



Citizens League Report

Access, Not More Mandates: A New Focus for Minnesota Health Policy

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***Public affairs
research and education
in the Twin Cities
metropolitan area***

**ACCESS, NOT MORE MANDATES:
A NEW FOCUS FOR MINNESOTA HEALTH
POLICY**

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EXECUTIVE SUMMARY

A mandated health insurance benefit is a state regulation of the content of health insurance policies. Through mandates the state requires health plans issued or renewed in the state to include specific health treatments, services, or levels of coverage.

Mandated health benefits have been enacted for a variety of purposes, but the committee identified and developed three fundamental purposes of mandates:

- Mandates ought to broaden people's access to health care services and offer additional choices of effective services to consumers. This is particularly important for higher-risk individuals and those populations that are typically underrepresented in the political arena.
- Mandates ought to spread the financial risk of health care coverage.
- State-established mandates ought to define the level of health coverage that is in the public interest.

However, experience with the mandates has shown they fail to adequately accomplish their intended purposes. Many Minnesotans are left unaffected by the mandates. Mandates do not directly affect either employees of self-insured firms (a growing percentage of all firms), uninsured Minnesotans who account for between eight and ten percent of all state citizens, or persons receiving publicly provided health coverage.

In addition, mandates are inequitable because they do not apply uniformly to all types of health plans. For example, health maintenance organizations (HMOs) must cover comprehensive health maintenance services, while other insurers have more flexibility in designing their plans. On the other hand, HMOs are not required to guarantee their clients access to nonphysician providers as are other insurers. Differences in state requirements also exist between group and individual policies.

Furthermore, the mandates create unintended consequences that reduce access to health care, contribute to costs, and do not enhance quality of care. Cost of insurance is a major factor in employers' decisions to offer health insurance, and hence, affects the availability of insurance. Because mandates may add to overall health insurance costs (albeit as one of several causes), they may inadvertently lead to fewer people covered.

Minnesota does not systematically use a comprehensive, objective process to determine whether a benefit should be mandated. Without such a systematic review process the potential adverse effects of mandates remain unchecked.

Although the state has used mandates in the interest of consumer protection to expand coverage for some residents, others have no coverage at all. This raises a question about whether the state should continue to use its regulatory power to expand coverage for some residents while some persons are without any health coverage. Providing access to coverage for those without any insurance ought to be the state's health policy priority.

Therefore, we recommend:

- ☐ **The Minnesota Legislature should declare a moratorium on enacting new mandated benefits.**

This means the state would not require Minnesota health insurers to cover any additional treatment benefits or require insurers' payment to new categories of providers until all Minnesotans have access to at least a basic level of health care coverage.

Instead, the Legislature should take several major steps:

- ☐ **First, direct any new public or private expenditures initiated by the state for health care in Minnesota to address the basic health care insurance needs of uninsured Minnesotans.**
- ☐ **Second, evaluate existing mandated health benefits and reauthorize only those that meet specific public policy criteria.**

Basic coverage in a universal access program is likely to provide somewhat lower benefit levels than what is currently mandated for employer-provided health insurance. Because state mandates for health insurance impose one level of health care coverage and a basic level would likely establish a second, leaner level of health coverage, the state must resolve whether it is appropriate public policy to mandate two disparate levels of coverage.

Consequently,

- ☐ **The Legislature should not impose additional health insurance mandates until the state determines that a dual level of required health care is in the public interest.**

INTRODUCTION

A mandated benefit is a means of regulating the content of health insurance plans. By enacting a mandate, the state requires the inclusion of specific health treatments, services, or levels of coverage in health plans issued or renewed in the state. Minnesota is among the states with the greatest number of mandates required of health plans.

Although the Citizens League study committee was charged specifically with examining the state's package of mandates, committee members found it impossible to talk about health plan mandates without also addressing some of the larger issues surrounding health care today.

Mandates may appear almost insignificant in the context of spiraling health care costs, increasing concern about the growing number of people who lack health insurance, and the need to monitor and foster quality health care. Yet the issues surrounding mandated health insurance benefits are connected to these overarching problems. Consequently, mandated benefits must be viewed in the context of: *Escalating cost, inadequate access, and unmeasured quality of health care.*

Escalating cost: Health care costs have risen dramatically in the United States. Total expenditures for health care in the U.S. rose from \$75 billion in 1970 to \$496 billion in 1987.¹ In 1988, over 11 percent of the country's gross national product was spent on health care.

Inadequate access: By one estimate, the number of American people without any health insurance grew from 28.4 million in 1979 to 36.8 million in 1986.² About one in seven Americans has no health insurance. One-third of these are children. Many of those without insurance do not seek medical care until expensive emergency care is needed.

Making sure people can get the health care they need was considered the number one health care priority for state government by over 60 percent of a random sample of state legislators and health regulators from across the nation.³

Unmeasured quality of care: Concerns about the quality and appropriateness of care are rising. Researchers have identified regional variations in the utilization of certain medical procedures that are not explained by differences in illness or

¹ Health Insurance Association of America, *Source Book of Health Insurance Data, 1988 Update*, Washington D.C., July 1988.

² U.S. General Accounting Office, *An Overview of the Working Uninsured*, Report to the Committee on Finance, U.S. Senate, February 1989, p. 11.

³ Louis Harris and Associates, Inc., *Health Care Outlook 1989: Survey II State Health Care Officials' Vision of the Future of Health Care in Their States*, New York, New York, 1989, p. 21.

medical need. Ongoing cost increases have piqued insurers' and employers' interest in measuring the health outcomes of various treatments.⁴

In Chapter 1 we show the connection between these overriding health care issues and mandates by examining how mandates have worked here and the effects they have created. In Chapter 2 we offer our recommendations for state policy on mandated health benefits in Minnesota.

⁴ Report of the National Leadership Commission on Health Care, *For the Health of a Nation*, Melrose Park, Illinois: Health Administration Press, 1989.

CHAPTER 1

MINNESOTA'S SYSTEM OF MANDATES: HOW IT WORKS

Although the state does not require employers to offer health insurance, Minnesota regulates what coverages health plans must include. Most Minnesotans receive their health insurance through employment or as a dependent of someone who is employed. About 80 percent of Minnesotans under age 65 had employer-provided coverage or other private individual or group coverage in 1986.¹

However, as will be explained in this chapter, the state's mandates do not affect all health insurance. They do not affect health coverage offered by self-insured companies or health care provided through publicly-funded coverage like Medical Assistance. Furthermore, their impact on other employer-offered health insurance is not uniform.

WHAT MANDATES ARE

One way in which the state regulates health insurance is mandating that the policies include certain benefits. Minnesota's mandated benefits come from two sources in state statutes:

- Laws governing the various health insurance plans (Chapters 62A, 62C, and 62D in Minnesota Statutes), and
- Qualified plan requirements set by the Comprehensive Health Insurance Act of 1976.

Statutory Mandates

The mandates specified in Minnesota Statutes Chapters 62A, 62C, and 62D apply to many, but not all, types of health plans in the state. Four general types of health plans exist (see Appendix 1 for further information on types of health plans):

- *accident and health insurance plans*, sometimes referred to as indemnity plans, pay the health care expenses resulting from illness or accidents,
- *nonprofit health service plans*, consist mostly of Blue Cross and Blue Shield plans in Minnesota,
- *health maintenance organizations (HMOs)*, providing comprehensive health services,

¹ Deborah Chollet, *Uninsured in the United States: The Nonelderly Population Without Health Insurance*, 1986, Employee Benefit Research Institute, October 1988.

- *self-insured plans*, in which the employer assumes the risk of paying for employees' health costs.

Variations in the statutory mandates also occur between group and individual policies.

Mandates can be divided into four groups:

- (1) Coverage of specific treatments.
- (2) Direct reimbursements to specific nonphysician provider groups.
- (3) Continuation of coverage following certain events like loss of employment, death, or divorce.
- (4) Dependent coverage.

Treatment Mandates and Provider Mandates

These mandates require health plans to cover services for specific treatments like chemical dependency, or to provide direct reimbursement to certain nonphysician providers like chiropractors. The requirements vary somewhat among the different health plans. None is required of self-insured health plans. Other variations are depicted in Table 1.1 and the following text.

Differences Between Group and Individual Policies

Not all treatment or provider mandates apply to both group and individual policies. Only group policies must provide outpatient mental health care, maternity benefits, residential facility care for emotionally disturbed children, and inpatient chemical dependency care. Direct reimbursements to licensed psychologists and licensed consulting psychologists are only required of group policies. Specific requirements to reimburse physicians, osteopaths, optometrists, chiropractors, and registered nurses on an equal basis apply to individual policies issued by accident and health insurers.

Explicit Requirements of HMOs

HMOs alone are required to provide comprehensive health maintenance services. However, unlike other types of health care coverage, HMOs cannot substitute benefits with others that are actuarially equivalent. Another major difference is that HMOs are not required to guarantee access to nonphysician providers as other health plans are.

The state has set explicit requirements of HMOs, although some of the requirements, such as inpatient hospital services, are similar to what is required elsewhere in the laws regarding qualified plan requirements. (See the description on page 6.) In addition to the mandates listed in Table 1.1, Minnesota requires the following of HMOs (these are not specifically required of indemnity plans or Blue Cross and Blue Shield):

- Preventive health care without copayments including health education, immunization, early disease detection, well-baby care, and prenatal care;
- Emergency services (medically necessary);
- Prescription drugs;
- Inpatient hospital and physician care;
- Outpatient health services
- Inpatient mental and emotional health care (HMO must provide a second opinion if treatment for mental health is deemed unnecessary).

TABLE 1.1

MANDATES REQUIRING TREATMENTS OR REIMBURSEMENT OF PROVIDERSTREATMENT MANDATES REQUIRED OF:

<u>TREATMENT</u>	<u>ACCIDENT & HEALTH PLANS</u>	<u>HEALTH SERVICE PLANS</u>	<u>HMOs*</u>
Chemical Dependency--Inpatient	X	X	X
Chemical Dependency-Outpatient	X	X	
Children's Health and Prenatal Services	X	X	X
Craniofacial Disorder	X	X	X
Cancer Screening	X	X	X
Cleft Palate	X	X	
DES Related Conditions	X	X	X
Maternity Benefits	X	X	X
Mental Health--Inpatient			X
Mental Health--Outpatient	X	X	X
Phenylketonuria (PKU) Dietary Treatment	X	X	X
Reconstructive Surgery	X	X	X
Residential Facility Care for Emotionally Disturbed Children	X	X	X
Scalp Prostheses for Alopecia Areata	X	X	X
Services for Ventilator Dependent Person (120 hrs.)	X	X	X
Temporomandibular Joint Disorder (TMJ)	X	X	X

PROVIDER REIMBURSEMENT REQUIRED OF:

<u>PROVIDER</u>	<u>ACCIDENT & HEALTH PLANS</u>	<u>HEALTH SERVICE PLANS</u>	<u>HMOs</u>
Advanced Nursing Services	X	X	
Chiropractor	X	X	
Dentist, Podiatrist	X	X	
Government Institutions	X	X	X
Government Operated Facilities	X	X	
Licensed Psychologist/Consulting Psychologist	X	X	
Optometrist	X	X	
Osteopath, Optometrist, Chiropractor, Registered Nurse**	X		
Outpatient Surgical	X	X	

*HMOs are also required to provide comprehensive health maintenance services. See p.4.

**Required specifically of individual policies issued by accident and health insurers.

Sources: "Mandated Health Care Benefits in Minnesota," Governor's Commission on Health Plan Regulatory Reform; *Health Plan Regulation*, Legislative Auditor's Office, February 1988; *Minnesota Statutes*, 1988; *Laws of Minnesota*, 1989.

Continuation Coverage

These laws provide for continued health care coverage upon changes in employment or marital status. Minnesota laws were changed in 1987 to generally (though not entirely) conform to the continuation coverage requirements of federal law. (See appendix 2 for description of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA.) Continuation of benefits is available to:

- terminated or laid-off employees, for up to 18 months,
- survivors of a deceased policyholder, until either the surviving spouse comes under another group policy or the date coverage would have expired had the policyholder lived,
- dependents of a policyholder who enrolls in Medicare, for up to 36 months or the date when the original coverage would have expired,
- dependents who cease to be dependent children as defined in the policy,
- dependents separated from the policyholder by divorce.

Those electing continuation of benefits will pay up to 102 percent of the premium charged to people in similarly situated plans. The statutes also specify that the beneficiaries may choose to convert to an individual policy when the group policy expires.

Dependent Coverage

If a health plan offers coverage for the dependents of the employee, the statutes on dependent coverage specify the plans must cover:

- handicapped dependents of the policyholder;
- handicapped children that reach adulthood but are incapable of self-sustaining employment because of mental retardation or physical handicap and are dependent on the policyholder;
- adopted children;
- newborn infants from date of birth;
- emotionally handicapped children in a licensed treatment facility.

Laws governing dependent coverage apply to accident and health insurance plans, HMOs, and Blue Cross and Blue Shield, but do not apply to self-insured companies.

Qualified Plan Requirements

The Minnesota Comprehensive Health Insurance Act of 1976 is another source of health plan mandates. This act defined three types of "qualified" health plans in the state, and described the minimum benefits that employers must make available, if they offer health coverage and have 10 or more employees who are Minnesota residents.

This act also established the state's health insurance risk pool known as the Minnesota Comprehensive Health Association or MCHA. (See description in appendix 1.)

Types of Qualified Plans

The Act lists three categories of qualified plans. All categories must offer coverage of 80 percent of the cost of services in excess of the deductible, are limited to \$3,000 per person out-of-pocket expenses annually, and must provide a maximum lifetime benefit of not less than \$500,000. The difference among the categories of plans is the amount of the

DISTINCTIONS AMONG THE QUALIFIED PLANS

<u>QUALIFIED PLANS</u>	<u>DEDUCTIBLE</u> (Per Person)
Number three	\$150
Number two	\$500
Number one	\$1,000

annual deductible.

Health maintenance organizations (HMOs) are considered to be number three qualified plans.

Services Required of Qualified Plans

Qualified plans must cover specific services, with one important distinction. The law requires qualified plans to provide the service *or its actuarial equivalent*. Unlike the statutory mandates described above, insurers may *replace* the minimum benefits required of qualified plans by a service considered to be its actuarial equivalent. This provision allows insurers considerable flexibility in designing benefit plans.

QUALIFIED PLAN REQUIREMENTS

- Hospital services
- Professional services rendered or directed by a physician
- Diagnostic x-rays or lab tests
- Home health agency services
- Radium, oxygen, and anesthetics
- Nondental prostheses
- Oral surgery
- Services of a physical therapist and occupational therapist
- Phenylketonuria (PKU) dietary treatment
- Limited outpatient mental health services
- Prescription drugs

HOW MANDATES HAVE WORKED

Mandated health insurance benefits serve many purposes. However, the mandates have also produced some unintended effects. For a true picture of how mandates have worked, the tradeoffs of mandates must be examined along with their advantages.

The committee started by asking:

- What ought to be the fundamental purposes behind mandating benefits?
- Are those purposes being fulfilled?

The results are explained below.

Fundamental Purposes of Mandates: Are They Fulfilled?

Minnesota's mandates were passed for a variety of reasons, but the purposes of the mandates are not stated in Minnesota statutes. Consequently, the committee identified many purposes of mandates and developed what it considered to be the fundamental purposes of mandates. The committee identified three fundamental purposes for mandating benefits:

1. Mandated benefits ought to broaden people's access to health care services and offer additional choices of effective services to health care consumers, especially to higher-risk individuals and those populations that are typically underrepresented in the political arena.
2. Mandated benefits should spread the financial risk of health care coverage.
3. Mandated benefits ought to define what level of health care is in the public interest.

Unfortunately mandates are not adequately serving these purposes. The following paragraphs explain why.

Purpose 1: Broaden Access

Mandates directly affect only a limited and decreasing share of the population. A misperception exists that a legislatively mandated benefit provides health coverage for a vast constituency--most Minnesotans. This is increasingly not the case. Although mandates expand the scope of health coverage for those covered by HMOs, indemnity insurers, and Blue Cross and Blue Shield, they leave many residents unaffected.

Mandated health insurance benefits do not directly affect the following:

- employees of self-insured firms (approximately 25 percent of Minnesota employees),
- uninsured Minnesotans (estimated at eight percent of the state's residents in 1985), or
- Minnesotans receiving publicly provided health coverage, such as Medicare or Medical Assistance (about 21 percent of the state's residents in 1987).²

Among the population that is affected directly by the mandates, the effect is uneven. Because the mandates do not apply uniformly to all types of health plans, they benefit some but not all policy holders.

And, instead of broadening access to health care coverage, mandates can actually contribute to the growing ranks of the uninsured. Increased costs of insurance, attributable in part to mandates, can cause some people to drop sufficient coverage, cause price-sensitive employers to increase the share of health premiums paid by the employee, or force some employers to forego offering coverage.

Mandates do nothing to help those individuals with high-risk health problems who have been shut out altogether from the private health insurance market.

Why aren't these groups directly affected by mandates?

Self-Insured Companies

A growing number of Minnesota employees receive health coverage through plans that are exempt from regulation by the state. "Self-insured" companies pay health claims for their employees instead of paying premiums for insurance. As a result of a 1974 federal law that preempts state regulation of employee benefit plans (Employee Retirement Income Security Act or ERISA), self-insured companies are not subject to state mandates. State mandates regulate insurance but because of ERISA have no regulatory authority over employee benefit plans.

National data suggest that self-insurance is increasingly popular in the U.S., particularly among larger firms. One study indicates a growth in the proportion of large U.S. firms that self-insure health benefits from 43 percent in 1982 to 67 percent in 1986.³

² Some persons may be double-counted because individuals may have supplemental health insurance policies to cover "gaps" in Medicare. And, Medical Assistance recipients may also be enrolled in an HMO. For instance, the Department of Health calculated that over 13 percent of the enrollees in the state's HMOs in 1988 also had Medicare or Medical Assistance.

³ Estimate by T.P.F. & C, "Self-Insurance," *Business Insurance*, 20:4, January 1986.

In Minnesota, the Office of the Legislative Auditor surveyed employers in 1987 about health insurance and reported that 75 percent of large firms (over 500 employees) self-insure at least one health plan.⁴ The Legislative Auditor estimated that nearly one-quarter of all Minnesota employees are enrolled in self-insured plans. According to the survey, the level of benefits provided by most large self-insured employers is generally comparable to that received by people under other insurance plans.

Although the state mandates do not directly affect the self-insured companies, they may have an indirect effect: They can and sometimes do set a standard to which companies look when designing their own benefit plans, as evidenced by the high percentage of self-insured companies that provide benefits similar to those of state-regulated plans.

Uninsured Minnesotans

Mandated benefits do not help people who are without privately provided insurance and are ineligible for publicly provided care. A study completed for the State Planning Agency estimated that 8.1 percent of Minnesotans were uninsured in 1985.⁵ A national study of the uninsured population under age 65 estimated that 10.6 percent of Minnesotans in 1986 had no health insurance coverage.⁶

Those most likely to be uninsured are: people employed by small firms, part-time employees, or unemployed people. About 75 percent of the uninsured across the country are either employed or dependents of someone who is employed.⁷

A 1986 University of Minnesota study indicated that only 25 percent of surveyed firms covered part-time employees.⁸ A separate estimate of health insurance coverage has not been made for the agricultural sector in the state. However, the University study (of businesses with five or more employees) revealed that 70 percent of firms not offering insurance were located outside the Twin Cities metropolitan area.

Contrary to common belief, uninsured people are not necessarily poor. An estimated 48 percent (over 163,500 people) of Minnesota's uninsured in 1985 were middle or high income; 15 percent (nearly 50,000 people) were between 125 and 200 percent of poverty; 38 percent (128,000 people) of the uninsured had incomes at or below 125 percent of the

⁴ Minnesota Office of the Legislative Auditor, Program Evaluation Division, *Health Plan Regulation*, February 1988, p. 61.

⁵ David Kennel and John Sheils, *Analysis of Health Insurance Coverage and Health Care Utilization and Expenditures in Minnesota for 1985*, prepared for Minnesota State Planning Agency by ICF Inc., November 1984.

⁶ Deborah Chollet, *Uninsured in the United States: The Nonelderly Population Without Health Insurance, 1986*, Employee Benefit Research Institute, October 1988.

⁷ Pamela Farley Short, et al, *Uninsured Americans: A 1987 Profile*, National Center for Health Services Research and Health Care Technology Assessment, Rockville, Maryland, November 1988.

⁸ Bryan Dowd, et al, *The 1985 Employer Survey Final Report*, Division of Health Services Research and Policy, University of Minnesota, October 1986.

poverty index.⁹

Minnesotans Covered by Publicly-Provided Health Care

The third group of people not directly affected by mandates is those persons who receive public health care coverage. Benefit levels are set by state and federal action.

The public programs include Medical Assistance, General Assistance Medical Care, Medicare, and the Children's Health Plan. (For a description of these programs and their benefit levels, see Appendix 1 of this report.)

About 565,000 Minnesotans were enrolled in Medicare in 1987. About 337,000 Minnesotans received Medicaid at any one time during 1987.¹⁰ Over 10,000 Minnesota children have been enrolled in the Children's Health Plan since it began in 1988.¹¹

Purpose 2: Spread Financial Risk

Although insurance in general helps spread the financial risk of an illness or injury, the risk for mandated treatments is not spread evenly because not every health plan is subject to the state's mandates. Only those persons enrolled in HMOs, indemnity plans, or Blue Cross and Blue Shield are subject to the mandates and subsequent costs. Because self-insured companies are not affected by mandates, these companies and their employees do not pay for the mandates unless the benefit is included in the package offered by the company.

For those employees enrolled in health plans regulated by mandates the cost burden is non-discriminatory. The increased cost of insurance falls both on those who can afford the increase and those who cannot.

A single mandate may not contribute noticeably to premium costs. However, the cumulative effect of many mandates can impose significant costs on policy holders. For instance, Blue Cross and Blue Shield of Minnesota estimated that between 1982 and 1987 between 14 and 20 percent of the premium resulted from mandated benefits. Between five and eight percent of the premium resulted from mandates for nonphysician providers during that period.¹²

Furthermore, because mandates involve costs that are not always immediately apparent, an analysis of their cost-effectiveness may indicate that the costs involved outweigh the benefits of the mandate. Studies have shown that extensive insurance coverage may lead to over-use of health services, use of more expensive sources of care, and resulting premium increases. Increased insurance costs, in turn, discourage some people from buying coverage and discourage some employers from offering health insurance.

⁹ David Kennel and John Shells, *Analysis of Health Insurance Coverage and Health Care Utilization and Expenditures in Minnesota for 1985*, prepared for Minnesota State Planning Agency by ICF Inc., November 1984, Table A-20.

¹⁰ U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States, 1989*, January 1989, p. 362.

¹¹ Minnesota Department of Human Services, *The Children's Health Plan: A Profile of the First Six Months*, January 1989.

¹² Presentation to research committee by Lois Wattman, Associate Counsel and Legislative Coordinator, Blue Cross and Blue Shield of Minnesota, January 30, 1989.

How do mandates add to costs?

Adding new mandated benefits can lead to increased costs, because they increase what is eligible for reimbursement. Research shows that cost reductions can only occur if the new benefits are substitutes for other benefits.¹³

Although mandates are certainly not the only factor causing health care costs to rise (medical price increases, new health care technologies, and an aging population are other major factors), some of the cost of health insurance is attributable to mandates.

Mandated Health Insurance Benefits Affect Insurance Costs

Evidence suggests that mandated benefits can increase insurance premiums. For instance, Northwestern National Life Insurance Co. in Minneapolis estimated that the child health supervision mandate effective August 1989 for all group policies will cost \$5.85 per month for each policy with dependent coverage. The 1988 mandate on routine screening for cancer adds approximately 2.5 percent to premium costs for each policyholder.¹⁴

A 1985 analysis of mandated and nonmandated benefits in Maryland reported that the cost of mandated benefits was 12 to 17 percent of the typical health insurance premium for individuals and families, respectively.¹⁵ A study of group health insurance coverages in Iowa indicated that several mandates accounted for measurable portions of the total claims paid. Inpatient mental health claims had the most significant impact, accounting for between 3.1 and 4.4 percent of total claims for various employee group sizes.¹⁶

Although the extent of mandates' impact on health insurance costs is not precisely understood, researchers contend that the cost of mandates has contributed to the number of uninsured.¹⁷

Health care insurance may encourage greater use of services, at higher overall costs, and often without any measurable improvement in health. For instance, one study concludes that insurance coverage for dental services increases the probability of their use, and also indicates that the use of basic dental services such as x-rays and cleanings is not dependent

¹³ Linda Lanam, "Mandated Benefits-Who is Protected?", paper in *Government Mandating of Employee Benefits*, Employee Benefit Research Institute, 1987, p. 185-189.

¹⁴ Conversation with Earl Hoffman, Second Vice-president and Actuary-Group Division, Northwestern National Life Insurance Co., September, 1989.

¹⁵ R.J. Mellman, *Maryland Mandated Benefits Report*, Health Insurance Association of America, Washington D.C., 1985.

¹⁶ Mark Power and August Ralston, "State Mandated Group Health Insurance Coverages," *Benefits Quarterly*, First Quarter, 1989.

¹⁷ John C. Goodman and Gerald L. Musgrave, *Freedom of Choice in Health Insurance*, National Center for Policy Analysis, Dallas, Texas, November 1988; Dr. Gail Jensen, *The Effects of State-Mandated Insurance Benefits on Employers: Preliminary Findings from Research in Progress*, School of Public Health and Department of Economics, University of Illinois at Chicago, June 15, 1988.

on dental coverage.¹⁸

The Cost of Insurance Affects Its Availability

Some firms do not offer insurance because of its cost. A survey of northeastern Minnesota businesses by the Health Insurance Coalition indicated that cost is an important factor in employers' decisions to offer health insurance. The survey results indicated 37 percent of employers did not offer insurance. Of these employers, 75 percent cited cost as the reason for not offering insurance. When asked what could change their minds, over half of the respondents said "reduced costs."

A 1985 survey of Minnesota firms indicated that the most important factor determining which health plan to offer was low premiums.¹⁹

Purpose 3: Define Level of Health Care in Public Interest

Currently, mandates define one among many different levels of health care available to Minnesotans. However, the level of health care available depends in large part on the company for which one works, and much less--if at all--on state mandates.

For example, health insurance provided by self-insured companies is exempt from state regulation; none of the mandates applies to coverage offered by the many self-insured employers in Minnesota.

Publicly-financed medical care entitles eligible recipients to an entirely different set of benefits than is available to enrollees of plans subject to mandates. Uninsured Minnesotans, many of whom are employed, have the lowest level of access to health care coverage.

Other Considerations About Mandates

Inequities

Mandated benefits are inequitable because they do not apply uniformly to all health plans. Some mandates apply to certain health plans but not others. For example, HMOs must cover comprehensive health maintenance services. Other insurers have more flexibility in designing their plans. Further, HMOs are not required to guarantee their clients access to nonphysician providers as are indemnity plans and Blue Cross and Blue Shield.

Nor are the mandates uniform for group and individual policies. Some benefits for specific services are required only of group policies and not of individual policies: Outpatient mental health care, maternity benefits, residential facility care for emotionally disturbed children, and inpatient chemical dependency care are examples.

At the same time, some mandates are for treatments needed by only a small portion of the population. Some critics question whether state law should support the interests of a few at the expense of many. For instance, the cost of the mandate covering temporomandibular

¹⁸ Curt D. Mueller and Alan C. Monheit, *Insurance Coverage and the Demand for Dental Care*, National Center for Health Services Research and Health Care Technology Assessment, Rockville, Maryland, July 1987.

¹⁹ Center for Health Services Research, University of Minnesota, *Employer Report #4, Employer Health Benefits Survey*, June 1986.

joint disorder, a low-incidence condition, is paid by all insured with coverage through an indemnity company, HMO, or Blue Cross and Blue Shield, regardless of whether the insured person experiences the disorder.

Lack of a Systematic Review

Minnesota does not have an objective rationale or an independent, systematic process for determining whether a benefit should be mandated. The mandates have been enacted in an incremental, piecemeal fashion. This lack of a systematic process has produced a package of benefits without adequate knowledge about either its intended or unintended effects.

Mandates appear to extend coverage to people in need without appropriating state money. However, the unintended effects of mandates make this illusory. The costs involved with mandated benefits and who bears the burden for those costs are not commonly understood. These potential adverse effects have not been systematically analyzed.

Minnesota and other areas of the country have developed a body of experience with mandates, giving states the opportunity to analyze the impacts of mandates on both costs and the number of residents they affect.

Other States Evaluate Mandates

Other states concerned with health insurance costs attributable to mandates have enacted systematic procedures to evaluate the social and financial effects of health benefits prior to mandating them. Since 1984, nine states have required some type of cost-benefit analysis as part of their legislative process in the consideration of mandates.²⁰

Many of these states specified criteria by which proposed mandates must be evaluated. The state of Washington was the first to require this analysis. Several other states simply adopted the criteria set by Washington state.

Their experience indicates that systematic evaluations could alter the number or type of mandates enacted. For instance, a 1988 study by the Legislative Auditor of Hawaii assessed the social and financial impacts of mandatory coverage of well-baby services. The study concluded that although the proposal supported a valuable service, it would impose coverage where none was needed.

Pennsylvania's Health Care Cost Containment Council reviewed evidence supporting a mandate to cover all costs associated with a baseline mammogram for women age 35 to 39, a biennial mammogram for women age 40 to 49 or more frequently if medically necessary, and an annual mammogram for women age 50 and over. The Council recommended against the proposal; however, it did recommend a mandate to cover certain costs associated with annual mammography screenings for women 50 and older. Its conclusion included a recommendation that the state collect information on the costs and results of such mammographic screening.

Other Tradeoffs

Beyond the fundamental purposes of mandates as identified by the committee, legislators have proposed and enacted mandates for a number of reasons. Both the support and opposition to the mandates are summarized in Figure 1.1.

²⁰ *State Health Notes*, No. 92, April 1989.

FIGURE 1.1

OTHER ADVANTAGES AND TRADEOFFS OF MANDATES

ADVANTAGES	TRADEOFFS
<p>Mandates covering specific treatments reduce gaps in coverage and may reduce stigma attached to receiving treatment.</p> <p>Mandates may reduce costs to society of sick people who go untreated.</p>	<p>Mandating a benefit raises the cost for all who are insured through Blue Cross and Blue Shield, HMOs, or indemnity companies, regardless of whether they use the benefit.</p> <p>Mandates may result in increased use of benefits and further increases in the cost of insurance.</p>
<p>Mandates for dependent coverage improve access to health care for higher-risk people or underrepresented populations.</p>	<p>Such mandates shift the cost for coverage from the individual beneficiary to the employer.</p> <p>Costs resulting from high utilization by the dependents will affect everyone under the group policy.</p> <p>Individual employees of small employers without coverage may have to purchase individual coverage, generally at a higher cost, or forego coverage.</p>
<p>Continuation coverage provides health insurance following events that would otherwise result in loss of coverage.</p>	<p>Although up to 102 percent of the applicable premium is paid by the beneficiary, individuals with high utilization rates may have adverse consequences for the entire group.</p> <p>Health coverage administrators say the two percent margin for administrative costs is insufficient.</p>
<p>Mandates covering nonphysician providers widen the choice of providers for the consumer and guarantee reimbursement for those providers.</p>	<p>There is no systematic assessment of whether nonphysician providers offer a cost-effective alternative for care by physicians. Further, HMOs do not have to offer access to specific nonphysician providers.</p> <p>Broadening the pool of providers increases costs which could constrain access to health care.</p>

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CHAPTER 2

RECOMMENDATIONS

CONCLUSION

The state is using its regulatory power to expand health coverage for only the portion of the population that is fortunate to have coverage. Many companies escape these state regulations by turning to self-insurance. The cumulative effect of the state's mandates may narrow access to health coverage.

SUMMARY OF THE RECOMMENDATIONS

We recommend that the Minnesota Legislature not enact additional health mandates until two conditions are met:

- **The state establishes universal access to a basic level of health coverage.**
- **The state determines that it is in the public interest to use its regulatory power to require a dual level of required health care.**

We recommend that, in addition to enacting a moratorium on new mandates, the Legislature should require evaluations of existing mandates based on legislatively-set criteria.

EXPLANATION OF THE RECOMMENDATIONS

Establishing a Basic Level of Health Coverage

- **The Legislature should not impose additional health insurance mandates until: the state establishes universal access to a basic level of health coverage. Ensuring access to a basic level of health care for all Minnesotans should become the state's priority in health care policy.**

What does universal access to health coverage mean? Although this report wholeheartedly recommends state action to address the problem of the uninsured in Minnesota, it endorses no specific proposal. Our committee discussed many proposals but did not perform a comprehensive analysis of them. It felt strongly that current concerns about cost, access, and quality of health care inherent for people covered in the general health care system are magnified for those who lack health insurance.

Because the committee's charge was limited to mandated health insurance benefits, the committee did not evaluate alternative means to cover the uninsured. However, it discovered a number of efforts are underway to determine how to provide such coverage.

Coalitions in Minnesota and around the country have started to tackle this problem of insuring uninsured persons. In Minnesota, the 1989 Legislature created a Health Care Access Commission to develop a plan of health care coverage for all uninsured residents. Among other matters, it is to explore all potential insurance options, study incentives to ensure employers continue to provide health insurance, and recommend alternatives for financing the state's share of the program's cost. The commission is to present to the Legislature a progress report by February 1990 and a final report by January 1991.

The National Leadership Commission on Health Care, which brought together leaders from health care, business, law, labor, academics, and politics, proposed a plan to assure universal access to a basic level of health services. Under the proposal the basic set of services would be determined at the national level. Persons without insurance through employment or unable to purchase it through other means could buy coverage through a "Universal Access" fund, financed by employers and individuals with incomes above 150 percent of poverty.

What is a "basic level of care?" State policymakers have not yet defined a basic package of coverage, but some reasonable equivalents exist. One possible standard is the "Small Employer Plan" endorsed by the Governor's Commission on Health Plan Regulatory Reform. Another option would be to use the benefits considered by the Health Insurance Coalition in northeastern Minnesota. Other models exist around the country. One is the basic medical care package now being developed in the state of Oregon. Another is the health benefits package included in U.S. Senator Edward Kennedy's proposed Minimum Health Benefits for All Workers Act.

Although the committee did not endorse a specific definition of a basic level of care, it became clear that a "basic level" of coverage would likely include fewer benefits than the number mandated today. To significantly reduce the cost of health plans it would be necessary to cut out some of the benefits now mandated. For instance, according to Harry Sutton, vice-president of Towers, Perrin, Forster & Crosby, an actuarial firm, eliminating the mandates for chemical dependency and mental health services could reduce health plan costs by ten percent.¹

It may be instructive to understand the differences between the level of benefits mandated today and the level of benefits that might possibly be included in a basic level of coverage. Figure 2.1 describes the benefits that would be included in the "Small Employer Plan" generated by the Governor's Commission on Health Plan Regulatory Reform. This plan was developed to attract small employers (with fewer than 50 employees) and their employees who would not otherwise have access to health coverage.

An Earlier Citizens League Plan for the Uninsured

Although the committee on mandates did not assess proposals for helping uninsured people, an earlier Citizens League committee did. A 1987 Citizens League report endorsed the creation of a voluntary health insurance plan for the uninsured.² The recommendations had three key elements: make the plan voluntary, target it to women with children, and use a broad funding source (such as the state's general fund) to finance it.

¹ Testimony by Harry Sutton to Citizens League Committee on Mandated Health Benefits, March 13, 1989.

² Citizens League, *Start Right with Right Start: A Health Plan for Minnesota's Uninsured*, Minneapolis, Minnesota, February 1987.

FIGURE 2.1

**FEATURES OF THE SMALL EMPLOYER PLAN
AS PROPOSED BY THE MINNESOTA COMMISSION
ON HEALTH PLAN REGULATORY REFORM**

**COVERED
EXPENSES**

Average semi-private hospital room and board
Intensive care up to three times average semi-private rate
Other hospital charges inpatient and outpatient
Usual and customary surgical and physical charges
Diagnostic x-ray and laboratory
Private duty nurse when medically necessary
Ambulance services
Medical equipment (e.g., casts and crutches)
Home health agency under written plan by physician
Well child care with no deductible or copayment
Maternity, up to \$1,500 maximum per case

**EXCLUSIONS
AND LIMITATIONS**

Prescription drugs
Mental health
Chemical dependency
Extended care facilities
Hospital preadmission certification
Mandatory second opinion
Restricted weekend admissions
One year pre-existing condition exclusion

Additionally, the League recommended that participants pay an income-related portion of the premium. Eligibility would be limited to children, pregnant women, or persons leaving AFDC, with incomes less than 200 percent of the federal poverty level.

The report also recommended incentives to employers to provide health insurance as a benefit of employment. It recommended that the state seek a waiver from federal law to provide flexibility to offer tax incentives for employers that provide health insurance.

The 1987 Legislature did enact the Children's Health Plan, encompassing some of that report's recommendations. The Children's Health Plan was expanded in 1989 to include children up to 18 years of age and to offer mental health services.

Evaluating Mandates

- ☐ **We recommend that, in addition to enacting a moratorium on new mandates, the Legislature should require evaluations of existing mandates based on legislatively-set criteria.**
- ☐ **The Legislature should ensure that the existing mandates are evaluated over the next six years, and should reauthorize those mandates that meet specific public-policy criteria.**
- ☐ **To ensure that the evaluations occur within a reasonable time, the Legislature should require that all mandates sunset after three bienniums unless evaluated and reauthorized.**

The intent of this recommendation is not to abolish existing mandates, but to subject them

to thoughtful policy analysis that considers the cumulative effect of Minnesota's package of mandates on individuals and their access to health insurance. A comprehensive evaluation is needed because the existing process for mandating a health benefit does not routinely and systematically examine the impacts of the mandate on health plan costs, or the proportion of people affected by them.

Because of the changing nature of the health care field, it is expected that periodic review of the mandates will be necessary over time.

- **The Minnesota Legislature should adopt a set of criteria that would be used to evaluate the existing mandates.**

Some criteria appropriately apply to all mandates; others are most appropriate for mandates specifically regarding providers and treatments. The following recommended criteria (listed in Figures 2.2 and 2.3) are categorized accordingly.

The underlying purpose of the criteria is to guide the decision about when government should regulate health plans by establishing mandated benefits. The criteria should help determine the mandates' financial ramifications and effects on access to health care coverage for the individual, and for society at large. Furthermore, a systematic evaluation should help identify the cumulative effects of the state's package of mandates, as well as any counterproductive effects created by the mandates.

The criteria are not intended to be answered in a "yes" or "no" fashion. Instead, conclusions about the appropriateness of a mandate should be based upon the degree to which the mandate fulfills the objectives of all criteria.

Issues Raised by Evaluating Mandates

- **Although every mandate should be evaluated, some mandates ought to receive a more rigorous evaluation than others.**

To prevent unnecessary expense, state mandates need not receive a full evaluation if they (1) largely duplicate requirements of federal law or (2) are included in a basic level of care.

Duplication with Federal Law

Less stringent evaluation should be given to those mandates that are largely parallel to requirements of federal law. For example, Minnesota's statutes on continuation/conversion coverage generally duplicate federal law. This law covers the length of time insurance will be in effect following loss of employment or other qualifying events. This guideline would mean that continuation/conversion coverages now mandated would receive less scrutiny than other mandates.

Mandates for a Basic Level of Care

Less stringent evaluation should be given to those mandates whose benefits would be included in a basic level of health care coverage. Those benefits that are deemed to be primary care, such as some amount of hospital services, physician services, and maternity care, would be more readily accepted as mandates for all health plans.

Which mandates qualify for a full evaluation would depend on the definition of "basic level of health coverage." As stated earlier, policymakers have not yet decided what a basic level of health care coverage might include. Until this is defined, the evaluation would have to rely upon a reasonable, equivalent definition.

FIGURE 2.2

CRITERIA TO EVALUATE ALL TYPES OF MANDATES

1. *The mandated benefit improves individual health as well as provides wider social benefits.* The intent of this criterion is to recognize the value of those services that benefit the community at large, as well as the individual with the illness or condition.
2. *Mandating the benefit is the only viable way to assure the coverage is provided.* The intent of this criterion is to use a less intrusive means of attaining the coverage if such a means is available. For instance, if the service can be readily obtained via the collective bargaining process then that means should be employed. A mandated offering, whereby health plans would make available a benefit on an optional basis to plan purchasers, is another form of a less restrictive method than a mandate.
3. *Mandating the benefit does not jeopardize people's ability to afford coverage by adding significantly to the cumulative costs of benefits.* The intent is to examine the impact of the cost of the entire package of mandates, not just a single mandate.
4. *Without the mandate people would be discouraged from seeking appropriate treatment.* The intent of this criterion is to ensure that people do not avoid seeking health care because of lack of insurance.
5. *Mandating the benefit enjoys broad popular support.* This criterion is intended to screen those benefits that are supported only by narrow interests. It will be necessary to determine a willingness to pay for the benefit on the part of the general population. This may require surveying people to ascertain their support.
6. *Without the mandate, people would suffer an unreasonable financial burden.* The criterion recognizes that one of the primary purposes of insurance is to spread the financial risk among a broad population. It acknowledges the need for possible financial assistance for high-cost, low-incident medical procedures.
7. *Mandating the benefit does not significantly increase the cost of insurance to individuals or businesses.* This criterion is intended to screen those benefits that singularly and excessively raise the cost of insurance.
8. *Mandating the benefit does not unduly interfere with labor/management collective bargaining.* A mandate should neither preclude labor from obtaining the health coverage needed for employees, nor prevent management from offering the health benefits package best suited to the company.

FIGURE 2.3

CRITERIA TO EVALUATE MANDATES REGARDING PROVIDERS AND TREATMENTS

1. *The mandate provides for a more cost-effective service than others currently available.* This criterion is intended to assess how well, and at what cost, a treatment works compared to other modes of treatment.
2. *The mandate helps avoid greater health care expenditures in the future.* This criterion recognizes the value of treatments that will prevent or lower the need for additional treatments in the future.
3. *The mandated benefit has been documented to produce its intended results.* This criterion favors those benefits for which empirical evidence or a panel of experts suggest beneficial health outcomes will result.
4. *The mandated benefit treats or prevents an illness or condition.* This criterion will require an objective definition of "illness or condition," as it is not intended to rule out procedures such as reconstructive surgery, but may be used to rule out cosmetic surgery.
5. *The mandated benefit is needed by, available to, and used by a significant share of the population.* The intent of this criterion is to gauge how many people will be affected by the benefit. If the service is purported to benefit only a small portion of the population, some less global action may be more appropriate than a statutory mandate.
6. *The mandated benefit is neither experimental nor investigative.* This criterion requires an objective definition of "experimental or investigative" that could be rendered through the judgment of a panel of major insurers and health plans.
7. *The mandated benefit does not increase the cost of the overall course of treatments or services.* The intent of this criterion is to screen out those services or providers that may be low-cost on a one-time basis, but prohibitively expensive with multiple applications.

It's likely that certain mandates will receive a full and rigorous evaluation. These include:

- mandates for coverage of the policyholder's dependents;
 - mandates for specific treatments that would not automatically be included in a basic level of care, such as chemical dependency treatment, mental health treatment, temporomandibular disorder (TMJ), craniomandibular disorder, scalp prostheses for alopecia areata, and phenylketonuria (PKU) dietary treatment; and
 - mandates for reimbursements to specific nonphysician provider groups.
- **The Legislature should enlist impartial analysts, without special interests in the outcome of the evaluation, to conduct independent evaluations.**

The Legislature should charge the Office of the Legislative Auditor with the technical

evaluation of how well mandates meet the criteria. The Legislative Auditor's Office has proven itself effective in the analysis and evaluation of whether state-funded activities and programs accomplish their goals efficiently.

The mandate evaluation is intended not as a financial audit, but rather as a policy analysis. The U.S. Office of Technology Analysis has performed similar policy analyses, evaluating the effectiveness and costs of a number of treatments and providers, such as alcoholism treatment and nurse practitioners. Before undertaking the evaluation, the Legislative Auditor should propose a plan indicating the methodology for the evaluation and the order in which the mandates will be evaluated. Then the Legislative Auditor should submit this plan for approval to the committees of the Senate and House of Representatives on Health and Human Services, Commerce, Financial Institutions, and Insurance.

Once the plan is approved, the Legislative Auditor's office would conduct the research and determine if a benefit meets a criterion completely, partially, or not at all. Based on the relative importance of the criteria and on how well the benefit meets them, the Office would recommend whether the mandate should continue, be amended, or allowed to lapse.

- **The Legislature and governor should appoint a citizens review committee to review the recommendations and the technical analysis.**

Following the Legislative Auditor's evaluation, a citizens review committee should review and comment on the recommendations. This review committee would guarantee a voice in the process for those consumers of health care services who might not otherwise be heard in considering a mandate.

Members of the citizens review committee should be appointed in equal numbers by the governor, the speaker of the House, and the majority leader in the Senate. Members should be impartial consumers of health care services and not selected by virtue of their professional ties to health care issues. The review committee should use the same criteria used in the evaluation and submit its comments to the appropriate legislative policy committees.

Legislators would retain final authority over the reauthorization of the existing mandates.

- **The Legislature should appropriate general fund money to conduct the evaluations.**

Based largely on Pennsylvania's experience, an evaluation may cost from \$50,000 to \$100,000 per mandate. That state contracts with three experts, a health economist, a health science researcher, and a biostatistician, to review a report on a proposed mandate. Proponents of the mandate submit the report for review. Combined with the public agency overhead costs, the reviews averaged \$100,000.

Using this experience as a guide, fully evaluating all mandates could cost the state between \$1.6 million and \$3.3 million over six years. Because not all mandates are expected to require the full evaluation, the total cost will be somewhat less. It is expected that the Minnesota Legislature would appropriate from the state's general fund sufficient money to evaluate all mandates over the course of three bienniums. One-third of the mandates should be evaluated by the end of the first biennium.

Determining the State's Interest in a Dual Level of Health Care

- **The Legislature should not impose additional health insurance mandates until: the state determines that it is in the public interest to use its regulatory power to require a dual level of required health coverage.**

We recognize that recommending both an evaluation of mandates and the establishment of a basic level of care leaves unanswered a fundamental question: Should the state, as a matter of equity, establish a basic level of care for some citizens while using its regulatory power to mandate a different, higher level of care for others?

We find this fundamentally and inherently inequitable. We do not find a case to believe that government should mandate two levels of care.

Consequently, the Legislature should charge the Health Care Access Commission (established in 1989 to develop a plan to provide access to care for all Minnesotans) with defining the relationship between state mandates and a basic health care package.

Remaining Issues

If the commission determines, and the Legislature subsequently agrees, that the state should not require different levels of health care, certain issues arise. Foremost, it should be clear that additional coverage would still be available in the health care market. Defining a basic level of care does not mean health plans would be limited to only that package of services. Services not considered "basic" would be obtainable and included in health insurance plans. As the Legislative Auditor discovered in its survey of self-insured companies, firms often provide benefits without a government mandate; the majority of enrollees in self-insured plans receive benefits similar to those mandated by the state.³

Other obvious questions would arise over the disparate levels of state-approved care for (1) state employees and for (2) Medical Assistance recipients. The state-required basic level of care can be and likely will be different from the level the state decides should be provided to state employees or Medical Assistance clients.

State Employees

In the case of health care for state employees, the state's role is that of employer. What the state and the employees' bargaining representatives negotiate to include in a health care package would remain just as in the typical employer/employee relationship. That is, the state as employer would be required to provide the level of benefits defined as the basic level of care. Anything above that level would remain a matter of collective bargaining.

Medical Assistance Recipients

In the case of health care for the Medical Assistance population, the state is not the employer but rather, a partner with the federal government in the financing and planning of the program. The state would retain its responsibility for setting the program's level of benefits. In addition to the mandatory services required by the federal government (see appendix 1 for description of the MA program), the state would determine which optional services to reimburse. The state would have to ensure that the basic level of care is available. Beyond that, it could make a separate decision to reimburse additional services.

³ Office of the Legislative Auditor, *Health Plan Regulation*, February 1988, p. 61.

APPENDICES

APPENDIX 1: HISTORY AND TYPES OF HEALTH PLANS

Employers Provide Insurance for Most Americans

Neither federal nor state law requires Minnesota employers to offer health insurance to their employees. Nonetheless, and in contrast to most other industrialized countries where health benefits are publicly provided, nearly two-thirds of the people covered by health insurance in the United States receive insurance through their employers or unions.¹ According to the Legislative Auditor's Office, about 71 percent of Minnesota employees are enrolled in an employment-related health plan.

The availability of health insurance became widespread following World War II. The number of people covered for hospital expenses in the U.S. grew from 32 million in 1945 to 137 million 20 years later, more than a 300 percent increase. About 180 million people had coverage for hospital or major medical expenses in 1986.²

Initially, health plans covered hospitalization and surgery costs; they dealt with curing illnesses and usually did not cover preventive check-ups. Most of these plans, whether offered through accident and health insurers or Blue Cross or Blue Shield, paid for the services rendered by any licensed provider on a fee-for-service basis.³ The treatment plan was completely in the hands of the medical professionals; insurers did not intervene.

Although started in the 1940s, prepaid health plans expanded in number partly in response to the great increase in health care expenditures occurring in the late 1960s and early 70s. In contrast to the insurance plans, prepaid plans focused on preventive services to reduce the need for more expensive hospitalization later.

The growth of health maintenance organizations (HMOs) was further stimulated by the federal HMO Act of 1973. This act set standards that HMOs had to meet to be federally qualified. It required HMOs to offer a comprehensive package of benefits, to open their enrollment each year, and to base their premiums on community-wide experience. To help HMOs, the act provided some funding for their development and required certain employers to provide an HMO option.⁴

¹ U.S. General Accounting Office, *An Overview of the Working Uninsured*, Report to the U.S. Senate Committee on Finance, February 1989, p. 11.

² Health Insurance Association of America, *Source Book of Health Insurance Data, 1988 Update*, July 1988.

³ "Blue Cross" began as a plan covering surgery and hospitalization costs. "Blue Shield" plans began as coverage for outpatient care of illness.

⁴ Minnesota Office of the Legislative Auditor, *Health Plan Regulation*, February 1988, p. 61.

Although this act was widely used in the 1970s, federal qualification has become less important. Five of the 13 HMOs operating in Minnesota in 1988 were federally qualified, according to InterStudy; the remaining HMOs were subject only to state regulations. (See the section on state regulations on page 30 and in Chapter 1.)

Types of Health Plans

Employers may offer more than one type of health plan. The general types of health plans available through the private market are: accident and health insurance plans, nonprofit health service plans, health maintenance organizations, and self-insured plans. Other health plans have evolved as hybrids or variations of the four types listed above, including preferred provider arrangements and combination plans.

FIGURE A.1

TYPES OF HEALTH PLANS

Accident and health insurance plans pay the health care expenses resulting from illness or accidents to the provider of the subscriber's choice.

Nonprofit health service plans consist mostly of Blue Cross and Blue Shield plans in Minnesota. These plans are nonprofits and cover health care costs on a fee-for-service basis.

Health maintenance organizations (HMOs) provide comprehensive health care services under prepaid arrangements.

Self-insured plans exist when the employer assumes the risk of paying for employees' health costs. The firm pays claims as they are submitted, rather than paying an insurance premium each month. Some self-insuring companies will employ third-party administrators who specialize in paying claims, keeping track of eligibility, and other administrative duties. Some self-insurers will also buy stop-loss insurance from a commercial insurance carrier or Blue Cross and Blue Shield; in this case, employers pay claims up to a certain dollar amount and the insurer pays some or all of the excess.

Variations

Preferred provider arrangements (PPOs) are a network of doctors and hospitals with a contract to provide health care services at a discounted rate in exchange for a given number of patients. This type of health plan may be offered by an insurance company, a Blue Cross and Blue Shield plan, an HMO, or arranged by a self-insurer. Unlike HMOs, PPOs are not legal entities in the business of insuring and financing health services.⁵

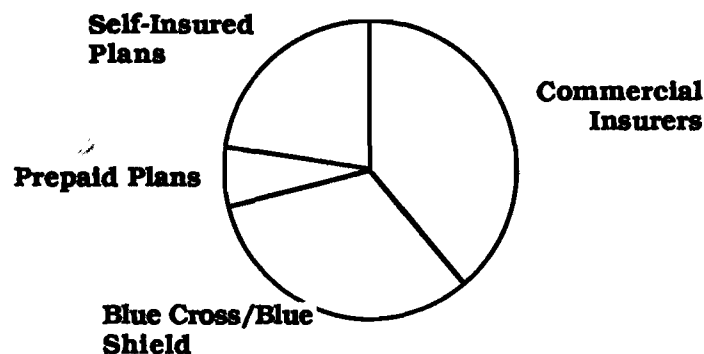
Combination plans, sponsored by HMOs, allow enrollees to be covered by the HMO or to receive indemnity coverage when using providers outside the HMO.

Nationwide, commercial insurance companies pay the largest proportion of private insurance benefits, followed in order by Blue Cross and Blue Shield, self-insured plans, and prepaid health plans.

⁵ Judith A. Hale and Mary M. Hunter, *From HMO Movement to Managed Care Industry*, Interstudy, June 1988.

FIGURE A.2

**NATIONWIDE PROPORTION OF PRIVATE HEALTH INSURANCE
BENEFITS BY SOURCE OF INSURANCE**



Source: *Health Trends Chartbook 1988*, Health Insurance Association of America.

Government-Provided Coverage

Individuals who cannot obtain insurance through their employment or buy it on their own may be eligible for public medical programs. Medicare is available for the elderly and some disabled persons. Depending on income level and assets Minnesotans may be eligible for General Assistance Medical Care, Medical Assistance, or the Children's Health Plan. In addition, individuals who have been rejected by regular insurers because of health risks may buy coverage through the Minnesota Comprehensive Health Association. Finally, some low-income uninsured persons are cared for by physicians, hospitals, community clinics, and public health care centers at reduced fees or without charge.

Medicare

Established in 1965 under Title XVIII of the federal Social Security Act, Medicare is a federal insurance program mainly for persons age 65 or older. Since 1973, Medicare has also been available for certain disabled people and persons with chronic kidney disease. The program has two separate but coordinated components: hospital insurance and supplementary medical insurance.

SERVICES PROVIDED BY MEDICARE

Hospital Insurance (referred to as Part A)

Inpatient services
Skilled nursing services
Blood (after the first three pints)
Home health services
Hospice care

Supplementary Medical Insurance (referred to as Part B)

Physician services
Medical supplies and services
Home health services
Outpatient services
Physical therapy, speech pathology
Other medical services and
supplies such as x-rays and lab tests

The supplementary insurance, known as Part B services, is financed in part by monthly premiums paid by the enrollee and in part by general revenues.

Medical Assistance (Medicaid or MA)

Medical Assistance originated under Title XIX of the federal Social Security Act. A program paid for historically by federal, state, and county governments in Minnesota, Medical Assistance pays for medical care for people who meet federal poverty guidelines. (In 1991 the state will begin to reimburse counties for local agency expenditures on MA benefits and services.) Medical Assistance is for recipients of Aid to Families with Dependent Children, needy children in foster care, and the aged, blind, or disabled. It is also for people whose medical expenses reduce their income below a certain threshold.

To be eligible a person must meet income and asset guidelines set by the federal and state governments. Different income standards apply to the aged, blind, or disabled, and to pregnant women and infants under one year. Pregnant women with children under the age of one need not meet asset limits; asset standards differ from other recipients for spouses of recipients in nursing homes.⁶ In Minnesota, Medical Assistance provides very comprehensive coverage; it includes virtually all services *permitted* by federal law as well as the services *required* by the federal government.

MEDICAL ASSISTANCE SERVICES

Required by Federal Law

- Inpatient and outpatient hospital services
- Lab and x-ray services
- Skilled nursing facility services
- Home health care
- Early and periodic screening for those under 21

Offered in Minnesota (Optional Under Federal Law)

- Mental health
- Enrollment in prepaid health plans
- Rehabilitation services
- Intermediate care facilities and regional treatment centers
- Day treatment services
- Nursing home rehabilitation
- Public health nursing
- Nurse anesthetist services
- Certified nurse mid-wife services
- Prescription drugs
- Medical equipment, prosthetic devices, hearing aids
- Emergency medical transportation
- Dental, optometric, psychological services
- Private duty nursing
- Physical therapy
- Speech and occupational therapy
- Podiatric, chiropractic, and audiological services
- Crippled children services
- Organ and tissue transplants covered by Medicare

⁶ Minnesota House of Representatives Research Department, *Minnesota's Public Assistance Programs*, December 1988.

General Assistance Medical Care (GAMC)

GAMC is a Minnesota program providing medical care for low-income persons ineligible under other programs. It is financed by the state of Minnesota and county governments. (Beginning in 1991, the state will reimburse counties for their share of GAMC program expenditures.) To be eligible, one must be a Minnesota resident and meet strict income and asset tests, or spend down one's income in excess of the limit. In addition to meeting the income guidelines (which are the same as for Medical Assistance), recipients must not have assets that exceed \$1,000, excluding some exempt property.

SERVICES AVAILABLE UNDER GAMC

- Inpatient and outpatient hospital services
- Prescription drugs
- Services provided by Medicare-certified rehabilitation agencies
- Eyeglasses and eye exams by a physician or optometrist
- Hearing aids and prosthetic devices
- Lab and x-ray services
- Medical supplies for diabetics
- Physician services
- Medical transportation
- Podiatric and chiropractic services
- Dental care
- Outpatient mental health services
- Specific services for mentally ill people

Children's Health Plan

The 1987 Legislature established the Children's Health Plan to provide low-cost health care coverage to children. The 1989 Legislature expanded the age of eligibility to include children up to the age of 18. The Plan requires an annual \$25 enrollment fee per child, up to a maximum \$150 per family. The Department of Human Services reports that 10,101 children have been enrolled since the Plan began.

In its first six months of operation (in the last half of 1988) the Plan paid out nearly \$300,000 for health services (for 4,972 enrollees), mainly physician services and prescription drugs. Besides the enrollment fees, the Plan is financed with one cent of the state's cigarette tax.

Seventy-five percent of the users live in nonmetropolitan Minnesota. About half of the families received public assistance in the past, but cannot currently afford health care coverage for their children.⁷

Services available through the Children's Health Plan are the same as those provided through Medical Assistance with the following exclusions:

- inpatient hospital services
- private duty nursing
- orthodontic services

⁷ Minnesota Department of Human Services, *The Children's Health Plan, A Profile of the First Six Months*, January 1989.

- medical transportation
- personal care assistant and case management services
- hospice care
- nursing home or intermediate care facilities
- chemical dependency services
- special education services

Mental health services had originally been excluded but were added to the Children's Health Plan services by the 1989 Legislature and are effective as of July 1, 1990.

Minnesota Comprehensive Health Association (MCHA)

This state-designed program provides a health insurance pool for people whose high-risk medical status prevents them from obtaining private health insurance. It is also available for individuals who are laid off from work, but unable to exercise continuation coverage for their health insurance. Participants must pay premiums which are set at up to 125 percent of the average premium charged for comparable coverage provided privately.

Since 1987, the excess MCHA costs (expenses over and above those paid by the premiums) have been financed with charges on insurers, Blue Cross and Blue Shield, and HMOs in the state. The operating loss in 1987 was \$11.3 million. MCHA paid out 192 percent of what it took in with premiums that year.⁸ In 1988 the loss grew to \$14 million.

APPENDIX TWO: INCENTIVES FOR AND REGULATION OF EMPLOYER-SPONSORED HEALTH PLANS

Role of Government in Employer-Sponsored Health Plans

The government plays a dual role in employer-sponsored health plans. First, government provides incentives for employers to offer health insurance to employees. Second, government has a regulatory role. It regulates insurers and health care providers and requires those employers who offer insurance to provide certain benefits. Both the federal and state governments are involved.

Government Provided Incentives

Under federal and state law, employers who offer health insurance plans (both group and individual policies) may deduct their contributions to employee health plans as business expenses. Furthermore, these contributions are not taxable income to the employees.

This tax exemption provides a significant advantage to employers and employees. According to estimates by the Minnesota Department of Revenue, the deduction for employers' contributions for medical insurance premiums and medical care reduced state tax collections by \$123.3 million in 1988.⁹

⁸ Minnesota Comprehensive Health Association, *Report to Commission on Health Plan Regulatory Reform*, July 1988, Exhibit 2.

⁹ Minnesota Department of Revenue, *Tax Expenditure Budget, Fiscal Years 1988-1991*, January 1989.

The federal 1986 Tax Reform Act extended the tax subsidy by temporarily allowing the exemption for premiums paid by self-employed people and unincorporated businesses.¹⁰

Government Regulation

Although government does not require employers to offer health insurance, both Minnesota and the federal government regulate what health insurance plans must include. However, not all regulations apply universally; differences occur among the types of health plans available and between group and individual policies.

Federal Regulations

Federal government regulations include mandates on continuation of health insurance coverage, and minimum HMO benefits.

Continuation coverage: In 1985, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA). This act provided for continued coverage of health insurance to certain persons.

PERSONS WHO QUALIFY FOR CONTINUATION OF COVERAGE

- Those who experience a loss of employment
- The spouse and children of a covered employee who dies
- Those entitled to Medicare
- Those who are no longer dependents because of marriage or reaching adulthood
- Former spouse and children (as a result of divorce or separation)

COBRA also grants certain rights for conversion of group coverage to an individual plan. All group health plans, including those offered by self-insured companies, are subject to COBRA requirements.

HMO minimum benefits: Federally qualified HMOs must provide basic health services.

BASIC HEALTH SERVICES REQUIRED OF HMOs

- Physician services
- Outpatient services
- Diagnostic and x-ray services
- Inpatient hospital care
- Medically necessary emergency services
- Inpatient and outpatient chemical dependency care
- Home health services
- Preventive services (immunizations, well-baby care and family planning)

As stated earlier, fewer of the newly forming HMOs seek federal qualification today than did in the mid-1970s.

¹⁰ Pamela Farley Short, *Trends in Employee Health Benefits*, National Center for Health Services Research, Summer, 1988.

Minnesota Regulations

Besides regulating the finances of accident and health insurers, HMOs, and nonprofit health service plans, the state has established laws regulating what coverages health plans must include (as described in Chapter 1).

Minnesota has over 30 statutory mandates, one of the highest number of mandates in the country.¹¹

In addition to the qualified plan requirements laid out in the Comprehensive Health Insurance Act in 1976, (see description in Chapter 1) Minnesota laws prescribe:

- Coverage of specific treatments
- Continuation of coverage following certain events
- Dependent coverage
- Direct reimbursements to specific nonphysician provider groups.

APPENDIX THREE: EVALUATION OF MANDATES ELSEWHERE

Activities in Other States to Evaluate Mandates

Several states have passed laws requiring an evaluation of health benefits prior to determining whether they should be mandated. Washington, Maryland, Wisconsin, Florida, Pennsylvania, Hawaii, Montana, Arizona, and Oregon each have a mandate evaluation process in law, although most have used the process infrequently or informally. A few of the evaluation processes are described here.

Washington State

In 1984, the state of Washington became the first to pass legislation requiring evaluation of health benefit mandates. The party advocating a mandate must prepare a report and submit it to the state health coordinating council (added in 1987) which makes a recommendation to the appropriate legislative committees.

Washington's guidelines for evaluating mandates have been duplicated by most other states subsequently requiring evaluations. Its criteria are listed in Figure A.3.

¹¹ Blue Cross and Blue Shield Association, Office of Government Relations, State Services Department, *State Mandated Health Insurance Laws*, August 1988; *Minnesota Statutes* 1988; *Laws of Minnesota* 1989.

FIGURE A.3

WASHINGTON'S CRITERIA TO ASSESS IMPACTS OF MANDATES***SOCIAL IMPACTS***

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

FINANCIAL IMPACTS

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

Pennsylvania

Pennsylvania passed a law in 1986 establishing a Health Care Cost Containment Council with 21 members: the secretaries of health, public welfare and insurance, six business community representatives, six representatives of organized labor, one representative each of consumers, hospitals, physicians, Blue Cross and Blue Shield, HMOs, and commercial insurance carriers.

The Council is instructed to review existing or proposed mandates upon request of the executive or legislative branches of government. In addition to soliciting documentation supporting and opposing the mandate, the Council holds a public comment period and

submits the documentation to the state Insurance Commissioner and Secretary of the state Health Department for their review.

The Council contracts with a Mandated Benefits Review Panel to provide independent review of the mandates. This panel consists of three senior researchers: one each in health research, biostatistics, and economics research.

The criteria used in Pennsylvania to review mandates are listed in Figure A.4.

FIGURE A.4

PENNSYLVANIA'S CRITERIA TO ASSESS IMPACTS OF MANDATES

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

Arizona

In 1985 Arizona adopted a reporting process comparable to that in Washington. The responsibility to prepare the report is vested in the organization proposing the mandate. The report must assess the social and financial impacts of the coverage and the effectiveness of the treatment or service.

The factors used to assess the impacts are virtually identical to those in Washington's statutes. The only difference is that the report goes directly to the appropriate legislative committee, not to a state health council.

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WORK OF THE COMMITTEE

Charge to the Committee

The Citizens League Board of Directors adopted the following charge to the research committee.

Mandated Health Insurance Benefits

The number and scope of legislatively-mandated benefits in Minnesota health insurance policies are among the most extensive in the nation. Each legislative season produces more mandates, often the result of pressure from special health provider groups. But along with more services comes increased cost pressure in the health-care system.

In a recent study, the Minnesota Legislative Auditor found that statutes and rules mandating benefits have proliferated in recent years and are difficult to track.

Advocates argue that additional mandates are necessary to ensure adequate coverage. Opponents argue that mandated benefits result in increased utilization and cost. The end result may be broader coverage at the expense of limited access.

The committee should recommend an objective method for determining whether and what health insurance benefits the state should mandate in the future. The committee should apply its objective method to current mandates and recommend changes, if needed, to current law.

The committee's examination should include:

- benefits that currently are mandated for different types of health insurance products;
- benefits that currently are not mandated, and the reason why some are and some are not mandated;
- trends in mandating health benefits in Minnesota and other states;
- the effect of mandated benefits on other types of health insurance policies in the state, including employer self-insurance;
- the cost of additional mandates to the consumer, and
- the effect of increasing benefits on consumer choice.

After learning about Minnesota's mandates and discussing the charge, committee members agreed to include the following three questions to focus and guide their discussions about mandates:

- What process ought to be used to mandate health benefits in Minnesota?
- What ought to be included on Minnesota's list of mandated benefits?
- How do the mandates affect access to health care?

Committee Membership

Under the leadership of Lyle Wray, chair, and Anthony Morley, vice-chair, 24 Citizens League members participated actively in the deliberations of the committee. They are:

Ellen Benavides
Curtis K. Carlson
Chris Dobbe
Bright M. Dornblaser
Lloyd Graven
Virginia Greenman
Mike Hickey
Susan M. Hoel
James W. Johnson
Linda Kohn
Frederick E. Lange
Gary LeDuc

Ralph Marlatt
Scott Mayer
Mary Miller
James L. Myott
Patrick R. O'Leary
Reinhard Priester
Carl Reuss
James Scheu
Vern Silvernale
John F. Stone
Casey Whelan
Michael Wolf

Shirli Vioni chaired the committee during the first half of its work.

Committee Meetings

The committee met for the first time on December 12, 1988 and concluded its work on July 31, 1989. A total of 23 meetings were held. During the first stage of the committee's work it relied upon testimony from the resource speakers listed below. It also discussed reports on mandated benefits from elsewhere in the country.

During the second phase of the committee's work, committee members identified the central issues about mandates and their impact on Minnesota residents, and how they related to other health care issues like cost and access to care. The committee members spent the final two months revising a report of their findings and recommendations.

Resource Speakers

The Citizens League and the committee members would like to thank these resource people for the assistance they provided. (Titles reflect the position held by the speaker at the time of the presentation):

Dr. Tom Allenburg, chiropractor and president of ChiroCare
Peter Benner, executive director of Council 6, American Federation of State, County, and Municipal Employees (AFSCME)
Leonard Boche, executive director of the Board of Medical Examiners and former state director of chemical dependency care
Bill Conley, Mental Health Association of Minnesota
Dick Gomsrud, department counsel for the Minnesota Department of Commerce
Nancy Gruver, director, Health Insurance Coalition
Dr. Stuart Hanson, Park Nicollet Medical Center, chair of the Legislative Committee of the Minnesota Medical Association

Mike Hickey, committee member, and director of Government Relations, National Federation of Independent Businesses

Dr. Keith Horton, doctor of psychiatry

Scott Mayer, committee member, and director of professional affairs for the Minnesota Chiropractic Association

Walter McClure, chairman, Center for Policy Studies

Ruth Mickelsen, Director of Legal and Policy Affairs, Minnesota Department of Health, staff to Minnesota Commission on Health Plan Regulatory Reform

Representative Paul Ogren, DFL-Aitkin, Chair of the Minnesota House of Representatives Committee on Health and Human Services, and author of the 1989 Healthspan bill

Brian Osberg, Vice-President for Medical Contracting and Affiliated Clinic Operations with Group Health, Inc.

Al Pertuz, Vice-President of Operations, Health Risk Management

David Strand, law firm of Popham, Haik, Schnobrich, and Kaufman

Harry Sutton, Vice-President, Towers, Perrin, Forster & Crosby

Lois Wattman, Associate Counsel and Legislative Coordinator for Blue Cross and Blue Shield of Minnesota.

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Patricia Drury, executive director of the Minnesota Coalition on Health;

Robert Kane, dean of the University of Minnesota's School of Public Health;

Ruth Mickelsen, partner with the law firm of Popham, Haik, Schnobrich, and Kaufman, and former staff to Minnesota Commission on Health Plan Regulatory Reform.

Assistance to the Committee

Research Associate Jody Hauer prepared this report. Staff assistance for the committee's work was provided by Allan Baumgarten, Dawn Westerman, Meredith Poppele, and Joann Latulippe.