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The Honorable James M. Jeffords
United States Senate

Dear Senator Jeffords:

The Congress is considering proposals intended to enhance the availability of health insurance. This debate has led to specific questions about the state regulation of health plans, including mandated benefit laws. In particular, you asked us to provide information on

1. state requirements affecting fully insured health plans and how they compare with federal requirements affecting self-funded health plans,

2. the number of states that have enacted particular mandated benefit laws,

3. estimates of the costs of mandated benefits in particular states, and

4. the extent to which commonly mandated benefits are provided by self-funded health plans that are exempt from state laws.

This letter provides interim information based on our ongoing work for you on the factors affecting the costs of state health insurance regulation. As part of this effort, we interviewed officials from the National Association of Insurance Commissioners (NAIC); several state insurance commissions; and national organizations representing actuaries, health insurers, and self-funded employers. We reviewed documents and used data provided by these groups as well as available studies on mandated benefits. In addition, we included and updated information from previous GAO reports on state insurance regulation and the Employee Retirement Income Security Act of 1974 (ERISA).[1] Our

[1]See Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995) and Health Insurance Regulation: Wide Variation in States'

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review was conducted between January and March 1996 in accordance with generally accepted government auditing standards. We expect to issue a report to you later this year that will provide a more detailed analysis of the factors affecting the costs of state health insurance regulation.

RESULTS IN BRIEF

We found that states have an average of 18 mandated benefits that health insurers must cover but the number of mandated benefits varies from a low of 6 in Idaho to a high of 39 in Maryland. However, assessing the costs of mandated benefits is difficult because their impact varies depending on state laws and employer practices. Published studies provide a range of cost estimates. For example, a recent study found that Virginia's mandated benefits accounted for about 12 percent of claims costs; earlier studies estimated that mandated benefits in Maryland cost 22 percent of claims and in Iowa cost 5 percent of claims. In general, cost estimates are higher in states with more mandated benefits and in states that mandate more costly benefits, such as mental health services and substance abuse treatment. We also found that self-funded health plans often offer similar benefits, even though they are exempt from state-mandated benefit laws. For example, a survey by KPMG Peat Marwick found that a large percentage of self-funded health plans offer benefits similar to those mandated for health insurers in many states.

REGULATORY FRAMEWORK DEPENDS ON WHETHER A HEALTH PLAN IS FULLY INSURED OR SELF-FUNDED

While states are able to regulate health insurance, state regulation does not directly affect everyone with private health coverage. ERISA preempts states from directly regulating employer provision of health plans.[2] This results in a very different regulatory framework depending on whether an employer purchases its health care coverage from an insurer that the state regulates or self-funds its

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Authority, Oversight, and Resources (GAO/HRD-94-26, Dec. 27, 1993).

[2]P.L. 93-406, 88 Stat. 829 (classified as amended at 29 U.S.C. 1144(a) et seq.) (1994).

health plan and is not directly affected by state regulation.[3]

States focus their regulation on the financial soundness of insurers and their market conduct, including benefit coverage. In addition, states impose taxes on insurers for general revenues as well as for financing specific programs. While federal requirements include fiduciary and other responsibilities, in many other areas no federal requirements exist for self-funded health plans that are comparable to state requirements for health insurers. In particular, self-funded health plans are exempt from state laws that mandate insurers to include coverage for specific benefits. Table 1 compares the requirements that fully insured and self-funded health plans must meet.

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[3]ERISA preemption effectively blocks states from regulating most employer-based health plans, but it permits states to regulate health insurers. The majority of employers purchase health coverage from a third-party insurer that is subject to state insurance regulation. However, for plans covering about 44 million people in 1993 the employer chose to self-fund and retain at least some financial risk for its health plan. Because these self-funded health plans are not deemed to be insurance, ERISA preempts them from insurance regulation and premium taxation. For a fuller discussion of the regulatory differences, see Employer-Based Health Plans (GAO/HEHS-95-167, July 25, 1995).

Table 1: Comparison of Relevant State and Federal Provisions Affecting Fully Insured and Self-Funded Health Plans

	State insurance regulations affecting fully insured health plans	**ERISA provisions affecting self-funded health plans[a]**
Financial requirements		
Licensing	States license insurance companies and the agents who sell insurance to ensure that companies are financially sound and reputable and that agents are qualified.	No comparable requirements.
Financial solvency	States set standards for and monitor financial operations of insurers to determine whether they have adequate reserves to pay policyholders' claims. States restrict how insurers invest their funds.	No solvency requirements but fiduciary duty to act in a prudent manner solely in the interests of plan participants and beneficiaries.
Rate reviews	States review and approve rates to ensure that they are both reasonable for consumers and sufficient to maintain the solvency of insurance companies.	No comparable requirements.
	Some states regulate insurer rating practices in the small group market to determine the factors insurers may use in setting premiums.[b]	No comparable requirements.

	State insurance regulations affecting fully insured health plans	ERISA provisions affecting self-funded health plans[a]
Market conduct requirements		
Plan benefit coverage and description	States review and approve insurance policies to make sure that they are not vague or misleading and to ensure that they meet state requirements, such as mandatory benefit provisions.	Disclosure requirements to provide summary plan description to participants and the Department of Labor. No requirements to provide specific benefits.
Consumer protections and complaints	States monitor insurers' actions to make sure that they are not engaging in unfair business practices or otherwise taking advantage of consumers and assist consumers by investigating their complaints, answering questions, and conducting educational programs.	Plan must reconsider denied claims at participant's request. States have no authority to pursue consumer complaints regarding self-funded plans. Department of Labor has responsibility for complaints regarding self-funded health plans.
Small group reforms	Most states require insurers selling to small employers to accept and renew employees who want health insurance coverage, establish short waiting periods for preexisting conditions, and require portability of coverage even when an individual changes jobs or insurers.[b]	States are preempted from applying small group reforms to self-funded health plans.

	State insurance regulations affecting fully insured health plans	ERISA provisions affecting self-funded health plans[a]
Tax requirements		
Premium taxes	States assess premium taxes on insurers.	States are preempted from assessing premium taxes on self-funded health plans.
Guaranty funds	States assess insurers to finance guaranty funds that provide financial protections to enrollees who have outstanding medical claims in the case of an insurer insolvency.	States are preempted from requiring self-funded health plans to participate in guaranty funds.
High-risk pools	Some states assess insurers to finance losses in high-risk pools that provide health coverage for individuals who otherwise had been denied health coverage due to a medical condition.	States are preempted from requiring self-funded health plans to participate in high-risk pools.

[a]ERISA requirements apply to all private employer and union health plans, including fully insured and self-funded health plans. See Employer-Based Health Plans (GAO/HEHS-95-167, July 25, 1995). While states are preempted from regulating self-funded health plans directly, some states regulate third-parties that provide administrative services for self-funded health plans and stop-loss insurance carriers that reimburse self-funded health plans for claims that exceed a predetermined threshhold.

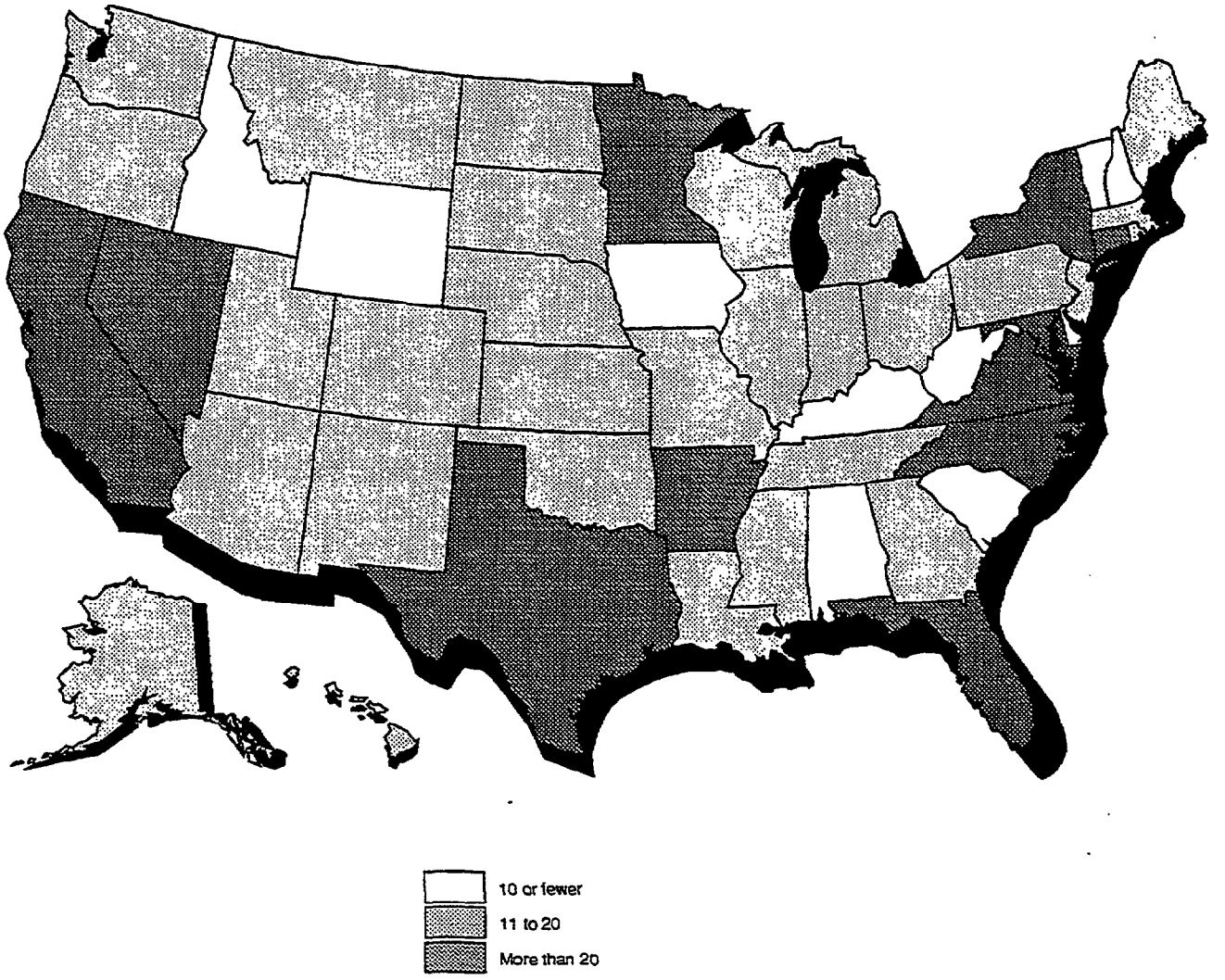
[b]For a listing of states that have enacted these reforms, see Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS-95-161FS, June 12, 1995).

NUMBER AND TYPE OF MANDATED BENEFITS ADOPTED BY STATES VARY

On average, states have enacted laws mandating about 18 specific benefits. As shown in figure 1, 15 states have over 20 mandated benefits while 9 states have 10 or fewer mandates. Maryland (39), Minnesota (34), and California (33) are the states with the highest number of mandated benefits. In contrast, Idaho has only 6 mandated benefits; Alabama, Delaware, Vermont, and Wyoming each have 8 mandated benefits.[4]

[4]The calculation of the number of mandated benefits includes requirements that insurers provide or continue coverage for specific populations, such as dependent students, as a mandated benefit. Thus, the number of mandated benefits per state includes these requirements as well as treatment-related and provider-related mandated benefits. See Blue Cross and Blue Shield Association, State Legislative Health Care and Insurance Issues: 1995 Survey of Plans (Washington, D.C.: Blue Cross and Blue Shield Association, 1995) for a list of mandated benefits for each state.

Figure 1: Mandated Benefits by State



Source: Blue Cross and Blue Shield Association.

States most frequently mandate coverage for preventive treatments like mammograms and well-child care or for treatment of mental illness or alcohol and drug abuse.[5] (See table 2.) In addition, states often require coverage for some types of providers like optometrists and chiropractors. States typically mandate that insurers cover specific benefits in all plans sold, whereas some states merely mandate that each insurer make this service available in at least one plan that it offers. In some cases, the mandates are limited to particular types of plans such as health maintenance organizations or group insurance plans.

[5]Many states have recently begun considering mandating that health insurance cover minimum postpartum hospital stays. For example, a state may require the insurer to cover 48 hours of hospitalization following a vaginal delivery or 96 hours following a caesarian delivery if recommended by the doctor, although in some states shorter stays may be allowed if they are accompanied by a home visit by a nurse or other medical professional. According to the National Council of State Legislatures, as of March 22, 1996, 10 states have enacted laws requiring coverage for postpartum care and bills are pending in nearly 30 other states.

Table 2: Commonly Mandated Benefits

	Number of states		
	Cover	Offer	Total
Treatment-related			
Mammography screening	42	4	46
Alcoholism treatment	23	16	39
Mental illness	15	16	31
Well-child care	21	4	25
Drug abuse treatment	13	10	23
Pap smear	17	0	17
Infertility treatment/ in vitro fertilization	12	2	14
Temporomandibular joint disorders	11	3	14
Off-label drug use	13	0	13
Maternity care	11	2	13
Breast reconstruction following mastectomy	9	2	11
Provider-related			
Optometrists	46	1	47
Chiropractors	43	3	46
Psychologists	42	0	42
Podiatrists	38	0	38
Social workers	26	0	26
Osteopaths	21	0	21
Nurse midwives	15	0	15
Physical therapists	14	0	14
Nurse practitioners	13	1	14

Source: NAIC, Compendium of State Laws on Insurance Topics: Mandated Benefits (Kansas City, Missouri: NAIC, 1995).

STUDIES VARY IN THEIR ESTIMATES OF THE COSTS OF MANDATED BENEFITS

Studies conducted in several states between 1987 and 1993 provide varying estimates of the costs associated with mandated benefits. (See table 3.) Among the most recent, the Virginia State Corporation Commission has required insurers to report cost and utilization information annually for each of the mandated benefits in the state. Overall, the commission reports that Virginia's mandated benefits accounted for about 12 percent of group health insurance claims in 1993. An earlier study in Maryland, the state with the most mandated benefits, estimated that mandated benefits represent 22 percent of average claims costs in 1988. At the other extreme, a 1987 study in Iowa estimated that the potential costs of introducing several commonly mandated benefits would be about 5 percent of claims costs.

Table 3: Studies of the Costs of Mandated Benefits in Selected States

State	Year	Percent of total claims costs
Maryland	1988	22.0
Massachusetts	1990	18.0
Virginia	1993	12.2
Oregon	1989	8.1
Wisconsin[a]	1989	7.9
Iowa[b]	1987	5.4

[a]Includes six mandated benefits: alcohol and other drug abuse treatment, chiropractic care, diabetes care, home health care, skilled nursing facility care, and kidney disease treatment.

[b]The study in Iowa examined potential costs of six commonly mandated benefits, including mental health, alcohol and drug abuse, podiatrists, optometrists, registered nurses, and physical therapists. Iowa has not adopted all of these mandates; according to the Blue Cross and Blue Shield Association, Iowa's current mandates are mammography screening, well-child care, chiropractors, dentists, registered nurses, optometrists, and diabetic education.

Sources: Jonathan Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," Journal of Public Economics, Vol. 55 (1994), pp. 433-464; Michael L. Hand and G. Marc Choate, "The Impact of State-Mandated Health Care Benefits in Oregon" (Salem: Associated Oregon Industries Foundation, 1991); Gail Jensen and Jon Gabel, "The Price of State Mandated Benefits," Inquiry, Vol. 26 (1989), pp. 419-431; Gregory Krohm and Mary H. Grossman, "Mandated Benefits in Health Insurance Policies," Benefits Quarterly, Vol. VI, No. 4 (1990), pp. 51-60; Virginia State Corporation Commission, "The Financial Impact of Mandated Health Insurance Benefits and Providers" (Richmond: Virginia State Corporation Commission, 1995).

To some extent, the differences in the cost estimates reported by the various studies are related to the number of mandated benefits included in each state. For example, the studies that showed the highest estimated costs were for Maryland and Massachusetts, states that have more mandated benefits than most states. Thus, these cost estimates cannot be generalized to other states.

While the studies report varying cumulative costs in different states, they generally agree that several specific mandated benefits account for a large share of the

additional costs. In particular, mental health and substance abuse are often cited as the most costly mandated benefits whereas other commonly mandated benefits, such as mammography screening, account for fewer than 1 percent of costs. Furthermore, in some cases, mandated benefits covering services offered by some alternative types of providers, such as nurse midwives, may reduce costs because they substitute for more costly forms of care. However, some provider mandated benefits may also increase the demand for services, thereby increasing costs. For example, while chiropractic services may be a less expensive alternative for some treatments, mandating their coverage may also lead to increased use.

One limitation of most studies on mandated benefits is that they have examined the impact of mandated benefits on claims costs, which does not necessarily capture the actual effect on employers' costs. In particular, multistate employers note that varying state-mandated benefits result in additional administrative cost. Employers that purchase health insurance must modify their plans to meet these differences in state-mandated benefits. Furthermore, employers are concerned that mandated benefits limit their flexibility in designing the most cost-effective health benefit plan to best meet the needs of their employees.

SELF-FUNDED HEALTH PLANS OFTEN COVER BENEFITS COMMONLY MANDATED BY STATES

The actual cost impact of mandated benefits to employers also depends on whether the employer offers a comprehensive or limited health plan, which in turn is often related to the size of the employer. Many of the commonly mandated benefits are often offered by employers, even those who self-fund and are not subject to the state mandates. In general, large employers are more likely to self-fund their health plans and also tend to offer more comprehensive benefits than small employers. For small employers, who typically purchase fully insured health plans and are less likely to offer health coverage at all, mandates may impose claims costs for benefits that they otherwise might not have covered.

Studies have shown that self-funded health plans typically offer many of the benefits that are commonly mandated by states for fully insured health plans. For example, as shown in figure 2, a KPMG Peat Marwick survey of employer benefits among all firm sizes indicates that self-funded health plans are more likely to offer well-child care, outpatient alcohol treatment, outpatient drug treatment,

mental health benefits, and chiropractic care than fully insured health plans. This survey also reports similar patterns for other benefits that are not typically mandated, including prescription drugs, adult physicals, and dental benefits.[6] Similarly, a survey of Wisconsin insurers also found that

> "self-funded health plans provide at least as many of the mandated benefits as insured health plans and in some cases provide more generous coverage."[7]

This result may partially be due to the tendency of large employers to both self-fund and offer more comprehensive benefits.

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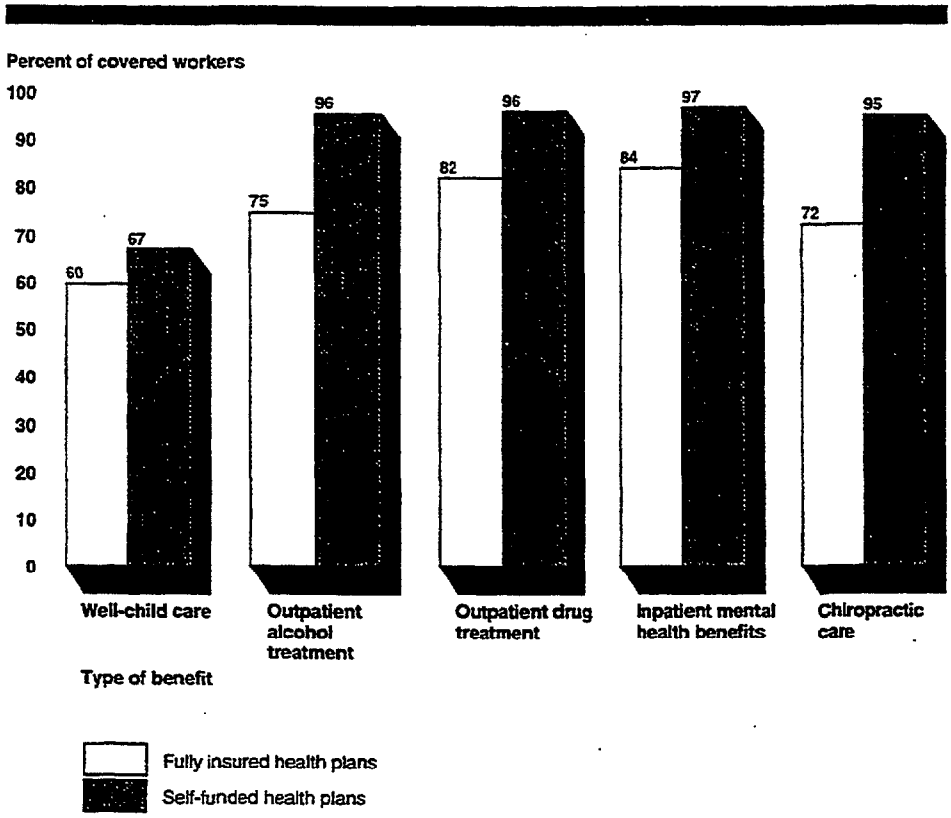
[6]The data in figure 2 represent the percentage of covered workers in conventional health plans. KPMG Peat Marwick reports similar findings for workers in preferred provider organizations and point-of-service plans that are either self-funded or fully insured. KPMG Peat Marwick is currently examining to what extent these differences in the rates of benefit coverage among self-funded and fully insured health plans can be explained by differences in firm size and premium levels.

[7]See Krohm and Grossman, Mandated Benefits in Health Insurance Policies, p. 56. The mandated benefits surveyed include substance abuse, diabetes, home health care, skilled nursing facility care, kidney disease treatment, and chiropractic care.

Figure 2: Comparison of Selected Benefits Offered by Fully Insured and Self-Funded Health Plans



Source: KPMG Peat Marwick, March 1996, based on 1995 employer surveys.

Although self-funded plans often offer the same types of benefits as are commonly mandated by states for insurers, they may include features that differ from the requirements of state mandates. For example, state mandates generally specify a minimum number of days of care that insurers must cover for inpatient mental health care. One employer association indicated that many employers prefer designing more flexible mental health benefits; for example, requiring case management rather than specifying a limited number of days of care. Thus, even though 97 percent of self-funded plans offer inpatient mental health care services, all these plans would not meet the state requirements for fully insured health plans.

Assessing the cost differences between self-funded and fully insured health plans resulting from mandated benefits is difficult. To the extent that self-funded health plans offer benefits that are similar to state-mandated benefits, they do not have lower claims costs due to their exemption from state-mandated benefit laws. For less commonly offered benefits, such as in vitro fertilization, self-funded employers would face additional claims costs if they were required to meet the state mandates.

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Please contact me at (202) 512-7119 or Michael Gutowski, Assistant Director, at (202) 512-7128 if you or your staff have any questions. Other major contributors to this letter are John Dicken and Carmen Rivera-Lowitt.

Sincerely yours,

William J. Scanlon for

Jonathan Ratner
Associate Director,
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