ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7038 HOUSE LABOR & COMMERCE

House Bill 45
Analysis of Financial Impact on
Mandatory Coverage of Mammograms
Prepared by the Division of Retirement and Benefits
Department of Administration
January 28, 1991

This bill will not result in additional operations cost for the Division of Retirement and Benefits.

The bill is estimated to increase the monthly health premium by $1.50 per employee. This equates to an annual increase of $270,000.

[$1.50 x 15,000 employees x 12 months = $270,000]

There will be an equivalent cost to school districts and participating political subdivisions and to the retirement funds. Future costs are assumed to remain level but will be determined by the plan's claim experience.

Alaska State Legislature

HOUSE OF REPRESENTATIVES

REPRESENTATIVE FRAN ULMER

MEMORANDUM
JANUARY 24, 1991

TO: Rep. David Finkelstein, Chair
House Labor and Commerce Committee

FROM: Rep. Fran Ulmer

RE: HB 45, relating to insurance coverage for mammograms

HB 45 requires health insurance carriers in Alaska to provide coverage for mammography screening in every policy which includes mastectomies and related procedures, including Medicaid. Mammography screening has proven to be the most effective means of detecting breast cancer in its curable stage.

The bill includes:

(a) a definition of "low-dose mammography"
(b) frequency standards for mammography screening (recommended by the American Cancer Society)
(c) provision for standard co-payment and deductibles
(d) placement of mammography screening on Medicaid funding priority list.

Industry cost estimates (provided by Aetna) indicate that the per person cost for state employees to have this benefit will be no more than $1.50 per month. That figure represents 0.4% of the monthly premium. This percentage (0.4%) should be the cost of this benefit in policies from other providers as well.

Thirty-four other states currently require some type of mammography screening coverage (see map attached). The experience of those states has shown that over 90% of women whose breast cancer is detected early survive. The medical cost saving from early detection is estimated to be, for the nation, approximately $200 million. That cost, coupled with the saving of lives which would otherwise be lost, recommends that Alaska take action to make mammography screening a routine procedure for every women of appropriate age.

This bill was requested by the American Cancer Society and is supported by the Hospital and Nursing Home Association and the Juneau Commission on Aging.

District 4B — Juneau
P.O. Box V • Juneau, Alaska 99811-3100 • (907) 465-4947

Recycled Paper

Alaska State Legislature

HOUSE OF REPRESENTATIVES

REPRESENTATIVE FRAN ULMER

MEMORANDUM
January 30, 1991

TO: Rep. David Finkelstein, Chair
House Labor and Commerce Committee

FROM: Rep. Fran Ulmer

RE: HB 45, re mammography screening

The following is a list* of those states which currently require insurance coverage for mammography screening:

Washington	Missouri
California	Illinois
Arizona	Kentucky
Nevada	Tennessee
Colorado	West Virginia
New Mexico	Virginia
Texas	Pennsylvania
Oklahoma	New York
Kansas	Massachusetts
North Dakota	New Hampshire
Minnesota	Maine
Wisconsin	Rhode Island
Iowa	Connecticut
Florida	

The largest, most populous states of the nation are included in this list. They have concluded that requiring insurance coverage for mammography screening is an effective means of promoting the use of this cost effective, preventive procedure.

*This information provided by the American Cancer Society.

District 4B — Juneau
P.O. Box V • Juneau, Alaska 99811-3100 • (907) 465-4947

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HB 45 -- RELATED TO MAMMOGRAPHY SCREENING
Sectional Analysis

Section 1.(a) Requires Alaska health insurance providers to include low dose mammography screening in every group and individual policy which covers mastectomies and related procedures.

(b) Establishes frequency standards for mammography screening, as recommended by the American Cancer Society.

(c) Requires that payment for mammograms should be not less favorable than for other radiological examinations and may be subject to standard co-payment and deductible provisions.

(d) States that these requirements are not applicable to supplemental contracts covering a specified disease or other limited benefits.

(e) Definition of "low-dose mammography screening".

Section 2. List of statutes that apply to service corporations operating as insurance providers in Alaska; the mammography requirement for insurance providers is included in this list so that the statutes are consistent.

Section 3. Includes mammography screening as a service which may be covered by Medicaid funding.

Section 4. Places mammography screening on the prioritized list of services which will not be funded if funds are not available.

Section 5. States that this act applies to individual and group health insurance policies and to hospital or medical service subscriber contracts entered into or renewed on or after the effective date of the Act.

BREAST CANCER EARLY DETECTION FACT SHEET

Incidence

Leading cause of premature death in American women
1 in 9 women develop breast cancer
1988: 135,000 new cases in the U.S.; 42,000 deaths
75% of breast cancers occur in women over age 50
40% of breast cancers occur in women over age 65

Early Detection Benefits

Mammography and physical exam detect 95% of breast cancers
Mammography most effective means to detect breast cancer in the curable stage
Over 90% of breast cancers detected early survive **vs** 60% whose tumors have spread **vs** 16% of late detection cancers

Compliance

15%-20% of eligible women have annual mammograms

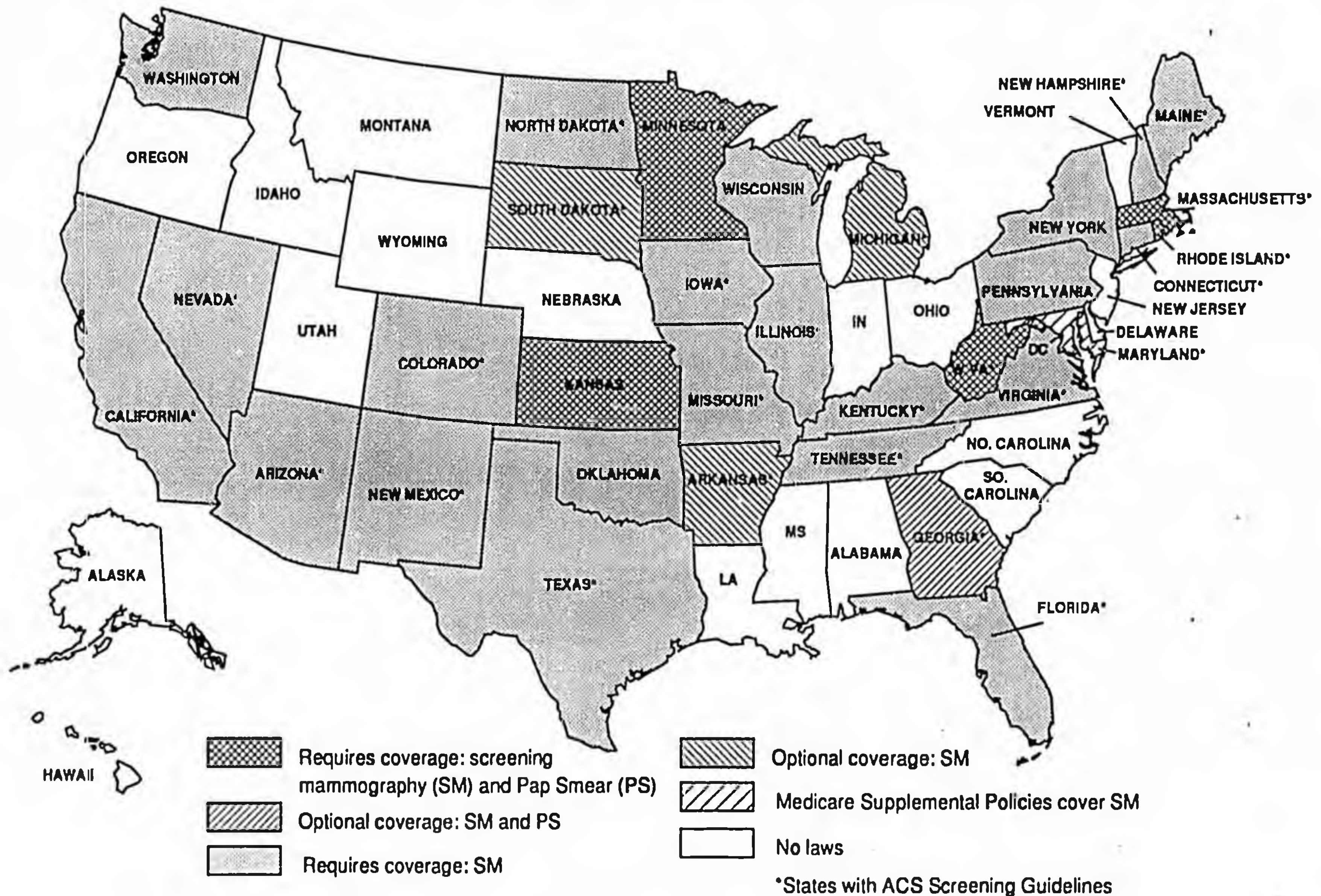
Costs

Early detection, breast cancer cured = $12,000 - $18,000
No early detection, cancer results in death = $60,000
Medical cost saving from early detection = $200 million
Additional productivity cost (individual, financial, societal)
per woman = $9,000
national total = $400 million
Total annual cost saving, national = $600 million

Barriers

Cost -- National avg = $100-$200 per mammogram
Fear of results
Fear of radiation - mammogram produces less radiation than a dental X-ray

State Insurance Laws: Cancer Early Detection Tests



POSITION PAPER/Department of Health & Social Services

POSITION PAPER

House Bill 45

"An Act relating to insurance coverage for mammograms; requiring the medical assistance program to cover mammograms; and reordering the priorities granted to services covered under the medical assistance program."

The purpose of this bill is to expand coverage for mammography screening under individual or group disability insurance, and under optional services related to state participation in the 50% federally funded Medicaid program.

This legislation would affect both health insurance coverage provided by private carriers and public funding of medical services provided, in Alaska, through the Division of Medical Assistance in the Department of Health and Social Services.

Health and disability insurance coverage provided by the health insurance industry, which would be affected by Sections 1 and 2 of the proposed legislation, is not within the responsibility of DH&SS, so the department does not take a position in regard to this kind of coverage under those programs, except to note the recognized value of mammography screening under today's medical standards.

Medical services available to eligible recipients of Medicaid, as administered in DH&SS by the Division of Medical Assistance, would be addressed by Sections 3 and 4 of the proposed legislation, and would allow the Department to provide mammography screening as an optional medical service to recipients of Medicaid.

The Department endorses periodic mammography screening as a cost-effective preventive health measure, and believes that payment for this service could be added at the low cost of $10,000 for FY 92 because we expect little increase in the number of referrals from physicians. Currently, Medicaid does pay for diagnostic mammograms when ordered by a physician.

In the interest of maintaining consistency in the Medicaid statutes, we offer the following comments and recommendations.

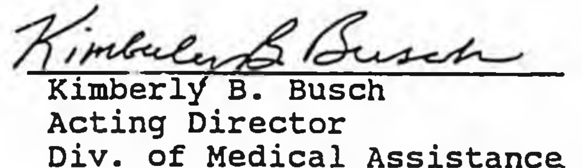
As a specific medical service, mammography is just one of several thousand CPT-4 codes used universally to bill for medical services, and CPT-4 codes are usually dealt with in regulation rather than singling specific codes out for special treatment in statutory form. The rest of AS 47.07.030 deals with broad categories of services rather than specific CPT-4 codes. Therefore, it would be inconsistent with existing statute to single out this particular CPT-4 code as HB 45 would do in its current form.

The Department would recommend the following alternative to the present Sections 3 and 4 of the proposed legislation.

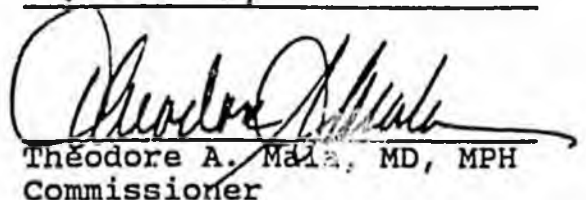
In AS 47.07.030(b) we propose changing "low-dose mammography screening" to "adult screening", making an identical change in AS 47.07.035, and defining the proposed term in the existing definitions section, AS 47.07.900, using the definition as stated in the proposed legislation on page 2, lines 14-17.

There is a sensitive issue in the matter of where this new service is to be placed in the priority list of AS 47.07.035. This statute lists the optional services in the order in which they must be suspended or deleted if appropriations are inadequate. Where any service is to be placed on this list is a very subjective matter and invariably arouses strong sentiments among both medical providers and Medicaid recipients. Rather than argue the comparative importance of various medical services, the Department suggests that it may be appropriate to fall back on a principle used by some past legislatures: listing the newest service as first to be suspended. This is defensible on the grounds that the degree to which the public has come to depend on the coverage of any service is, in large measure, a function of how long that services has been covered.

It would therefore be our recommendation that the priority ranking for "adult screening" under AS 47.07.035 be revised to (1).

Recommended by: 
Kimberly B. Busch
Acting Director
Div. of Medical Assistance

Date: 1-29-91

Approved by: 
Theodore A. Mala, MD, MPH
Commissioner

Date: 29 Jan 1991

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF LABOR RELATIONS

WALTER J. HICKEL, GOVERNOR

P.O. BOX C
JUNEAU, ALASKA 99811-0220
PHONE: (907) 465-4404

February 4, 1991

FEB 05 1991

The Honorable David Finkelstein
Chairman
House Labor and Commerce Committee
Alaska State Legislature
P.O. Box V
Juneau, AK 99811-3100

Dear Mr. Chairman:

Re: House Bill 45 (Mammogram Screening)

During you committee's January 29 hearing on House Bill (HB) 45, I was asked to determine if the State could obtain costs for breast cancer related treatment and benefits paid through the current State active employee insurance plan. Through the Division of Retirement and Benefits, I have been provided the enclosed inpatient cost and utilization figures from our present carrier (Aetna), for 1990. Unfortunately, outpatient costs associated with breast cancer are an unusual event and figures are not easily retrievable; Aetna "estimates" perhaps another $1,400 per admittance and will advise us later if they find that estimate unsupportable.

The short version is that there were nine (9) admissions for our active employee groups (all branches of State government), with $60,733 submitted expenses and $57,303 paid in benefits. If we add in another $1,400 per admit for outpatient costs, the total benefits paid were $69,903 ($57,303 + $12,600 [$1,400 x 9]). Parenthetically, the State would have paid $41,580 in health insurance premiums for these employees in 1990 if each were employed for the full year ($385/mo. x 12 x 9 = $41,580).

Since this bill left your committee before I could provide the requested information, I am taking the liberty of copying the Health, Education and Social Services Committee with the same information; no doubt, the question will arise.

02-818LH

Thank you for the opportunity to present my testimony and your professional reception of it.

Sincerely,

Bruce Cummings
Director

BC/mme
15/8D2/020402-1
Enclosure
cc: The Honorable Pat Carney
The Honorable Georgianna Lincoln
Co-Chairpersons
House Health, Education and
Social Services Committee
Alaska State Legislature
P.O. Box V
Juneau, AK 99811-3100

The Honorable Fran Ulmer
Alaska State Representative
P.O. Box V
Juneau, AK 99811-3100

Millett Keller
Commissioner
Department of Administration

STATE OF ALASKA
INPATIENT COST AND UTILIZATION ASSOCIATED WITH BREAST CANCER
ACTIVE GROUP ONLY

CALENDAR YEAR 1990

NUMBER OF ADMISSIONS	9
NUMBER OF BED DAYS	24
TOTAL SUBMITTED EXPENSES	$60,735
TOTAL COVERED EXPENSES	$59,941
TOTAL BENEFITS PAYABLE*	$57,303
AVG. BENEFIT PER ADMIT	$6,367
AV.G BENEFIT PER DAY	$2,388

* Benefits Payable is defined as the regular benefits payable after plan provisions, i.e. deductible and coinsurance, but before coordination of benefits.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

January 24, 1991

Representative David Finkelstein, Chair
Labor & Commerce Committee
House of Representatives
P. O. Box V
Juneau, AK 99811

Support: HB 45

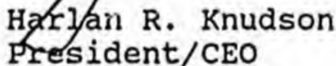
Dear Representative Finkelstein:

The Alaska Hospital & Nursing Home Association would like to lend its support to the passage of HB 45, mandating insurance coverage for mammograms.

Unfortunately I will be out of Juneau on January 29 and will not be able to testify at your Committee hearing on that date.

The bill speaks for itself. It is regretful the Legislature should have to tell either buyers or sellers of health insurance that this type of "preventive" medicine is just good common sense and should be part of an individuals insurance program.

Sincerely,



Harlan R. Knudson
President/CEO

HRK/ma
cc: Members, House Labor & Commerce Committee
Representative Parnell
Representative Ivan
Representative Donley
Representative Bruckman
Representative Taylor
Representative Zawacki
Representative Ulmer

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

WELLSPRING

A WELL-HEALTH CENTER

Mary Lou Follett, RNC, ANP
Advanced Nurse Practitioner & Counselor

Constance Trollan, RNC, ANP
Advanced Nurse Practitioner & Counselor

January 26,1991

Representative Fran Ulmer
Alaska House of Representatives
P. O. Box V
Juneau, Alaska 98211-3100

Dear Representative Ulmer:

Thank you for introducing legislation which will require health insurance carriers in Alaska to provide coverage for mammography screening.

The American Cancer Society states that annually 175,000 new cases and 44,500 deaths will result from breast cancer. This translates into one in nine women in America affected by this disease.

To detect breast cancer in its early, more curable stages, the American Cancer Society recommends breast self-exams every month for women ages 20 and older, a breast exam by a health professional every three years for women ages 20-40, and over 40 years, a clinical exam every year. In addition the American Cancer Society recommends a baseline mammogram for women 35-39 years, a biannual mammogram from 40-49, and an annual mammogram from ages 50 and over.

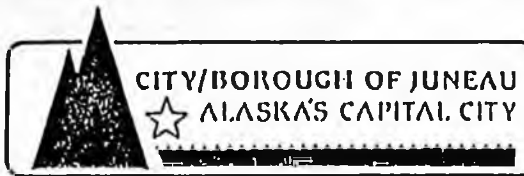
I believe that insurance carriers in Alaska should be required to pay for breast examinations including mammography as delineated by the American Cancer Society. As mammography and radiologist fees are expensive in Alaska, and as these should not be barriers to women seeking adequate women's health care, I suggest that a minimum payment of $100.00 per woman for mammography be specified in legislation. This will enhance compliance with American Cancer Society guidelines and enable early detection of breast cancer in Alaskan women.

I wholeheartedly support your legislative attempts to require Alaskan insurance carriers to provide coverage.

Sincerely,

Constance Trollan
Women's Health Care ANP

2215 N. Jordan Ave. • Juneau, Alaska 99801 • (907) 789-1812 • FAX (907) 789-7168



LOOKING TO THE FUTURE

1991 ALASKA CONFERENCE ON AGING

JUNEAU COMMISSION ON AGING

COMMUNITY FORUM -- SENIOR CONCERNS

Assembly Chambers
Juneau, Alaska
January 26, 1991

RESOLUTION IN SUPPORT OF HB 45

RELATING TO MAMMOGRAPHY SCREENING

WHEREAS, breast cancer is the leading cause of premature death in American women; and

WHEREAS, 75% of breast cancers occur in women over age 50, and 40% of breast cancers occur in women over age 65; and

WHEREAS, mammography screening is the most effective means of detecting breast cancer in its curable stage; and

WHEREAS, in over 90% of the breast cancers detected in early stages the patient survives; and

WHEREAS, only 15% - 20% of women who should have a regular mammogram receive one; and

THEREFORE, BE IT RESOLVED, that it is in the interest of senior women to have insurance coverage for mammography screening; and

BE IT FURTHER RESOLVED, that HB 45, relating to insurance coverage for mammography screening, sponsored by Rep. Fran Ulmer, receives the support and endorsement of this organization.

SIGNED [signature]

DATE 1-26-91

NFIB Alaska

National Federation of
Independent Business

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
(NFIB/ALASKA)

TO THE

HOUSE LABOR and COMMERCE COMMITTEE

ON

HB 45

AN ACT RELATING TO INSURANCE COVERAGE FOR MAMMOGRAMS; REQUIRING THE MEDICAL ASSISTANCE PROGRAM TO COVER MAMMOGRAMS; AND REORDERING THE PRIORITIES GRANTED TO SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.

State Office
9159 Skywood Lane
Juneau, AK 99801
(907) 789-4278

The Guardian of
Small Business

Mr. Chairman, members of the Labor and Commerce Committee, my name is Resa Jerrel, and I represent the National Federation of Independent Business/Alaska - NFIB/Alaska. Before giving my testimony on HB 45, it might be appropriate to briefly describe NFIB/Alaska and its legislative program.

NFIB/Alaska is comprised of 5292 small and independent business owners. Our members have 15 or fewer employees and have annual gross receipts of $1 million or less.

The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our membership on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues. We then share the results of our poll with the Legislature and Administration. There is not enough space on the annual poll to place every possible issue to our membership. Therefore, we also use the three previous years ballots as guidance on issues.

The board issue of mandated benefits is of great concern to our membership. On the 1990 ballot, we polled our members regarding their views on mandated mental/nervous disorders. The ballot results clearly show that small business owners overwhelmingly - 93% - oppose the government imposing such mandates on them. Any employee benefit package should be worked out between the employer and employee.

In recent years there has been an explosion of states passing laws requiring health insurance policies to cover specific diseases and specific health care services. Mandated health insurance benefits cover services ranging from acupuncture to naturopaths.

Mandated benefits cover everything from life saving techniques to purely cosmetic devices, such as hairpieces in Minnesota. Collective, these mandates have added considerably to the cost of health insurance and they prevent people from buying no-frills insurance at a reasonable price.

We understand the purpose of this legislation is to act as an incentive for people to utilize this screening service. It is doubtful that will occur, because in Juneau a mammogram cost $150 -$171. Most health insurance policies have a $250, $500 or $1,000 deductibles. A person is still going to have an out of pocket expense of $150 -$171 even if their policy covers the x-ray service or they do not even have health insurance.

Our members believe in the freedom of choice in health insurance. This means being able to buy a health insurance policy tailored to individual, family and employee needs. With this in mind, we would offer an alternative to mandating this coverage: have the insurance companies offer this coverage as an option. With the ability to pick and choose a person can purchase it or choose not to purchase it.

We believe the issue is not whether this benefit and other similar benefits should be extended to employees; rather we believe it is instead, should this benefit be mandated by the Legislature.

Mr. Chairman, Members of the Committee, thank you for the opportunity to present our views on this issue.

Arch Times 1-25-91

Breast cancer risk up

ASSOCIATED PRESS

NEW YORK — The average American woman runs a one-in-nine risk of developing breast cancer during her lifetime, an increase over the previous estimate, the American Cancer Society said Thursday.

The increase reflects rising breast cancer rates and the fact that women are living longer, the society said.

About 175,000 American women will get breast cancer this year, and 44,500 women will die from the disease, the society said in releasing its annual projections.

"Every American woman should consider herself at risk," Dr. Clark Heath, the society's vice president for epidemiology and statistics, said in a statement.

The society had projected a 1-in-10 risk since 1987, based on data from the early 1980s. The new estimate is based on federal figures for 1987, the latest available, said cancer society statistician Catherine Boring.

Edward Sondik, the National Cancer Institute's deputy director of the division of cancer prevention and control, noted that the change means going from a risk of 10 percent to one of 11 percent.

Medicine

COVER STORIES

A Puzzling Plague

What is it about the American way of life that causes breast cancer?

By CLAUDIA WALLIS

In the bad old days, some 20 years ago, no one had the heart even to talk about it. Breast cancer struck the most evident of a woman's assets, where the motherly and the erotic are joined. And treatment of the disease was a nightmare of pain, disfigurement and uncertainty too terrifying to contemplate. A seemingly healthy woman with nothing more than a tiny lump in her breast (and a larger one forming in her throat) could agree to have a biopsy performed and not know whether she would awake from surgery with a small bandage on her breast—or no breast at all.

Much has changed since then. For one thing, breast cancer is widely discussed. Celebrity after celebrity—a veritable Breast Cancer Hall of Fame—has stepped forward to demystify the disease and soften its stigma, beginning with Shirley Temple Black, Ingrid Bergman and Betty Ford, and more recently including Nancy Reagan and Gloria Steinem. Lessons on cancer detection and the importance of mammo-

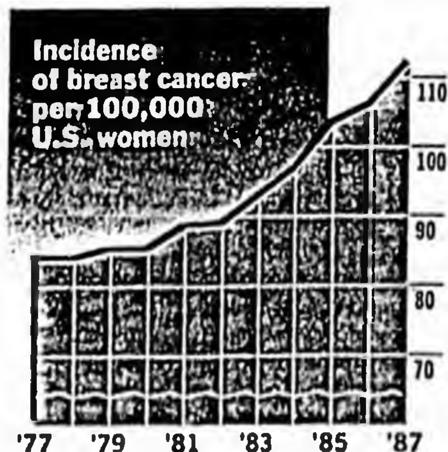
One out of every ten American women will get breast cancer. Of those who do, one out of four will die of it.

grams are the subject of elaborate public information campaigns.

More important, the surgical and postsurgical options have multiplied. Chastened by better educated and more demanding patients, doctors now wait after a positive biopsy to discuss these options before moving in to amputate. Just last year a consensus meeting convened by the National Institutes of Health formally recommended lumpectomy, the removal of a cancerous lump plus a small amount of surrounding tissue, followed by radiation therapy, as an equally effective alternative to breast removal in many cases. And the success rate for treatment is up—not dramatically, but up. Nowadays, 76.6% of breast-cancer patients survive five years after surgery, and 63% are alive 10 or more years later. In 1970 the five-year survival rate was 68%.

But there is also bad news about breast cancer. The number of cases continues to soar. According to the National Cancer Institute (NCI), the U.S. incidence increased 32% between 1982 and 1987. Only lung cancer is rising faster. Cancer is the leading cause of death for women 35 to 50, and breast cancer is the most common malignancy in this age group. All in all, an American woman has a 1-in-10 chance of developing breast cancer over the course of her lifetime, and that risk keeps on rising.

The big question is why. Most experts on the disease agree that part of the increase can be attributed to earlier detection of tumors. Some 65% of American women over 40 have had a mammogram, up from about 20% in 1979. The widespread use of this tool, a low-dose X ray of the breasts, has meant that more women are discovering their tumors in the early stages, before a lump can be felt. In past decades, prior to the spread of mammography, such women might have died of other causes before their breast cancer was diagnosed.



TIME Chart Source: National Cancer Institute Annual figures are for all ages

Nonetheless, most investigators of the epidemic believe early detection is only part of the story. They look at the fact that breast cancer is far less common in other parts of the world and conclude, ominously, that the answer lies in some facet of the American life-style. "Something in our environment is contributing," contends Dr. Marc Lippman of Georgetown University.

Study after study has explored the possibilities. Could it be the birth control pill? Probably not, since dozens of investigations into that question have produced a quag-

The ouch factor: a good mammogram is uncomfortable

Two out of three older women fail to get checked regularly.

A color-enhanced mammogram shows a white spot of cancer

The technique reveals pinpoint tumors undetectable by touch.

mire of contradictions. How about smoking? Again, there is no clear connection. Alcohol? Drinking seems to raise the risk of the disease slightly, but the association is too weak to account for America's prodigious rate. What about the widespread use of estrogen therapy following menopause? Studies show only a mildly elevated risk. And while food additives and even lack of sunlight have come under suspicion, there is little evidence to convict them.

THE FAT FACTOR

Instead, many researchers around the world are pointing to another component of the Western way of life: a diet rich in fat. Researchers have known for more than 40 years that high-fat diets promote the growth of mammary tumors in laboratory animals. They have also observed that the varying rates of breast cancer in various countries correlate neatly with the amount of fat in a nation's diet. The U.S., Britain and the Netherlands, which have some of the world's richest diets, also have among the highest breast-cancer rates. Meanwhile, in countries such as Japan, Singapore and Romania, where the diet is very lean, the incidence of breast cancer is one-sixth to one-half the U.S. rate.

On the theory that genetic factors might be responsible for such national variations, researchers have looked at immigrant groups. They have found that when Japanese move to the U.S., or Italians to Australia, their previously low breast-cancer mortality rate rises to match the higher rate of their adopted country within a generation or two, as diet and lifestyle change. "The results are too consistent to believe that the association is indirect," says Maureen Henderson, an epidemiologist at the Fred Hutchinson Cancer Research Center in Seattle. When it comes to the breast cancer–fat connection, she says flatly, "I'm sure of it."

Japanese researchers are also convinced. Breast cancer is one of the fastest-growing diseases among Japanese women, with the incidence up 58% between 1975 and 1985. "The largest factor behind the sharp rise is the Westernization of eating habits," says Dr. Akira Eboshida, chief deputy director of the Health and Welfare Ministry's Disease Control Division. "We are eating more animal fat and less fiber." Cancer of the breast is not the only ailment rising with the larding of the Japanese diet. Heart disease is also surging, as is cancer of the colon, ovaries and prostate. All have been linked to a high-fat diet. On the other hand, stomach cancer, historically the most common cancer in Japan, is falling as the nation moves away from its traditional diet of salty, pickled and smoked foods. "If the current trend continues," predicts Eboshida, "breast cancer will replace stomach cancer as the No. 1 killer of Japanese women in the next century."

Despite such evidence, not everyone shares the conviction that fat is the villain. Critics of this theory point out that statistical correlations are not the same as proving cause and effect. Many researchers argue that there are probably several lifestyle factors rather than a single culprit. "The high rates are not due to one bad habit, but to our whole way of life," says Mary-Claire King, a cancer geneticist at the University of California, Berkeley.

According to Dr. Walter Willett at the Harvard School of Public Health, overall calories may play a larger role than fat: Americans may simply be eating too well. Willett points out that breast-cancer rates tend to be highest in prosperous countries where people are well nourished. In such lands of plenty, girls begin to menstruate at an earlier age, women tend to have their children later in life and menopause also comes later. Late menopause (after 50), delayed childbearing (after 30) and early onset of menstruation (before 12) are all acknowledged "risk factors" for breast cancer. For older women, obesity also increases the risk of the disease. King notes that better education and job opportunities for women have furthered the trend toward postponed motherhood and childlessness (also a risk factor). "All the things that cause women to be healthy, well-educated and have careers put them at risk for breast cancer."

Critics of the fat theory also point to

several studies that seem to refute it, including a survey by Willett of 90,000 nurses from 34 to 59. Though the diets ranged from 32% fat content to about 44% (the U.S. average is 42%), the Harvard researcher could find no correlation between fat intake and the incidence of breast tumors. One problem with Willett's study: many researchers believe that dietary fat must be more radically reduced, to about 20% of total calories, to affect the occurrence of breast cancer.

The proof, of course, is in the pudding, or in this case, not eating any. Unfortunately, researchers seeking conclusive evidence of the effects of a very low-fat diet have had little success in obtaining funds. One concern is cost. Another is that women participating in such trials would have trouble adhering to the drastic regimen, which would mean very limited amounts of meat, dairy products and oils of any kind.

To show that it can be done, Henderson in Seattle completed a three-year pilot study, funded by the National Institutes of Health, of 2,000 postmenopausal women who were painstakingly taught how to follow a 20% fat diet. "We give them a Ph.D. in fat," she explains. Her hope was that the pilot would lead to NIH funding of a 10-year effort with 24,000 women. No such luck. A competing proposal for a similar study that would cost $107 million was on the verge of being financed when an NCI advisory panel decided last month to put it on hold—a crushing disappointment for many researchers.

THE ESTROGEN CONNECTION

If fat does figure in the development of breast cancer, just what role does it play? No one in the research community believes that too many thick shakes and fries can in themselves cause normal, well-behaved cells to mutate into unruly malignant ones. In fact, no one has the faintest notion what causes the initial genetic changes to occur. "In lung cancer we have a reasonable idea that the major cause is cigarette smoking," says Dr. Philip Leder, chairman of Harvard's department of genetics. "In skin cancer we understand that the major cause is ultraviolet light, which is absorbed by DNA and causes it to break. But with breast cancer we don't have any idea what the precipitating factors are."

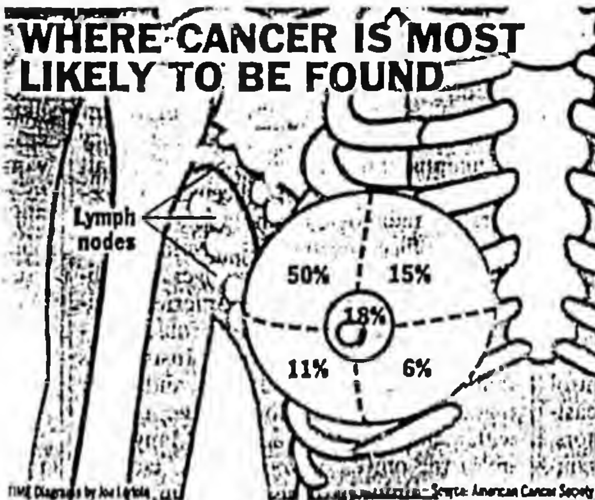
Doctors have long been convinced that some people are genetically predisposed to develop breast cancer. A woman whose mother or sister had the disease before menopause has five to six times the usual risk of developing it. If either one had the disease in both breasts, then the woman's risk is five to 10 times the norm.

Though scientists do not know how breast cancer begins, they do have some ideas about how it progresses. The female hormone estrogen, which is produced in the ovaries and causes a young girl's breasts to develop, also plays an unmistakable role in promoting the growth of tumor cells. Why do childlessness, late menopause, early onset of menstruation and delayed childbearing all increase the risk of breast cancer? One likely explanation is that all involve a prolonged, uninterrupted presence of high levels of estrogen in the bloodstream. Doctors have also noticed that women whose ovaries were removed before age 40 rarely get breast cancer.

Researchers focusing on the role of fat in the development of cancer have been particularly intrigued by the estrogen connection. Biologists have long known that estrogen is produced not only in the ovaries but also in fat cells. Obese women have higher levels of estrogen than thin ones—a probable factor in their greater risk of breast cancer after menopause.

But it has been only in the past five years that researchers have found a link between estrogen levels and fat in the diet. Women who eat lots of hamburgers, thick shakes and other fatty foods have higher overall levels of estrogen and especially large amounts of the "biologically active" form. Equally significant, endocrinologist David Rose of the Naylor Dana Institute in Valhalla, N.Y., has found that when women switch to a very low-fat diet (20% of total calories), their estrogen levels quickly drop by 20%. Advocates of the dietary-fat theory regard this observation as a crucial bit of supporting evidence. Given estrogen's established role in promoting breast cancer, the fact that fatty foods directly affect estrogen levels means that, as Maureen Henderson puts it, "it's biologically rational that fat can influence cancer."

Obese women who carry excess weight on their upper bodies (apple shaped) are at three times the average risk of getting breast cancer, possibly because they have unusually high levels of certain estrogens. Overweight women who are pear shaped have no increased risk. Apple-shaped women are also more susceptible to heart disease and diabetes.



Considering all the fuss over fish oil and polyunsaturates in the world of heart disease, one might wonder if the type of fat consumed makes any difference. "The data are very confusing on this," admits Rose. Some researchers believe that certain fats are more villainous than others with respect to cancer, but Henderson and others say all fat should be reduced. Drastically.

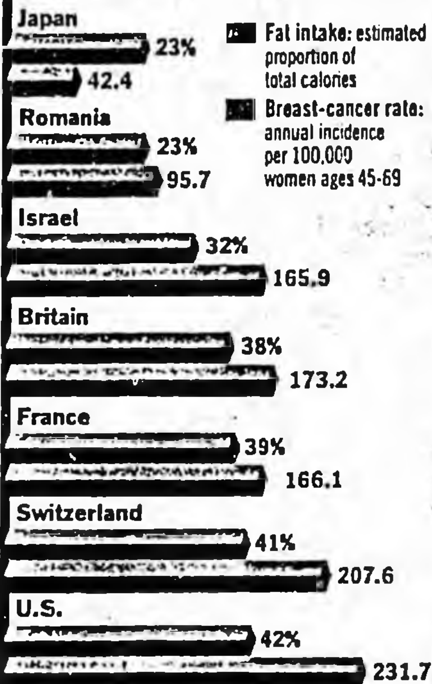
THE MAMMOGRAM MUDDLE

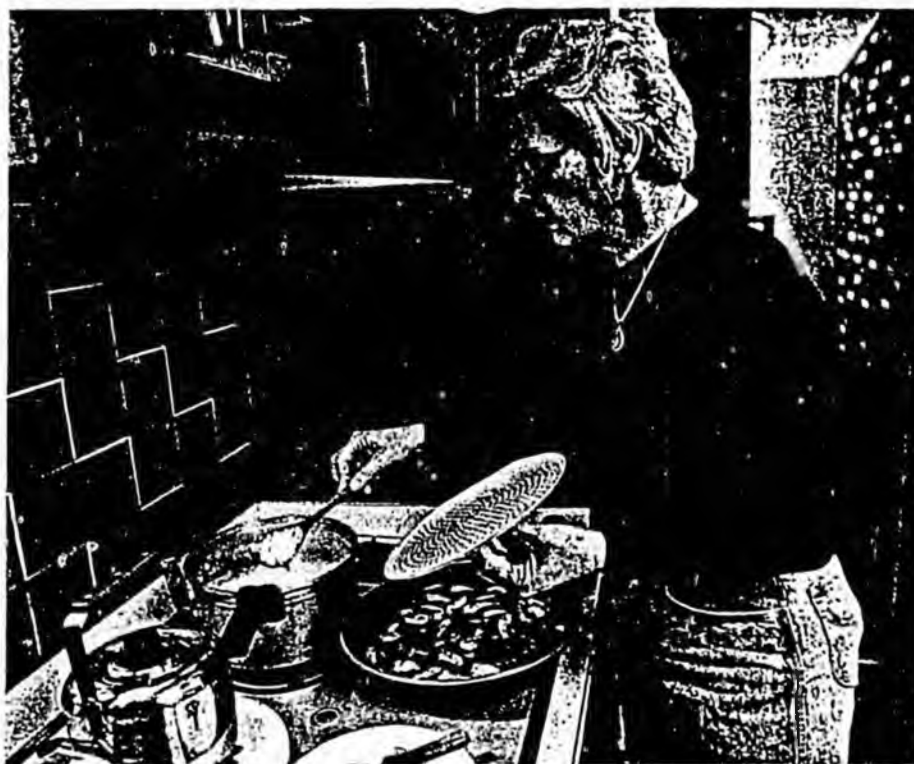
Until the government decides to fund a long-term dietary study and until the work is completed, the value of an ultralow-fat diet in preventing breast cancer will remain open to question. For women 40 or older, however, there is one bit of medical counsel that has almost unanimous approval: Get a mammogram. Now. And do it regularly.

Consider these facts. By the time a breast tumor is large enough to be felt as a lump, it is generally more than 1 cm (0.4 in.) in diameter and contains several billion cancer cells, some of which may have broken loose, circulated through the bloodstream and begun to infiltrate other organs. A mammogram can detect pinpoint tumors that are less than 0.5 cm (0.2 in.) across, often well before the process of metastasis has started. This is not to say that a manual exam by a doctor or the woman herself is a waste of time. Such exams can sometimes turn up tumors missed by X rays. But the early-detection capability of mammography clearly saves lives. A 1987 study found that for women whose tumors were discovered early by mammograms, the five-year survival rate was about 82%, as opposed to 60% for a control group.

And if that is not incentive enough, early detection through mammography can sometimes bring another bonus: surgery that spares the breast. A small, early tumor can often be removed with a lumpectomy procedure rather than a mastectomy.

Why, then, aren't American women running en masse to the mammographer's





An intriguing link with eating habits: a Seattle woman, participating in a study on cancer prevention, prepares a special low-fat meal

office? Why do less than a third of women over 40 have mammograms every one to two years, as experts recommend? One reason may be lingering fears about radiation exposure. Nowadays, however, mammography doses are about one-tenth of what they were 20 years ago—less than one receives from cosmic rays on an airplane flight. A more significant factor, says Dr. Sarah Fox, a UCLA professor of family medicine, is "that physicians aren't making the recommendations." Doctors often feel that mammograms are unnecessary for women who are not in a high-risk category. "Sometimes they'll say, 'You've had a couple of children and you've got no family history, so relax,'" explains Dr. Robert Smith of the Centers for Disease Control in Atlanta. Yet three out of four breast-cancer victims have no known risk factors, says Smith. No woman over 40 should consider herself safe. And certainly her doctor should know better.

The cost of mammograms may also discourage women. Insurance frequently fails to cover the $50 to $200 procedure. Medicare just began paying for it this year. Public hospitals do not always offer such screening, and some state Medicaid programs have refused to provide reimbursements, which helps explain why breast cancer is often diagnosed too late among the poor. For black women in particular, the five-year survival rate is only 64%, in contrast to 77% for white women.

Adding to the confusion on mammography is the unfortunate fact that medicine's powerful professional societies cannot agree on what to recommend. The American Cancer Society urges a mammogram every one or two years for women between ages 40 and 49, and annually thereafter. The American College of Physicians disagrees, claiming that a mammogram is not "cost-effective" for women under 50, since only 20% of malignancies occur in these women.

As if matters were not muddled enough, a storm has erupted in recent years over the uneven quality and accuracy of mammograms around the U.S. "Half the states do not have a licensing procedure for radiologic technologists. It could be the office receptionist pushing those buttons," warns Marie Zinninger, a quality-control specialist for the American College of Radiology. Another problem, according to the National Cancer Institute, is that General Electric, Philips and other manufacturers have flooded the market with mammography machines. Many wind up in the offices of doctors who lack the proper training in the use and maintenance of these machines. The College of Radiology has responded with a drive, launched in 1989, to examine and certify mammography facilities. It advises patients to choose a high-volume accredited facility. Another sign that a mammogram is up to snuff: the ouch factor. To get a good picture, the mammography machine must compress the breast. "If you're not uncomfortable," says UCLA's Fox, "you're probably getting a bad mammogram."

A POLITICAL SOLUTION?

In recent years a ground swell of breast-cancer victims, feminists and legislators, inspired by the success of the AIDS lobby in bringing attention and funds to that epidemic, have been pushing for better regulation of mammography standards, for mandatory insurance coverage of mammograms, and generally for more research into the still mysterious roots of breast cancer. They point out that the U.S. government spends only $77 million a year investigating ways to prevent the illness, against $648 billion on heart-disease prevention. Last week Congresswoman Mary Rose Oakar of Ohio sought to redress the shortfall by introducing a bill that would add $25 million to the NIH budget expressly for basic research on breast cancer. Meanwhile the National Women's Health Network, a lobbying group in Washington, continues to press for federal funding of studies on the effects of diet.

But given the demands on the limited federal research budget, such efforts will probably fail. Perhaps as unfortunate, notes Dr. Geoffrey Howe, a leading researcher on cancer and diet at the University of Toronto, is the fact that "political pressure is the criterion for deciding what scientific research needs to be done."

For patients, the lack of answers and of resources to find them amounts to an all too literal deadlock. "I am scheduled to die because I have metastatic breast cancer," says Elenore Pred, founder of the Breast Cancer Action group in San Francisco. "I'm part of the 44,000 women for whom there is no cure. But I refuse to be written off." Pred is devoting her days to lobbying for more research and better public education on the disease. As the mother of two daughters, she could leave them no healthier legacy. *—Reported by J. Madeleine Nash/Chicago and James Willwerth/Los Angeles*

The Rough Road to Recovery

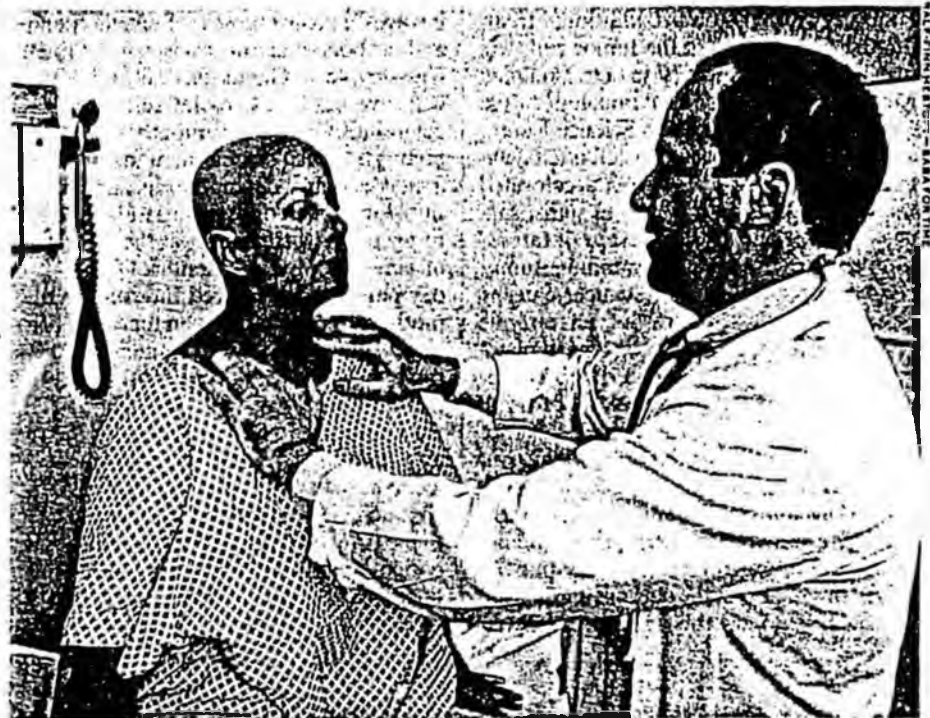
Options for therapy have multiplied, but making the right choices can be daunting for both doctors and patients

By CLAUDIA WALLIS

Colleen Fallscheer, a cheerful 40-year-old mother of two from Waterford, Mich., is living proof that breast-cancer therapy is not the horror show it used to be. A little over a year ago, a mammogram revealed a bright malignant spot, no more than 1.5 cm (about 0.6 in.) across, imbedded in the translucent tissue of her left breast. A surgeon recommended a mastectomy, to be followed by chemotherapy. Fallscheer was appalled. She sought a second opinion from David August, a surgical oncologist at the University of Michigan Medical Center, who told her that her tiny malignancy made her an ideal candidate for a lumpectomy, a less drastic procedure.

Last November, in a two-hour operation, Dr. August's team removed the cancer plus a margin of surrounding tissue, leaving Fallscheer with a 5-cm (about 2-in.) scar in an otherwise normal-looking breast. To catch any residual cancer cells, she received six weeks of daily radiation therapy, which produced a light suntan but left no permanent trace. "A lumpectomy plus radiation does not cure more women than mastectomy," says radiation oncologist Allen Lichter of the University of Michigan, "but it creates fewer physical and emotional scars." Fallscheer concurs: "It was only after I saw Dr. August that I felt I wasn't going to die after all."

Ten years ago, lumpectomy would not have been an option for Fallscheer. Since then, studies have shown that when a tumor is small, confined to a single area and readily accessible to the surgeon's scalpel, lump removal plus radiation is no less effective than removing the entire breast. But as Fallscheer's experience shows, not every surgeon is convinced. Nor does every eligible patient choose the lesser operation. Though about 50% of breast-cancer patients are candidates for lumpectomy, only about half of those elect it. Many, including Nancy Reagan, feel safer if the entire breast is removed. "For most women, whether or not they lose their pectorals is not the issue," explains University of Chicago surgeon Monica Morrow. "It's whether or not they lose their lives."



The "caterpillar stage": Crossley, who received high-dose chemotherapy, gets a checkup

Choice of surgery is only the first of many decisions faced by patients and doctors. None are simple, and women sometimes get the impression that there are as many variations in therapy as there are doctors. The key question following surgery, however, is whether the cancer has spread. It is not localized disease in the breast that kills more than 40,000 U.S. women a year, but the dissemination of the cancer to other, more vital organs, usually the brain, the bones, the liver or lungs.

To determine if the deadly process of metastasis has begun, surgeons performing mastectomies and lumpectomies routinely remove 10 to 25 lymph nodes from under the arm near the affected breast and examine these glandular structures for signs of cancer. A woman with "positive" nodes has a 37% to 75% chance of a cancer relapse within five years, depending on the number of affected nodes and the size of the original tumor. In such cases, chemotherapy or hormone therapy will be urged.

The kind of drug treatment depends on many things, including a woman's age and the biology of her tumors. The cancer cells of postmenopausal patients often require the hormone estrogen in order to grow. If lab tests show the presence of estrogen receptors in a tumor (a sign of a good prognosis), therapy with tamoxifen, an estrogen-blocking drug, is usually recommended. It reduces the risk of disease recurrence by approximately 20%, with relatively mild side effects.

Younger women and those who have no estrogen receptors usually receive combinations of two to five chemotherapy agents, such as Cytoxan and methotrexate, over a period of four months to a year. Because these drugs target rapidly dividing cells, they not only destroy cancer cells but also cells in the hair follicles, the lining of the digestive tract and the bone marrow. That produces the dreaded side effects of chemo: hair loss, nausea and a decline in infection-fighting white blood cells. Premature menopause can be another consequence. Even this harsh treatment provides no guarantee of a cure, though in certain groups of patients, it can increase survival rates as much as 40%.

Today, thanks to the widespread use of mammograms, breast tumors are being discovered earlier, before the cancer has spread. Now 60% of patients are "node negative," up from 50% 10 years ago. Increasingly, cancers are being found at a very early, localized stage, known as "in situ carcinoma" (cancer in place).

While early detection vastly improves the chances of a cure, it also raises questions for doctors. No one is certain how much treatment is right for in situ carcinoma. Nor is it easy to determine therapy for patients whose cancer has begun to spread but has not yet affected the lymph nodes. Experience has shown that up to 30% of these node-negative women will develop a recurrence. The question: Which 30%?

Frequently, doctors use a variety of factors to determine which patients are at highest risk. One major consideration: tumor size. "One centimeter [0.4 in.] is considered the major turning point," says Dr.

Larry Norton at Memorial Sloan-Kettering in New York City. "Over 1 cm, and I lean very strongly toward additional treatment." A close look at the tumor cells will provide other clues, says Dr. William McGuire, chief of medical oncology at the University of Texas Health Science Center at San Antonio. Misshapen cell nuclei, abnormal amounts of DNA or an accelerated rate of cell division are all bad signs, suggesting a need for chemotherapy or tamoxifen. Newer tests include examining tumor cells for extra copies of cancer-causing genes or excess amounts of an enzyme called Capthepsin D, which seems to play a role in metastasis. Says McGuire: "Today we know that if you have a low score on all these markers, your chance of recurrence is less than 10%. If you score high, your chance is greater than 50%."

To have the cancer return even after the trauma of surgery and the misery of chemotherapy is the nightmare of every patient. When this happens, the outlook is grim. But in recent years doctors have been experimenting with a controversial treatment for advanced and recurring breast cancer that involves massive doses of chemotherapy and a bone-marrow transplant. Annette Crossley, 45, of Glendora, Calif., is hoping it will save her life. Crossley suffered a cancer relapse just a few months after completing a course of treatment that included a mastectomy, chemotherapy and radiation. Given slim odds of survival, she chose to try the new treatment at the University of Chicago Medical Center. Over a five-day period, she received intravenous chemotherapy in four to seven times the usual doses. Because such treatment destroys the bone marrow, healthy marrow was extracted from Crossley's pelvic bone before she began the toxic therapy. After the sessions and some rest, the marrow was re-injected into her body.

Such high-dose therapy is perilous. Until the transplanted marrow replenishes the patient's supply of white blood cells, she is highly vulnerable to infection. Jacob Bitran, Crossley's oncologist, believes that the procedure is worth the risk. He and his associates have treated 67 advanced breast-cancer patients in this manner over the past four years. Though 11 have died of complications, mostly infections, 16 are in complete remission, seemingly disease free. "That means 1 in every 4 is a long-term survivor," he says. Others are not persuaded. "I am not convinced that we have the benefits to justify the toxicity," says Harvard oncologist I. Craig Henderson, noting that, regardless of treatment, 10% of women with advanced, metastatic disease will be alive after 10 years. Such doubts have led many insurance companies to refuse to pay for the procedure, which typically costs about $120,000.

For Annette Crossley, cost is not the main concern. Slowly regaining strength, with little hair left on her head, she remains a picture of hope. "This is the caterpillar stage," she says, grinning gamely, "the ugly stage before the butterfly comes out." *—Reported by J. Madeleine Nash/Ann Arbor*

Restoring Lost Curves and Confidence

Last November, at the age of 43, Carol Beebe lost her left breast to cancer. But when she awoke from mastectomy surgery at New York City's Columbia-Presbyterian Medical Center and gazed down at her chest, nothing appeared to be missing. Beebe, an IBM employee from Point Pleasant, N.J., had chosen to have a reconstruction of her breast immediately following the mastectomy. In a single operation, plastic surgeons shaped a new breast from Beebe's own abdominal tissue, moving it into place minutes after the general surgeons had removed the diseased breast. The technique spares the patient the anguish of amputation. "Our basic philosophy is that you don't leave the hospital without a breast," explains Plastic and Reconstructive Surgery chairman Norman Hugo, who performed the operation.

Breast, left, rebuilt with abdominal tissue

Rebuilding the breast after mastectomy has become increasingly popular in recent years: more than 34,000 U.S. women chose some form of reconstruction in 1988, up 71% from 1981, according to the American Society of Plastic and Reconstructive Surgeons. Younger patients are particularly drawn to the procedure, though Hugo has reconstructed breasts for women of all ages and types, including a nun.

The majority of reconstructions are done with implants, small bags that are inserted under the muscle of the chest wall and filled with either silicone gel or saline solution. The inflation must be done gradually over a period of weeks to allow time for the muscle and skin to stretch, a process that can cause discomfort and sometimes lead to infections.

Linda Lehman, 43, a mother of two from Newville, Pa., received two silicone implants last February, three months after undergoing double mastectomies. That summer she went out and bought a new two-piece swimsuit. "Losing your breasts is a terrible experience," she says. "You mourn the loss. You have the same phantom feelings as when you lose a limb." The implants, she says, have restored her spirit along with her figure. "I wear more revealing clothing than before, and I've never looked better."

Silicone implants are not without drawbacks. Because they sit high on the chest and are compactly curved, the implants most closely reproduce the look of a young woman's breast and can be a poor match for an older patient. They can also make the breast feel hard, interfere with mammography and, on occasion, rupture, causing inflammation if silicone has been used. This spring, as a result of pressure from patient-advocacy groups and members of Congress, the FDA will require implant manufacturers to provide proof of the safety of their products. Still, many surgeons say the risks have been exaggerated.

Reconstruction using a flap of abdominal tissue, as Beebe had, avoids most of the implant problems but is a far more complex operation, lasting upwards of six hours and requiring a longer recovery period. The plastic surgeon must carve a large, almond-shape swath from the belly, about 16 cm by 30 cm (6 in. by 12 in.), carefully lifting up the skin, fat and an underlying muscle, without severing the artery that supplies the tissue. The flap is then fashioned into a new breast. A new nipple can be created later by twisting the tissue and tattooing on an areola. For Beebe, there was abdominal pain at first and cramping of the relocated muscle that continued for several weeks following her surgery. But she has no doubt that she made the right choice. "It feels natural and moves naturally," she says. "I don't even feel like I've lost a breast. It's just a little different now." ■

Tantalizing Clues to a Lethal Legacy

Research into the genetic factors is raising hopes of better screening and treatment

By J. MADELEINE NASH CHICAGO

To most women, the notion of undergoing a mastectomy in order to *prevent* breast cancer smacks of wild paranoia. But for Maria Burkhardt of Covington, La., the unthinkable slowly became the inevitable. Twenty years ago, an aunt was stricken with the disease. Her mother died from it a decade later. In 1986 Maria's younger sister Jo Ann began fighting for her life. Next her older sister Rose developed an aggressive tumor. Maria consulted a doctor and was told she was "a ticking time bomb." Ominously, her tissues were judged too dense for mammograms to scan reliably.

So last summer, at 47, Maria decided to have both breasts removed. Her own graceful curves were replaced with silicone implants that harbored no trace of her family's lethal legacy. A short time later, Maria received a report that vindicated her decision. A postoperative examination of her breast tissue had found precancerous lesions. "I just broke down and cried," she recalls. "I'd done this knowing I might never know if I'd made the right choice."

Families like Maria Burkhardt's are rare, accounting for a tiny fraction of breast-cancer cases. But the malevolent genes they pass down through the generations are beginning to yield important clues to all breast malignancies. "Cancer," declares celebrated molecular biologist James D. Watson, "is a disease of the DNA," the master molecule that encodes the genetic blueprint for every living cell. Tumors develop as the result of rearrangements in DNA, specifically in the genes that govern cell growth.

In most cases, the changes that lead to breast cancer begin accumulating after birth, perhaps triggered by some set of environmental stresses, whether random cosmic rays or a dietary factor. Some women, however, start out with the genetic deck stacked against them. Like Burkhardt and her sisters, they stand a greater risk of developing breast cancer, in both breasts and at an earlier age, than other women.

Recent months have brought a series of discoveries about the genetic mutations involved in breast cancer. "Information is accumulating at an astounding rate," says University of Utah geneticist Mark Skolnick.

"A ticking time bomb": after her sisters Jo Ann, left, and Rose, right, were stricken with aggressive breast tumors, Maria Burkhardt opted for preventive mastectomies. "Half the people I talked to said I'd be crazy, but it's not worth waiting for cancer."

Changes in at least two types of genes play a role: those that direct cells to grow and divide; and those that issue commands to halt growth. Much of the research has focused on a growth-enhancing gene on chromosome 17, often referred to as the HER-2/*neu* oncogene. An estimated 30% of breast-cancer patients have somehow acquired abnormal quantities of this gene—as many as 50, as opposed to the normal two.

The extra copies are a bad omen. Patients that have them suffer three times the rate of cancer recurrence of other patients, says UCLA oncologist Dr. Dennis Slamon. Such patients, he says, should "absolutely" get further treatment. But one genetic abnormality is not enough to transform healthy, law-abiding breast cells into anarchic tumors. "The genes responsible for this disease are like pieces of a patchwork quilt," says geneticist Mary-Claire King of the University of California, Berkeley. The patchwork pattern may vary from one woman to the next, but each case probably involves five or six separate mutations occurring over a period of years.

Researchers at the Cancer Institute in Tokyo have implicated five genes on four different chromosomes. Dr. Yusuke Nakamura speculates that the loss of a growth-suppressing gene on chromosome 17 may be one of the earliest changes on the road to malignancy. Other groups have also pointed to sites on chromosome 17. Last November a team led by scientists at Massachusetts General Hospital Cancer Center identified one such gene as the likely cause of Li-Fraumeni syndrome, a rare genetic disorder that increases susceptibility to breast cancer and other malignancies. Since then, King and her colleagues at Berkeley have identified another segment of chromosome 17 that is associated with familial breast cancer. Other researchers, including a group in Strasbourg, France, are unraveling the genetics behind the deadly process of metastasis.

The flood of insights into the genetics of breast cancer will ultimately provide physicians with more effective weapons. This year Dr. Slamon and his colleagues hope to begin clinical trials of a genetically engineered antibody that locks onto the protein made by the HER-2/*neu* oncogene, interfering with its function. This antibody has already been shown to inhibit tumor growth in mice.

Researchers like Berkeley's King dream of diagnostic tools powerful enough to identify abnormal genes in breast cells long before they become fully cancerous. Such tools could begin to lift the burden of uncertainty from women who, like Maria Burkhardt, come from cancer-prone families and wonder if they carry the dreaded trait. Someday, if King has her way, tests for breast-cancer genes could become as commonplace as Pap smears. And then, she says optimistically, "no one need die of breast cancer anymore." *—With reporting by James Willwerth/ Los Angeles*

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Screening Mammography: Increasing the Effort toward Breast Cancer Detection

ABSTRACT

Mammography is the only modality with the potential for detecting a breast cancer while it is non-palpable and at a stage of high curability. Early detection of breast cancer is important because survival is directly related to tumor size and lymph node status, and prognosis is best for small lesions without axillary node metastasis. Many studies have indicated that screening mammography is tremendously underused. This article focuses on the effectiveness of mammography and the importance of detecting a breast cancer at an early stage. Health care providers have a responsibility to inform their clients about the benefits of mammography. In addition, women need to be taught breast self-examination and undergo regular clinical breast examinations by a health care professional. The American Cancer Society guidelines for screening breast cancer are given.

Deborah A. Hamwi, R.N., N.P., M.S.N.

The high incidence of breast cancer among women in the United States has made early diagnosis the focus of screening efforts. It is estimated that in 1990 a total of 150,000 women will be diagnosed with breast cancer, and approximately 44,000 will die of this disease.[1] Many advances have been made in early detection and especially in screening mammography, which has been shown to be effective in detecting breast cancer at preclinical stages. However, more than 90 percent of breast cancers are first detected by women themselves.[2] The size of breast cancers detected by this method averages about 2.5 centimeters (approximately one inch), and approximately 50 percent of the women have lymph node involvement at the time of discovery.[3]

Early detection of breast cancer is important because survival is directly related to tumor size and lymph node status, and prognosis is best for small lesions without axillary node metastasis. Small, nonpalpable (preclinical) cancers found by screening mammography have a 10-year survival rate of 95 percent and can thus have a major impact.[2,3] When nodes are involved, the survival rate drops to 63 percent or less. Presently, the majority of breast cancers are detected at this stage.[3]

In February 1990 a study sponsored by the National Cancer Institute and the Jacobs Institute of Women's Health was done to determine whether expanded media coverage, national and local information efforts and screening programs had increased the use of mammography. The survey of 980 women age 40 and older showed that 64 percent had had at least one mammogram, up from 37 percent in 1987. The study also indicated that only 31 percent of the women were following mammography guidelines established by the National Cancer Institute, the American Cancer Society and 11 other medical organizations. Nearly three-fourths of the women 40 years of age or older who had had a mammogram reported that they did so because their doctors recommended it — a finding that was consistent across age, race, income and education categories. Forty-five percent of the women who had never had a mammogram reported that their physicians did not tell them to do so. These women were also more likely to be uncomfortable in asking their physicians for a mammogram if their physicians did not mention it first. It is estimated that breast cancer death rates could be decreased by 30 percent if women received mammograms at recommended intervals.[4]

The American Cancer Society (ACS) recommends a baseline mammogram for all women be-

Brief Summary:
Contraindications: Patients who have had allergic reactions to NAPROSYN, ANAPROX or ANAPROX DS or in whom aspirin or other NSAIDs induce the syndrome of asthma, rhinitis, and nasal polyps. Because anaphylactic reactions usually occur in patients with a history of such reactions, question patients for asthma, nasal polyps, urticaria, and hypotension associated with NSAIDs before starting therapy. If such symptoms occur, discontinue the drug.
Warnings: Serious GI toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAIDs. Remain alert for ulceration and bleeding even in the absence of previous GI tract symptoms. In clinical trials, symptomatic upper GI ulcers, gross bleeding or perforation occur in about 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. Inform patients of signs and/or symptoms of serious GI toxicity and what steps to take if they occur.
Studies have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious GI events and other risk factors associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well and most spontaneous reports of fatal GI events are in this population. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity.
Precautions: DO NOT GIVE NAPROSYN® (NAPROXEN) CONCOMITANTLY WITH ANAPROX® OR ANAPROX® DS (NAPROXEN SODIUM) SINCE THEY CIRCULATE IN PLASMA AS THE NAPROXEN ANION. Acute interstitial nephritis with hematuria, proteinuria, and nephrotic syndrome has been reported. Patients with impaired renal function, heart failure, liver dysfunction, patients taking diuretics, and the elderly are at greater risk of overt renal decompensation. If this occurs, discontinue the drug. Use with caution and monitor serum creatinine and/or creatinine clearance in patients with significantly impaired renal function. Use caution in patients with baseline creatinine clearance less than 20 ml/minute. Use the lowest effective dose in the elderly or in patients with chronic alcoholic liver disease or cirrhosis. Borderline elevations of liver tests may occur in up to 15% of patients. Elevations of SGPT or SGOT occurred in controlled trials in less than 1% of patients. Severe hepatic reactions, including jaundice and fatal hepatitis, have been reported rarely. If liver disease develops or if systemic manifestations occur (e.g., eosinophilia or rash), discontinue therapy. If steroid dosage is reduced or eliminated during therapy, do so slowly and observe patients closely for adverse effects, including adrenal insufficiency and exacerbation of arthritis symptoms. Determine hemoglobin values periodically for patients with initial values of 10 grams or less who receive long-term therapy. Peripheral edema has been reported. For patients with restricted sodium intake, note that each tablet contains approximately 25 or 50 mg (1 or 2 mEq) sodium. Use with caution in patients with fluid retention, hypertension or heart failure. The drug may reduce fever and inflammation, diminishing their diagnostic value. Conduct ophthalmic studies if any change or disturbance in vision occurs. **Information for Patients:** Side effects can cause discomfort and, rarely, more serious side effects, such as GI bleeding, may result in hospitalization and even fatal outcomes. Physicians may wish to discuss with patients potential risks and benefits of NSAIDs, particularly when they are used for less serious conditions where treatment without NSAIDs may be acceptable. Patients should use caution for activities requiring alertness if they experience drowsiness, dizziness, vertigo or depression during therapy. **Laboratory Tests:** Because serious GI tract ulceration and bleeding can occur without warning symptoms, follow chronically treated patients and inform them of the importance of the follow-up. **Drug Interactions:** Use caution when giving concomitantly with coumarin-type anticoagulants; a hydantoin, sulfonamide or sulfonylurea; furosemide; lithium; beta-blockers; probenecid; or methotrexate. **Drug/Laboratory Test Interactions:** May decrease platelet aggregation and prolong bleeding time or increase urinary values for 17-ketogenic steroids. Temporarily stop therapy for 72 hours before adrenal function tests. May interfere with urinary assays of 5HIAA. **Carcinogenesis:** A 2 year rat study showed no evidence of carcinogenicity. **Pregnancy:** Category B. Do not use during pregnancy unless clearly needed. Avoid use during late pregnancy. **Nursing Mothers:** Avoid use. **Pediatric Use:** Single doses of 2.5-5 mg/kg (as naproxen suspension), with total daily dose not exceeding 15 mg/kg/day, are safe in children over 2 years of age.
Adverse Reactions: In a study, GI reactions were more frequent and severe in rheumatoid arthritis patients on 1650 mg/day naproxen sodium than in those on 825 mg/day. In children with juvenile arthritis, rash and prolonged bleeding times were more frequent, GI and CNS reactions about the same, and other reactions less frequent than in adults. **Incidence Greater Than 1%, Probable Causal Relationship:** GI: The most frequent complaints related to the GI tract: constipation,* heartburn,* abdominal pain,* nausea,* dyspepsia, diarrhea, stomatitis. CNS: headache,* dizziness,* drowsiness,* light-headedness, vertigo. Dermatologic: itching (pruritus),* skin eruptions,* ecchymoses,* sweating, purpura. Special Senses: tinnitus,* hearing disturbances, visual disturbances. Cardiovascular: edema,* dyspnea,* palpitations. General: thirst. *Incidence of reported reaction 3%-9%. Where unmarked, incidence less than 3%. **Incidence Less Than 1%, Probable Causal Relationship:** GI: abnormal liver function tests, colitis, GI bleeding and/or perforation, hematemesis, jaundice, melena, peptic ulceration with bleeding and/or perforation, vomiting. Renal: glomerular nephritis, hematuria, interstitial nephritis, nephrotic syndrome, renal disease. Hematologic: agranulocytosis, eosinophilia, granulocytopenia, leukopenia, thrombocytopenia. CNS: depression, dream abnormalities, inability to concentrate, insomnia, malaise, myalgia and muscle weakness. Dermatologic: alopecia, photosensitive dermatitis, skin rashes. Special Senses: hearing impairment. Cardiovascular: congestive heart failure. Respiratory: eosinophilic pneumonitis. General: anaphylactoid reactions, menstrual disorders, pyrexia (chills and fever). **Causal Relationship Unknown:** Hematologic: aplastic anemia, hemolytic anemia. CNS: cognitive dysfunction. Dermatologic: epidermal necrolysis, erythema multiforme, Stevens-Johnson syndrome, urticaria. GI: non-peptic GI ulceration, ulcerative stomatitis. Cardiovascular: vasculitis. General: angioneurotic edema, hyperglycemia, hypoglycemia.
Overdosage: May have drowsiness, heartburn, indigestion, nausea, vomiting. Empty stomach and use usual supportive measures. In animals 0.5 g/kg of activated charcoal reduced plasma levels of naproxen.
Dosage and Administration for Mild to Moderate Pain, Dysmenorrhea and Acute Tendinitis and Bursitis: Recommended starting dose is 550 mg, followed by 275 mg every 6 to 8 hours. Total daily dose should not exceed 1375 mg. **Dosage and Administration for Rheumatoid Arthritis, Osteoarthritis and Ankylosing Spondylitis:** Recommended dose in adults is 275 mg or 550 mg twice daily. In patients who tolerate lower doses well, the dose may be increased to 1650 mg per day for limited periods when a higher level of anti-inflammatory/analgesic activity is required. At this dosage, physicians should observe sufficient increased clinical benefits to offset potential increased risk.
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tween the ages of 35 and 39, mammograms every one to two years for women who are 40 to 49 (depending on risk factors), and mammograms every year for all women age 50 and over.[5] In addition, the ACS recommends the practices of breast self-examination and regular clinical examinations (see Table 1, p. 31).[6-7]

Screening mammography and clinical breast examination can contribute much to early detection and overall reduction in breast cancer morbidity and mortality. Health care professionals can play a vital role in thoroughly evaluating their clients and making appropriate referrals. In addition, health care professionals can instruct their patients in breast self-examination, which can help them detect abnormalities in between mammographies and regular clinical examinations.

Biology of Breast Cancer

Medical understanding of the biology of breast cancer has changed over time. The spread of cancer was once believed to occur in an orderly progression from the breast to the axillary nodes and then to distant sites via the lymphatics. However, treatment often failed; systemic disease appeared and many patients died after what had appeared to be "successful" local treatment.

The currently held concept is that blood-borne metastases occur early in the majority of patients with breast cancer, and that success in treatment of breast cancer requires successful systemic control in addition to local control. There is also thought to be a relatively long preclinical phase, probably lasting approximately two to three years, during which time a cancer can be detected only by mammography. At this stage, the likelihood of nodal and distant metastasis is low, and screening mammography can have its greatest impact.[3,8]

Mammography

Mammography — or soft tissue roentgenography of the breast — has been available since the first half of the 20th century. However, its use in clinical medicine did not become widespread until two decades ago.[9-10]

Mammography now has two main diagnostic uses: first, to screen essentially healthy asymptomatic women; and second, to evaluate the breast tissue of women with symptoms such as breast lumps, nipple discharge or mastalgia.[9]

Many studies have demonstrated the efficacy of mammography in early detection of breast cancer. The Health Insurance Plan of Greater New York conducted a study between 1963 and 1970 involving 30,000 women who underwent screening mammography, history and physical examinations. The study demonstrated a 33-percent reduction in breast cancer mortality among all screened women and a 40 percent reduction in mortality in women over age 50.

The Breast Cancer Detection Demonstration Project was a much larger study involving 280,000 women and sponsored by the American Cancer Society and National Cancer Institute. The women underwent history, physical examinations and mammographies. Forty-two percent of the cancers discovered were detected by mammography alone. In addition, mammography appeared to have been effective not only in women older than age 50, but also in women ages 40 to 49. In the latter group, mammography alone detected 35 percent of cancers, and mammography combined with physical examination detected 50 percent of the cancers.

More recently, screening studies from the Netherlands and Sweden have further documented the importance of mammography. In the Swedish report, 163,000 women underwent a single-view screening mammography every two to three years. The seven-year study demonstrated a 31-percent reduction in breast cancer mortality and a 25-percent reduction in the number of advanced breast cancers.[8,11-12]

Radiation Risk

A concern of many is the radiation risk associated with mammography. In 1976, there was intense debate about whether mammography, which uses X rays, might in itself produce breast cancer. Although not a likely cause of breast cancer, radiation exposure will substantially increase a woman's risk after a 10- to 20-year latency period. This conclusion is based on observations of women exposed to relatively high doses of

radiation, such as in the Hiroshima and Nagasaki atomic bomb blasts, multiple fluroscopies for the treatment of tuberculosis, and X-ray treatment for postpartum mastitis.[13]

However, there appears to be very little increased risk to women exposed to radiation after the age of 40 — the age when mammography is most indicated. The prepubescent breast is sensitive to the carcinogenic effect of radiation, and the breast may become gradually less sensitive to the effects of radiation during adolescence. There are no epidemiologic data demonstrating that routine use of mammography — even repeated mammograms at yearly intervals — is ever associated with an increased risk of breast cancer. In addition, the radiation doses currently used for screening mammography have been significantly reduced from earlier doses to the range of 0.2 rad per breast per examination. Women need to be educated that the dose of radiation from a mammogram is negligible and should not deter them from receiving regular mammograms.[13]

Historically, radiation risk estimates have been taken from studies of women exposed to relatively high doses of radiation such as atomic bomb survivors, patients exposed to multiple fluoroscopic examinations and women treated for postpartum mastitis. These groups received more than 50 rad of radiation and did have an increased incidence of breast cancer. The age at irradiation was identified as a major determinant of risk. Women irradiated when younger than 20 years old had a higher risk of radiation induced breast cancer.[2,12]

It is not known whether very low doses of radiation, such as those used in current mammographic techniques (0. 1 to 0. 8 rad), can cause breast cancer. The risk, if it does exist, is so small that it has never been observed but only inferred from the greater incidence of breast cancer seen in women exposed to doses of greater than 50 rad.[2,10,13]

Currently, mammograms are most often produced by a screen-film technique. The average glandular radiation dose for a two view examination is 0.1 to 0.2 rad. There has been considerable improvement over earlier techniques including a significant reduction in radiation dose and considerable improvement in diagnostic image quality.[10,12-13]

TABLE 1
American Cancer Society Recommendations for Asymptomatic Women

Women 40 years of age or less:
- Breast self-examination every month.
- Clinical breast examination at least every three years.
- Baseline mammogram between the ages of 35 and 39.

Women between 40 and 49 years of age:
- Breast self-examination every month.
- Clinical breast examination annually.
- Mammogram every one to two years, depending on risk factors.

Women age 50 and over:
- Breast self-examination every month.
- Clinical breast examination annually.
- Mammogram annually.

> **Nearly three-fourths of the women 40 years of age or older who had had a mammogram reported that they did so because their doctors recommended it — a finding that was consistent across age, race, income and education categories.**

Compression

Adequate compression is an essential factor in reducing the scatter of the X-ray beam, production of a more uniform density of the breast, and preservation of image clarity by prevention of movement. In addition, compression can reduce the radiation dose, since a lesser thickness of breast tissue needs to be penetrated. When the breast tissue is compressed, suspicious lesions are more easily identified.[14-15] The importance of adequate compression should be explained to the patient prior to a mammogram so that she is better able to tolerate the minimal discomfort associated with each exposure. Occasionally, women will experience pain. They should be instructed to communicate discomfort immediately to the technologist. In order to reduce chances of discomfort, mammography should be obtained following the menstrual period when the breasts are least likely to be tender.[8,12,14-15]

Radiologist and Technologist

Competently performing the examination and recognizing the subtle signs of early breast cancer require that the radiologist and technologist be qualified and experienced with mammography. The technologist is responsible for positioning the patient properly so that as much of the breast as possible appears on the film and so that the breast is compressed to as thin a layer as possible. In a population of healthy women age 40 to 74, only 2 percent of the women have a pathological lesion. The radiologist interpreting screening mammograms must be familiar with the wide range of mammographic appearances that are present in normal breasts.[12,14-15]

Cost of Mammography

In 1986, the American Cancer Society sponsored a community-wide low-cost mammographic screening project. The goal of the ACS campaign was to encourage a long-term reduction in the cost of mammographic screening and increase public and physician awareness of the value of mammographic screening. The project provided mammographic examinations at a cost of $50 each for 18,264 asymptomatic women ages 35 years and over.[16]

The mean fee for a screening mammography in 1988 was $111; however, this fee can vary contingent on facilities' volumes and subsidies. Women have reported the high cost of mammography as one reason for not undergoing mammograms at recommended intervals. This can have a major impact on women in low socioeconomic groups who are unable to pay out-of-pocket expenses. In the past, many insurance companies did not authorize payment for routine

screening purposes. However, insurance coverage for screening mammograms is increasing. As of July 1990, 29 states require insurance companies to provide some level of coverage for mammography. With the coverage provided by insurance companies and the expected increase in procedural volume, competition for patients will hopefully result in lower fees. The availability of low-cost screening for women requires the involvement and cooperation of screening centers, health care professionals and third-party payers.[2,7,16-17]

In a population of healthy women age 40 to 74, only 2 percent of the women have a pathological lesion. The radiologist interpreting screening mammograms must be familiar with the wide range of mammographic appearances that are present in normal breasts.

Limitations and Recommendations

Mammography is the only modality with the potential for detecting a breast cancer while it is non-palpable and at a stage of high curability. However, large screening projects have found that 15 to 20 percent of cancers are not detectable on mammograms. It is known that mammography is most limited in the dense breast and is therefore of little diagnostic value in women under age 35. It should be emphasized that neither palpation nor mammography are 100-percent accurate. Therefore, a patient with a suspicious lesion found on clinical examination and a negative mammogram requires further work-up.[2]

American College of Radiology Accreditation

Two years ago, the American College of Radiology (ACR) began a voluntary mammography-accredited program to provide quality assurance to consumers through comprehensive assessment of mammog-raphy units and facilities. So far, the ACR has accredited more than 770 mammography units in the United States, and 1,500 more units have applied for accreditation. ACR accreditation ensures that a facility has been evaluated by peer radiologists for equipment quality, staff qualifications, quality of the image and the amount of patient exposure to radiation.[18] The American Cancer Society offices have lists of accredited facilities in their areas.

Conclusion

Motivation of women to accept the procedure of mammography is an important factor in successful screening. Use of mammography must continue to increase, and women must return for repeat mammograms at recommended intervals. Efforts in this direction must be ongoing and persistent. Special efforts are needed to ensure that older women and women in lower socioeconomic groups receive mammograms. Screening centers must be readily available and easily accessible to all women. More programs that promote the benefits of early breast cancer detection are needed. The American Cancer Society has made a substantial impact in educating and stimulating interest among women about this procedure.

Breast cancer is a disease that threatens both femininity and life itself. There must be an increased awareness among women and health care professionals that will facilitate early detection and diagnosis. Vital to this process are mammography to detect small, non-palpable cancers, breast self-examination and clinical breast examinations by a health care professional.[16] Application of these guidelines will result in early diagnosis and the saving of many lives.

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About the author: Deborah A. Hamwi, R.N., N.P., M.S.N., is a nurse practitioner in the department of operating room services at the University of California at Irvine Medical Center.

HIAA

Health Insurance Association of America

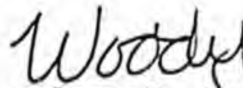
April 25, 1990

Dear Colleague:

Every year state legislators present us with an ever increasing amount of legislation important to our business. These proposals are examined and pursued in light of HIAA's policy on any given issue. In order to place the Association in a proactive posture and gain wider understanding of the industry's legislative program, we have developed kits describing the background and explaining our positions on key issues affected by state legislative initiatives.

HIAA is glad to provide you with our new State Health Insurance Issues Kit. Please feel free to request additional copies for legislative and regulatory activities by writing HIAA, P.O. Box 41455, Washington, D.C. 20018. Our goal is to expose legislators, regulatory officials, business leaders and public interest groups to HIAA's state legislative program. Please help us do this by distributing any of the individual issues briefs, or the entire kit, at hearings, meetings or visits with policymakers.

Sincerely,



Woodrow E. Eno
Senior Associate General Counsel

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HIAA
ON
STATE HEALTH
INSURANCE
ISSUES

ISSUE: STATE MANDATED BENEFITS
(as of March 1990)

BACKGROUND: Over the years, the list of state mandated benefits and providers has grown dramatically. In all, there about 800 different state mandated benefit laws nationwide, ranging from such disparate services as acupuncture and Chinese medicine, pastoral counseling, chiropractic and podiatry, to a variety of mental health benefits.

While the merits of any particular benefit or provider group can be vigorously defended by its proponents, the cumulative effect is a hodgepodge of state laws that increase the cost of health insurance, particularly to small employers who are most in need of relief from the high cost of health care.

One negative effect of the myriad mandated benefit laws that increases the cost of coverage is that multistate insurers must monitor and comply with many different state laws. They are precluded from developing lower-cost prototype plans which they can market across state lines.

More importantly, many of these benefits are expensive in their own right. Substance abuse treatment, coverage for psychiatric hospitals and psychologists' visits substantially increase the cost of both individual and group coverage. With few exceptions, mandates raise the price of insurance coverage.

Taken together, the mandated benefits in some states provide a comprehensive benefit package that many small employers simply cannot afford. Studies indicate that approximately 16 percent of small businesses that do not offer health benefits to their employees would offer them in a less heavily mandated setting. This creates a serious problem for the health insurance industry, which is trying to develop lower cost health plans for small employers in its efforts to increase coverage to the 31 million Americans without health insurance, many of whom are full-time workers or their dependents and employed by small firms.

Furthermore, state mandated benefit laws do not apply equally to all health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws. Thus, mandated benefits have encouraged firms to self-insure and thereby escape state oversight from mandated benefits, reserve and financial solvency requirements and premium taxes.

In general, only large employers can afford to self-insure, which not only allows multi-state employers to save administrative costs, it also allows them to pick and choose the benefits that are most desirable and cost-effective for their employees. Employers too small to self-insure, however, do not have this flexibility, thus making it less likely that they will offer health insurance at all. In 1984, 37 percent of all workers and their families were covered by self-insured plans. This places the burden of mandated benefits on small employers.

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HIAA

ON

STATE HEALTH

INSURANCE

ISSUES

ISSUE: ACQUIRED IMMUNE DEFICIENCY SYNDROME
(as of March 1990)

BACKGROUND: The first case of AIDS in the United States was diagnosed in 1980. As of spring 1989, 88,000 cases have been reported to the Centers for Disease Control, which estimates that by the year 1992, 365,000 Americans will have died of AIDS or progressed to the later stages of the disease.

Despite intense biomedical research efforts, there remains no cure, nor is an effective vaccine likely to be developed in the immediate future. Health officials estimate that between 1 million and 1.5 million Americans are infected with the human immunodeficiency virus (HIV). Available data support the view that, absent any effective therapy, virtually all those infected with HIV will eventually progress to AIDS or severe HIV illness.

The human and financial costs of this tragic epidemic have been staggering, with many young adults being stricken during their most active and productive years. Loss of wages resulting from illness and disability and loss of future earnings as a result of premature death are estimated at $7 billion in 1986. An ongoing survey of AIDS-related life and health insurance claims by HIAA-ACLI member companies documents these losses, reporting an estimated $263 million in life insurance death claims in 1987.

Medical care costs for AIDS patients are estimated at $3 billion in 1988, and health insurers have borne a significant portion of this cost. Although 1988 data are not yet available, the HIAA-ACLI survey showed that member companies paid $35.9 million in individual claims and $188 million in group claims in 1987, the latter representing more than twice the amount paid during the previous year.

The cost of AIDS per case has decreased over time, primarily due to the development of alternative outpatient treatments. Health insurers have responded quickly to these innovative approaches, and companies continue to develop methods, through case management programs, that provide appropriate and humane care to AIDS patients while at the same time realizing tremendous cost savings. Home care, a major component of case management, can result in savings of $3,000 to $15,000 per month and allows AIDS patients more independence.

Because there is no AIDS vaccine, effective treatment or cure, and because of the high morbidity and mortality associated with HIV infection, people with AIDS and HIV infection represent medical risks that must be considered uninsurable. For most of the 90 percent of the insured population who receive insurance through the work place, evidence of individual health status is not required. However, for those currently uninsured who seek to obtain individual or small group coverage, health status must be tested to determine insurability. Evidence of HIV infection (like heart disease, diabetes and cancer, for example) would necessarily require some initial restrictions on coverage, or possibly exclusion from coverage. The HIV antibody test, now regarded as a reliable indicator of viral infection, is an essential tool available to insurers to determine medical insurability.

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1025 Connecticut Avenue N.W., Washington, DC 20036 ☐ 202-223-7780 ☐ FAX 202-223-7897

ISSUE: HEALTH MAINTENANCE ORGANIZATIONS
(as of March 1990)

BACKGROUND: In slightly more than a decade, health maintenance organizations (HMOs) have become a well-established force in most major American metropolitan areas. Today, HMOs serve approximately 13 percent of the U.S. population and provide effective competition for traditional fee-for-service plans.

Along with consumer acceptance of HMOs have come sophisticated oversight procedures by state authorities. Consumers in all states are covered by a well-developed framework of laws and regulations.

Increasing HMO enrollments, coupled with a few major insolvencies and a competitive climate, have stimulated many state regulators to consider additional HMO solvency requirements. At least five states have enacted legislation that includes HMOs in a guaranty fund.

In 1987, the HIAA's Government Relations Committee established a task force to study HMO issues. The first assignment was to study the problem of solvency.

The National Association of Insurance Commissioners (NAIC) and the National Association of Health Maintenance Organization Regulators recently completed an examination of existing HMO requirements. In December 1988, the NAIC adopted amendments to the model HMO act that provide for increased net worth and deposit requirements, mandatory hold harmless provisions, continuation of benefits and replacement coverage. In December 1989, the NAIC also adopted an assessment provision to be included in the HMO model act, which is in lieu of the HMO guaranty association proposal originally under its consideration.

HIAA POSITION: HIAA supports the position that the goals of the original federal HMO act have been met, and there is no longer a need for a significant federal role. The act should be repealed.

HIAA supports a comprehensive approach to the problems associated with HMO insolvencies. In addition to the approach adopted by the NAIC, the Association supports the use of parental guarantees to meet net worth and deposit requirements.

Moreover, HIAA opposes creation of HMO state guaranty funds or assessments because they do not prevent insolvency, strengthen regulatory oversight or improve standards for licensure. They might even create a false sense of security. The Association believes that guaranty funds or assessments will not assure continued medical services for enrollees. Further, if providers are bailed out of a failed HMO by a guaranty fund or assessment, they may have less incentive to control utilization and costs.

HIAA will actively seek enactment of a comprehensive solution to the problem of HMO solvency and will vigorously oppose guaranty funds or assessments for HMOs.

See also the enclosed position paper on managed care.

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CORRECTION

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HIAA

ON
STATE HEALTH
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ISSUES

ISSUE: STATE MANDATED BENEFITS
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More importantly, many of these benefits are expensive in their own right. Substance abuse treatment, coverage for psychiatric hospitals and psychologists' visits substantially increase the cost of both individual and group coverage. With few exceptions, mandates raise the price of insurance coverage.

Taken together, the mandated benefits in some states provide a comprehensive benefit package that many small employers simply cannot afford. Studies indicate that approximately 16 percent of small businesses that do not offer health benefits to their employees would offer them in a less heavily mandated setting. This creates a serious problem for the health insurance industry, which is trying to develop lower cost health plans for small employers in its efforts to increase coverage to the 31 million Americans without health insurance, many of whom are full-time workers or their dependents and employed by small firms.

Furthermore, state mandated benefit laws do not apply equally to all health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws. Thus, mandated benefits have encouraged firms to self-insure and thereby escape state oversight from mandated benefits, reserve and financial solvency requirements and premium taxes.

In general, only large employers can afford to self-insure, which not only allows multi-state employers to save administrative costs, it also allows them to pick and choose the benefits that are most desirable and cost-effective for their employees. Employers too small to self-insure, however, do not have this flexibility, thus making it less likely that they will offer health insurance at all. In 1984, 37 percent of all workers and their families were covered by self-insured plans. This places the burden of mandated benefits on small employers.

Health Insurance Association of America
1025 Connecticut Avenue N.W., Washington, DC 20036 ☐ 202-223-7780 ☐ FAX 202-223-7897

HIAA POSITION: HIAA opposes all mandated benefit laws. When an employer cannot afford all benefits that may be beneficial for its employees, the choice of which benefits to buy should be made by the purchaser.

The existing preemption of state mandated benefit laws that currently applies to self-insured employee health plans should be extended to insured plans. Small employers should not be forced to choose between a "Cadillac" plan and none at all.

HIAA
ON
STATE HEALTH
INSURANCE
ISSUES

ISSUE: ACQUIRED IMMUNE DEFICIENCY SYNDROME
(as of March 1990)

BACKGROUND: The first case of AIDS in the United States was diagnosed in 1980. As of spring 1989, 88,000 cases have been reported to the Centers for Disease Control, which estimates that by the year 1992, 365,000 Americans will have died of AIDS or progressed to the later stages of the disease.

Despite intense biomedical research efforts, there remains no cure, nor is an effective vaccine likely to be developed in the immediate future. Health officials estimate that between 1 million and 1.5 million Americans are infected with the human immunodeficiency virus (HIV). Available data support the view that, absent any effective therapy, virtually all those infected with HIV will eventually progress to AIDS or severe HIV illness.

The human and financial costs of this tragic epidemic have been staggering, with many young adults being stricken during their most active and productive years. Loss of wages resulting from illness and disability and loss of future earnings as a result of premature death are estimated at $7 billion in 1986. An ongoing survey of AIDS-related life and health insurance claims by HIAA-ACLI member companies documents these losses, reporting an estimated $263 million in life insurance death claims in 1987.

Medical care costs for AIDS patients are estimated at $3 billion in 1988, and health insurers have borne a significant portion of this cost. Although 1988 data are not yet available, the HIAA-ACLI survey showed that member companies paid $35.9 million in individual claims and $188 million in group claims in 1987, the latter representing more than twice the amount paid during the previous year.

The cost of AIDS per case has decreased over time, primarily due to the development of alternative outpatient treatments. Health insurers have responded quickly to these innovative approaches, and companies continue to develop methods, through case management programs, that provide appropriate and humane care to AIDS patients while at the same time realizing tremendous cost savings. Home care, a major component of case management, can result in savings of $3,000 to $15,000 per month and allows AIDS patients more independence.

Because there is no AIDS vaccine, effective treatment or cure, and because of the high morbidity and mortality associated with HIV infection, people with AIDS and HIV infection represent medical risks that must be considered uninsurable. For most of the 90 percent of the insured population who receive insurance through the work place, evidence of individual health status is not required. However, for those currently uninsured who seek to obtain individual or small group coverage, health status must be tested to determine insurability. Evidence of HIV infection (like heart disease, diabetes and cancer, for example) would necessarily require some initial restrictions on coverage, or possibly exclusion from coverage. The HIV antibody test, now regarded as a reliable indicator of viral infection, is an essential tool available to insurers to determine medical insurability.

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1025 Connecticut Avenue N.W., Washington, DC 20036 ☐ 202-223-7780 ☐ FAX 202-223-7897

HIAA POSITION: The health and life insurance industries have paid a significant portion of the costs associated with AIDS and will continue to do so. For those AIDS patients who are now uninsured, HIAA believes that alternatives should be developed that address their health care needs. HIAA has recently adopted an innovative proposal on the needs of all the uninsured, including people with AIDS. Of particular significance is the availability of coverage for the medically uninsurable. HIAA continues to seek legislation that would establish state pools for uninsurable individuals.

On the issue of testing, HIAA believes that legislation that forces insurers to ignore reliable evidence of health status will create underwriting inequities, and continues to voice strong opposition to such laws. Insurers must be permitted to use the results of HIV tests in the underwriting process. HIAA supports the 1986 model guidelines, adopted by the National Association of Insurance Commissioners, that set limits on permissible application questions and establish underwriting guidelines.

HIAA

ON STATE HEALTH INSURANCE ISSUES

ISSUE: HEALTH MAINTENANCE ORGANIZATIONS
(as of March 1990)

BACKGROUND: In slightly more than a decade, health maintenance organizations (HMOs) have become a well-established force in most major American metropolitan areas. Today, HMOs serve approximately 13 percent of the U.S. population and provide effective competition for traditional fee-for-service plans.

Along with consumer acceptance of HMOs have come sophisticated oversight procedures by state authorities. Consumers in all states are covered by a well-developed framework of laws and regulations.

Increasing HMO enrollments, coupled with a few major insolvencies and a competitive climate, have stimulated many state regulators to consider additional HMO solvency requirements. At least five states have enacted legislation that includes HMOs in a guaranty fund.

In 1987, the HIAA's Government Relations Committee established a task force to study HMO issues. The first assignment was to study the problem of solvency.

The National Association of Insurance Commissioners (NAIC) and the National Association of Health Maintenance Organization Regulators recently completed an examination of existing HMO requirements. In December 1988, the NAIC adopted amendments to the model HMO act that provide for increased net worth and deposit requirements, mandatory hold harmless provisions, continuation of benefits and replacement coverage. In December 1989, the NAIC also adopted an assessment provision to be included in the HMO model act, which is in lieu of the HMO guaranty association proposal originally under its consideration.

HIAA POSITION: HIAA supports the position that the goals of the original federal HMO act have been met, and there is no longer a need for a significant federal role. The act should be repealed.

HIAA supports a comprehensive approach to the problems associated with HMO insolvencies. In addition to the approach adopted by the NAIC, the Association supports the use of parental guarantees to meet net worth and deposit requirements.

Moreover, HIAA opposes creation of HMO state guaranty funds or assessments because they do not prevent insolvency, strengthen regulatory oversight or improve standards for licensure. They might even create a false sense of security. The Association believes that guaranty funds or assessments will not assure continued medical services for enrollees. Further, if providers are bailed out of a failed HMO by a guaranty fund or assessment, they may have less incentive to control utilization and costs.

HIAA will actively seek enactment of a comprehensive solution to the problem of HMO solvency and will vigorously oppose guaranty funds or assessments for HMOs.

See also the enclosed position paper on managed care.

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1025 Connecticut Avenue N.W., Washington, DC 20036 ☐ 202-223-7780 ☐ FAX 202-223-7897

ISSUE: LONG-TERM CARE
(as of March 1990)

BACKGROUND: Long-term care has engendered growing interest among insurers, government policy makers and groups concerned with aging. Common to all is a strong belief that the current financing arrangement, which relies on a welfare program and the private resources of individuals, is inadequate. New solutions are needed, and for many, private insurance coverage is an alternative.

Recently, there has been tremendous growth in private long-term care insurance. Today, more than 100 companies sell such products, and as of June 1989, more than 1.3 million people had purchased a policy. The introduction of employer-sponsored plans is particularly promising. Almost 35 large employers have begun to offer this coverage as of June 1989. Despite rapid growth, there remains great uncertainty as to how large a role the private sector can play in paying the nation's long-term care bill.

More than 50 bills on long-term care financing have been introduc ' in Congress, the focus of which include incentives to stimulate the private market and federalization of long-term care financing.

Initiatives with strong private sector orientation include tax clarifications and changes necessary for continued growth in the private market. For example, several bills would clarify the tax status of long-term care insurance regarding premiums paid and benefits received under individual and group contracts. Other private market approaches and incentives should be encouraged, especially given the nation's many pressing budget priorities. Other congressional proposals seek to establish a federal oversight role in the sale of private long-term care insurance. Sponsors of these bills do not believe that states can regulate this new product adequately. However, since adoption of the long-term care insurance model act in December 1986 by the National Association of Insurance Commissioners (NAIC), 26 states have passed legislation based on this model statute. Another 11 states have passed legislation or adopted regulations more stringent than the NAIC model act. And, as of the end of 1989, legislation is pending in several other states.

HIAA POSITION: HIAA strongly believes that government's role in financing long-term care should be targeted to those who are in greatest need. To the extent possible, individuals of all ages should be encouraged to use their own resources to purchase private insurance. Private coverage offers the elderly and their families the greatest flexibility in determining individual needs and is also the most appropriate vehicle for allowing families to preserve financial assets. The latter is not the proper role of government. HIAA also believes that the rapid growth of the private market should be encouraged, especially given the nation's many pressing budget priorities.

Action at the state level has been significant. HIAA strongly believes that, as for other types of insurance, the states are the responsible body for governing the sale of long-term care insurance. Further, the Association believes that the states have acted with unprecedented speed in setting standards for this new product.

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1025 Connecticut Avenue N.W., Washington, DC 20036 ▭ 202-223-7780 ▭ FAX 202-223-7897

HIAA supports the provisions of the NAIC long-term care insurance model act and regulation and has made its passage in those remaining states a top priority in 1990.

HIAA supports the following:

- o An expanded uniform public program to provide coverage for people who cannot provide for themselves;
- o Appropriate and adequate state consumer protection to ensure that consumers have access to high-quality long-term care providers and fair and affordable insurance policies;
- o Greater consumer education efforts to promote the public's understanding of their potential need for long-term care and its costs; and
- o Legislative and regulatory initiatives to promote the public interest and the availability of long-term care policies, and to encourage flexibility and innovation in developing long-term care coverage.

HIAA ON STATE HEALTH INSURANCE ISSUES

ISSUE: MANAGED CARE
(as of April 1990)

BACKGROUND: The high cost of health care is a major problem for the United States. All who pay – employers, individuals, and government – are burdened by continual increases in health expenditures. Moreover, escalation of health costs greatly complicates the task of finding ways to provide coverage for the large number of Americans who are without either public or private health insurance.

Although cost escalation has many causes, research shows that one key problem is that patients receive much care that is not appropriate for their condition. Some get care that is more intense and expensive than necessary. Others receive care that is not beneficial and may even be harmful. Eliminating such inefficiencies – which may account for 25 percent or more of medical expenditures – is clearly a critical objective, both as a way of reducing costs and improving quality of care.

Payers of health care are aware of such inefficiencies and are demanding more accountability and better performance from those who make health care decisions in order to assure that patients receive good value for money spent. Increasingly, managed care is recognized as the best mechanism for carrying out such improvements. The key objective of managed care is to assure that patients receive appropriate care, that is, high quality care efficiently provided in the least costly setting.

DEFINITION: Because it is still evolving, managed care embraces a variety of existing and developing structures. It may be defined as systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following basic elements:

- o Arrangements with selected providers to furnish a comprehensive set of health care services to members;
- o Explicit standards for the selection of health care providers;
- o Formal programs for ongoing quality assurance and utilization review; and
- o Significant financial incentives for members to use providers and procedures associated with the plan.

Managed care organizational structures are evolving in response to marketplace demands and will continue to do so. Today's structures include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs), as well as mixed arrangements that combine elements of HMOs, PPOs and indemnity plans to accommodate employer and operating environment requirements.

Managed care plans arrange with selected providers to furnish health care services to plan members. Explicit criteria are used for the selection of providers, and formal programs for ongoing review of the quality and appropriateness of services are incorporated into the plan.

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1025 Connecticut Avenue N.W., Washington, DC 20036 ▭ 202-223-7780 ▭ FAX 202-223-7897

Plans provide financial incentives for covered individuals to use providers who deliver appropriate quality care. In some managed care plans, the cost of services is covered only when health care is received from selected providers. Other managed care plans provide individuals more latitude in the choice of providers. Out-of-pocket costs, however, are usually higher when out-of-plan providers are chosen.

Some state legislators are concerned that managed care, including both contracting arrangements with providers and utilization review techniques, could adversely affect the quality of health care. Their concerns have been encouraged by some associations of providers representing hospitals, physicians, dentists, pharmacists and allied health professions. These groups have drafted and advocated state legislative proposals that would restrict or prohibit the operation of managed care programs.

HIAA POSITION: HIAA is firmly committed to the expansion of managed care programs and techniques in order to assure high-quality, cost-effective health care. Managed care systems have the means to avoid unnecessary and inappropriate care.

Therefore, HIAA is opposed to legislation or regulations that would impose barriers to the development and implementation of managed care in its current and evolving forms. Legislation or regulation that unduly limits insurers' ability to carry out rigorous utilization review is one such barrier. Legislation that opposes utilization review takes many forms, but generally seeks to put inappropriate restrictions on who can conduct reviews and what can be reviewed.

HIAA is also opposed to legislation that would restrict an insurer's freedom to form networks or contract selectively with providers. Legislation that opposes networking also takes many forms, but generally seeks to put restrictions on the ability to pay providers anything but their usual and customary fees, or to contract with a limited number of providers.

HIAA believes:

- o Insurers should be free to negotiate whatever price they can with providers. One important way to reduce costs is to be able to buy provider services at lower prices, and managed care systems need to have freedom to negotiate lower prices. On the other hand, in some instances plans may wish to offer higher-than-usual fees to especially efficient providers.
- o Insurers should be able to pay providers in ways that create appropriate incentives. If provider reimbursement systems reward high-cost medical practice, it will be very difficult to reduce costs. Managed care systems need to be able to alter reimbursement incentives to reward efficient providers. Severe restrictions on capitation payment, for example, are inappropriate and unwarranted.
- o State laws should not place artificial limits on the amount of consumer cost sharing that can be imposed on PPO plan enrollees who choose to get care from off-panel providers. If a PPO has a panel of providers that can provide needed high-quality services more efficiently than other providers, it is entirely appropriate to require consumers who choose not to use these efficient providers to pay the extra costs. HMOs, which all states allow, do not pay anything when consumers receive care from non-HMO providers.

- o Legislation should not establish inappropriate barriers to insurer efforts to establish effective utilization review programs and should require providers to make available, at a reasonable cost, patient records and other information necessary to monitor cost and quality of care. Monitoring medical practice patterns is critical to managing care. If reviewers cannot get access to medical records at reasonable cost, or if excessive restrictions are put in place to limit who does utilization review or what the process will be, managed care plans cannot accomplish the critical task of encouraging providers to become more efficient.

- o Insurers who are negotiating to form provider panels should not be compelled to enroll every provider who wishes to be included. A key mechanism that managed care plans use to constrain costs is to contract only with efficient providers. If plans are required to include on their panels all willing providers, his critical element of control is eliminated.

- o States should not mandate that insurers cover services and categories of care, since doing so often adds to costs and limits the plan's ability to develop cost-effective benefit packages. Research evidence shows that legislation that requires coverage of certain provider categories or particular services generally causes a net increase in costs. The buyers of insurance plans, not state government, should be the ones who decide what services and provider groups should be covered. Legislation mandating coverage of particular provider groups is often simply a reflection of that group's desire to create demand for their own services as a way of enhancing income.

HIAA supports the concept of physician peer review as a method of determining appropriateness of care. In doing peer review, however, it is not appropriate to rely solely on local peer assessment. Studies of differences in patterns of medical practice from area to area within a state demonstrate that the typical method of treatment in one community is often significantly different from that in another community even though the conditions of the patients are essentially identical. The differences, in other words, are not medically justified. Thus, local habit or customary practice is not necessarily the best standard for assessing medical appropriateness or necessity for a given treatment.

The collective judgment of physicians who are experts in a given field and who have done a systematic study of the scientific research must ultimately form the basis for determining what is appropriate care in a given situation. It is for this reason that HIAA supports the development of medical practice guidelines and protocols. When developed, these can form a rigorous, scientifically defensible standard for educating physicians about the best medical practice and for judging the appropriateness of care.

GLOSSARY: Below is a list of some of the current managed care structures now available:

Health Maintenance Organization (HMO): This was the original managed care arrangement, first emerging as prepaid group practices in the 1930s. The name "health maintenance organization" was coined in the early 1970s, and was given to 1973 federal legislation promoting its development. HMOs provide:

- o An organized system for providing health care in a certain geographic area, as well as responsibility for providing or otherwise assuring delivery of that care;
- o An agreed-on set of basic and supplemental health maintenance and treatment services; and
- o A voluntarily enrolled group of people.

In exchange for a set amount of premium or dues, HMOs provide all the agreed-on health services to their enrollees; there are generally no deductibles and no or minimal copayments. The HMO bears the risk if the cost of providing the care exceeds the premium received. There are now several types of HMOs.

- The staff model, where providers are directly employed by the HMO;
- The group model, where medical groups contract with the HMO (Kaiser plans are the best-known example of this type);
- The independent practice association (IPA), where the HMO contracts with physicians in independent practice, or with associations of independent physicians. IPA physicians frequently have arrangements with more than one HMO; and
- The network model, which contracts with two or more independent group practices.

Preferred Provider Organization (PPO). A PPO consists of groups of hospitals and providers that contract with employers, insurers, third-party administrators or other sponsoring groups to provide health care services to covered persons and accept negotiated fee schedules as payment for services rendered. There are different sponsoring arrangements:

- Hospital-sponsored PPOs, which often include a network of institutions in order to cover a wider geographic area, as well as many of the physicians on their medical staffs;
- Physician-sponsored PPOs, which are developed by local medical societies, other local professional associations or clinics, or groups of physicians;
- Third-party payer-sponsored PPOs, which include those initiated by commercial insurers and Blue Cross and Blue Shield plans;
- Entrepreneur-sponsored PPOs, which create a broker relationship with the entrepreneur acting as an intermediary between the provider and payer of service;
- Employer- or labor-sponsored PPOs, which contract directly with providers on behalf of their employees or members;
- Other provider-sponsored PPOs, which are developed by nonhospital and nonphysician providers, such as dentists, optometrists, pharmacists, chiropractors and podiatrists, through their professional associations, local groups or clinics.

Exclusive Provider Organization (EPO). People belonging to an EPO must receive their care from affiliated providers; services rendered by unaffiliated providers are not reimbursed.

Point-of-Service Plans. Also known as open-ended HMOs or PPOs, these plans permit insureds to choose providers outside the plan at any time yet are designed to encourage the use of network providers. If a provider is affiliated with the HMO or PPO, the service is covered (perhaps after a modest copayment). If an out-of-network provider is chosen, reimbursement may be significantly reduced.

A number of managed care techniques are used to assure quality and appropriate care. These include, but are not limited to, quality assurance, utilization review, case management and use of a primary care physician. Although the combination of elements will differ among plans, each managed care plan operates as an organized system where patient services are subject to review and coordination by health professionals.

- Quality assurance is a process by which a managed care plan monitors and takes action as necessary to assure that quality care is delivered by selected providers. The process measures the extent to which quality has been attained and periodically reevaluates health care to assure that established standards are being met.

- Utilization review is a system of reviewing the medical necessity and appropriateness of patient services within guidelines developed by physicians. Performed by health care professionals, it is comprised of several processes and may be used for both inpatient and outpatient services. Processes may include preadmission certification, application of practice guidelines, continued stay review, discharge planning, second surgical opinion and retrospective review. Because of the explosion of costs in all aspects of ambulatory care in recent years, programs to require preauthorization of ambulatory procedures are now evolving.

- Preadmission certification is a process in which a health care professional (such as a registered nurse) evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.

- Continued stay review, also called concurrent review, is a process whereby a review organization continues to examine medical information during a patient's hospital confinement to determine the need for continued hospitalization.

- Discharge planning is a process in which a health care professional from a review organization works with an attending physician and hospital staff to arrange for appropriate discharge of a patient from the hospital, including a plan for the patient's subsequent care. Its purpose is to determine when patients are ready to go home, perhaps with the support of a nurse or other home health provider, or are able to be transferred to a nursing home.

- Second surgical opinion programs require patients to seek a second surgeon's opinion if elective surgery is recommended for certain conditions. Elective surgery is defined as that which can be avoided or delayed without undue risk to the patient and which allows sufficient time to seek another opinion.

- Retrospective review provides for the establishment of a utilization profile of inapproppriate care for monitoring trends and addressing excessive use or cost.

Other managed care techniques include case management, which is a process that provides a comprehensive plan of care and rehabilitation for people suffering from severe conditions such as trauma, premature birth or AIDS. Through flexible interpretation of plan provisions, case management coordinates the use of all appropriate types of therapy and equipment in the most appropriate setting. Case management often supports alternatives to institutional care, such as physical therapy and other services delivered in the home, that achieve better patient outcomes at lower cost.

In many managed care plans, a primary care physician serves as the initial screening, testing, treatment and referral source for a patient. This physician oversees health care services rendered to patients by other providers and assumes continuing responsibility for the overall course of treatment.

Health Insurance Association of America
1025 Connecticut Avenue N.W., Washington, DC 20036 □ 202-223-7780 □ FAX 202-223-7897

HIAA
ON
STATE HEALTH
INSURANCE
ISSUES

ISSUE: McCARRAN-FERGUSON ACT
(as of March 1990)

BACKGROUND: In 1945, after the U.S. Supreme Court ruled that insurance is interstate commerce and therefore subject to federal regulation, including antitrust laws, Congress passed the McCarran-Ferguson Act to exempt the business of insurance from some federal antitrust laws. Cooperative efforts among insurance companies (e.g., collection of industrywide loss data, ratemaking and establishment of risk pools) were exempted, provided they were regulated by the states. Insurers were not exempted from the federal prohibition against boycott, coercion or intimidation.

The perceived crisis over the availability and affordability of commercial liability insurance and concern about insurance rates has focused renewed attention on the McCarran-Ferguson Act. Federal legislation was reintroduced in the 1989-1990 session, which would modify the insurance antitrust exemptions provided by the act.

The insurance industry is subject to the laws and regulations of a variety of state and federal agencies, but for the most part, insurance regulations are a state matter and Congress has been reluctant to involve the federal government in regulating it more actively.

HIAA questions the public benefits to be gained by abandoning the limited antitrust exemption and stresses the dynamic nature of the insurance regulatory process and the ability of each state to respond efficiently to its residents' needs.

HIAA POSITION: The McCarran-Ferguson Act makes the system of state regulation of insurance workable, and the law should not be repealed or amended to eliminate or restrict the already narrow exemption the act provides.

Repeal or amendment could be detrimental to the public interest by creating unnecessary and duplicative regulation and might give the federal government unwarranted supremacy over the states on this issue.

The health insurance industry is already highly competitive, and there is no evidence that repeal of McCarran-Ferguson would enhance competition. On the contrary, economic disruption, with consequent premium price increases, might ensue.

Health Insurance Association of America
1025 Connecticut Avenue N.W., Washington, DC 20036 ☐ 202-223-7780 ☐ FAX 202-223-7897

ISSUE: MEDICARE SUPPLEMENT POLICIES
(as of March 1990)

BACKGROUND: Title XVIII of the Social Security Act, otherwise known as Medicare, was enacted in 1965 and provides hospital and other health care services to people age 65 and over and to disabled individuals.

To a large extent, the health insurance needs of older Americans are borne by the federal government, but because of Medicare's deductibles, copayment provisions and benefit limits, older people are not fully protected against the possibility of large unexpected medical expenses. These limitations in Medicare's benefit structure have prompted development of private supplementary insurance policies (known as Medigap).

There are more than 33 million people in the United States over age 65 – approximately 13 percent of the total population. The number of elderly, most of whom are not employed, is expected to increase well into the next century. The vast majority of these individuals no longer have access to a health care plan provided by an employer, and except for those who are part of a retiree health plan, the elderly must rely on Medicare and private insurance to pay their health care expenses.

Since the health insurance industry will be called on to help find a solution to the growing problem of meeting the health care needs of the elderly, the Medicare program presents an important issue for private industry.

The Medicare Catastrophic Act of 1988 went into effect Jan. 1, 1989, and substantially increased Medicare benefits, but it was repealed on Dec. 31, 1989. The repeal was largely due to the outrage of consumers over age 65 because of cost increases and the surtax placed on high-income individuals age 65 and older.

The National Association of Insurance Commissioners (NAIC) was forced to respond immediately to the repeal by enacting transition requirements at its December 1989 meeting. Basically, these requirements returned policies issued prior to Jan. 1, 1989 to their original benefit levels and required insurers to offer to former policyholders, who dropped their medical policies during 1989, the opportunity to reinstitute their old policies without penalty.

During the December 1989 meeting, the NAIC also adopted consumer protection amendments to the existing model Medicare Supplement Act and Regulation. The amendments require insurers to issue guaranteed renewable policies, limit insureds to one Medicare supplement policy, provide more extensive reporting of this line of business and increase penalties for violations.

These actions will once again require all 50 states to establish a regulatory format equal to or more stringent than standards established by the NAIC model act and regulation covering Medicare supplement policies. This format defines such a policy, regulates policy provisions and loss ratios, sets rules for replacement of such policies and establishes minimum benefit standards.

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1025 Connecticut Avenue N.W., Washington, DC 20036 ▭ 202-223-7780 ▭ FAX 202-223-7897

HIAA POSITION: The Association encourages the states to adopt the NAIC regulatory format for Medicare supplement policies. It opposes federal government intrusion into the private insurance market. HIAA's position is that private insurance meets the needs of Medicare recipients for supplementary coverage and that current state regulations are sufficient to protect purchasers of Medicare supplement policies.

HIAA

ON STATE HEALTH INSURANCE ISSUES

ISSUE: RISK CLASSIFICATION
(as of March 1990)

BACKGROUND: Health insurance companies use risk classification methods to set premium rates commensurate with the level of risk an individual or group represents. The use of such techniques by insurers has expanded the availability of health insurance, as well as consumer options, since premiums are set at levels that represent the relative risk of insuring a given group or individual.

Risk classification also helps to form a direct link between health care expenditures and the cost of coverage. Since employers who self-insure avoid subsidizing other higher-cost employer groups, insurers must be able to classify risk in order to offer reasonable prices to clients preferring traditional insurance. Moreover, if insurers were prevented from charging a client the true cost of coverage, a major incentive for employers to hold costs down would be diminished. Employers would have less reason to provide safe work environments, establish wellness programs or seek efficient providers of care. Without risk classification, every group would pay the same in premiums, regardless of its true health care costs.

The process of risk classification depends on fairness. Discrimination by insurance companies against individuals seeking coverage is governed by federal civil rights statutes as well as state laws and regulations. The National Association of Insurance Commissioners (NAIC) model regulations on discrimination on the basis of sex or blindness have been adopted by a majority of states, and they serve as a basis of resolving claims of unfair treatment by insurance companies. HIAA also has developed a model risk classification bill for use in states considering actions in this area.

Some state regulators have urged equal, rather than equitable, treatment of insureds and have attempted to ignore the difference in projected health care expenses among people. For example, HIV testing of insurance applicants has become the focus of special interest groups that want to prevent insurers from testing applicants, despite the fact that HIV-positive individuals represent a risk that is 26 times greater than average.

Without the ability to use risk classification, insurers may encounter adverse selection, which is the tendency of consumers to buy health insurance only after the onset of illness or when a likelihood of major illness has become apparent. Adverse selection can seriously threaten insurers' financial stability.

HIAA POSITION: In order to ensure the financial soundness of the industry, health insurers must be permitted to classify their policyholders according to expected risk of loss. This necessarily includes the use of readily available data about applicants' age, sex, occupation and health status.

HIAA recognizes the need to make affordable coverage available to all, and has developed proposals for reinsurance and risk pools for high-risk employers and individuals.

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1025 Connecticut Avenue N.W., Washington, DC 20036 ☐ 202-223-7780 ☐ FAX 202-223-7897

The Association opposes legislative interference with legitimate and necessary risk classification and ratemaking procedures and believes that insurers should be allowed to collect and use information that has a statistically demonstrable relationship to the cost of providing coverage.

Insurers do not seek to stereotype or discriminate unfairly against individuals or groups. However, to ignore data that ties the cost of claims to a fair premium cost is to invite financial failure.

HIAA

ON STATE HEALTH INSURANCE ISSUES

ISSUE: STATE POOLS FOR UNINSURABLES
(as of March 1990)

BACKGROUND: State risk pools are designed to guarantee the availability of private health insurance to all Americans under age 65 who want to purchase protection, who are willing to pay for it but who are not considered medically insurable. Without guaranteeing such access to health insurance, the industry risks government intrusion into the health insurance market.

The commercial health insurance industry has actively supported such initiatives since the late 1960s. However, the Association's chief concern about state pools is that they be equitably funded.

Funding mechanisms vary. While the majority of state pools for uninsurables are supported through direct payments from the state or by tax credits allowed against insurer assessments, some states use other mechanisms, such as imposing the cost of pool losses entirely on insurers (Wisconsin) or imposing a hospital use tax (Maine).

HIAA POSITION: Insurers should be allowed to retain their ability to underwrite. We support state legislation to establish voluntary risk pools for individuals who are denied insurance coverage because of poor health or medical conditions, as well as federal legislation encouraging states to take such action.

HIAA believes that funding for these pools should be broadly based, preferably from general tax revenues. Assessing only commercial insurers for pool losses drives up the cost of private insurance and gives self-funded plans a competitive advantage over insured plans. In addition, HIAA maintains that cost controls and managed care should be incorporated into pool administration.

Health Insurance Association of America
1025 Connecticut Avenue N.W., Washington, DC 20036 202-223-7780 FAX 202-223-7897

HIAA

ON STATE HEALTH INSURANCE ISSUES

ISSUE: THE UNINSURED
(as of March 1990)

BACKGROUND: Approximately 31 million Americans have no public or private health care coverage. Commentators have stated that the uninsured population has increased significantly in the past decade for the following reasons: the economic downturn of the early 1980s and its effect on employment; Medicaid cutbacks; a probable decline in employer-based coverage of dependents in what may be a response to rising health care costs; an increase in state mandated benefits; and increasing numbers of workers in industries less likely to offer health insurance.

The uninsured have greater problems gaining access to the health care system than do those who have insurance. Therefore, they often forego necessary care or delay getting care until it is either too late or more costly. For all these reasons, it is incumbent on policy makers to devise ways to fill the gaps in the health financing system.

Contrary to popular belief, the uninsured are not mainly poor and unemployed. In fact, fewer than one-third have incomes below the federal poverty line, although a significant number are in the near-poor category. Most uninsured people (approximately 62 percent) are either full-time workers themselves or family members of such employees.

Data have shown that it can be difficult for small employers to obtain group health insurance, although there are a number of insurance companies and mechanisms through which such coverage can be purchased. One of the principal barriers for small employers is the cost of health insurance, and HIAA's program on the uninsured calls for tax subsidies for financially vulnerable groups to encourage the purchase of coverage.

In addition, policy makers have stated that certain underwriting and rating practices in the small employer market exacerbate the problem of the uninsured. A portion of HIAA's program also addresses these concerns.

A number of bills have been introduced at the federal level to require or encourage employers to offer coverage. At the state level concern over the uninsured has received widespread attention, and by the end of 1989, more than 40 states were studying and/or considering legislation on the uninsured.

HIAA POSITION: HIAA believes that neither a private nor a public effort, by itself, will adequately meet the needs of the uninsured. However, a cooperative effort can help solve the problem.

HIAA is faced with the ever-increasing need to respond to a growing number of state proposals for the uninsured. Many of these initiatives have their own characteristics, reflecting the special interest groups behind the proposal and the state's political atmosphere, collective social consciousness and financial resources.

HIAA's state policy on the uninsured needs to be consistent with federal policy, but allow more room to incorporate a variety of ways to meet its objectives. To best serve these needs, HIAA has not adopted a specific proposal on the uninsured, but instead supports

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1025 Connecticut Avenue N.W., Washington, DC 20036 ▭ 202-223-7780 ▭ FAX 202-223-7897

state legislation that aims to improve access for some or all of the state's uninsured and that is consistent with the following six points.

- **State programs must be expanded to cover the poor and near-poor populations.** States should expand their Medicaid programs to cover all mandatory and optional categorical groups up to the federal poverty line.

  For those poor individuals who do not fall into a federally defined Medicaid categorical group, states have the obligation to provide similar coverage using their own funds.

  For near-poor individuals (those between 100 percent and 150 percent of poverty), and possibly some of the noncategorical poor, states should establish a public buy-in program, which would cover a range of primary and preventive services (no inpatient hospital or major outpatient surgery) in exchange for an income-related premium.

  If public funds are limited, states should give first priority to low income children and pregnant women.

  States should take advantage of recent federal welfare reform legislation that allows Medicaid to pay low income workers' share of employer-based premium contributions in order to help such individuals participate in available employer-based coverage for a transitional period when returning to work. They should also extend this notion to pay employees' share of premium even after the transition period for all workers whose family incomes are below poverty, whether or not federal matching funds are available for this purpose. HIAA recommends federal Medicaid matching funds when states elect to implement such a buy-out program.

  States should urge the federal government to break the income and categorical links between cash assistance and eligibility for Medicaid so that federal Medicaid matching funds are available to all poor individuals regardless of family structure or work status. States should also urge the federal government to make federal funds available to cover the near-poor population through Medicaid buy-in and other similar programs. Finally, the federal government should be urged to expand welfare reform to apply to all poor and near-poor workers for a transitional period.

- **HIAA is opposed to employer mandates or a compulsion on employers to provide health insurance to employees and their dependents, including tax penalties for failure to provide coverage.** HIAA has developed a separate position paper on employer mandates which is available on request.

- **There are several fundamental tenets of the health insurance industry that HIAA should actively pursue to shape the outcome of any state proposal on the uninsured.**

  They include: essential underwriting freedom; appropriate rate latitude; noncompetition between private and public programs; maintenance of a private market, including the agent distribution mechanism (e.g., no state fund); meaningful cost containment; and elimination of state benefit mandates.

- **Small employers should have reliable premium levels and access to group health insurance.** HIAA has developed a set of standards dealing with small group reforms in connection with the establishment of a reinsurance mechanism, including making coverage available to entire employer groups, and not subjecting employees to new preexisting conditions when they change jobs or their employer changes carriers. These reforms are intended to help assure a viable private marketplace and place meaningful limits on the rate of premium increases, on renewal of coverage and on the degree to which rates vary for groups that are similar with respect to their plan design, geography, demography and industry.

- **Uninsurable individuals (as defined by HIAA policy) who are also ineligible for private group coverage, should have access to coverage through high-risk pools.**

  Even with Medicaid expansions and increased employer-based coverage, uninsurable individuals will remain without coverage. High-risk pools should be established to make coverage available to them, but participation should be limited as defined by HIAA policy. Measures should be included in legislation that prevent risk pools from competing with existing private coverage, such as capping premium rates at a multiple of standard rates (e.g., 150 percent). Pool losses should be funded by general revenues or similar sources, which spread the cost across virtually all citizens.

- **Individuals and groups unable to afford coverage should receive subsidies to purchase it. Whenever possible, such coverage should be sold in the private sector.**

  Some individuals and businesses are insurable but cannot afford to buy coverage. Publicly funded subsidies for private coverage should be available to them but should be limited to truly hardship employers. Subsidies can be direct public funds used to purchase coverage, or incentives such as tax credits to individuals, employees or employers. In addition, alleviation of a premium tax on coverage that insurers sell to those eligible for subsidies further reduces the cost of coverage.

  If an individual or business is both uninsurable and unable to afford coverage, subsidies should be available through the high-risk pool. But subsidies should not be available exclusively to pool participants.

- **Cost is a key barrier to access to health care. In order to make coverage more affordable, it must be free from mandated benefit requirements, and payers must be permitted to use managed care techniques to control cost and maintain quality of care.**

  Health care cost containment principles and techniques should be incorporated into any reform package as an essential element of an affordable and comprehensive proposal for the uninsured. State law should permit the delivery of quality health care coverage tailored to the needs and resources of employers and consumers, but it should not impair the ability of third-party payers to use appropriate managed care techniques, including prepaid funding, selective contracting, provider networks, utilization management and fee schedules.

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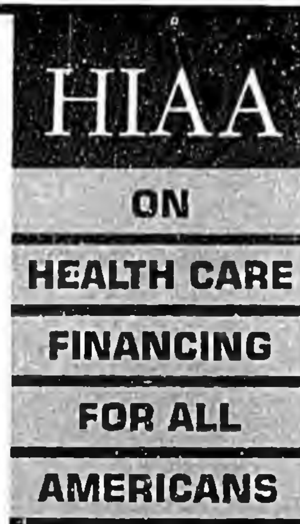

PROVIDING HEALTH CARE FINANCING FOR ALL AMERICANS

PROPOSAL

Today, more than 30 million Americans have neither public nor private health care coverage. These Americans often have greater problems gaining access to the health care system than do those who have coverage. They may forgo necessary care or delay getting treatment until their problems worsen—and become more costly.

These individuals represent the widening gap in our nation's health care financing system. The Health Insurance Association of America (HIAA) believes that policy makers must devise ways to close the gap. More precisely, government action is needed to provide the legislative and fiscal base that will enable both public and private providers of health care coverage to meet the health care financing needs of all Americans.

HIAA's proposal focuses on expanding health care coverage through the workplace and expanding public coverage for the poor and the near poor. As a complement to its proposal, HIAA also is recommending ways to curtail the relentless rise in health care costs that has contributed to the increase in the numbers of the uninsured. **The four essential elements of HIAA's proposal are:**

- **Adopt reforms to assure the availability and reliability of private health insurance in the small employer market;**
- **Allow insurers to offer more affordable coverage to small employer groups;**
- **Provide targeted tax assistance so that small employers and their financially vulnerable employees can afford health insurance coverage; and,**
- **Expand public coverage for the poor and the near poor.**

These objectives can be achieved through carefully crafted policy, embodied in responsible legislation. In addition, efforts to expand the nation's health care coverage must be coupled with meaningful cost-containment measures, since improved access largely depends on reducing the rate of increase in health care costs while maintaining quality of care. Thus, action to halt the rise in health care costs will also help stem the rise in the numbers of the uninsured. Such actions include promoting managed care, medical malpractice reform, assessment of new medical technologies and their uses, and wellness and preventive activities.

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DISCUSSION

The early 1980s were marked by a significant increase in the numbers of people without health care coverage. This increase has been attributed to many causes: the economic downturn and increased unemployment of the early 1980s, a decline in Medicaid's coverage of the poor, a small decline in employer-based coverage of dependents, a rise in health insurance costs due to the proliferation of state-mandated benefits, and the growing number of workers in industries less likely to offer health insurance. Not the least important factor has been the steady rise in the cost of health care.

Since the mid-1980s, the number of people without health care coverage in the United States has remained high but relatively constant. While estimates vary, the U.S. Bureau of the Census figure of 31.5 million is the most frequently cited. This population is demographically diverse. And, while three out of ten are poor, four out of ten have incomes of more than twice the federal poverty level.

The low-income individual under age 65 is less likely to have health coverage or to be covered through public programs. On the other hand, the individual whose family income rises above 150 percent of the federal poverty level is far more likely to have private health care coverage and less likely to have no coverage or coverage obtained from a public source. (Figure 1)

The vast majority of the non-elderly (approximately 150 million people) obtain health coverage through an employment-based plan. Yet most individuals without health care coverage still have some association with the work force. In fact, 66 percent of the uninsured are full-time workers or belong to families of full-time workers. Another 14 percent either work part-time (18 to 34 hours a week) or belong to families with one or more working members. (Current Population Survey, U.S. Dept. of Health and Human Services, March 1988 tabulations)

The relationship of health care coverage to income level and workplace to has important policy implications.

First, in order for expanded public coverage to be cost effective, it should be targeted to the poor and the near poor. Extending public coverage to higher income individuals inevitably will lead to costly and unnecessary substitution of public coverage for private coverage.

Second, efforts to make coverage more available and more affordable should reflect that most Americans receive their health care coverage through employment. Thus, a realistic approach should focus on improving the ability of financially vulnerable employers to offer health insurance to their employees—who, for the most part, have low incomes. In addition, some low-income employees—who may or may not work for small employers—need direct government assistance so that they can meet their share of premiums.

Finally, HIAA also believes that efforts to expand the nation's health care coverage system must be complemented by responsible cost-containment measures. HIAA's policy on cost containment includes an emphasis on the development of managed health care systems including health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other effi-

cient networks. It also calls for greater scrutiny of one of the major causes of high costs—the use of new, often unproven technologies and procedures. Once again, HIAA recommends a mechanism for assessing the cost effectiveness of such technologies and the adoption of medical practice guidelines and protocols. HIAA also strongly supports wellness and prevention activities, as well as economic incentives for the consumer to be 'cost conscious' in the use of medical resources and in choosing health plans.

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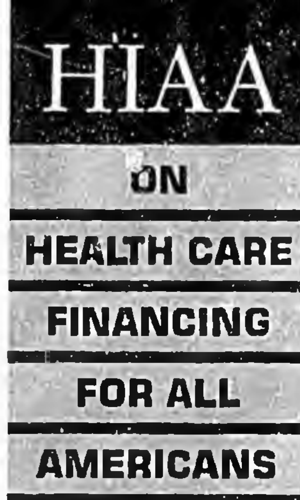

PROPOSAL ON PROVIDING HEALTH CARE FINANCING FOR ALL AMERICANS

In Brief

I. Adopt reforms to assure the availability and reliability of private health insurance in the small employer market.

A. Enact small-employer market reforms to assure that coverage is available on a continuing basis for all small employers and that individual high-risk employees are not denied coverage. If an employer changes insurers or an employee changes jobs, new preexisting condition restrictions would not be imposed. Limits would apply to variations in premiums and premium increases.

B. Authorize a private reinsurance mechanism for the small-employer health benefit market. This would allow insurers to implement market reforms by permitting insurers to spread losses for high-risk people equitably across the market. Under the HIAA proposal, no employer would have to pay more than 150 percent of the relevant market averages for basic coverage.

C. Establish state pools for medically uninsurable individuals who are not part of an employer group. Losses should be financed by state general revenues or other broad-based funding. If a state does not act, the U.S. Department of Health and Human Services should be authorized to set up a federally funded pool in that state to pay for losses. The funds for the pool would come from funds that HHS would otherwise spend in that state.

II. Allow insurers to offer more affordable coverage to small employer groups.

Allow insurers to market lower-cost prototype plans through exemptions to costly state provider and service coverage mandates (given to self-insured plans) to insured employer plans

III. Provide targeted tax assistance so that small employers and their financially vulnerable employees can afford health insurance coverage.

A. Help small businesses afford coverage by extending to the self-employed the 100 percent tax deduction that is available to other employers (as long as they provide equal coverage for their employees).

B. Target new tax subsidies to financially vulnerable groups. Subsidies should be directed toward financially fragile employers and low-income employed individuals.

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IV. Expand public coverage for the poor and the near poor.

A. Expand Medicaid to cover all those below the federal poverty level, regardless of family structure, age or employment status. Eliminate Medicaid's link to welfare categorical restrictions.

B. Extend the Medicaid "spend-down" program to all states and set eligibility thresholds so that no one is impoverished by medical expenses.

C. Allow low-income individuals above the poverty level to "buy into" an income-related package of primary and preventive health care services.

D. Establish an optional "buy out" program for employed individuals who are Medicaid-eligible; that is, allow states to reduce government costs and provide a transition to self-sufficiency by paying the employee share of available employer group insurance.

A more detailed discussion of this proposal is available.

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HIAA ON HEALTH CARE FINANCING FOR ALL AMERICANS

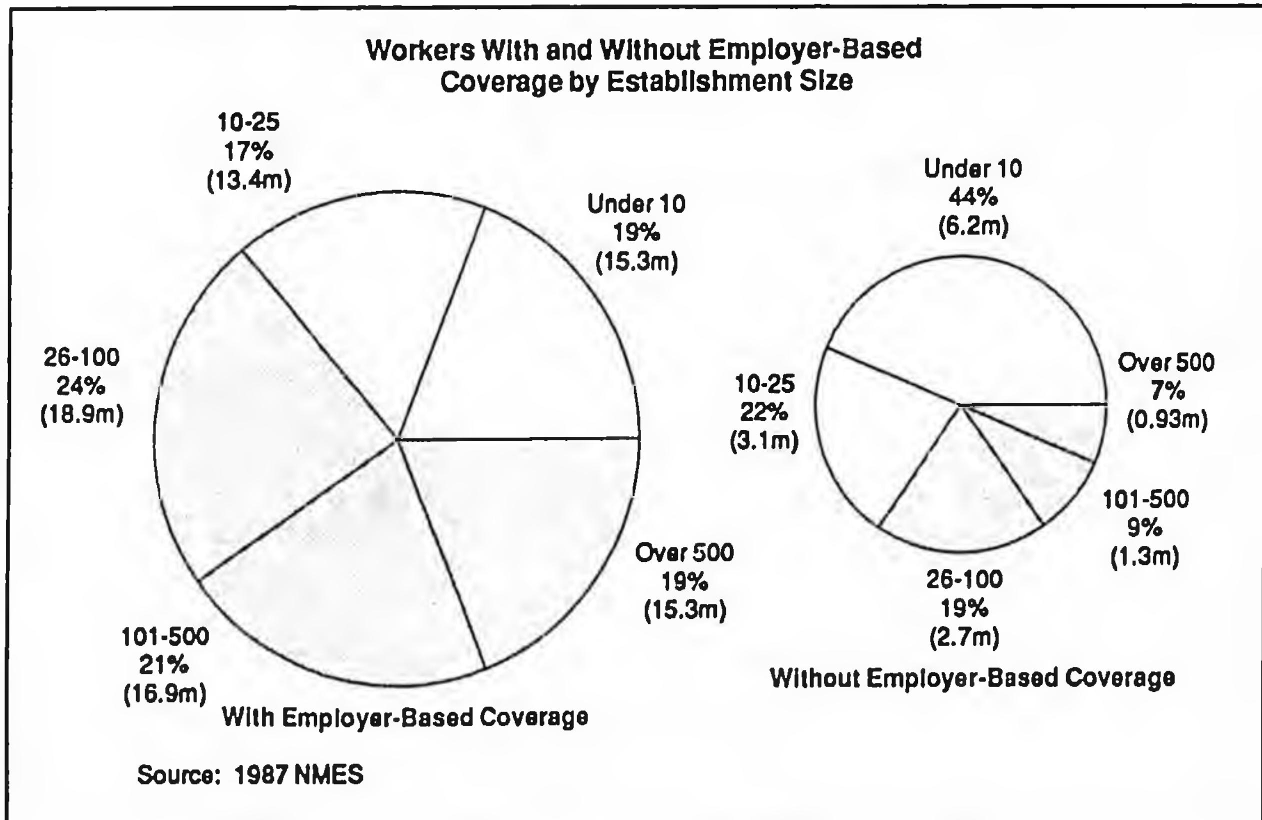
PROPOSAL ON PROVIDING HEALTH CARE FINANCING FOR ALL AMERICANS

In Detail

I. Adopt reforms to assure the availability and reliability of private health insurance coverage in the small employer market.

The small employer health benefit market is receiving increasing attention. This is largely because, as shown below, a high proportion of workers without health care coverage—fully two-thirds—work for business establishments with 25 or fewer employees. This is not surprising since only one in three firms with fewer than 10 employees offers health benefits.

Increasingly, small employers seek relief from rising health care costs by an aggressive search for the lowest possible price for health care coverage. Those with healthy employees are more



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likely to seek, and obtain, coverage at prices that reflect their low risk. This has made it more difficult for insurers to spread risks as broadly as in the past.

In general, small employers have greater difficulty than large employers in affording and sometimes even obtaining health coverage. This is particularly true for those employers with employees at high-risk of incurring medical expenses. Furthermore, the greater frequency with which small employers change carriers and their workers change jobs exposes individuals in this market to greater risk of being left out of the system. Finally, small employers are generally highly sensitive to very large, unanticipated premium increases and may fail to initiate or retain coverage in a marketplace where individual employer experience is highly unpredictable.

- ***Small Employer Market Reforms***

HIAA has developed market reforms and reinsurance recommendations that would ensure fair access to, and continuity of coverage for, small employers and their employees. These reforms would introduce a greater degree of predictability and stability to the small employer health benefit marketplace.

- **Guaranteed Availability**. All small employer groups would be able to obtain private health insurance regardless of the health risk they present.
- **Coverage of Whole Groups**. Coverage would be made available to entire employer groups; neither an employer nor an insurer would be able to exclude from the group's coverage individuals who present high medical risks.
- **Renewability of Coverage**. At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be cancelled because of deteriorating health.
- **Continuity of Coverage**. Once a person is covered in the small employer market and satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.
- **Premium Pricing Limits**. Insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

  More specifically, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate (halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's "trend" (the year-to-year increase in the lowest new business rate). Separate trends should be allowed for managed care and non-managed care to reflect health care cost/efficiency differences in these structures.

  In order for the reforms to succeed, the implementing legislation will have to pertain to all competitors in the small employer market. If any one company or segment of the market pursues such reforms independently, without rules for marketplace behavior spelled out in legislation, it might invite financial ruin. Within the scope of these rules, insurers would be allowed to assess risk, set rates, and determine which individuals for whom to purchase reinsurance.

- ***Private Reinsurance***

A private marketwide reinsurance system would make these small employer reforms possible. Reinsurance means to "insure again." Under reinsurance, an insurance company, called the ceding or direct-writing insurer, purchases insurance from the reinsurer to cover all or part of the loss against which it protects its policyholder. The reinsurer is, in a sense, a silent partner of the original insurer. Reinsurance enables an insurer to accept a greater variety of risks. By sharing these risks with a reinsurer, the ceding insurer obtains an adequate spread within which the law of averages can operate.

Reinsurance will allow individual insurers (or other small employer health plan entities) to implement reforms without facing high financial losses. Reinsurance will assure that small employer groups that present a high health risk may obtain a basic set of benefits from private carriers at a rate no higher than 50 percent above the applicable average market premium. For groups already covered by an insurance carrier, the premium pricing limits described above would pertain, and would in many cases limit a high risk employer's rates to a level below the guaranteed marketwide maximum level of 50 percent above average.

Under the approach developed by HIAA, carriers could: (a) reinsure entire high-risk small employer groups at a reinsurance premium price of 150 percent of average market costs or (b) reinsure high-risk individuals within groups at 500 percent of average market costs. To reduce the volume of reinsured claims, reinsurance would be on a three-year basis. (If reinsurance were permitted annually, carriers would declare more groups or individuals high-risk and utilize reinsurance more often increasing reinsurance losses to unacceptable levels.)

The reinsurer would cover the costs associated with reinsured cases. The process of reinsurance is invisible to employers and employees and is purely a transaction between the ceding insurer and the reinsurer.

Because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price would be capped in order to encourage carriers to participate in the small employer market, in the aggregate the cost of the reinsured persons will exceed the reinsurance premiums. Under the HIAA proposal, the reinsurer losses would be spread equitably across all competitors in the private marketplace.

The losses would be covered first through contributions from all carriers in the small employer market. If losses were significantly higher than expected, a second "safety valve" of private financing will be made available from health benefits plans in general. In the highly unlikely event that the first and second financing tiers were inadequate, governmental assistance might be sought.

HIAA will continue to pursue reinsurance and related small employer market reform in the states. HIAA will also recommend Federal legislation to give states the authority to assure compliance with the market reforms outlined here and to finance the reinsurance system.

- ***Establish State Pools for Uninsurable Individuals***

Even with increased employer-based coverage and with Medicaid expansions (see below), medically uninsurable individuals who are not part of an insured employer group would remain without coverage.

High-risk pools should be established to make coverage available to such individuals. Pool losses should be funded by general revenues or similar sources, which spread the cost broadly across society.

As of December 1990, 25 states have enacted broad-based pools for uninsurable individuals.

II. Allow insurers to offer more affordable coverage to small employer groups.

Over the years, the list of state laws mandating that insurance cover specific services and providers has grown dramatically. There are about 800 such laws nationwide—and they mandate coverage of such disparate services as chiropractic, podiatry, acupuncture, pastoral counseling, and mental health. The cumulative effect of this hodgepodge of state laws is to increase the cost of health insurance, particularly to small employers who are most in need of relief from the high cost of health care and who are too small to self-insure and thus escape these mandates.

One reason that mandated benefit laws increase the cost of coverage is that multi-state insurers must monitor and comply with so many different state rules and regulations. Insurers are precluded from developing lower-cost prototype plans that would be marketable across state lines. Instead, they are often forced to offer only "Cadillac" plans based on a multitude of mandates from many states.

Many of these benefits, such as those for mental health, are expensive in their own right. Taken together, mandated benefits in many states provide a package that many small employers simply cannot afford.

A 1989 study conducted by Gail Jensen, then a University of Illinois health care economist and now at the University of North Carolina, concluded that 16 percent of small employers not now providing health insurance would offer benefits in the absence of state mandates.

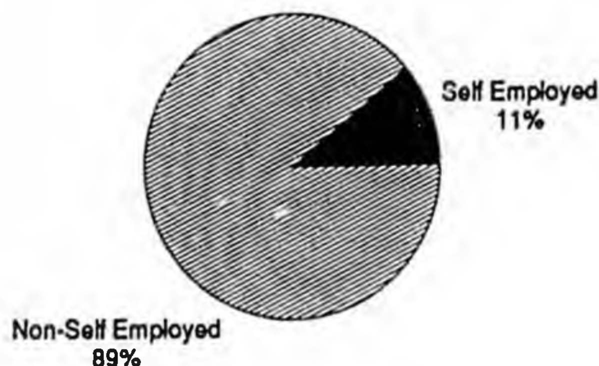
Furthermore, state-mandated benefit laws do not apply equally to all health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws and other forms of state insurance regulations. In general, only large employers have the financial resources or the risk-spreading base to self-insure; self insurance allows multi-state employers not only to save administrative costs through plan uniformity but to pick and choose those benefits that are most desirable and cost effective. Employers too small to self-insure do not have this flexibility, and they are thus less likely to offer health insurance at all.

In 1985, the U.S. Supreme Court ruled that to put employee health benefit plans on the same footing as self-insured plans required congressional action. Moreover, in recent years, there also has been a proliferation of state actions that obstruct or hinder private sector managed care efforts that would make health care coverage more affordable. These state bills are aimed at limiting contractual arrangements with cost-effective provider networks, as well as preventing or limiting insurers' ability to carry out effective utilization review programs. Again, small employers should be able to benefit from the same cost-management approaches as do larger employers.

III. Provide targeted tax assistance so that small employers and their financially vulnerable employees can afford health insurance coverage.

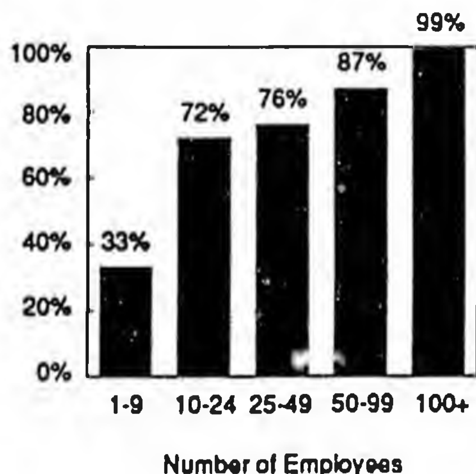
Small businesses tend to be younger, financially less stable and employ a lower wage work force. Thus, health benefits often represent a greater financial burden to small businesses, who are far less likely to offer them than are other employers. A 1989 HIAA survey found that only 33 percent of firms with fewer than 10 employees offer health benefits. Conversely, over 95% of firms with more than 25 employees offer health benefits.

Percentage of Uninsured Workers Who are Self-Employed



Source: HHS Tabulations of the March 1987 Current Population Survey

Percentage of Firms That Offer Health Benefits by Numbers of Employees



Source: HIAA

Eleven percent of uninsured workers are self-employed. They are uninsured in part because self-employed workers receive only a 25 percent income tax deduction for the cost of health benefits. Other (incorporated) businesses receive a full 100 percent deduction.

The financial vulnerability of small employers and uninsured workers, as well as government fiscal realities, suggest that additional tax assistance should be carefully targeted to those populations most in need. For instance, government should:

- Direct new tax subsidies to assist employers and individuals with inadequate financial resources (e.g., certain small employers) in purchasing private coverage; for example, firms with 25 or fewer employees, and that pay low average wages, could be subsidized on a sliding scale. Employees with low incomes could be assisted in paying their share of premiums.
- Extend to the self-employed the 100 percent tax deduction enjoyed by other employers (as long as they provide equal coverage for their employees, if they have any).

IV. Expand public coverage for the poor and near poor.

Thirty percent of the uninsured have family incomes below the federal poverty level ($10,560 for a family of three in 1990). Another 17 percent have family incomes between one and one and a half times the federal poverty level. The current federal/state Medicaid program covers only four out of ten poor Americans. Many states do not have a medically needy program, and Medicaid income eligibility thresholds for the non-elderly generally fall far below the poverty level.

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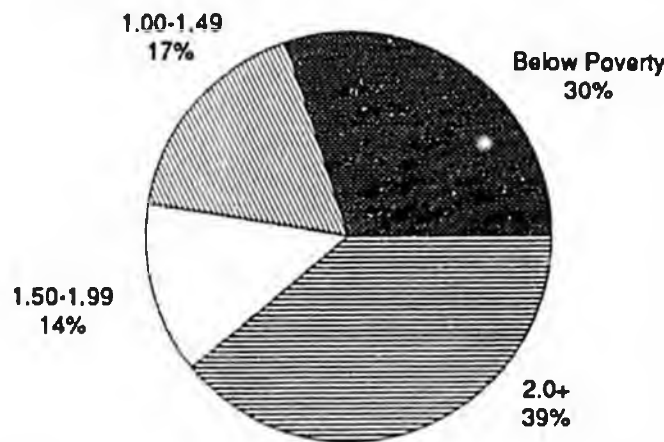
Persons Without Health Care Coverage
By Family Income as a Percentage of Poverty



Source: Tabulations of the March 1988 Current Population Survey

Because the poor and many of the near poor do not have the means to purchase coverage on their own, the health care financing responsibility for these populations rests largely with the government. HIAA proposes the following actions:

- The Medicaid program should be extended to cover all poor Americans regardless of age, family structure or employment status. To carry out this recommendation fully, Medicaid eligibility will have to be independent of cash assistance programs such as Aid to Families with Dependent Children (AFDC.) Recent congressional action to phase in coverage for all poor children under age 19 over the next ten years is a good start.

- For poor workers with access to employer-based private coverage, states should be given the authority to buy out employed individuals and their families from the Medicaid program. States should pay the poor employees' premium contributions and cost sharing (co-pays and deductibles) associated with available employer plans. This approach would be used for all Medicaid eligible employees of employer plans that, if used, would reduce net government costs. It would build upon existing private plans and would ease individuals' transition into economic self-reliance. In determining whether this approach will yield savings to the state, attention should be focused on the characteristics of the employer plan (coverage levels, amount of employer premium contribution) and on its value to a typical employee rather than on the characteristics of the individual employee. (Recent congressional action requires states to implement a "buy-out," but is vague as to how cost-effectiveness will be determined.)

- Near-poor individuals with family incomes between one and one-and-a-half times the federal poverty level should be allowed to "buy in" to a lower cost package on a sliding scale related to their income. This package should cover primary and preventive care services only. Such a limited buy-in package would target government assistance to the primary and preventive services the near poor most often forgo and for which cost-sharing sometimes presents a financial obstacle; adopting this approach would also avoid the costly substitution of comprehensive public coverage for existing private coverage.

- To assure that no American falls beneath the poverty level as a consequence of medical expenses, all states should deduct medical expenses from income when determining eligibility for Medicaid. "Medically needy" or "spend-down" programs (and many states have already adopted such programs) constitute a last-resort financial safety net covering a full range of health services.

Raising eligibility standards for Medicaid to 100 percent of the federal poverty level will give an estimated 9.5 million to 11 million uninsured Americans access to Medicaid coverage. (The Medicaid program currently pays for the care of over 21 million people annually.) While costly, these reforms would increase Medicaid costs by only about 25 percent while more than doubling the population served by the program. This is because three quarters of Medicaid spending now goes for long-term care and other services for the elderly and disabled. Medicaid coverage for poor uninsured populations is far less expensive on a per capita basis.

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HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

COUNTING THE UNINSURED

Estimates of the number of uninsured Americans can be derived from a number of different government based sources. The most frequently cited figures are generated from the Census Bureau's Current Population Survey (CPS). This survey source is popular primarily because it is conducted every year, it allows general short-term trend analysis, and because the data is easy for researchers to work with. In 1988, the number of uninsured individuals, according to the CPS, was 31.5 million.

Other data sources sometimes used are the Health Interview Survey (HIS), the Survey of Income and Program Participation (SIPP) and the National Medical Expenditure Survey (NMES). Each of these sources has produced slightly different estimates of the number of uninsured Americans. For example, preliminary tabulations of NMES have determined uninsured counts for 1987 to be in the neighborhood of 37 million. This number, however, is expected to be revised downward in future NMES estimates. In addition, part of the discrepancy between the NMES and CPS estimates may be the result of different survey designs. For example, the two surveys ask somewhat different questions regarding individuals' health insurance status.

Much larger uninsured counts have been cited recently from the SIPP data. The fundamental difference between the recent SIPP estimates and the CPS and NMES estimates is that the SIPP estimates are measuring the number of individuals who were uninsured at any time during a 28-month period. This survey's data find that over a 28-month period (1986-88), 62 million individuals were without health coverage at some time. The same data show that at any time, roughly 31 million are without coverage (close to estimates based on the CPS). This suggests that lack of health coverage is a transitory phenomenon in many cases, but a core of uninsured remains.

It should be noted that in 1988 the Census Bureau redesigned its questionnaire. In doing so, the estimates of uninsured Americans dropped from roughly 37 million to 31 million. Most of this adjustment can be attributed to a more discrete classification of the coverage status of children. The questionnaire change led to a reduction in the number of children counted as uninsured, and hence, an increase in the number of insured children.

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HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

THE FOLLOWING STATES HAVE HIGH-RISK POOLS FOR UNINSURABLE INDIVIDUALS

- California
- Colorado
- Connecticut
- Florida
- Georgia
- Illinois
- Indiana
- Iowa
- Louisiana
- Maine
- Minnesota
- Missouri
- Montana
- Nebraska
- New Mexico
- North Dakota
- Oregon
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Utah
- Washington
- Wisconsin
- Wyoming

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HOW REINSURANCE WORKS

For more than two years, the Health Insurance Association of America (HIAA) has been developing the components of a reform package designed to address the unique requirements of the small employer market. These reforms, when taken as a whole, will ensure fair access to and continuation of coverage for small employers and their employees. These reforms constitute a meaningful basis for enhancing and expanding health care coverage.

Small employers, unlike their larger counterparts, are likely to go into and out of business frequently. Similarly, their employees tend to move from job to job frequently. Finally, small employers change insurance carriers more often in an attempt to obtain more favorable rates. All of these factors, combined with growing health care cost pressures, make it exceedingly difficult for insurance carriers to provide coverage to the small employer and they also make it more likely that individuals within this market will lose health care coverage at some point. HIAA's small employer market reforms tackle these problems in a reasonable and workable manner.

The HIAA proposal would ensure that any small employer may obtain coverage (regardless of the health condition of its employees or the inherent administrative burdens they pose). The following examples illustrate how this would work.

SITUATION: Tom's Tree Trimmers opens for business with a full-time work force of five employees. With workers engaged in dangerous work, where statistics suggest that personal injury is far more likely to occur than in, say, a computer sales and repair outlet, obtaining affordable health insurance may be difficult. Let us suppose that two employees, Harry and Sam, have serious health problems, which insurance companies term **pre-existing conditions**. To obtain coverage, the president of Tom's Tree Trimmers could face the following options: terminate Harry's and Sam's employment, insure everyone except Harry and Sam, or provide no insurance for any of the employees.

SOLUTION: Under the HIAA reform proposal, Tom's Tree Trimmers would not be excluded from coverage because it is engaged in dangerous work or because two of its employees, Harry and Sam, have pre-existing conditions. Also, the carrier selling insurance to the company would be permitted to reinsure Harry and Sam, the high risk employees (unbeknownst to Harry, Sam, and their employer), by paying a reinsurance premium. In exchange for the reinsurance premium, the reinsurer would agree to reimburse the insurer for Harry's and Sam's costs.

SITUATION: During the course of the year a third employee at Tom's Tree Trimmers, George, becomes seriously ill. Will his condition threaten coverage for himself or his coworkers?

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SOLUTION: Under HIAA's reform proposal, insurance coverage would be maintained for all employees, regardless of any of the employees' conditions. Tom's Tree Trimmers' insurance carrier would be obligated to renew the contract (unless the company failed to pay its premiums in a timely fashion or was dishonest with the carrier).

SITUATION: George, who has had several months of poor health, is on the road to recovery. He decides to leave Tom's Tree Trimmers to gain experience at a small computer sales and repair outlet, the Corner Computer Company. He is concerned that he will not be able to obtain coverage with his new employer because of his health record with Tom's Tree Trimmers. He is aware that, prior to the reforms in the small employer market, employees who changed jobs or employers that changed carriers could face recurring pre-existing condition limitations. George realizes that this could leave him without health care coverage.

SOLUTION: Under the HIAA proposal, George would be guaranteed continuity of coverage and would not be subject to any new pre-existing condition limitations if he changes jobs or his employer switches carriers, since he satisfied those while employed by Tom's Tree Trimmers (this assumes that George did not allow his coverage to lapse for a sustained period of time).

SITUATION: Both Tom's Tree Trimmers and the Corner Computer Company are concerned that their health premiums will rise inordinately if one or more employees is found to be seriously ill.

SOLUTION: Under the HIAA proposal, an insurance carrier would have to limit how much its rates, based upon the group's health history, varied. Carriers could vary their rates for similar small employer groups (those with similar demographics, plan type, and geographic area) by no more than 35 percent above or below their midpoint rate (the midpoint rate is halfway between the carriers lowest and highest rate). Carriers would also have to limit their industry rating adjustment to 15 percent. Finally, the year-to-year premium increase for a group could be no more than 15 percent above the carriers "trend" (defined as the increase in the lowest new business rate). To reflect cost differentials between managed care and non-managed care products, carriers could establish separate trends.

SITUATION: A new firm, Tree Doctors, Inc., opens for business in the same community as Tom's Tree Trimmers. Like its competitor, Tree Doctors employs five employees. At the time it opens for business, all of its employees are healthy. The president of Tree Doctors, Inc. knows that he is in stiff competition with Tom's Tree Trimmers. He is concerned that he may be at a competitive disadvantage if any of his costs are higher than those of Tom's Tree Trimmers. Since Tom's Tree Trimmers has been in business for some time, the owner of Tree Doctors, Inc. is concerned that he may not be able to purchase health insurance coverage at a rate that will be similar to the rates charged to his competitor.

SOLUTION: Under the HIAA proposal, the availability of reinsurance combined with the premium rate limits would moderate the premium difference between groups. The HIAA plan would ensure that Tree Doctors, Inc. did not incur inordinately high premiums relative to demographically similar firms.

December 1990

SIMPLIFIED NUMERICAL RATING LIMIT ILLUSTRATIONS

Year 1990

(1) **Typical Employer**[1] - Carrier XYZ is selling a health plan to a typical employer at a midpoint premium rate which amounts to $200 per month, per employee (i.e., this figure would be an average of the premiums for some single persons and some families). The employer pays, on average, 80 percent of the premium ($160); the employee pays 20 percent of the premium ($40).

Low Risk Employer - While a second employer has similar demographic, area and industrial composition as the typical employer, it has, on, average a very low health risk. Because the employer is low risk, Carrier XYZ agrees to sell coverage at a rate which is 35 percent below the midpoint rate of $200 per employee. In this instance, the health plan would cost $130 per month, per employee. Of this amount, 80 percent ($104) is contributed by the employer and 20 percent ($26) is contributed by the employee.

(3) **High Risk Employer** - A third employer has demographic, area, and industrial compositions similar to the above employers but has a very high medical risk. Carrier XYZ may charge this employer no more than $270 per month, per employee for the same health plan (35 percent above the midpoint rate of $200). Of this amount, $216 (80 percent) is contributed by the employer and $54 (20 percent) is contributed by the employee.

Year 1991

Assumption: Carrier XYZ's "trend" (the percentage increase in their lowest new business rate[2] from 1990 to 1991) is 12 percent.

(4) **Typical Employer** - Although the typical employer's workforce remained the same, a number of employees became seriously ill during 1990 and submitted major claims. From 1990 to 1991, carrier XYZ may increase the typical employer's rates by no more than 15 percent above "trend." Therefore, the rate charged to the typical employer in 1991 would be no more than $254 per employee (12 percent+15 percent above the midpoint rate of $200). Of this amount, $51 is contributed by the employee and $203 is contributed by the employer.

(5) **High Risk Employer** - While the high risk employer's workforce also remained the same, several additional employees became seriously ill and submitted major claims. Since the high risk employer is already at the top of carrier XYZ's rating limit, XYZ can increase the high risk employer's rates by no more than the trend. Therefore, the rate charged to the high risk employer in 1991 could be no more than $302 per month, per employee for the health plan (35 percent above the group's 1991 mid-point rate of $224), which amounts to an increase from 1990 to 1991 of no more than trend (12 percent). Of this amount, $60 is contributed by the employee and $242 is contributed by the employer

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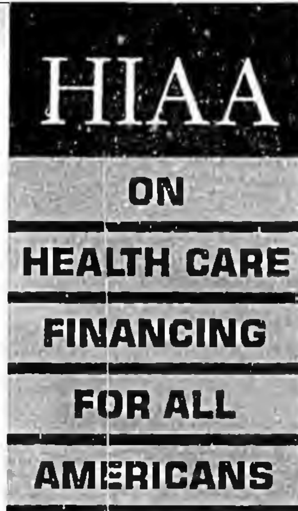
[1] By "typical" we mean a small employer group that does not contain an unusually large number of cases with high or low medical risk. For example, a small employer group that has been covered by a carrier for several years is often going to be a typical employer. On the other hand, a small employer group that is newly covered is more apt to be considered low risk since in the first year or so health plan costs are often lower (due to preexisting condition limits, for example).

[2] This is believed the best measure of a carrier's general yearly increase in premiums.



HEALTH CARE ACCESS LEGISLATION BY STATE

ALASKA

House Bill 581

Creates a Universal Health Care Task Force to design a cost efficient program allowing access to a basic level of health care for all state residents. Members appointed by the governor to include a representative of the insurance division. The task force is charged with soliciting advice and information from all interested groups, including the insurance industry and includes consideration of state health insurance for low income indigent residents, an uninsurable risk pool, reestablishing the state catastrophic illness insurance program, mandated employer coverage and virtually every other aspect of and option for health care coverage. Specifies delivery options. Chapter 179-90. Effective February 1, 1991.

Senate Bill 326

Creates a grant program for community health care planning in municipalities and rural areas. Chapter 107-90. Effective July 1, 1990.

Senate Bill 334

Directs the U.S. Department of Health and Social Services to seek options and receive waivers under the federal Medicaid program for the cost of home or community-based services for developmentally delayed or disabled children and adults. Chapter 90-26. The bill became effective 5-4-90.

ARIZONA

House Bill 2249

Expands coverage for pregnant women and infants under the Arizona health cost containment system and increases the maximum allowable qualifying family income to 133 percent of the federal poverty level. Chapter 90-27. The bill became effective 4-6-90.

CALIFORNIA

Senate Bill 1412

Establishes a state health care for the indigent program and appropriates money from Proposition 99 funds for allocation to counties that do not contract with the State's Department of Health Services for the provision of health services to the indigent. Chapter 90-50. The bill became effective 4-17-90.

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COLORADO

House Bill 1305

Creates the Colorado Uninsurable Health Insurance Plan, designed to provide health insurance coverage for eligible Colorado residents. Coverage is available for those residents considered medically uninsurable because they had been denied health insurance coverage or because such coverage is available to them only at prohibitively high rates. The initial premium rates for coverage under the plan shall not exceed 150 percent of the standard risk rate established pursuant to subsection (2) of §10-8-512. Subsequent premium rates shall provide fully for expected costs of claims, including recovery of prior losses and operating expenses. However, subsequent premium rates shall not exceed 175 percent of the standard risk rate determined pursuant to subsection (2) of §10-8-512. Funding for losses of the uninsurable pool will be met by imposing a $2.00 charge on Colorado taxpayers whose federal income tax return indicates an adjusted gross income in excess of $15,000 for a single return, or a $4.00 charge on a joint return. This law becomes effective July 1, 1990 and will remain in effect until July 1, 1993. The bill was approved 5-31-90.

Senate Bill 63

Creates the Colorado Uninsurable Pool to provide health coverage for Colorado residents who are medically uninsurable. Rates for coverage shall be between 150 percent and 175 percent of the standard risk rate. Pool losses will be funded through premiums paid by insured participants and by monthly assessments on each employed person. The assessment amount would range between 10 cents per employee per month up to a maximum of 25 cents per employee per month. This bill authorizes employees who are not eligible for an employer's group health insurance program to participate under the uninsurable pool with funding provided by the employer in an amount equal to that paid by the employer for other employees. Employers may pass assessments on to each employee and qualify for a tax credit equal to the amount of their assessments. Adds a new 39-22-117 to impose an additional tax on individuals whose federal tax return indicates adjusted gross income in excess of $5,000, in the amount of $1.20 per single/separate returns and $2.40 for every joint return. Such amounts will be transmitted to the state treasurer and credited to the Colorado Uninsurable Health Insurance Cash Fund.

CONNECTICUT

House Bill 5936

Alters the income eligibility for Medicare assignment by increasing limit on annual income from 150 percent to 175 percent of the qualifying income level established in the ConnPACE program. Chapter 90-185. The bill was approved 6-6-90.

Senate Bill 342

Implements the recommendations of the Blue Ribbon Commission on Health Care Access to, among other things, (1) provide medical assistance to children from low-income families; (2) authorize Medicaid to "buy-in" to employment-based plans for low-income persons and pay COBRA continuation premiums; (3) authorize a new program for pregnant women whose income is within 250 percent of the federal poverty level; (4) provide a grant program for providers serving the uninsured in low-income communities; and (5) require the development of a plan to lower Medicare cost shifting. In addition, this bill requires the Colorado Health Reinsurance Association to develop a special policy for small employers with employees who have incomes below 200 percent of the federal poverty level. This proposal substantially reforms the small group market by (1) requiring insurers to accept all applicants in the small employer

market; (2) making such policies guaranteed renewable with few exceptions; and (3) imposing limits on experience rating/durational rating and preexisting conditions. The bill establishes a reinsurance pool to support the new guaranteed issue requirements funded by assessments not exceeding 6 percent of the small employer premium base. The bill was approved 5-17-90. Chapter 90-134.

FLORIDA

Senate Bill 2794

Authorizes certain groups of small employers to sell "basic" policies but the bill remains ambiguous about which mandated benefits may be omitted. Among the allowable exclusions are: co-insurance options, midwives and birthing centers, mastectomy prostheses, ambulatory surgical benefits, home health care, and acupuncture. Furthermore, it alters required mental benefits. This bill has been sent to the governor.

GEORGIA

House Bill 1696

Establishes the Indigent Care Trust Fund in order to, among other things, expand Medicaid eligibility and provide primary health care to indigent citizens. Chapter 90-738. The bill became effective 3-6-90.

Senate Bill 434

Among other things, provides that the profiles of groups of 50 or fewer members who are separately covered under group accident and sickness insurance must be fully pooled for rating purposes. It requires that insurers issuing individual major medical policies make available to applicants optional cash deductible amounts of at least $5,000. Senate bill 434 also allows insurers to offer higher optional deductibles to existing policyholders as a means of reducing the cost of such policies or offsetting premium increases. Chapter 90-1338. The bill became effective 10-1-90.

HAWAII

House Bill 2908

Places a ceiling on the personal care services program expenditures, limiting total expenditures to not more than 75% of the annual medical assistance cost to maintain recipients at their appropriate level of institutional care. The medical assistance cost, which shall be the basis for the expenditure ceiling, shall be determined by the department of human services. Act 145-90. Effective June 15, 1990.

Senate Bill 3079

Raises the state general fund expenditure ceiling. Rates of payment to individual practitioners shall be based upon the most current profile available of usual and customary fees and the percentage of the profile in proportion to the funds appropriated by the legislature. The director shall submit a report to the legislature on or before January 1 of each year indicating an estimate of the amount of money required to be appropriated to pay providers at the maximum rates permitted by federal and state rules in the upcoming fiscal year. Act 263-90. Effective July 1, 1990.

IDAHO

House Bill 582

Creates a medical assistance program for low-income persons not eligible under the state plan for Medicaid. The program shall be a payer of last resort. Regulatory standards will be developed for the eligibility requirements for participation in this program and for payment of medical claims for eligible persons. Chapter 90-87. The bill was approved 3-23-90.

Senate Bill 1377

Amends section 39-5602, Idaho Code, to include "personal care services" in the Medicaid program. Defines "case management" and other terms related to personal care services. Establishes standards for personal care services. Chapter No. 90-326. The bill was approved 4-9-90.

ILLINOIS

House Bill 3339

Appropriates $18,779,200. from the general revenue fund to the Board of the Comprehensive Health Insurance Plan. Act 86-1059. Effective July 1, 1990.

House Bill 3528

Establishes a program whereby small employers may obtain affordable "no frills" group health insurance to increase access to health care, assist in the reduction of the amount of uncompensated care, and reduce the amount of uninsured state residents. Act 86-1407. Approved September 11, 1990.

IOWA

House Bill 2496

Requires insurers, upon request, to provide information to policyholders, including number of claims processed to date, cost of such claims, and average cost per claim. This bill limits the cost reporting requirements for group health insurance to once in a 12-month period and limits the requirement to groups of more than 100 persons; it deletes the reporting of reserves. The bill became effective 7-1-90.

KANSAS

House Bill 2610

Enacts new section in the Insurance Statutes and State Income Tax Statutes to provide income tax credits for employers contributing to a health benefit plan for employees. Allows different variables in coverage offered by employers to employees in order to obtain tax credits. The bill was approved 4-12-90.

KENTUCKY

Senate Bill 239

Establishes a health care delivery network system. Among other things, this bill would (1) permit Medicaid reimbursement of networks and practitioners and increase payments to family practice physicians in certain underserved areas; (2) encourage employers to provide health insurance; and (3) allow premiums paid for health insurance to be treated as an income tax credit for state income tax purposes. The bill is effective 7-13-90.

Senate Resolution 81

Urges the President of the United States and the U.S. Congress to develop a comprehensive system to adequately address the health care needs of Americans. Adopted 2-21-90.

LOUISIANA

House Bill 2030

Creates the Louisiana Health Insurance Association to make health insurance coverage available to persons otherwise unable to obtain coverage due to health conditions. The program is similar to the HIAA and NAIC model uninsurable pooling mechanism bills, requiring all companies doing business in the state to become an association member; limits premium rates to not less than 150% nor more than 200% of rates applicable for comparable standard risks. Coverage shall consist of comprehensive benefits with specified optional deductibles. Excess losses are funded through hospital admission charges. Policies are not required to be issued by the association until the later of year July 1, 1991 or the date on which the association accumulates service charges for an amount equal to the minimum capital and surplus requirements of domestic stock insurers regarding a certificate of authority to transact health insurance business. Act 131-90. Approved June 29, 1990.

MAINE

House Bill 1509

Establishes a third mandated care insurance plan demonstration program in one urban, one rural, and one undetermined site for individuals without health insurance. This bill would continue two established sites until December 31, 1992. Chapter No. 90-905. The bill became effective 4-24-90.

MARYLAND

Senate Bill 388

Provides comprehensive medical and other health care under the Maryland Medical Assistance Program for: (1) pregnant women and children under the age of 1 whose family income falls below 185% of the federal poverty level; (2) children 1 through 5 years of age whose family income falls below 133% of the federal poverty level; and (3) children 6 and 7 years of age whose family income falls below 100% of the federal poverty level. Chapter 90-418. Effective July 1, 1990.

MINNESOTA

House Bill 2343

Among other things, provides that (1) certain data on eligible persons and enrollees of the State Comprehensive Health Plan be classified as private; (2) a person may enroll in the Plan with a waiver of preexisting condition limitations provided certain requirements are met; (3) every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance must provide the applicant with written notice of rejection or the underwriting restrictions applied; and (4) under certain conditions, employers be liable to the Comprehensive Health Association for the costs of any preexisting conditions of the employers' former employees or their dependents during the first 6 months of coverage under the Plan. Employers are required to pay a special assessment to the Association for the costs of the preexisting conditions. Chapter No. 90-523. The bill was approved 4-26-90.

House Bill 2521

Substitute for SBN 2286 to add ten members to the commission currently studying the uninsured situation in the state. Chapter No. 90-373. The bill became effective 8-1-90.

Senate Bill 1696

Includes the Commissioners of Human Services, Commerce and Health in the design of the demonstration project for uninsured low-income persons. Revises enrollee eligibility and participation requirements. Chapter 454. Effective April 17, 1990.

Senate Bill 2621

Establishes demonstration projects to allow health insurers and nonprofit health service plans to extend coverage for health services to individuals or groups currently unable to afford coverage. An insurer or health service plan corporation electing to participate in a demonstration project may apply to the commissioner for approval. Chapter No. 90-568. The bill was approved 5-3-90.

MISSISSIPPI

House Bill 1269

Authorizes the Department of Health to contract with the state medical association to establish a statewide program to provide medical services at no charge to uninsured persons unable to pay for the services. Chapter No. 90-544. The bill became effective 7-1-90.

House Bill 1467

Among other things, defines Medicaid eligibility and expands Medicaid reimbursement to include periodic screening and diagnostic services. Chapter No. 90-548. The bill was approved 4-4-90.

House Bill 2769

Increases the statutory limit on the annual appropriation to the state Medicaid program to $160,000,000. Chapter No. 90-390. The bill became effective 6-30-90.

MISSOURI

House Bill 998

Establishes a pooling program for individuals (except those having coverage, Medicaid recipients, a person having terminated coverage in the pool unless 12 months have lapsed, any person receiving $1,000,000 in pool benefits, and inmates of public institutions) requiring participation by all insurers and self-insurers in the state. Pool losses will be borne by participants according to premium volume (110 percent of claims for self-insurers) with assessments allowed as an offset against premium and other taxes. Coverage to be determined by the pooling board, with rates of not less than 150 percent nor more than 200 percent of average individual standard rates. This bill has been sent to the governor.

NEW HAMPSHIRE

House Bill 1348

Continues the process started by the committee on access to health care established in 1989, 332:2 by arranging for and overseeing an actuarial study for a benefits package, designing the

final benefits package, designing, but not implementing, a pilot program, and evaluating and identifying funding needs and sources for an ongoing program. Chapter No. 90-227. The bill became effective 7-1-90.

Senate Bill 403

Establishes a committee to study the problem of uninsurables in the state and the possibility of establishing a comprehensive risk pool for the uninsurables. The committee shall report its findings to the legislature on or before December 1, 1990. Chapter No. 90-159. The bill became effective 4-19-90.

NEW MEXICO

House Bill 133

Expands the Indigent Hospital Claims Act to include any community-based public health program operated by a political subdivision or other non-profit health organization that provides prenatal care delivered by New Mexico licensed or certified health care practitioners. Chapter No. 90-37. The bill became effective 5-16-90.

Senate Bill 293

Creates the Indigent Catastrophic Illness Hospital Funding Act to reimburse hospitals for eligible claims incurred by the "medically indigent." "Medically indigent" is defined as a state resident not eligible for Medicaid or Medicare whose income does not exceed 250 percent of the federal poverty level. Chapter No. 90-93. The bill became effective 5-16-90.

OKLAHOMA

Senate Bill 346

Enacts the "Health Insurance Opportunities for Employed Uninsured Oklahoman's Act." Establishes the Oklahoma Basic Benefits Board charged with approving and implementing the terms and conditions of a state certified basic health benefits plan for those employers and employees eligible for participation. Effective July 1, 1990.

RHODE ISLAND

House Bill 7815

Memorializes the United States Congress to support the enactment of a national health insurance act. Resolution 105-90. Adopted March 29, 1990.

Senate Bill 1746

Provides for a basic health care plan to certain eligible persons delivered through managed health care systems. The basic health plan shall be exempt from all mandatory benefits which insurers are required to provide to their insureds but shall include, at a minimum: (1) inpatient hospital care up to 20 days per year; (2) certain outpatient hospital care; (3) emergency room care; (4) physician care and well baby exams with up to 6 visits in a child's first year and childhood immunizations through age 8; (5) physician office visits or community health center visits for primary or sick care (up to 4 visits per year) and laboratory fees; (6) maternity care; (7) psychiatric and substance abuse care; (8) home nursing care up to 20 visits per year; and (9) newborn metabolic and sickle cell screening, mammography and pap tests. Effective July 10, 1990. Chapter 90-271.