

**STUDY OF
PROPOSED MANDATORY HEALTH INSURANCE
FOR WELL-BABY SERVICES**

**Conducted by the
Office of the Legislative Auditor
and**

**Peat Marwick Main & Co.
Certified Public Accountants**

A Report to the Legislature of the State of Hawaii

**Submitted by the
Legislative Auditor of the State of Hawaii
Honolulu, Hawaii**

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FOREWORD

In 1987, the Legislature enacted Act 331 which requires the Legislative Auditor to assess the social and financial impact of measures proposing to mandate health insurance benefits. The purpose of the assessment is to provide the Legislature with a rational and objective basis for evaluating proposals that require health insurance coverage for particular health services.

This report assesses the social and financial impact of Senate Bill No. 518, S.D. 2, H.D. 2 (1987 Regular Session) which proposes to mandate health insurance coverage for child health supervision or "well-baby" services. We were assisted in the preparation of this report by the certified public accounting firm of Peat Marwick Main & Co. which assessed the financial impact of the proposed measure.

We wish to express our appreciation for the cooperation and assistance extended to us by the staff of various state agencies, private insurers, and other interested organizations we contacted in the course of doing the assessment.

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Chapter 1

INTRODUCTION AND BACKGROUND

Act 331, SLH 1987, states that the Legislature shall request the Legislative Auditor to assess the social and financial impact of measures proposing to mandate health insurance benefits. The purpose of the assessment is to provide the Legislature with an independent, systematic review of the ramifications of these proposals so that it can determine whether the proposed coverage would be in the public interest.

This report assesses the social and financial impact of Senate Bill No. 518, S.D. 2, H.D. 2 (1987 Regular Session) which proposes to mandate health insurance coverage for child health supervision (or "well baby") services. The report consists of four chapters. Chapter 1 provides background information on health insurance and some current trends and issues. Chapter 2 discusses mandated health insurance, the context in which it would operate in Hawaii, and the framework for our assessment. Chapter 3 contains background information on the proposed mandated health insurance benefit, and Chapter 4 presents our assessment of the proposed measure.

Background on Health Insurance

Health insurance serves economic, medical, and social purposes. Health insurance, as we know it today, became popular during the Depression when hospitals developed Blue Cross plans to help finance their operations and to help subscribers meet the cost of hospital care. This was followed by the Blue Shield

plans which provided insurance coverage for physician services. Soon, commercial insurers also began to offer health insurance plans.

With the support of the federal government, insurance began to evolve into a financing measure to increase access to health care. During World War II, the federal government encouraged its growth by excluding employers' contributions to health insurance from wage controls and taxable income. More direct federal involvement began with the Medicare program which provides insurance for the elderly and the Medicaid program which provides payments for medical care for eligible needy and low income patients.

Today, health insurance not only finances and supports access to health care, it is used as an instrument of social policy.

In looking at state policy on health insurance, the New York State Council on Health Care Financing recently noted,

"Health insurance is not simply insurance in the conventional sense. It is fundamentally different from other types of insurance because it forms the base for allocating an essential social good and because its existence has a profound effect on the availability, costs, and use of medical services. Health insurance today is a form of social budgeting and State policy must recognize it as such in order to better guide the medical care system and to ensure an equitable health insurance system."¹

Private health insurance. A recent analysis of data from the 1977 National Medical Care Expenditure Survey (NMCES) found that private insurance plays a central role in financing health care in the United States, affecting both the magnitude and distribution of personal health care expenditures. Roughly four out of five Americans had some form of private coverage, with employers paying for most of the cost of coverage.²

The NMCES found that health insurance coverage varied according to whether it was group or nongroup insurance. Group insurance was generally work related

health insurance. Group members had more comprehensive coverage than those with nongroup insurance with the comprehensiveness of coverage increasing with the size of the group. Most of those receiving benefits through their employers had little choice about the benefits they received.

Those with nongroup coverage were generally the privately insured poor, the elderly, young adults, nonwhites, and female heads of households. Generally, those least able to pay for health care also had the least insurance because their lack of employment meant less income and also lack of group health insurance.

Forms of private health insurance. Private health insurance falls into three main categories: (1) the Blue Cross and Blue Shield Plans, (2) the commercial insurance companies, and (3) the independent plans such as health maintenance organizations (HMOs), self-insured plans, preferred provider organizations, and other variants of these plans.

The Blue Cross and Blue Shield are the largest and oldest private health insurers. They are the traditional fee for service plans where reimbursements are made for services provided by participating physicians and hospitals.

The commercial carriers are insurance companies such as Aetna Life, Travelers, and Prudential. Like the Blue Cross plans, they provide reimbursements for medical services.

HMOs are a more recent development. They furnish a benefit package of maintenance and treatment services for a fixed periodic fee. Their emphasis is on preventive health care.

Independent plans are the fastest growing category of health insurance, particularly self-insurance plans which have more than doubled in the past five years. Self-insurance, or more correctly noninsurance, refers to the assumption by

an employer, union, or other group of all or most of the risk of claims for a policy year. Employee claims are paid directly from an employer's bank account or a trust established for that purpose.³

Self-insurance has several advantages. It is exempt from state regulation under the federal Employee Retirement Income Security Act of 1974 (ERISA). Hence, state laws mandating coverage of specific facilities, practitioners, or therapy do not apply to these plans. Self-funded plans are also able to avoid most premium taxes. In addition, they give employers access to the claim reserves for business uses and provide tax-free interest on reserves. However, self-insurance plans are feasible primarily for employers with enough employees to create a sufficiently large risk pool.

Today, there are other variations. Many insurers provide administrative services only for self-insured employer plans without bearing any of the risk. Insurers also contract with employers for plans which are split into self-funded and insured portions, with the insurer providing partial protection that is comparable to that of a traditional insurance plan or for catastrophic levels of claims.

Another significant change is the growth in "cafeteria" plans which offer employees choices among health insurance coverages and other employee benefits, such as additional vacation days or wages.

Increasing cost of health care. The greatest concern in recent years has been the increasing cost of health care. The most significant impact has been on government expenditures for health care. The federal government, through Medicare, Medicaid, and other programs, pays for more than half of all third party reimbursements.

The amount paid by employers for health insurance has also risen sharply. In recent years, health insurance premiums have increased an average of 20 percent annually. Health benefits are now the third largest cost element after raw materials and straight time pay for most manufacturers. A recent study found that corporate expenses for health care were rising at such a rate that if unchecked, they would eliminate in eight years all profits for the average "Fortune 500" company and the largest 250 nonindustrials.⁴

Health care costs are of even greater concern for small businesses which have lower and more variable profits, high turnover in employees, and more part-time, seasonal, or young workers. Their insurance is more costly, and they get less for their dollar. Data indicate that their premiums are 10 to 15 percent higher than those of large firms.⁵

Small businesses are also subject to all mandated health insurance laws since they are not in a position to self-insure. Many small businesses also suffer a tax disadvantage. Business owners who are unincorporated or individuals who have more than 5 percent ownership of a Chapter S corporation cannot take a tax deduction for their own health insurance premiums as can incorporated owners.

Current concerns. The two dominant and closely linked issues in health care today are the need to ensure access to adequate health care for the uninsured and the underinsured and the need to contain the costs of health care.

The first issue is based on social considerations such as the obligation of a just society to finance health care fairly for all its members without regard to income, race, sex, race, or individual circumstances. These social considerations underlie federal initiatives for national health insurance, catastrophic insurance, and recent

actions in many states to create statewide insurance pools and state sponsored and state subsidized health care plans.

The second issue focuses on cost containment. Much of the blame for the crisis in health costs is attributed to the prevalence and comprehensiveness of health insurance, the perverse incentives it creates, and the complex public and private third party payments system predominant today.

There is extensive evidence that insurance encourages unnecessarily high levels of utilization and expenditures. Medical economists estimate that as many as 70 percent of physician/patient contacts are for common colds, upset stomachs, and other routine ailments that do not require professional care.⁶

Health insurance allows individuals to choose their own health care but insulates them from paying for all of the cost of such care. Prior to World War II, most patients paid for their own medical care. Today, the financial responsibility for medical care has shifted from patients to third party insurers. Most of the cost of health care is paid by reimbursements made by private insurance and government.

Most of the insured have more benefits than they need. The NMECS found that the average family paid out more in premiums than was returned in benefits. It found that the current system tends to lock different groups who face predictably different risks into buying the same insurance at the same premium. As a result, better risks have more insurance than the costs and benefits warrant. However, they have every incentive to make use of the benefits since they have no reason to forego services they might want and which their insurance will finance.

Until recently, no checks were placed on services furnished by providers. The open ended fee for service reimbursement system created incentives for providers to perform more services than were necessary. Reports of unnecessary surgery and expensive tests have been commonplace.

Changes sought. There is concern that medical costs are increasing so rapidly that they endanger access to health care and conflict with other pressing social and economic priorities. The policy problem is to control medical expenditures without sacrificing adequate medical care and insurance protection.

Some current approaches are to encourage competition in the health care marketplace to limit or to provide more flexible coverage, to promote a prudent buyer approach on the part of consumers, and to place providers under more careful scrutiny and control. This has led to changes in the forms of insurance, in the kinds of benefits offered, and in the reimbursement system.

New insurance plans try to restructure benefits to neutralize the financial incentives which encourage overinsurance and to make consumers better aware of the insurance they are buying. The focus is on promoting more efficient and cost-conscious behavior on the part of patients and providers.

Employers are increasing employee payments through deductibles (the amount patients must pay before benefits begin) and copayments (the portion of the expense of a covered service for which patients are responsible). Some companies have found that they can save almost 50 percent of the cost of insurance when they increase deductibles and coinsurance provisions.⁷

Employers are also using approaches such as offering multiple choice plans which allow employees to choose among various benefit packages; allowing employees to allocate the employer's benefit contributions among health care, vacation, or deferred compensation; or providing incentive programs where employees will receive deferred compensation if they spend less on health care.

Finally, the federal government is creating incentives for providers to keep costs down by changing its reimbursement system to a prospective payment system

that pays a fixed fee based on the patient's diagnosed illness regardless of the actual cost of care. Emphasis is also being placed on peer review and utilization review to ensure that only appropriate medical services are being provided.

CHAPTER 2

MANDATED HEALTH INSURANCE BENEFITS IN THE HAWAII CONTEXT

There has been a significant increase in the number and variety of mandated health insurance benefit laws across the nation. Hawaii already has some health insurance mandates, such as requiring reimbursement for dentists who perform oral surgery, for psychologists performing within their lawful scope of practice, and, most recently, for *in vitro* fertilization. However, individual mandates requiring insurers to cover specific health services are relatively new to the State. This chapter discusses mandated health insurance benefits and the Hawaii context in which a mandate would operate.

Mandated Health Insurance Benefits

Beginning in the 1960s, various states began to mandate additional health insurance benefits, such as coverage for alcohol and drug abuse treatment, maternity care, and catastrophic care.⁸ Mandated benefit laws were used to expand coverage to health professionals who had previously been excluded from reimbursement, such as psychologists, and to fill gaps in insurance coverage due to changing demands and improvements in medical technology.

There has been a significant increase in the number and variety of mandates. In 1974, there were 48 state mandated benefit laws. By 1987, there were more than 680 with an equal number reported to be pending at state legislatures.⁹ These laws take two approaches, either mandating that the benefit must be *included* in all policies issued by insurers, or mandating that it must be *offered* to anyone requesting such coverage.

The legal challenge to the right of the states to mandate health insurance benefits was resolved in June 1985 when the U. S. Supreme Court ruled in *Metropolitan Life Insurance Company v. Commonwealth of Massachusetts* that a Massachusetts law requiring insurers to provide minimum mental health care coverage was a valid and unexceptional use of the Commonwealth's police power. The court held that mandated insurance benefit laws are insurance laws that fall within states' regulatory authority and are not preempted by the Employees Retirement Income Security Act of 1974 (ERISA). However, the court exempted self-insured plans from mandated benefit laws based on ERISA's preemption of employee pension and welfare benefit plans.¹⁰

Arguments for and against mandated health insurance benefits. Generally, mandated health insurance benefit laws are supported by providers and recipients of the treatment to be covered, and they are opposed by businesses and insurers. Proponents of mandated health benefits base their arguments primarily on medical and social premises. Opponents base theirs largely on economics and costs.

Arguments for. Those who support specific mandated benefits say that gaps in insurance coverage keep individuals from seeking or receiving much needed care.

They say that the current system is inequitable by discriminating against certain providers, such as psychologists or chiropractors, or against certain conditions, such as mental illness. This discriminatory system often prevents individuals from obtaining more efficient or more effective care.

Supporters contend that mandated benefits would support the development and maintenance of a wider range of effective treatment settings. They also say that improved health insurance coverage will lead to cost savings in the long run even

though mandated benefits might lead to increased utilization. For example, proponents for mandated benefits for the treatment of alcoholism argue that there would be offset savings from the reduction of other general medical and hospital services currently used by alcoholics. Another argument is that mandated coverage would spread costs over many people, thereby increasing the size of the risk pool and keeping costs down.

Arguments against. Employers have generally been opposed to mandated benefits since they pay most of the cost of health insurance. They say that mandated benefits add to the cost of employment and to the cost of production and that they reduce other—perhaps more vital—benefits. Small businesses complain that they are especially affected adversely by mandates because they have lower profit margins and are less able to absorb increased premium costs. Insurers oppose mandates because they create an incentive for employers to self insure, thereby reducing the risk pool and making insurance coverage more costly and insurers less competitive.

Opponents say that mandates could raise the cost of premiums beyond what employers and consumers may be willing to pay and reduce the total number of individuals to whom coverage is available. Employers could also shift more of the cost of premiums to employees.

Critics also say that financing health care through insurance mandates is highly regressive since they raise premium costs for all, resulting in a greater hardship on individuals with lower incomes. They argue that this is especially unfair when the mandates reflect the needs of only special interest groups.

Finally, there is the argument of freedom of choice. Opponents say that mandates reduce the freedom of employers, employees, and unions to tailor benefit

packages of their own choosing and that they interfere with the collective bargaining process. They also run counter to the effort to avoid overinsurance and to encourage a prudent buyer approach by consumers.

Health Insurance in Hawaii

Health care is one of Hawaii's largest industries. It is larger than the construction industry and more than three times the size of sugar and pineapple. Statistics indicate that Hawaii's population is healthier than that of the rest of the United States. Hawaii ranks first in the nation in longevity for both men and women. Hawaii also has one of the lowest death rates in the United States.¹¹

Hawaii's population is comparatively well insured in terms of the number covered and the breadth of coverage. The HMSA is the Blue Shield plan for Hawaii. It provided health insurance coverage to more than 60 percent of the civilian population in 1986.¹² The second largest health insurer is the Kaiser Foundation Health Plan, a nonprofit health maintenance organization (HMO) which covers approximately 15 percent of the population. Island Care, comprised of a group of participating providers including the Honolulu Medical Group, Garden Island Medical Group, and Hilo Medical Group, is Hawaii's third largest health insurance plan.

In addition to these private programs, health insurance coverage is provided by Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program for military dependents and military retirees.

Two important laws define and constrain health insurance in Hawaii. These are the State's Prepaid Health Care Act and the Hawaii Public Employees Trust Fund.

Prepaid Health Care Act. Hawaii is unique in health insurance coverage since it is the only state in the nation with a mandatory health insurance law. The Hawaii Prepaid Health Care Act was enacted in 1974 after a study commissioned by the Legislature found that a significant number of the State's employed were not adequately protected by health insurance. The act was intended to ensure adequate access to health services for Hawaii's working population.

All employers with one or more regular employees (those working at least 20 hours per week) must provide them with health insurance benefits. These benefits must be equal to, or "medically reasonable" substitutes for, the benefits offered by prepaid health plans which have the largest number of subscribers in the State.

The law also specifies that every plan must include the following basic benefits:

- . 120 days of hospital benefits per calendar year plus outpatient services;
- . Surgical benefits, including anesthesiologist services;
- . Medical services, including home, office, hospital visits by a licensed physician, and intensive medical care;
- . Laboratory, X-ray, and radio-therapeutic services; and
- . Maternity benefits.

Employers must submit their health insurance plans to the Director of the Department of Labor and Industrial Relations to determine if the plan meets the standards in the law.

The employer must pay at least half of the premium cost. However, the employee's contribution may not exceed 1.5 percent of the employee's monthly wages. The act exempts government employees, employees covered by a federal

program or receiving public assistance, agricultural seasonal employees, insurance and real estate salesmen, or brokers paid solely on commission.

Legal issues. In 1976, the Prepaid Health Care Act was amended to add insurance benefits for the treatment of substance abuse. Shortly thereafter, Standard Oil of California filed suit against the State on the grounds that ERISA preempted any state laws which regulate employee benefit plans. Standard Oil was particularly opposed to the amendment requiring coverage for substance abuse treatment. In a decision that was upheld by the U.S. Supreme Court in 1981, the courts found that the Hawaii Prepaid Health Care Act did constitute an employee welfare benefit plan within the definition of ERISA and was therefore preempted by ERISA.¹³

In 1983, Hawaii's congressional delegation obtained an amendment exempting the Prepaid Health Care Act from ERISA. However, the exemption was limited to the law as it was enacted in 1974. ERISA would continue to preempt any amendments made to the Prepaid Health Care Act after 1974 except where the amendment was needed for more "effective administration" of the law.¹⁴

In 1984 the Council of Hawaii Hotels brought suit against the State to prevent enforcement of a 1978 amendment to the Prepaid Health Care Act requiring plans resulting from collective bargaining to have benefits that are equivalent to those imposed by the act. The Council argued that the amendment involved more than was necessary for "effective administration" of the law. The U. S. District Court agreed, holding that the 1983 exemption to ERISA was intended to be construed narrowly and that the 1978 amendment regulating collectively bargained plans could not be interpreted as providing for more "effective administration" of the law.¹⁵

These decisions raise questions about the legality of mandated health insurance laws in Hawaii. Although mandated insurance laws have been found to fall within the authority of states to regulate insurance, there may be a problem in Hawaii because Hawaii is the only state in the nation to also have a prepaid health insurance law. The law requires all employers to provide certain insurance benefits but limits these to those mandated in 1974 or those covered by the most prevalent health plan. Amendments made in 1976 requiring insurance coverage for substance abuse were specifically voided by the courts.

If a mandated benefit is enacted, e.g., for substance abuse, then all insurance plans, including the most prevalent plan, HMSA Plan 4, must provide the benefit. This in turn would mean that all employers must purchase the benefit in order to comply with the Prepaid Health Care Act. It is possible that any mandated benefit will be challenged as a way of bypassing the limitations placed on the Prepaid Health Care Act by ERISA.

Public Employees Health Fund. Chapter 87, HRS, creates a Public Employees Health Fund to finance health insurance benefits for state and county employees and retirees. The State and the counties are the largest purchasers of health insurance in Hawaii, currently paying out over \$70 million in premiums annually.¹⁶

The fund is administered by a board of trustees that determines the scope of benefit plans, contracts for the plans with insurance carriers, and establishes eligibility and operating policies for the health fund.

While the scope of benefits to be provided is determined by the trustees, the amount contributed by public employers towards the premium is established through collective bargaining. Currently, the employers' portion is approximately 60

percent with employees contributing the remaining 40 percent. The employers' contribution is fixed for the duration of the collective bargaining contracts.

Unless a specific exemption is made for the State and counties, the state health fund will be subject to any mandated benefits law. Any increase in premium costs for current employees resulting from the mandate will have to be absorbed entirely by the employees since the employers' contribution has already been fixed under current collective bargaining contracts.

Another problem would be any increase in premium cost for retirees. The health fund law requires public employers to pay for the full cost of health fund benefits for retirees. This amounted to \$27.9 million in premiums in 1987.¹⁷ One in three enrollees in the health fund's medical plan is now a retiree. Retirees now consume a greater share of fringe benefit funds on a pro rata basis than active employees. The costs are expected to increase due to the increasing number of retirees, inflationary health care costs, and longer life expectancies.

Legislative concern about the high cost of premiums for retirees led the Legislature to adopt Senate Resolution No. 138 in 1987, asking for a study of benefit costs for retirees and alternatives that would enable the State to continue a reasonable level of funding of benefits for employees and retirees.

Assessment of Proposals for Mandated Health Insurance Benefits

Over the years, an increasing number of proposals for mandated insurance benefits have come before the Legislature. There has been concern over the cost impact of these proposals and their effect on the quality of care. Proponents and opponents of these measures seldom agreed on their costs and benefits.

Hawaii followed the solution adopted by several other states, such as Washington, Oregon, and Arizona, in enacting legislation calling for a systematic assessment of the social and financial impact of mandated health benefits and their overall effect on the health care delivery system.

Unlike some states where assessments are done by proponents of such measures, the Hawaii State Legislature was concerned with the financial burden such studies would place on health care providers and the questionable validity of assessments conducted by those other than an independent third party. Therefore, Act 331 states that before any measure proposing mandated health insurance benefits can be considered, the Legislature shall adopt concurrent resolutions requesting the Legislative Auditor to conduct an assessment of the social and financial impacts of the proposed mandated insurance coverage.

Criteria for assessments. Act 331 requires the Legislative Auditor to evaluate proposals to mandate health insurance coverage according to the following social and financial criteria:

"The social impact.

1. The extent to which the treatment or service is generally utilized by a significant portion of the population;
2. The extent to which such insurance coverage is already generally available;
3. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;
4. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;
5. The level of public demand for the treatment or service;
6. The level of public demand for individual or group insurance coverage of the treatment or service; and

7. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and
8. The impact of indirect costs which are costs other than premiums and administrative costs on the question of the costs and benefits of coverage."

"The financial impact.

1. The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;
2. The extent to which the proposed coverage might increase the use of the treatment or service;
3. The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;
4. The extent to which insurance coverage of the health care service provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policy holders; and
5. The impact of this coverage on the total cost of health care."

In conducting the assessment of the proposed measure, we reviewed the research literature for information on the utilization, coverage, cost, and impact of insurance coverage in other jurisdictions. We examined similar mandates in other states for their experience with the cost effectiveness of the proposed coverage. We gathered and analyzed information from insurers, providers, and other programs providing insurance coverage in Hawaii. Interviews were held with employers, unions, and other interested parties to assess public interest and demand for the proposed coverage.

The major sources of information on utilization, coverage, and costs were HMSA, Kaiser, and Island Care. We also analyzed data on the Medicare, Medicaid, and CHAMPUS programs taking into account these programs will not be affected by the proposed measures and do not serve a comparable population.

Chapter 3

BACKGROUND ON WELL-BABY SERVICES

This chapter presents some background information on the child health supervision services for which mandated insurance coverage is being proposed. We also discuss the proposed bill, its scope, and the impetus behind it.

National Level

At the national level, the Ninety-Ninth Congress considered the Child Health Incentive Reform Plan (CHIRP) in 1985. This bill would amend the Internal Revenue Code of 1954 to deny any employer a deduction for group health plan expenses unless such plan included coverage for pediatric preventive health care. The bill sought to give employers a strong incentive to offer these services. The bill did not pass, apparently because the tax code was considered to be an inappropriate vehicle for promoting preventive child health services. Nevertheless, testimony given at the national level is very applicable to the Hawaii situation. In fact, in Congress and at the State Legislature, arguments for and against well-baby coverage were very similar.

Pediatric preventive health care, commonly referred to as "well-baby" visits, is considered part of basic pediatric care. They are known as well-baby visits because they are checkups administered to babies in apparent good health. Their purpose is "to keep the well-child well and promote the highest possible level of complete well being."¹⁸

They stress a preventive approach to child health care. These visits would help to monitor the child's physical, mental, and to a limited extent, their social growth and development; provide immunizations, tests and curative measures where necessary; and establish a working-learning relationship with the parents. They would help both to educate the parents so that they will provide more competent child care and to enable the physician to become familiar with the child, parents, and the environment in which the child resides.

A congressionally appointed Select Panel for the Promotion of Child Health issued a report to the Congress and the Secretary of the Department of Health and Human Services, stating that comprehensive health care for children from birth through age five (along with two other types of service) were found to provide "such a clear consensus regarding their effectiveness and their importance to good health that it should no longer be considered acceptable that an individual be denied access to them for any reason, because of financial barriers; barriers resulting from the time, place or manner in which the services are provided; inadequate personnel capacity; or other reasons."¹⁹

The select panel noted that "many of the strategies most likely to decrease overall mortality and morbidity in mothers and children lie in the domain of preventative services and primary care."²⁰ They went on to say:

"Early infancy and young childhood are critical life stages during which vulnerabilities are great and the possibilities for helpful health care interventions numerous. If a child is helped to mature through this period safely, with preventable health problems avoided, with others identified and managed as early as possible, with effective measures such as immunizations taken to avoid later health problems, and with the nurturing capacities of his or her parents developed and supported, the young person's chances for a healthy childhood and adulthood are increased dramatically."²¹

The panel's report advocated many of the same things brought up in testimony at the State Legislature, especially the concept of the "medical home." A "medical home" is essentially a sole practitioner who is able to provide most, if not all, "essential" services to an individual. Its emphasis is on continuity and availability of care. In instances where they are unable to provide the needed services, they would be able to refer the patient to the appropriate care facility or specialist.

The panel recommended that policymakers dealing with child health issues consider (1) the accessibility and availability of needed health and health-related services for all infants, children, adolescents, and pregnant women; (2) the development of maternal and child health factors outside of personal health services, (e.g., schools, the media, and voluntary organizations); and (3) building the knowledge base to further enhance maternal and child health through education and research into child-related topics.

Senate Bill No. 518, S.D. 2, H.D. 2

Senate Bill No. 518, S.D. 2, H.D. 2, entitled: "A BILL FOR AN ACT RELATING TO HEALTH INSURANCE," seeks to amend Chapter 431, Hawaii Revised Statutes, to require all individual and group accident and sickness insurance policies issued in this State, individual or medical service plan contracts, nonprofit mutual benefit associations, and health maintenance organizations which provide coverage for the children of the insured, to also provide coverage for child health supervision services or well-baby care to these children from the moment of birth till their sixth birthday.

The bill defines "child health supervision services" as physician-delivered, physician-supervised, or nurse-delivered services. These services are to be delivered to eligible children in the scope and at the intervals specified in the bill.

Scope of services required. The coverage proposed would include the following services for each visit: a history, physical examinations, development assessment by the physician on the satisfactory physical and mental development of the child for that particular age, anticipatory guidance to the parents on the behavior to be expected of a child of that age, and appropriate immunizations and laboratory tests, "in keeping with prevailing medical standards."

A total of twelve visits would be provided at "approximately" the following intervals of a child's development: birth, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, and five years.

Only children currently receiving some kind of insurance coverage would receive the benefits mandated by the bill. Children who are not currently covered under an insurance policy would not be affected by this bill.

Also, this bill would not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies. The services provided are to be exempt from any deductible provisions in the health insurance policy or contract.

Testimony at the legislature. Proponents of the bill included spokespersons from the American Academy of Pediatrics, Department of Health, Office of Children and Youth, and the Hawaii Medical Association. Proponents of well-baby coverage pointed to the importance of well-baby visits as a part of normal childraising. They also referred to the economic hardships encountered by young parents and low-income families who might have to pay for these services out of pocket.

Opponents said that coverage is already offered to interested parties by private insurance carriers or Medicaid and that these type of visits are plannable

and affordable, negating the need for mandating insurance coverage of these services. They brought up the impact a mandate would have on premium costs and on businesses.

In reviewing the measure, the House Committee on Consumer Protection and Commerce reported:

"Your committee believes that health promotion and disease prevention services are important elements of a comprehensive health care delivery system and that early intervention with children will provide long-term benefits to the overall health of our population."²²

The Legislature passed the bill. However, it was vetoed by the Governor who stated that there are defects in the bill that could defeat the intent of the legislation and cause significant problems for health care providers. In addition, the Governor noted that separate legislation had been enacted requiring an assessment of the impact of mandating insurance coverage of child health supervision services.

Chapter 4

SOCIAL AND FINANCIAL IMPACT OF MANDATED INSURANCE COVERAGE FOR WELL-BABY SERVICES

This chapter assesses the social and financial impact of Senate Bill No. 518, S.D. 2, H.D. 2 mandating insurance coverage for child health supervision or "well-baby" services. We also assess whether the bill would accomplish the Legislature's intent.

Summary of Findings

Due to limitations in data, it was not possible to arrive at clearcut answers on some of the social and financial impacts of mandating insurance coverage of well-baby services. However, we were able to come to the following conclusions:

1. Utilization of well-baby services is generally high.
2. Most insurers offer some form of well-baby coverage that is comparable to the coverage mandated by the bill.
3. There appears to be little demand for coverage over and above what is currently being offered.
4. Due to a variety of factors, current coverage should not result in a lack of needed or desired treatment or in financial hardship.
5. Utilization, premium rates, and overall costs are expected to increase with mandated coverage, but due to the relatively small number of additional services that would have to be provided, the impact should be small.
6. There is no research to support the additional coverage proposed in the bill.

The Social Impact

The social impact assessment focuses on current use and need for well-baby services, the insurance coverage for these services, and the level of public interest in the treatment services or in insurance coverage of these services. The criteria for making the assessment are those specified by Act 331, SLH 1987.

The extent to which the treatment or service is generally utilized by a significant portion of the population. The extent to which the general public uses well-baby services would be an indicator of the need for insurance coverage of such services. We contacted a number of different organizations for information on the utilization of well-baby services and found they are being highly utilized by a significant portion of the population.

The firms and organizations contacted included the Hawaii Medical Services Association (HMSA), Kaiser Permanente, Island Care, Medicaid, Department of Health (DOH), Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Queen's Health Care Plan, the Travelers Insurance Company, Aetna Life Insurance, and Provident Life. The different organizations had varied insurance plans which differ in the number of well-baby visits and other services that are covered and the amount of copayment required. Details of the coverage are shown in Table 4.2 and will be discussed further in the next section. Here we note that utilization rates differ among the plans and variations in record keeping among the organizations made comparisons difficult.

HMSA provided utilization statistics for its fee for service plans for federal and state workers and its Health Maintenance Organization (HMO) plans: the Community Health Plan (CHP) and Health Plan Hawaii (HPH). Table 4.1 shows the

HMSA utilization rates in 1986 for well-baby visits per 1,000 children in their most popular plans.

Table 4.1

HMSA WELL-BABY VISITS PER 1000 CHILDREN IN 1986

<u>Age Group</u>	<u>Federal Plan</u>	<u>State Plan</u>	<u>HMO Plans</u>
0-1 year	4,660	3,910	4,490
1-2 years	835	1,530	2,050
1-11 years	205	NA	345

We find utilization rates to be highest in the 0-1 age group, dropping sharply in the second year and even more in later years. There were significant variations in utilization among the plans. In 1986, there were 4,660 visits per 1,000 children aged 0-1 in HMSA's federal plan, or almost five visits per eligible child. Utilization rates under the State plan were somewhat lower for the 0-1 age group, and rates under the HMO plans fell between the first two plans. The rates dropped sharply for children between the ages of 1 and 2 for several reasons. There is less need for children to see physicians after the first year. There is also a significant difference in coverage among the plans after the first year. The federal plan provides for nine visits in the first year but none in the second year whereas the state plan allows three visits in the second year. The HMO plans allow an unlimited number of visits and, as might be expected, shows the highest utilization after the first year.

Kaiser Permanente provided utilization data showing 5,915 visits per 1,000 individuals in the age group 0-4 in 1986, or almost six visits per child. However, this data is not comparable to HMSA data since they include both well-baby visits and visits for illnesses. Kaiser does not keep separate records for well-baby visits.

Medicaid has two different "plans" for well-baby type services. The first is the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT); the other is their standard well-baby service program. Both programs are available to all Medicaid eligible children although EPSDT is considered an optional service and eligible individuals are asked if they wish to participate. The EPSDT program covers the period between birth and 20 years of age and offers services that are equal to those specified in the American Academy of Pediatric (AAP) guidelines. In addition, the EPSDT program will cover and pay for eyeglasses, hearing aids, and dental checkups. The EPSDT services are much more generous than the standard well-baby service program but enrollment is low. In 1986, only 1,660 out of 22,799 Medicaid eligible children enrolled. Utilization of services averaged 1.3 visits per enrollee in the 0-5 age group.

There has been a push in the past half year to increase the number of physicians participating in the EPSDT program by increasing EPSDT reimbursement amounts. In July 1, 1987, the reimbursement for an EPSDT visit increased from \$27.81 to \$40.00. Medicaid participating physicians are now also required to state if they wish to provide EPSDT service, thereby creating a list of providers willing to provide EPSDT service. The EPSDT program officials hope that this increased participation will make the services more available. In fact, there has been a marked increase in visits in the first half of 1987 over the same period in 1986.²³

The CHAMPUS utilization in 1986 for children in the 0-2 age group was 1,287 visits for 617 children or 2 visits per child.²⁴ This figure is somewhat low and reports from the first two quarters of 1987 show roughly a doubling in participation over 1986 figures. The current increase in utilization can primarily be attributed to a 20-30 percent annual increase in CHAMPUS claims volume during the 1985-1987

period. There has also been a push to make CHAMPUS eligible individuals better aware of their benefits for well-baby care.

Child Health Conferences (CHC) are administered by the DOH and are temporary child health clinics held in various parts of Oahu at various times. They are open to any interested participant. All the services outlined in the proposed bill are furnished at these clinics.

The CHC program conducted 1,861 sessions during fiscal year 1987. During these sessions they serviced 11,176 individuals for a total of 24,028 visits.²⁵ These statistics include services to Medicaid eligible individuals as well as to those who have partial insurance or no coverage for well-baby services.

The CHC program is unique in that it covers many well-baby services, is free of charge, and is required to be available to anyone regardless of income. This puts this program in the position of "filling in the gaps" of other programs. The department reports that these conferences are operating at capacity. It estimates that approximately 14 percent of the participants are Medicaid eligible individuals.²⁶ Partially completed surveys of CHC participants seem to indicate that participation by individuals who have some insurance coverage is at least comparable in size to Medicaid recipients.

Island Care submitted utilization information showing that their well-baby services were used at a rate of 231 visits per 1000 eligible children in the 0-3 year eligible age range.

The extent to which such insurance coverage is already generally available. Insurance coverage for well-baby services is available, and coverage is generally comparable to that mandated in the bill. The primary difference between current coverage and the mandate is the number of well-baby visits that would be covered.

The mandate requires 12 visits and current coverage ranges between 9 and an unlimited number of visits.

The bill proposes to mandate coverage consisting of a total of 12 visits at the following intervals: birth, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, and five years. At each visit, appropriate immunizations and laboratory tests in keeping with prevailing medical standards are to be covered as well.

We compared well-baby benefits in the major plans in Hawaii in four areas of coverage: (1) frequency of visits allowed in the physician component, which includes the physical exam, growth assessment, and anticipatory guidance; (2) appropriate immunizations; (3) X-rays and laboratory tests; and (4) the "out of pocket" expense for the family due to co-payment charges and partial coverage of services. Summaries of the benefits offered in the major insurance plans can be found in Table 4.2.

We found that coverage of well-baby services varied in both scope and substance, e.g., ranging from nine well-baby visits to unlimited visits, and from 0 percent copayment to 100 percent copayment for X-rays and laboratory tests. However, most plans offer benefits comparable to those proposed by the bill. The major exceptions are the HMSA federal and state plans that cover only nine well-baby visits.

It is interesting to note that, unlike the bill, none of the plans recognized or required a set schedule to be followed for well-baby visits and for services such as immunizations or laboratory tests. In most cases, the particular physician or clinic had the discretion to determine when services were "appropriate" for that particular individual and had a degree of flexibility in the manner in which they dispensed particular well-baby services.

Table 4.2

INSURANCE COVERAGE FOR CHILD HEALTH
SUPERVISION SERVICES THROUGH AGE FIVE

Plan	Age Group	No. of Visits	Cost of immunizations	Cost of X-Rays Laboratory Tests	Out-of-Pocket Expenses
HMSA Federal	0-1 1-5	9 2 ^b	20%	50% ^a	20%
HMSA State	0-2 2-5	9 0	50%	100%	20%
HMSA HMO	0-5	No Limit	0	\$1-\$5 ^c	0-\$5
Kaiser	0-5	No Limit	0	0-50%	0-\$5
Island Care	0-3 3-5	No Limit 3 ^d	0-\$5	0	0-\$5
Queen's Health	0-2 2-5	9 0	\$2	0	\$5-\$7
Aetna "Partners"	0-1 1-5	6 5 ^d	0	0	\$5
Provident Life "Health Care Plus"	0-2 2-5	9 0	50%	50%	10%

a - Lab + X-Rays at 50% when done during a health appraisal visit every two years.

b - Must be separated by two years.

c - No charge when done with other services for which copayment is made.

d - Annual visits.

If coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing the treatment. Proponents of the bill expressed concern that a significant portion of the population now have to pay for well-baby services out of pocket, placing a strain on their already marginal financial resources. However, we find that comparable coverage is generally available for these services. Consequently, most of the insured do not have substantial out-of-pocket expenses. In addition, child health services are readily available to anyone without cost from the State's CHC program, and tuberculosis tests are administered free of charge at a number of state clinics.

It is difficult to determine the degree of financial hardship that might be faced by those needing the treatment because families in financial straits could take at least partial advantage of free state programs. The extent of their participation in these programs would determine their expenses for well-baby services.

Nevertheless, we considered a "worst case scenario" where a family without coverage would receive and pay for all the services as prescribed under the bill.

We estimated the cost for all the well-baby services specified in the proposed bill for a non-covered family based on HMSA's non-member rates for physician visits, immunizations, and laboratory tests. Since the bill is not specific on the number of immunizations and the kinds of laboratory tests that would be covered, we followed the guidelines issued by the American Academy of Pediatrics for well-baby services.²⁷ These would represent a high standard of care. Table 4.3 shows the costs of well-baby care at each age and at the end of five years. With HMSA's cost figures, total cost at the beginning of the second year would be \$278.50. At the end of five years, the total costs would be \$694.00. After the first year, costs range approximately between \$50 and \$100.

Table 4.3

COST OF CHILD HEALTH SUPERVISION
SERVICES THROUGH AGE FIVE*

	Average charge per procedure	Charges	Total cumulative costs
Under age 1:			
Six office visits	\$ 29.00	\$174.00	
Three DPT injections	13.50	40.50	
Three oral polio vaccines	12.50	37.50	
Tuberculin test	9.00	9.00	
Hemoglobin or hematocrit	8.50	8.50	
Urinalysis	9.00	9.00	
		<u>\$278.50</u>	<u>\$278.50</u>
Age 1:			
Two office visits	29.00	58.00	
MMR vaccine	24.50	24.50	
DPT injection	13.50	13.50	
Oral polio vaccine	12.50	12.50	
		<u>\$108.50</u>	<u>\$387.00</u>
Age 2:			
Office visit	34.00	34.00	
Urinalysis	9.00	9.00	
		<u>\$ 43.00</u>	<u>\$430.00</u>
Age 3:			
Office visit	34.00	34.00	
Vision screening	49.00	49.00	
Hemoglobin or hematocrit	8.50	8.50	
Tuberculin test	9.00	9.00	
		<u>\$100.50</u>	<u>\$530.50</u>
Age 4:			
Office visit	34.00	34.00	
Pure tone audiometry	12.00	12.00	
DPT injection	13.50	13.50	
		<u>\$ 59.50</u>	<u>\$590.00</u>
Age 5:			
Office visit	34.00	34.00	
Vision screening	49.00	49.00	
Pure tone audiometry	12.00	12.00	
Tuberculin test	9.00	9.00	
		<u>\$104.00</u>	<u>\$694.00</u>

*Based on guideline for services provided by the American Academy of Pediatrics; average charges provided by the Hawaii Medical Service Association based on data from January through July 1987 rounded to the nearest \$0.50.

The costs would be highest in the early years where more visits and other services are needed. However, the group that would be affected by this bill, i.e., insured families, would already have coverage for the early years. Subsequent expenses after the first year should be within the reach of insured families.

If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment. Because coverage is generally available, the costs of services are within the reach of most insured households, and government programs provide services for free, it is unlikely that children would be unable to receive necessary health care because of their lack of insurance coverage.

The level of public demand for the treatment or service and the level of public demand for individual or group insurance coverage of the treatment or service. The level of public interest in well-baby services or in additional coverage can be a useful indicator of the need to mandate coverage. We found that utilization of insured services as well as government sponsored programs is relatively high. However, the current level of services appears to be sufficient in scope and availability to meet the current demand. There also appears to be little public interest in increasing coverage.

The HMSA's customer service, marketing, and group administration departments reported no interest in increased coverage above what is currently offered. Insurers, benefit consultant organizations, and employee groups contacted in our study reported no interest in well-baby care. The employee groups either already have sufficient coverage, or their membership prefers other services such as coverage for prescription drugs, dental services, and eyeglasses/contact lenses.

It should be noted that in a majority of cases, employee preferences are not a primary consideration in what employers purchase in an insurance plan. The employers' first consideration is to select a plan that conforms with Hawaii's Prepaid Health Care Law. In many cases, the size of the employee group will determine the plan the employees get. Small organizations usually have little flexibility in choosing their benefits as they are usually put under a group "umbrella" type plan.

The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts. Another consideration in assessing the social impact of mandated insurance for well-baby services is whether collective bargaining units would be interested in this coverage since the vast majority of people are enrolled in group health plans either through their unions or their employers. We found no interest in increasing insurance coverage for well-baby services among the collective bargaining organizations we interviewed.

Unions, as well as employers, have become increasingly aware of the costs of coverage. Administrators of the Public Employees Health Fund and several bargaining agents for public and private employees reported no interest in negotiating for increased coverage for child health services. If they were to add coverage, they indicate that it would be for vision or dental care or prescription drugs.

The impact of indirect costs (costs other than premiums and administrative costs) on the question of the costs and benefits of coverage. The indirect costs of the lack of adequate coverage for well-baby services may be important in weighing the costs and benefits of mandatory insurance coverage. Proponents maintain that the lack of preventative care could result in such problems as the failure to detect

vision or hearing deficiencies which could lead to school failure and behavioral problems. Failure to catch debilitating childhood illnesses in time could also result in expensive long-term care in the future. Although there is some evidence that preventive care can be cost effective, it is not clear how much improved insurance coverage would contribute to such care and what its exact impact would be on indirect costs.

The Financial Impact

The financial impact criteria focus on the costs of treatment, whether the mandate would result in alternative less expensive alternative treatment, and what the effects might be on the costs of premiums, and the total cost of health care. As with the assessment of social impact, the assessment of financial impact in this section follows the criteria listed in Act 331, SLH 1987.

The extent to which the insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service. Child health supervision services have only recently been mandated in one state, Florida, and no research has been done on the extent to which insurance coverage would increase or decrease the cost of the services. In general, the current wisdom regarding insurance coverage is that providing coverage for a service increases the price of that service. The Medicare and Medicaid programs are cited as primary examples of what happens to prices when insurance coverage is provided. Prices and utilization increased drastically. The magnitude of the proposed coverage for child health supervision services, however, is much less and cannot be expected to have the same results. This is particularly true since most of Hawaii's population already has well-baby coverage, although not all as extensively as would be covered under the mandate.

A study for the Virginia state insurance department which considered mandated benefits in general concluded that:

"The general effects of expanding benefits/coverage by whatever means are threefold: (a) it usually lowers the out-of-pocket costs to the consumer for use of covered services; (b) when the out-of-pocket cost is lowered, the consumer has more cash to expend on non-covered health care services; and (c) it assures a flow of revenue to providers. The more direct results are an increase in the price and level of utilization of covered health care services."²⁸

Research in the field suggests that costs will increase, but the extent of the increase cannot be determined.

The extent to which the proposed coverage might increase the use of the treatment or service. There is also no clear answer to the question of the extent to which providing health insurance coverage might result in higher utilization. Research in the field suggests that use of services increases with improved coverage. However, researchers have also found that there is no significant difference in the health status of children who used less care.

There are two major ways that utilization of child health supervision services might increase with mandated benefits. *First*, those who currently have some form of coverage might increase the number of visits because they would incur less out-of-pocket costs. *Second*, individuals who currently have no coverage for well-baby services would increase their use of these services if the expenses are paid by insurers.

The Rand Health Insurance Experiment studied the effect of cost-sharing and insurance reimbursement on the use of medical services by children. Rand researchers concluded that there is an increase in the number of individuals utilizing a service when the copayment amount for that service is reduced. The researchers found that 95 percent of the children under age four who had free care utilized

outpatient services, while only 82 percent of the children who had a 95 percent copayment utilized the outpatient services.²⁹

In addition, the Rand study found that the average number of visits per child decreased when a copayment was required. For children aged 0 to 13 years, the average number of episodes of well-baby care per year was 1.06 for those children which had free care and 0.81 for those children who had a copayment. This indicated that patients seek well-baby care more often when the services are paid solely by insurance. However, researchers found no difference in the health status of children receiving free care from those having to pay a portion of the bill on measures of physiological function, physical health, mental health and general health perceptions.

Utilization rates under three different HMSA plans shows that the highest use occurs in plans that place no limit on the number of visits. However, the difference was small after the second year. This suggests that there will be some increase but that the increase will be small.

The extent to which the mandated treatment or service might serve as an alternate for more expensive treatment or service. Another consideration is whether the service might serve as an alternative to more expensive treatment, thereby reducing expenditures in the aggregate. Well-baby care services focus on preventive care which could reduce the incidence of health problems. This, in turn, should reduce the overall utilization of health care services and the total costs.

Proponents have testified to cost offsets based presumably on studies relating to the effectiveness of the federally-funded EPSDT screening programs and some other preventative programs.

While most research indicates that EPSDT-screened children have lower health care costs than nonscreened children, there are several limitations in using EPSDT studies in determining whether well-baby care is cost effective. *First*, EPSDT participants are Medicaid clients who are not representative of the general population. *Second*, it has been suggested by researchers that those who take the time and effort to go to treatment, or screening, are more conscientious about their health.³⁰ They will probably tend to be healthier and use less health care than those who are less conscientious. Those who are not enrolled in EPSDT program may wait until their children are ill before they seek medical care, thus resulting in higher costs of care. Finally, the comparisons may not be valid since it is not clear whether researchers included all EPSDT costs such as screening costs, and administrative expenses, in the studies.

Interestingly, the Hawaii Medicaid program, found that, in most instances, the children under six years of age who have been screened under EPSDT incur higher Medicaid costs than the nonscreened children. Based on information from two different fiscal years and two different age groups, the screened category is 5.5 percent to 20 percent more costly than the nonscreened group with one exception. The nonscreened children aged 0 to 2 years in the 1987 fiscal year were found to be 8 percent more costly per capita than the screened children.

Several studies looked at the cost benefits of particular preventive services, such as studies on the phenylketonuria (PKU) program (tests for an enzyme deficiency) and immunizations against measles. The Massachusetts PKU program was estimated to have saved that state over \$300,000 in two years.³¹ The Center for Disease Control determined that \$1.3 billion was saved between 1966 and 1974 due to an immunization program against measles.³²

Although the research is limited in this area, it appears that well-baby services probably reduce utilization of more costly forms of medical treatment. However, the magnitude of the cost offset cannot be determined given the lack of research on the general population.

The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders. The results of the analyses in the previous sections indicate that insurance coverage of well-baby services could result in some increase in utilization, but that some reduction in overall expenditures could also be expected in the long run because of the benefit of providing these services.

The claims volume and associated administrative costs to the insurer can be expected to increase. An increase of costs relating to peer review, quality assurance, and utilization review are costs which will most likely be passed on to consumers. However, the overall cost of health care is likely to decline by some percentage. Although the insurance companies should incur a decrease in the total cost of health care services in the long run, they are likely to institute a premium increase to cover initial start up and administrative costs.

Florida's law mandating insurance coverage for child health supervision services went into effect on October 1, 1986, and no studies on the affect of the mandate have yet been published. However, several actuarial studies have been conducted. In 1982, AAP commissioned an actuary to determine the cost of providing all of the preventive services recommended in the guidelines for health supervision for children up through 21 years of age, plus two newborn well-baby visits in the hospital.

The actuary used a nationwide employer group of 45,930 employees based on information provided by Metropolitan Life Insurance Company. In addition, 42 pediatricians from 29 states were surveyed to obtain fee data regarding cost for services to be provided. Assuming that all eligible children would participate and that 100 percent of every possible service would be utilized, the actuary arrived at an average premium of \$2.28 per child per month.³³

In July 1985, the Metropolitan Life Insurance Company responded to these estimates, saying:

"In the opinion of our actuaries, the figure [\$2.28] is unrealistically low for the set of benefits intended to be priced. Moreover, it is incorrect to refer to amount as a premium. Data in the worksheets related only to the cost of providing services, i.e., the claims costs. Premiums would include amounts to cover additional costs such as premium taxes, risk charges and reserve factors, and marketing and administrative costs."³⁴

However, Metropolitan Life Insurance Company did not provide an estimate of what the cost should be. At the same hearing, using AAP's protocol as a basis, the Blue Cross and Blue Shield Association presented a statement in which they determined the cost of well-baby care for children under 21 years of age to be \$5.47 per month per child.³⁵ There have been some estimates which are seven times more than the above estimates, but their validity has not been established.

HMSA estimates their administrative costs will be about 10 percent of the benefits in the first year of the mandate and will be expected to decrease to 8 percent thereafter. HMSA has estimated that based on the assumption that 40 percent of children will use the services, the additional premium cost would be \$0.30 per month per child, or \$0.85 per month per family.

Premiums can be expected to increase initially at HMSA and some of the commercial carriers. Premiums should not increase at Kaiser or Island Care since

they already have coverage comparable to that required in the bill. However, based on the experience of Blue Shield of Western Pennsylvania, it may not be as much as HMSA anticipates. In 1980, Blue Shield of Western Pennsylvania charged \$2.50 per child per month for well-baby coverage. In 1984 the rates were reduced to \$0.55 per child per month, based on utilization experience.³⁶

The impact of this coverage on the total cost of health care. We projected the impact of coverage on the total cost of health care under three scenarios: conservative use of the services, medium use of the services, and high use of the services. The total estimated cost of child health care in each scenario is based on the numbers using the services, their rate of use, and the cost of the service.

Estimated numbers affected. The children who would be affected by this mandate are those covered under certain HMSA plans and similar plans offered by commercial carriers. Subscribers to Kaiser, Island Care, HMO plans offered by HMSA, and other HMSA groups are not included because they already have the insurance coverage mandated under the bill. Medicaid, CHAMPUS, and uninsured children are also excluded as they are not covered under the bill.

The estimated number of children with inadequate coverage who would be affected by the proposed bill is shown in Table 4.4 based on the information furnished by HMSA and our assumptions about the numbers covered by the commercial carriers.

HMSA provided information on the total number of children under six who either belong to plans without well-baby coverage or who did not have coverage to the extent proposed in the bill. Since HMSA had no further breakdown by age group, we assumed that the number of children without coverage was distributed equally among the six age groups.

The commercial insurance carriers in the State had no information on the number of children covered in this State. Therefore, we assumed that the percentage of their enrollees under six years of age would be the same as that in HMSA plans and that coverage was comparable to HMSA's group plans. We also assumed that the percentage with inadequate well-baby coverage would be the same as that under HMSA plans.

Table 4.4

ESTIMATED NUMBER OF CHILDREN BY AGE GROUP
WITH INADEQUATE COVERAGE*

	Age Group					
	Under one year	One year	Two years	Three years	Four years	Five years
HMSA	1,300	1,300	2,100	7,000	7,000	7,000
Commercial carriers	<u>100</u>	<u>100</u>	<u>100</u>	<u>700</u>	<u>700</u>	<u>700</u>
Total	<u>1,400</u>	<u>1,400</u>	<u>2,200</u>	<u>7,700</u>	<u>7,700</u>	<u>7,700</u>

* Estimated based on information provided by Hawaii Medical Service Association.

Utilization. HMSA provided utilization information on three of its plans. The utilization rate under its federal plan is 50 percent. HMSA's utilization of well-baby services under the state, group, and individual plans which cover these services is 60 percent. The use of HMSA's HMO coverage also averaged 50 percent. For purposes of comparison, utilization information was obtained from CHAMPUS and the EPSDT program. The rate for CHAMPUS was about 55 percent and EPSDT utilization was 65 percent.

Based on the above, a utilization rate of 50 percent was used for the conservative scenario, 60 percent for the medium use scenario, and 70 percent for the high use scenario.

Estimated charges. The total charges for the health services proposed for each age in a child's life through age five were shown in Table 4.3. As reported earlier, we followed the guidelines recommended by AAP in determining the number and kinds of services to be included. HMSA provided information on the average charge for each of the services that would be covered in the bill. These charges were compared with the average Kaiser and CHAMPUS charges and were found to fall within 15 percent of each other.

Total estimated costs. Table 4.5 contains our calculations on the estimated total cost of child health services under a conservative scenario, a medium scenario, and a high use scenario based on different levels of utilization. We multiplied the number of children who would be affected by the cost of the proposed health services for that age group to arrive at the additional cost if well-baby services were to be fully utilized. The varying utilization rates were then applied against this figure to arrive at the total estimated cost under each of the three scenarios. We reduced these costs by the amounts that would be paid under HMSA's partial coverage for its federal and group plans to arrive at the total additional costs under each scenario. The total estimated cost of health care ranged from \$1.3 million for the conservative scenario to \$1.8 million for the high use scenario. Because the nature and extent of any cost offsets could not be determined, they were not included in the calculations.

Table 4.5

ADDITIONAL COST FOR CHILD HEALTH
SUPERVISION SERVICES UNDER THREE SCENARIOS

			SCENARIO I	SCENARIO II	SCENARIO III	
	Number of children	Charge per child	Additional cost at 100% utilization	Additional cost at 50% utilization	Additional cost at 60% utilization	Additional cost at 70% utilization
Under 1 year old	1,400	\$ 279	\$ 390,600	\$ 195,300	\$ 234,360	\$ 273,420
One-year old	1,400	109	152,600	76,300	91,560	106,820
Two-year olds	2,200	43	94,600	47,300	56,760	66,220
Three-year olds	7,700	101	777,700	388,850	466,620	544,390
Four-year olds	7,700	60	462,000	231,000	277,200	323,400
Five-year olds	<u>7,700</u>	104	<u>800,800</u>	<u>400,400</u>	<u>480,480</u>	<u>560,560</u>
	<u>28,100</u>		<u>\$2,678,300</u>	<u>\$1,339,150</u>	<u>\$1,606,980</u>	<u>\$1,874,810</u>
Less credit for HMSA's partial coverage for office visits, DPT injections				<u>\$ 71,400</u>	<u>\$ 85,700</u>	<u>\$ 100,000</u>
Total Additional Cost				<u>\$1,267,750</u>	<u>\$1,521,280</u>	<u>\$1,774,810</u>

**Assessment of Senate Bill
No. 518, S.D. 2, H.D. 2**

The bill attempts to promote preventive health care for children by increasing insurance coverage for well-baby services, services that seem to be highly desirable and cost effective. However, we find that the bill will probably have little impact because the proposed coverage is already generally available.

Minimal impact. The majority of individuals in this state already have coverage for well-baby services until the age of two. Individuals in HMO type plans typically have preventive health coverage that is even more extensive than that proposed in the bill. The bill proposes to cover children until their sixth birthday.

Even using the high standard recommended by the AAP, this would only result in an increase of three visits, one lab test, one immunization, two TB tests, and three screening tests (one hearing and two vision). These extra visits and services would amount to \$264 in expenses over three years using HMSA cost data. These costs would be even less if the individual sought some of them from a government-sponsored program.

The only group that the bill would benefit are those who are insured but who do not have well-baby coverage. HMSA estimates that they have 7,500 children in this category. These "gap group" children are not covered for visits but immunizations are covered at 50 percent of the eligible charge.

Standards of care. Most of the research studies favor well-baby care. However, none of the studies clarified the issue of frequency of visits or established clear standards of care. While AAP has issued guidelines for a schedule of services, this is based on expert "consensus" opinion without supporting data.³⁷

A study published in 1975 attempted to determine what level of service constituted adequate well-baby care. In this study,

"Two hundred forty-six full term, first-born, well infants were randomly assigned to receive well-baby care during their first year in one of four ways: six visits by a physician; three visits by a physician; six visits by a pediatric nurse practitioner (PNP); or three visits by a PNP ... Essentially no differences were observed in the endpoints measured within settings between providers of care, between visit schedules, or between any of the provider and visit schedule combinations."³⁸

Over the years, AAP has issued varying guidelines for meeting the basic health needs of most children "who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion."³⁹ The AAP's first guideline, issued in 1967, suggested 17 visits before the sixth birthday, 9 in the first year alone. In 1975, AAP reduced the

frequency to 10 visits in the 0–5 age group. Currently, AAP recommends 12 visits. It is clear that AAP intended the visits schedule to be used only as a guideline, to allow for variances in individual child and family. However in light of the study's findings and the AAP's varying opinions on the frequency of visits, the question of the number of visits that represents "adequate" well–baby care remains unresolved.

Unclear coverage. The bill does not specify some of the particulars of the coverage to be offered, e.g., the percentage of the costs to be paid by the insurer and insured. We had to make certain assumptions about copayments to project utilization and premium cost figures, but in the bill this should be made clear. The bill also calls for immunizations and laboratory tests "in keeping with prevailing medical standards." If the intent is to provide a specific level of coverage, then this phrase should be made more specific, especially when considering the frequency of laboratory and screening tests.

Conclusion

The proposed bill supports a valuable service, but it imposes coverage where none is needed. Well–baby care consists of a number of preventive care services that are grouped together under one general heading. While a few studies have been done on the effectiveness and desirability of some of the individual services under the general heading of well–baby care (e.g., PKU screening) there have been very few studies about the effectiveness of all the services, taken as a whole.

Studies have been conducted on the effectiveness of EPSDT services, but their findings have limited applicability in this situation. The EPSDT recipients are Medicaid eligible individuals who are disadvantaged. The individuals affected by this bill would be people who, for the most part, are not disadvantaged.

While well-baby services may be desirable, there is no evidence that current coverage is inadequate, or that more coverage would lead to better health.

As a concluding note, the question of the relationship between the State's Prepaid Health Care Act, its exemption under the federal Employees Retirement Income Security Act of 1974, and any new mandated health insurance law may have to be resolved in the courts.

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