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Economic Affairs Interim Committee

60th Montana Legislature

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MEMO

To: **Economic Affairs Committee Members**
From: **Pat Murdo, Staff for HJR 48 Study on Health Insurance Reform/Coverage**
Re: **Mandate "Light" research**

Questions asked at the Economic Affairs Committee's June 17 teleconference call regarding "mandate light" included:

- how much would mandates add to the cost of premiums; and
- do policies now cover emergency care?

SUMMARY:

Local estimates are not yet available for what mandates add to the cost of an individual policy premium. A general indication of costs per person per month, distributed in 2007 by Blue Cross Blue Shield of Montana, indicated current federal and state mandates in 2006 added $21.22 per covered person per month to the cost of a premium (generally a group premium).

On the other major question asked: Even though only policies under the Managed Care statutes in Title 33, chapter 36, require coverage of emergency services, all policies in Montana cover emergency care in some manner.

DETAILS ON MANDATE COSTS

Studies typically estimate impacts in three ways: the total add-on to premium costs, impact on claims, or impacts on total health costs. A caveat for the claims estimates is that some mandates are for preventive care (screening), which may save money in the long term. The definition of mandates usually includes mandated services by more than one type of practitioner. Although some types of practitioners may charge less than others, insurers say that costs do not decrease because the expansion of the provider pool ends up increasing the total claims or costs. A report (http://liberty.pacificresearch.org/docLib/20080630_Heart_to_Hair.pdf) by the Pacific Research Institute provides examples:

> ***Claims:*** The Congressional Budget Office estimated in 2000 that mandates, or services for mandates, made up between 5% and 22% of claims, with each mandate adding between 0.25% to slightly more than 1% to the cost of claims. ... A more recent report to the Maryland Health Care Commission indicated that Maryland's 42 mandated benefits amounted to 15% of claims in the group market and 19% of claims in the individual market.
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> ***Premiums:*** A study of the cost of 12 common mandates by the actuarial firm Milliman and Robertson in 1997 found that the mandated benefits increased premium costs by 15% to 30%. ... Separately, the Council for Affordable Health Insurance recently estimated that, depending on the mandate, the additional cost to premiums per mandate ranged from less than 1% up to 10%.
>
> ***Total health costs:*** A 2008 report on Maryland's mandates by the Council for Affordable Health Insurance said that mandates accounted for 24% to 57% of total health care costs.

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Another impact is to overall affordability of the premium and the subsequent decision not to buy or continue buying health insurance. For example, a review of proposed mandates in the 2008 California legislature by the California Health Benefits Review Program estimated that a proposal for cancer screening would increase premiums by $1.63 billion in the employer market and $287.5 million in the individual market, leading to an estimated loss of coverage for 82,000 people. (Fact Sheet from the California Association of Health Plans, April 14, 2008) A 1988 econometric study by John Goodman and Gerald Musgrave indicated that, in general, state- mandated benefits hiked insurance affordability out of range for 14% to 25% of people. They further calculated that each mandate had the potential to increase the share of people without health insurance by about one-third of 1%. (quoted in the Pacific Research Institute report)

DETAILS ON EMERGENCY COVERAGE AND OTHER QUESTIONS:
The questions asked of representatives from the 3 major Montana-based insurers, followed by their answers were:

- **If insurance covers emergency services, what is covered? Which policies cover emergency services?**

  Allegiance
  - Allegiance does not sell individual policies. Its group policies cover emergency services, e.g. ambulance, emergency room, ER doctor, supplies.
  - Benefits for covered services by a non-PPO (preferred provider organization) providers are paid as if rendered by a PPO provider for an emergency defined by the policy.
  - Benefits for an emergency are limited to procedures necessary to treat and stabilize an eligible illness or injury and to procedures necessary for the insured to be transported to a PPO hospital, clinic, or facility or discharged.
  - An emergency is defined as an illness or injury of such a nature that failure to get immediate medical attention or treatment could put the insured's life in danger or cause serious bodily harm to the insured's bodily functions.
  - Emergency services are billed under the medical portion of the policy.

  Blue Cross-Blue Shield
  - All BCBSMT policies cover emergency room treatment if the medical emergency criteria are met. If the criteria are not met, BCBSMT would still cover physician and other ancillary charges but not the emergency room charges. (For example, ER facility charges for St. Peter's Hospital are estimated to be about $188, according to its website.)
  - One BCBS policy provides that, for emergency room services to be covered under the policy, which is an individual policy, the patient must be admitted to the hospital.

  New West
  - All health policies provided by New West cover emergency services. The discussion at the June 17 meeting about requirements for coverage referred to managed care statutes: 33-36-201 and 33-36-205, MCA. These require emergency service coverage for managed care policies and were based on a National Association of Insurance Commissioners' model in 1987. The effort was to make sure that health management organizations requiring insureds to receive care in network for coverage could not avoid paying for an insured who needed emergency care elsewhere, regardless of how the rest of the benefits were covered. The provider, if out of network, would not be prohibited from balance billing the individual, which an in-network provider would be.

- **What are the costs of mandates for individual policies, separate from group policy mandates? Are deductibles different, depending on the mandate inclusions?** *(General information from Tanya Ask regarding how BCBS calculated mandate cost information in 2006: "The*

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mandate cost information was based on claims for all lines of business, not broken out by individual deductible and coinsurance. The deductible level would not impact the cost because benefit costs are determined first. Then a factor is applied to the entire premium based on the level of the deductible. Not all services are eligible for deductibles, including some mandated services.")

Allegiance

- No actuary doing an estimate on what different mandates cost.
- Sells only group policies.

Blue Cross-Blue Shield

- Actuary still working on the numbers.

New West

- Does not employ a staff actuary. Anticipates that general costs for benefits would be comparable to BCBS costs because populations, utilization, and provider practices, as well as geography, are similar.

- **How many HMO and non-HMO policies, individual and group, are sold? How many covered lives in each?**

Allegiance

- Does not sell HMO policies or individual policies.
- Allegiance Life & Health Insurance Company, Inc., a domestic for-profit health insurer, as of Aug. 4, 2008, had 156 total group policies underwritten with approximately 9,455 total covered lives.
- As a third-party administrator, Allegiance Benefit Plan Management, Inc., handles 101,500 lives through approximately 45 self-funded group plans.

Blue Cross-Blue Shield

- 8 traditional individual products and one individual HMO product plus one group HMO product.
- Individual policies cover about 31,000 lives.

New West

- Three basic product types with variations, covering 1,300 to 1,400 individual lives.
- Separate contract covering more than 2,000 individuals who are former Libby, Montana residents.
- Medicare Advantage and Medicare Supplement plans include an additional 1,950 people.
- The majority of New West's business is through the HMO structure, covering 29,000 individuals under group products.

- **Would insurers offer a mandate light policy that offered a menu of choices or would there be one, standardized "mandate light" policy?**

Allegiance -- Expectation of going with standardized "mandate light" option

Blue Cross-Blue Shield -- Would sell a full mandate policy plus what the public wants. If the public wants a mandate light, it would be sold. If the public wanted an ala carte option, the public would get that too.

New West - Would continue selling policies subject to Montana's current requirements. The marketplace would help determine modifications to policies along with a decision of whether evidence-based benefits would enhance the overall health of someone covered by the benefit plan (balancing what is affordable with what is necessary to improve a person's health).

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- **Do insurance agents get higher commissions, depending on the number of lives covered?**
  Answered by Don Allen, representing insurance agents:
  - Commissions paid on a percentage basis, whether group or individual policies.
  - Commission is a percent of the premium, excluding administrative fees charged by the insurer.
  - Commissions are usually a lower percentage for group policies than for individual policies because the total premiums are larger. Varies from company to company.
  - Commission percentage may be higher for first year of premium then lower for renewal periods, again varying by company.
  - Variation on whether an agent gets a higher commission for selling an individual policy that covers multiple people in a family vs. 1 or 2. Some do not increase the commission, some do.

Some history: A review of mandated benefits by an interim subcommittee in 1991-1992 recommended that legislation be adopted to create an 11-member commission to review mandated health insurance benefits. HB 75, initially tabled in committee in the 1993 session, passed on 2nd reading 55-43, and then was referred to appropriations, where it was tabled in committee.

Previous effort: The previous limited coverage demonstration project, codified in 33-22-262, was for physician/professional services and geared to primary and preventive care, plus disease management. Also, it was only for previously uninsured people. It is to expire June 30, 2009. New West sold fewer than 75 individual policies under this pilot project.

Elsewhere: North Dakota requires in 54-03-28 that its legislative council contract with a private entity to do a cost-benefit analysis of any mandated health insurance coverage or service. I have an email to the North Dakota Legislative Council to see what types of activity, if any, this statute has generated.