have experienced large declines in take-up rates. Thus, while family take-up rates were fairly similar by age and wage level in 1987, they are now 15 to 20 percent lower for young and low-wage workers relative to others.

There has been a slight increase in the proportion of workers without employment-related or union coverage (18.5 percent in 1987 versus 21.6 percent in 1996) (Exhibit 3). More dramatic, though, is the change in the proportion of those workers who had access to such coverage. In 1987 approximately 16 percent of workers without employment-based or union coverage had access to employment-related coverage; by 1996 this proportion had reached 29 percent. Although approximately fifteen million workers lacked access to employment-related insurance in 1996, the real change has been in the number of workers who were not taking up coverage—approximately six million workers in 1996, or an increase of more than 140 percent since 1987. From a policy perspective, these patterns suggest that proposals aimed at improving the rate at which workers accept coverage (for example, subsidies) may be increasingly important.

Selected results from this paper were presented at the annual meeting of the Association of Health Services Research (AHSR), Chicago, June 1997. The authors thank Joel Cohen, Paul Fronstin, Stephen Long, Alan Monheit, and Eric Schone for helpful comments. Chao-Sung Yu of Social and Scientific Systems provided exceptional computational assistance. The views in this paper are the authors'. No official endorsement by the Agency for Health Care Policy and Research or the Department of Health and Human Services is intended or should be inferred.

NOTES

1. P. Fronstin and S. Snider, "An Examination of the Decline in Employment-Based Health Insurance between 1988 and 1993," *Inquiry* (Winter 1996/1997): 317–325; and J. Holahan, C. Winterbottom, and S. Rajan, "A Shifting Picture of Health Insurance Coverage," *Health Affairs* (Winter 1993): 253–264.
2. C. Pemberton and D. Holmes, eds., *EBRI Databook on Employee Benefits* (Washington: Employee Benefit Research Institute, 1995); and U.S. Bureau of the Census, *Statistical Abstract of the United States* (Washington: U.S. Bureau of the Census, 1991 and 1996). The annual rate of increase in health plan costs has slowed to approximately 5 percent since 1993.
3. J. Gabel, P. Ginsburg, and K. Hunt, "Small Employers and Their Health Benefits, 1988–1996: An Awkward Adolescence," *Health Affairs* (September/October 1997): 103–110.
4. For detailed state-specific information, see National Association of Insurance Commissioners, *Compendium of State Laws on Insurance Topics* (Kansas City, Mo.: NAIC, 1997).
5. T. Buchmueller and G. Jensen, "Small Group Reform in a Competitive Managed Care Market: The Case of California, 1993 to 1995" (Working paper, University of California, Irvine). The authors find some evidence that is consistent with increased provision of insurance as a result of small-group market reforms in California. They do not find similar effects in other states with reforms.
6. U.S. Congress, House Committee on Ways and Means, *Overview of Entitlement Programs, 1996 Green Book* (Washington: U.S. Government Printing Office, 1996).
7. There is disagreement regarding the "crowd-out" effects of Medicaid. See, for example, Holahan et al., "A Shifting Picture of Health Insurance Coverage;" D.M. Cutler and J. Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs* (January/February 1997): 194–200; and L. Dubay and G. Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs* (January/February 1997): 185–193.
8. J. Cantor, S. Long, and M.S. Marquis, "Private Employment-Based Health Insurance in Ten States," *Health Affairs* (Summer 1995): 199–211; and S.H. Long and M.S. Marquis, "Gaps in Employer Coverage: Lack of Supply or Lack of Demand?" *Health Affairs* (Supplement 1993): 282–293.
9. Fronstin and Snider, "An Examination of the Decline in Employment-Based Health Insurance."
10. J. Gabel, P. Ginsburg, and K. Hunt, "Tracking Small Firm Coverage, 1989–1996: More Firms but Fewer Enrollees" (Unpublished).

11. Long and Marquis, "Gaps in Employer Coverage."
12. Detailed information on the 1987 NMES can be found in W.S. Edwards and M. Berlin, *Questionnaires and Data Collection Methods for the Household Survey and the Survey of American Indians and Alaska Natives*, DHHS Pub. no. (PHS)89-3450 (Rockville, Md.: Public Health Service, 1989). Information on the MEPS is contained in J. Cohen et al., "The Medical Expenditure Panel Survey: A National Health Information Resource," *Inquiry* (Winter 1996/1997): 373–389.
13. We excluded self-employed persons from our samples because they can choose whether their firms offer health insurance coverage (the decision to offer and accept insurance are essentially the same decisions). Our final samples consisted of 11,566 workers in 1987 (representing approximately eighty-seven million workers) and 8,594 workers in 1996 (representing more than 100 million workers).
14. For the purposes of this analysis, *health insurance* is defined as a plan that covers hospitalizations, physician visits, and other health expenses.
15. For a small number of cases in 1996, information was missing regarding whether a person was offered health insurance. The results reported use imputed values for these missing cases. Other results, available upon request, excluded these missing cases from the analyses. The results were insensitive to their exclusion. The 1987 and 1996 questionnaires ascertained this information in slightly different ways. In 1987 survey respondents were asked if they had health insurance from their job. If they did not, they were then asked if they were eligible for insurance from the job. In 1996 persons were asked if they had health insurance from their job and, if not, whether they were offered health insurance. Given that the wording in the follow-up question for persons who were not policyholders was different, there could be systematic differences in the way persons responded. If there are systematic differences, there are no apparent reasons to expect the bias to be in any particular direction. Also, our measure of offers of insurance does not directly account for union coverage. Persons were simply asked if an employer provided insurance. Thus, it is possible that some persons included union coverage in this measure, while others did not.
16. All statistics are weighted to be nationally representative for their respective years, and standard errors are adjusted to account for the complex design of both the 1987 NMES and the 1996 MEPS. The sampling weights account for nonresponse to the survey and poststratification adjustments to population estimates from the 1987 and 1996 CPS. All results described as statistically significant have probability values of 5 percent or less.
17. These patterns also hold when we subset the sample by hours of work, although offer rates are somewhat higher for full-time workers. For example, for persons working thirty or more hours per week, offer rates rose from 78.7 percent in 1987 to 82.0 percent in 1996, and take-up rates declined from 89.2 percent to 81.3 percent.
18. We did not include union coverage in the take-up rates we observed since we could not identify workers who are offered and decline an insurance policy from a union. Sensitivity checks that include workers with union coverage result in marginally higher offer and take-up rates (results available from the authors upon request). The general trends we observed, however, remain the same.
19. This result was marginally significant ($p < .10$).
20. Long and Marquis, "Gaps in Employer Coverage;" and P. Cooper and A. Johnson, *Employment-Related Health Insurance in 1987*, AHCPR Pub. no. 93-0044 (Rockville, Md.: AHCPR, 1993).
21. That access rates are not 100 percent for workers covered by employment-based coverage reflects the fact that some workers obtain insurance from a retirement job, a supplementary job, from family members outside the household, or through coverage obtained through Consolidated Omnibus Budget Reconciliation Act (COBRA) provisions.
22. Results of the authors' analysis of the characteristics of workers who decline coverage are available from the authors.
23. Our finding of an increase in the offer rate of employment-related insurance contrasts to the findings of Fronstin and Snider, who observe a slight decline in offer rates. These findings are not directly comparable, since our measure accounts for workers' eligibility for insurance, which Fronstin and Snider do not consider.
24. Male high school dropouts experienced a 22.5 percent fall in real wages between 1979 and 1993, while real wages for males with at least a college degree increased by approximately 9.8 percent. Corresponding figures for females were 6.3 percent and 27.1 percent. See R. Blank, *It Takes a Nation* (Princeton: Princeton University Press, 1997).

APPENDIX K

National Center for Policy Analysis Study on Costs of Mandated Benefits Conducted by Milliman and Robertson

BRIEF ANALYSIS
No. 237
For immediate release:
Wednesday, August 13, 1997

The Cost of Health Insurance Mandates

For more than 30 years, state legislatures have passed laws driving the cost of health insurance higher. Known as mandated health insurance benefit laws, they force insurers, employers and managed care companies to cover — or at least offer — specific providers or procedures not usually included in basic health care plans.

Recently, the federal government imposed two mandates that affect health insurance policies nationwide.

While actuaries, insurers and health economists agree that virtually all mandates increase the cost of health insurance, the magnitude of their effects has been subject to debate. A new analysis prepared for the National Center for Policy Analysis by the actuarial firm Milliman & Robertson estimates the costs of 12 of the most common mandates and finds that, collectively, they can increase the cost of insurance by as much as 30 percent.

National Center for Policy Analysis Estimated Additional Costs for Certain Benefits, Calendar Year 1997

Benefit	Estimated Additional Annual Cost	
1. Minimum Stay Maternity	less than 1%	<$35*
2. Speech Therapy	less than 1%	"
3. Drug Abuse Treatment	less than 1%	"
4. Mammography Screening	less than 1%	"
5. Well Child Care	less than 1%	"
6. Podiatry	less than 1%	"
7. Papanicolaou (Pap) Smears	less than 1%	"
8. Vision Exams	1% to 3%	$35-$105
9. Chiropractic Treatment	1% to 3%	$35-$105
10. Alcoholism Treatment	1% to 3%	$35-$105
11. Infertility Treatment	3% to 5%	$105-$175
12. Mental Health Care	5% to 10%	$175-$350
Total	15% to 30%	$525-$1,050

* Based on a standard family policy without mandates costing $3,500 per year.

Source: Milliman & Robertson.

The Explosion of Mandated Benefits. Although there were only seven state-mandated benefits in 1965, there are nearly 1,000 today. While many mandates cover basic providers and services, others require coverage for such nonmedical expenses as hairpieces, treatment for drug and alcohol abuse, pastoral and marriage counseling.

These mandates apply only to those health insurance policies controlled by state health insurance laws — usually policies purchased by small businesses and individuals. Most large companies avoid state mandates by self-insuring under the Employee Retirement Income Security Act (ERISA), which exempts self-insured companies from state oversight. However, the federal government's new mandates — banning "drive-through" baby deliveries and requiring that any cap on mental health benefits be the same as the cap on physical health benefits — apply to all insurance. Moreover, Congress appears likely to pass even more mandates in the future.

How Much Do Mandates Increase the Cost of Health Insurance? The Milliman & Robertson analysis of 12 of the most common mandates is based on policies in a representative state.

Assuming that a mandate-free, basic health insurance policy costs a family about $3,500 a year, the study found that [see the table.]:

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- Several of the mandates would increase the cost of a policy by less than $35 each.
- Infertility treatment could increase the cost between $105 and $175 a year.
- Mental health parity, which requires insurers to treat mental illnesses like physical illnesses, could add between $175 and $350 to the cost of a policy.

Taken together, the package of 12 mandates could increase the cost of a family health insurance policy by as much as 15 to 30 percent, or $525 to $1,050 a year. Based on these estimates, we conclude that a small business employing 25 people — with a standard mix of 40 percent single and 60 percent family coverage — could see its premiums rise by $20,000 a year.

Who Pays for Mandated Benefits. Many employees believe their employers pay for the insurance they provide. However, economists recognize that employee benefits are a substitute for wages in the employee's total compensation package. Higher benefits often force employees to take lower wages whether they like it or not. A 1990 survey of the literature by National Bureau of Economic Research economist Olivia S. Mitchell found that the cost of mandated benefits is usually borne by employees in the form of reduced wages, reduced work hours or loss of employment.

The Impact of Mandates. While mandated benefits mean that people with health insurance have more health care options, they also mean that fewer people are insured. When employers who canceled their employees' health insurance policies have been polled on why they did so, the majority claimed that it was because the price was too high.

Lower-income employees are most likely to lose coverage. According to a 1989 study by health economists Gail Jensen and Jon Gabel, mandated coverage increases premiums by 6 to 8 percent for substance abuse, 10 to 13 percent for mental health care and as much as 21 percent for psychiatric hospital care for employee dependents.

The Threat to ERISA. Since 1974, many large- and medium-sized employers have escaped the cost-increasing impact of state health benefit mandates by self-insuring under the Employee Retirement Income Security Act. As a result, thousands of employers have been able to offer health insurance policies tailored to their employees' needs and their companies' budgets.

However, a number of proposals currently before Congress would impose new mandates at the federal level. For example, they would require coverage for mammograms for women under age 50, ban "drive-through" mastectomies and preclude managed care in many instances. Because the federal mandates would apply universally, self-insured companies would come under federal control.

Conclusion. The real threat behind the Congress's newfound interest in mandating health insurance benefits is incremental rather than immediate. One or two federal mandates may not increase the cost of health insurance significantly but, as in the states, once the door is open every special interest will hurry through to besiege the legislature.

When the legislators succumb and the dust settles, health insurance will cost more, employers and individuals will cancel more policies and Congress will face a growing uninsured "crisis" — a crisis largely of its own making.

This Brief Analysis was prepared by NCPA President John C. Goodman and Vice President of Domestic Policy Merrill Matthews Jr.

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1947-1997 50 YEARS OF EXCELLENCE

March 18, 1997

Dr. Merrill Matthews, Director
National Center for Policy Analysis
12655 N. Central Expressway - Suite 720
Dallas, TX 75243-1739

Re: Estimated Costs for Certain Benefits

Dear Merrill:

We have completed our review of the estimated cost to provide health coverage for certain benefits. The estimated costs shown in the following table reflect the additional cost to a health plan that excludes all of the listed benefits. These cost estimates are placed in one of the cost ranges you requested.

National Center for Policy Analysis
Estimated Additional Costs for Certain Benefits
Calendar Year 1997

	Benefit	Estimated Additional Cost
1.	Alcoholism Treatment	1% to 3%
2.	Infertility Treatment	3% to 5%
3.	Minimum Stay Maternity	less than 1%
4.	Speech Therapy	less than 1%
5.	Drug Abuse Treatment	less than 1%
6.	Mammography Screening	less than 1%
7.	Well Child Care	less than 1%
8.	Vision Exams	1% to 3%
9.	Mental Health Care	5% to 10%
10.	Chiropractors	1% to 3%
11.	Podiatrists	less than 1%
12.	Papanicolaou (Pap) Smears	less than 1%

This letter describes the results and methodology used to estimate the cost for the listed benefits. Exhibit I contains a description for each of these benefits.

Results

The cost estimates for the requested health benefits varied from less than 1% for certain benefits to 5% to 10% for the mental health benefit. These cost estimates were based on information contained in our *Health Cost Guidelines* and are based on specific assumptions regarding benefits, reimbursement levels, cost containment features, demographics, geographic area, population, and time period.

The cost estimates do not include any excess utilization adjustments and were developed assuming the additional benefits would apply to all insureds. The cost estimates shown in this letter are not appropriate for situations where the additional benefits are selected at the option of the insured.

In addition, these cost estimates do not include the potential impact of adverse selection that may result due to the cost of adding mandates (additional benefits) to a basic benefit offering. In this context, adverse selection means the additional premium necessary to pay for the additional benefits may cause those insureds in better health to reduce or drop health insurance coverage. As a result, those remaining insured may be in poorer health which may cause the cost of health coverage for those insureds to increase.

The increase in costs due to adverse selection could vary widely depending on the unique circumstances and the number of additional benefits implemented.

Because the economy and the health care system are dynamic, there is an intrinsic uncertainty in projecting costs for any health care reform proposal, and this uncertainty applies to our work. Therefore, actual costs will be different than these estimates. In addition, these cost estimates do not reflect the cost impact of the additional benefits for different populations (e.g., Medicare, Medicaid, Individual, Small Group), geographic area (e.g., California), reimbursement arrangements (e.g., capitation), cost containment features (e.g., HMO environment), base benefit plans (e.g., $10 office visit copay), additional benefits (e.g. 100% coverage), or time period. Also, premium rate estimates published by other researchers for similar programs may not be consistent with our underlying assumptions, so caution should be used when comparing results.

This letter is intended for the internal use of the National Center for Policy Analysis. However, the letter can be provided to outside parties in its entirety with the written permission of M&R. Any other written or oral references to M&R performing the work are acceptable if our entire report is released in its entirety. Milliman & Robertson, Inc. does not support any particular health care reform policy.

Methodology

In preparing our estimates, we followed a three-phase approach.

Phase 1 was to estimate the cost for a basic comprehensive major medical (CMM) plan which does not include coverage for the listed benefits. The estimated cost for the base plan is consistent with an actively at work population consisting of a large group of relatively benefit-conscious individuals covered under a CMM plan with a $250 annual deductible, 80% coinsurance, and a $1,000 out-of-pocket maximum. The cost estimate reflects health benefits provided through a traditional, undiscounted, fee-for-service environment without meaningful cost containment measures. The cost estimate for the base plan is also consistent with the demographics of the U.S. Labor Force population. The cost estimate for the base plan was developed from our *Health Cost Guidelines* and reflects claim costs for calendar year 1997 with utilization and average charges representing nationwide averages.

Phase 2 was to develop cost estimates for each of the requested health benefits. The definition of the services provided for each of these benefits is contained in Exhibit I. The cost estimates for each of the requested health benefits were developed from our *Health Cost Guidelines* with the benefit, reimbursement, cost containment, demographic, geographic area, population, and time period assumptions consistent with those used to develop the estimated cost for the base plan.

Phase 3 was to divide the estimated cost for each of the requested health benefits by the estimated cost for the base plan. This ratio provided the estimated cost increase to the base plan to include coverage for the requested health benefit. This cost increase was then placed in one of the cost ranges you requested. The cost ranges consist of less than 1%, 1% to 3%, 3% to 5%, 5% to 10%, and 10% or more.

If you have any questions or we can be of further assistance, please let me know.

Sincerely,

Mark E. Litow, F.S.A.
Consulting Actuary

MEL/jas

Encl.

National Center for Policy Analysis
Estimated Costs for Certain Benefits
Definitions

1. Alcoholism Treatment

For hospital inpatient treatment, an alcohol confinement consists of confinements with a primary diagnosis involving an alcohol condition. Alcohol stays are subject to an annual maximum of 60 days. Detoxification and limited rehabilitation stays are included. For outpatient treatment, the benefit provides for treatment of alcohol abuse by a qualified professional. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

2. Infertility Treatment

Benefits for infertility treatment include an initial OB/GYN visit for history and physical examination. Evaluation and testing will determine if the husband or wife, or both, need follow-up. Treatment may include the following:

a. Drug Therapy
b. Artificial Insemination (using the husband's or donor sperm)
c. Gamete Intra Fallopian Transfer
d. In-Vitro Fertilization

The benefit is limited to three attempts. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

3. Minimum Stay Maternity

This benefit provides for a hospital stay of at least 48 hours after a normal birth and 96 hours after a caesarean section unless the patient and the attending physician agree on an earlier discharge. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

4. Speech Therapy

This benefit provides for services performed by a qualified professional. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

(March 18, 1997)

National Center for Policy Analysis
Estimated Costs for Certain Benefits
Definitions

8. Vision Exams

This benefit provides for eye exams conducted by a licensed ophthalmologist or optometrist. Coverage is limited to one exam per year. Benefits are subject to the deductible, coinsurance, and out-of-pocket limits.

9. Mental Health Care

For hospital inpatient treatment, a psychiatric confinement consists of confinements with a primary diagnosis involving a psychiatric condition. Psychiatric stays are subject to a 60-day maximum. For outpatient treatment, the benefit provides for psychiatric treatment by a qualified professional. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

10. Chiropractors

This benefit provides for visits to a licensed chiropractor's office including those visits involving manipulations. This benefit does not include x-rays taken in the chiropractor's office. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

11. Podiatrist

This benefit provides for services performed by a licensed podiatrist. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

12. Papanicolaou (Pap) Smears

This benefit provides for annual cervical and endometrial cancer screenings (pap smears). The benefit includes the pap smear and the associated OB/GYN office visit. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

National Center for Policy Analysis
Estimated Costs for Certain Benefits
Definitions

5. Drug Abuse Treatment

For hospital inpatient treatment, a drug abuse confinement consists of confinements with a primary diagnosis involving a drug abuse condition. Drug abuse stays are subject to an annual maximum of 60 days. Detoxification and limited rehabilitation stays are included. For outpatient treatment, the benefit provides for treatment of drug abuse by a qualified professional. Benefits are subject to the deductible, coinsurance, and out-of-pocket maximum limits.

6. Mammography Screening

Coverage is provided for mammographic screening on referral by a patient's physician subject to the following guidelines:

a. A baseline mammogram for women from age 35 to 39.

b. A mammogram for women from ages 40 to 49 every two years (or more, based on the recommendation of the woman's physician).

c. A mammogram every year for women 50 years of age and over.

Benefits are subject to the deductible, coinsurance, and out-of-pocket limits.

7. Well Child Care

This benefit provides for normal periodic examinations of well children under two years of age. The benefit is provided for CPT-4 codes 99381, 99382, 99391, 99392, and 99432. Benefits are subject to the deductible, coinsurance, and out-of-pocket limits.

APPENDIX L

Statutory Provision Relating to Regulatory Agenda

5 § 8060. Regulatory agenda

Each agency with the authority to adopt rules shall issue to the appropriate joint standing committee or committees of the Legislature and to the Secretary of State an agency regulatory agenda as provided in this section.

1. Contents of agenda. Each agency regulatory agenda to the maximum possible extent shall contain the following information:

A. A list of rules that the agency expects to propose prior to the next regulatory agenda due date;

B. The statutory or other basis for adoption of the rule;

C. The purpose of the rule;

D. The contemplated schedule for adoption of the rule;

E. An identification and listing of potentially benefited and regulated parties; and

F. A list of all emergency rules adopted since the previous regulatory agenda due date.

2. Due date. A regulatory agenda must be issued between the beginning of a regular legislative session and 100 days after adjournment.

3. Legislative copies. The agency shall provide copies of the agency regulatory agenda to the Legislature as provided in section 8053-A.

4. Availability. An agency which issues an agency regulatory agenda shall provide copies to interested persons.

5. Legislative review of agency regulatory agendas. Each regulatory agenda shall be reviewed by the appropriate joint standing committee of the Legislature at a meeting called for the purpose. The committee may review more than one agenda at a meeting.

6. Application. Nothing in this section or section 8053-A may be construed to prohibit agencies from adopting emergency rules that have not been listed or included in the regulatory agenda pursuant to this section.