2007 Annual Report of the Colorado Commission on Mandated Health Benefits

To The Colorado General Assembly

November 30, 2007

Colorado Commission on Mandated Health Insurance Benefits

Annual Report to the General Assembly
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Introduction

The Commission on Mandated Health Insurance Benefits was created through the enactment of Senate Bill 03-068, sponsored by Senator Hagedorn and Representative Brophy. The Commission is charged with reviewing existing and proposed health benefit mandates for their impact on individuals, employers and health insurers. The statutory authority for the Commission is found at Colo. Rev. Stat. §10-16-103.3.

In 2004, the Commission adopted the following mission statement, consistent with the enabling legislation, as a guide to its work:

> *To serve the people of Colorado and the State Legislature by providing objective information and recommendations on the impact and structure of current and proposed health insurance mandated benefits.*

Commission Membership

The Commission's membership is set by statute. Colo. Rev. Stat. §10-16-103.3(1)(a)(III) provides that the Governor appoint members representing the following groups:

- An employee of the Division of Insurance
- A representative of the health insurance industry
- A representative of a health maintenance organization
- Two health care providers
- Two citizen members – one with an interest in mandated health insurance benefits, and one representing a consumer health advocacy group
- Two members who are business owners with less than 50 employees, one from Denver and one from a rural area

Two legislators, one each from the House and Senate, and members of the Business Affairs and Labor Committees are appointed by the legislative leadership. Colo. Rev. Stat. § 10-16-103.3(1)(a)(I and II). All members of the Commission are appointed for five year terms. Colo. Rev. Stat. §10-16-103.3(1)(b).

For 2007, two new legislative members were appointed to the Commission, Senator Lois Tochtrop and Representative Morgan Carroll. During the course of 2007, three of the other Commission members resigned or their positions were declared vacant: Dr. Michelle Velkoff (provider – declared vacant), Deb Higgins (rural business – resigned),

and Gail Lindley (Denver business – resigned). At present, these vacancies have not been filled. A list of the current Commission membership is attached at Appendix A and is available on the Division of Insurance's website at http://www.dora.state.co.us/insurance/meet/MHB/07members.pdf.

The Commission functioned without a chair for 2007 with Vice Chair Leo Tokar assuming the leadership responsibilities. Colo. Rev. Stat. §10-16-103.3(1)(c). The Commission was staffed by Deputy Insurance Commissioner for Consumer Affairs Peg Brown, who serves as a member of the Commission, and Assistant to the Commissioner Michael Mawhinney, with assistance from other Division of Insurance staff including Director of External Affairs Julie Hoerner and Life and Health Supervisor Dayle Axman. Colo. Rev. Stat. §10-16-103.3(4)(a).

Processes and Procedures

The Commission followed the processes and procedures established in prior years to fulfill its responsibilities. Pursuant to the provisions of Colo. Rev. Stat. §10-16-103.3(6) and Senate Joint Resolution 05-04, the legislative chairs of committees having jurisdiction over proposed legislation containing health insurance mandates are to request the Commission study and assess the social and financial impact of a proposed mandate and forward the Commission's findings to the committee prior to the initial hearing of the bill.

To accommodate legislative referrals of proposed bills, the Commission established a tentative schedule of meeting on two Friday afternoons a month from 2 to 4 p.m. during the legislative session. One challenge the Commission faced in 2007 was the acquisition of a quorum for Commission meetings, particularly when bill referrals were made on Wednesday or Thursday for a Friday meeting and the Commission was requested to provide its recommendation to the committee by Monday or Tuesday noon of the following week. In 2007, short turn around times between bill referral and Commission deadlines to report to the legislative committees proved frustrating for Commission members, Division staff, bill proponents and opponents, and the public. In some cases, the Commission could not accommodate the Legislature's requested timeframes. In other cases, the Commission was unable to consider bills referred to it because the bill sponsors or proponents were unable to present the proposals due to the Legislature's schedule, i.e. floor sessions on Friday afternoons.

Since its inception, the Commission has requested bill sponsors or advocates to utilize an assessment tool including key information on which the Commission's analysis can be based. The assessment tool was developed to incorporate and complement the information proponents of a proposal are to submit to the legislative committee of reference to address the social and financial impact of the proposed coverage. Colo. Rev. Stat. §10-16-103. A copy of the assessment tool is attached as Appendix B and on the Division's website at http://www.dora.state.co.us/insurance/meet/MHB/MHB%20assess%20tool.pdf.

While most bill proponents utilized the assessment tool, several commented to the Commission that the information requested in the assessment tool is not available to proponents. The Commission understands this criticism and is discussing options to obtain the information necessary to perform its analysis without burdening a proposal's advocates who may not have access to the required data.

Minutes of the 2007 Commission meetings are attached as Appendix C and are available on the Division of Insurance's website at http://www.dora.state.co.us/insurance/meet/MHB/MHB.html.

Commission Reports

The Commission was asked to review five legislative proposals in 2007, more than in any previous year. In its first year, 2004, the Commission reviewed one bill, three in 2005, one again in 2006, and five in 2007. Of the five bills reviewed in 2007, all five ultimately made it through the legislative process were enacted and signed into law. The five bills were:

SB07-78 Concerning the Restoration of the Mandatory Offer of Hospice Care Coverage in Small Group Health Benefit Plans

HB07-1253 Concerning a Prohibition Against an Insurance Carrier from Denying Coverage to Persons Serving in the Uniformed Services of the United States

SB07-04 Concerning a Coordinated System of Payment for Early Intervention Services for Children Eligible for Benefits under Part C of the Federal "Individuals with Disabilities Education Act," and, in connection therewith, Requiring the Department of Human Services to Develop a Coordinated Payment System, Requiring Coverage of Early Intervention Services by Public Medical Assistance and Private Health Insurance, and making an Appropriation.

HB07-1301 Concerning Increasing the Availability of Cervical Cancer Immunizations, and, in connection therewith, Establishing the Cervical Cancer Immunization Program, Encouraging Federally Qualified Health Centers to Contract with Local Health Agencies to Administer Cervical Cancer Immunizations, Requiring a Cervical Cancer Immunization Public Awareness Campaign, Specifying that Cervical Cancer Immunization is a Benefit for Medicaid Recipients, Requiring that Certain Health Insurance Policies Provide Coverage for Cervical Cancer Immunizations and making an Appropriation.

SB07-36 Concerning the Inclusion of Certain Additional Mental Disorders in the Mandatory Health Insurance Coverage for Mental Illness, and, in connection therewith, making an Appropriation.

Copies of these reports are posted on the Division of Insurance's website at www.dora.state.co.us/Insurance/meet/MHB/MHB.html and are attached as Appendix D.

Additional Considerations

In March 2007, the Commission addressed a memorandum to the legislative leadership about referral of legislation to the Commission, scheduling of Commission meetings, the Assessment Tool, Commission "hearings" on proposals, and the Commission's reports. The Commission hoped that this memorandum would clarify for legislators the role, purpose, and procedures of the Commission and alleviate the concerns and frustration of legislators and Commission members by establishing a common understanding of Commission processes. A copy of this memorandum is attached as Appendix E.

Further, due to criticism received by the Commission from legislators, including bill sponsors who appeared before the Commission and others, including proponents of bills and the public, after the 2007 legislative session ended, the Commission held three meetings to assess its purpose, procedures and options. At its meeting on September 21, 2007, the Commission requested comment from legislators and the public. The minutes of the June 22, September 21, and November 16, 2007 meetings reflect the comments received by the Commission and discussion by the Commission about these issues. *See* Appendix C.

To further its internal discussions of purpose, process and procedure, the legislative members of the Commission requested a review by Legislative Council of the other states with a mandated benefits commission. The report received from Legislative Council is attached as Appendix F.

Future

Pursuant to the continuation of the Commission enacted in 2005, the Commission will sunset on July 1, 2010 unless it is continued by the Colorado General Assembly. Commission members recognize that there is some controversy about whether the Commission should exist, how it is structured and operates, and whether it provides value to the General Assembly and the public. The Commission urges full and fair discussion of the issues involved and looks forward to resolution of these issues.

Appendix A

Roster of Commission Members

Commission on Mandated Health Insurance Benefits

Roster

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Vacancies: **Health Care Provider (Michelle Velkoff – declared vacant)**
Small Business Owner – Rural (Deb Higgins – resigned)
Small Business Owner – Metro (Gail Lindley – resigned)

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Appendix B

Assessment Tool

Commission on Mandated Health Insurance Benefits
Assessment Tool

INTRODUCTION

The Commission on Mandated Health Insurance Benefits exists to serve the people of Colorado and the State Legislature by providing objective information and recommendations on the impact and structure of current and proposed health insurance mandated benefits. In order to accomplish our mission, the Commission requests that all proposed mandates clearly define:

- the scope of services to be covered,
- the level of benefit intended, and
- the health insurance markets directly impacted (e.g., individual, group, etc.)

In providing answers to the following questions, the Commission requests that sources be cited, or actuarial analysis be presented, for the information provided. Information without a source cited or analysis submitted will be assumed to be opinion and anecdotal.

A. Social Impact

1. If coverage is not generally available, what is the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment due to cost, access to care, or other factors? Specify:
   a) Financial impact to an individual seeking the specified course of treatment;
   b) Barriers to care, aside from financial hardship, that arise due to lack of coverage; and
   c) Medical outcomes likely to result from a lack of treatment.

2. The extent to which coverage for the proposed benefit mandate is already available through coverage provided by the following entities:
   a) Medicare;
   b) Medicaid;
   c) FEHBP;
   d) Colorado State employee plan;
   e) Major insurance carriers (specify if offered market segments to which benefit is offered);
   f) Any government, community, or charitable programs.

3. What is the level of public demand from consumers and/or providers for the service or treatment? Is meeting this demand consistent with the role of health insurance and the prudent management of medical expenses for the greater good of the general populace?

4. In which states has a similar mandate been promulgated? What is the likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states?

5. What are possible alternatives to meeting the identified need?

B. Financial Impact

1. What is the health insurance premium impact on a pmpm basis anticipated over the next three years due to the proposed benefit mandate? Specify:
   a) Direct health care costs (cost per service), utilization assumptions, and administrative expenses;
   b) Indirect costs, such as inappropriate or excessive treatment;
   c) Savings directly related to the proposed mandate, such as improved health outcomes; and
   d) Indirect savings related to the proposed mandate, such as employee productivity.

2. Does the proposed mandate provide for a more or less expensive treatment alternative than is already commonly covered in the market today? Explain.

C. Medical Efficacy

1. How does the proposed benefit mandate meet generally accepted medical treatment standards?

2. What criteria exist to determine the appropriateness (medical necessity) of providing the proposed mandated benefit?

3. What improved and lasting outcomes will result from providing the proposed mandate?

4. What medical, behavioral, and lifestyle alternatives exist for treating the specified conditions?

D. Balance

1. To what extent does the need for coverage of the proposed mandate outweigh the costs of mandating the benefit?

2. What is the potential number of persons that may no longer be able to afford coverage as a result of this mandate?

Appendix C

Minutes of Commission Meetings in 2007

Commission on Mandated Health Insurance Benefits

February 2, 2007

Meeting Minutes

Commission Members in Attendance

Leo Tokar, Vice Chair
The Honorable Morgan Carroll
Peg Brown
Richard Rush
Pam Nicholson (via teleconference)
Debra Higgins (via teleconference)

Division of Insurance Personnel

Dayle Axman, Supervisor, Life and Health
Mike Mawhinney, Assistant to the Commissioner

Public Attendees

Edie Busam, Lobbyist for Colorado Hospice Organization
Cordt Kassner, Executive Director, Colorado Hospice Organization

I. Welcome and call to order

Vice-chair Leo Tokar called the Commission to order and welcomed Commission members and guests.

II. Referral of SB07-78 and Commission Discussion

Due to her involvement in Senate floor activities, Senator Suzanne Williams was unable to attend the meeting and present SB07-78 to the Commission. She asked Edie Busam and Cordt Kassner, Ph.D. to provide the Commission with information regarding this proposed bill's social and financial impacts.

Ms. Busam presented information contained in the document provided to the Commission. She stressed that the objective of this bill was to "restore" the mandatory offer of hospice coverage, not to mandate the coverage itself. In 2003, the legislature removed the mandatory offer of hospice coverage from the basic health benefit plan

option. There is interest in drafting mandatory coverage legislation in future legislative sessions when additional data can be aggregated to support that mandate.

Ms. Busam presented the information prepared regarding the social and financial impact of this offer of coverage and said that insurers, including the Health Plan Association, were neutral regarding the passage of this bill

A commission member questioned the extent of the mandate of home health services and whether they were tied to the hospice coverage mandate. Ms. Busam indicated Legislative Legal Services had indicated to the bill sponsor that the home health services are those related to hospice care.

Another commission member remarked that any offer of coverage, due to administrative complexity and higher claim costs associated with adverse selection, should be made at the employer level, not to each employee. Mandates that must be offered to each employee rather than at the employer level are difficult and costly for insurers to administer and, when elected at the employee level, only those employees choosing to pay the additional amount would value the benefit, creating the adverse selection problem. Mr. Kassner responded that the offer is to be made to the employer, stressing again that this bill is not a change to the current mandate. Other commission members indicated that they believed that many carriers make it a part of the benefit packages offered rather than worry about providing the employers with “boxes” to check, particularly for a benefit choice that is at most a nominal amount of additional premium.

The Commission discussed if it would make more sense to make this mandatory coverage now versus restoring the offer of coverage this year and following with a mandate for coverage in future years. Ms. Busam indicated that there is a significant amount of data that needs to be aggregated and analyzed prior to proposing mandated coverage legislation.

Regarding the information provided to the Commission regarding the financial impact, Ms. Busam indicated that nothing was provided in response to item one as the bill is for a mandated “offer” versus mandated coverage. One of the commission members indicated that it is still important to understand the impact a rider would have on a policyholder’s premium.

As an additional source of information about the costs of mandated benefits, the Commission referred the bill’s proponents to the Maryland Health Care Commission. It has extensive information of costs for the coverage that is mandated in Maryland. There was additional clarification that this bill is for the restoration of the offer in the small group *limited mandate basic health plan* only; other small and large groups currently must be offered hospice coverage.

Mr. Kassner reviewed the medical efficacy portion of the information provided to the Commission. Hospice providers have indicated that, since 2003, there has been an increase in the number of patients that are unaware of the availability of hospice coverage. He stated that for every $1.00 spent for hospice coverage, $1.52 is saved. Hospice care averages about $132 per day which is much less expensive than inpatient hospital ICU care. He also noted that most admissions are within two weeks of the patient’s death. A commission member asked about the statistics for patients who actually survive the six-month demise expectation for hospice care. Mr. Kassner

indicated that approximately 10%-15% of patients are discharged from hospice “alive”, i.e. no longer meeting the criteria for hospice care due to pain and medication management.

Ms. Busam stressed that it is important to understand that hospice care includes treatment for the family and that bereavement care can continue up to one year after the patient dies. In many cases, this care can reduce or eliminate the family’s need of other health services related to dealing with a loved one’s death. The Commission members would be interested in receiving information regarding the health care savings that bereavement care may provide.

Hospice care is comprehensive care over a broad spectrum of services, including palliative care. Although other care providers and facilities may offer “pieces” of hospice care, no other provider offers all of the services. Mr. Kassner noted that, unfortunately, hospice providers are now serving a broader range of patients that in the past, particularly younger patients.

The Commission asked if hospices are licensed: yes. Will other facilities be looking to be reimbursed for the certain types of hospice services they provide? Mr. Kassner stated that hospice services are provided on a per diem basis versus a fee for each service provided as each individual patient requires his/her own unique set of services that can change as the patient’s condition changes. Additionally, Medicare requires that hospices have 5% of all services provided by volunteers. Hospices actually started as all-volunteer organizations.

The Commission asked why this bill was being proposed at this time. Mr. Kassner said the CO Hospice Organization did fight the exclusion of this coverage in 2003, but perhaps not in the most effective manner. He stated, again, that providers are telling them that a number of the patients under 65 don’t have a hospice benefit and specifically that providers report that patients didn’t have hospice benefit because their employer had chosen a Basic “mandate-lite” design. One commission member said that he thought it was unusual for commercial business to not have some type of hospice care, though another commission member noted that she was aware of the availability of hospice services in her geographic area but noted that hospice coverage was not addressed in her own employer’s coverage.

It was noted that hospitals do provide palliative care and that some hospitals have pastoral nurses. Concern was raised that the component parts of hospice services might be broken into separate services and charged for on a fee-for-service level.

One actuary on the Commission stated that in his opinion, the premium impact of adding this coverage back into the basic plan is $0. Additional discussion included comments by that it would be helpful to have the home health services coverage clarified as services only provided by a hospice and assurance that the offer will always be made at the employer level.

Ms. Brown said that a draft report for the Commission to review should be drafted by close of business on Monday, February 5, 2007. The report is due to the Committee on Thursday, February 8, 2007.

III. Presentation of SB07-36

No one was present to provide the Commission with information regarding this bill. Additionally, it was referred to the Commission yesterday which did not provide the Commission an opportunity to do its own research into the possible social and financial impact of the bill. It was noted that HB07-1112 is addressing similar concerns and the Commission's review would be more effective if both were presented at the same time. This bill is being heard in Committee on Monday, February 5, 2007; therefore, a report is due. It was decided that a very brief report would be prepared.

IV. Discussion of Commission's Objectives and Challenges

The challenge of the Commission is the timely receipt of referrals of bills. There are specific deadlines to be met for reviewing and preparing a report. It is difficult to achieve a quorum when meetings have to be scheduled without sufficient lead time.

A commission member suggested that it may be helpful to have the bill drafters provide a "heads-up" in the cover to the bill paper that the proposed bill may require Commission review.

The Commission members also discussed the value of the Commission to the legislative process. Although there is no staff or budget, the Commission can provide a high-level broad review by a cross-section of individuals that provides feedback to bill sponsors. It would be helpful for the Commission to also review the administrative burdens mandates may place on the system with associated costs and premiums. Additionally, it would be helpful to allow referral to the Commission by an individual legislator versus a Committee.

It was noted that some legislators are hesitant to send bills to the Commission because they expect negative feedback.

It would be helpful to meet with the Committee Chairs and leadership. Additional consumer representation on the Commission would require a change in the statute. It was also noted that having a cost-benefit analysis through the independent Mandated Health Insurance Benefits Commission is important.

It was decided that a standing meeting will be scheduled every Friday from 2:00-4:00 in the Division of Insurance's Conference Room B. Telephone conferencing will be available for those who cannot attend in person. The Commission will also request that the Commission meeting schedule be placed on the Legislative calendar.

V. Adjournment

Commission on Mandated Health Insurance Benefits

February 9, 2007

Meeting Minutes

Commission Members in Attendance

Leo Tokar, Vice Chair
The Honorable Morgan Carroll
Peg Brown
Richard Rush
Greg Dyson (via teleconference)
Chris Miller (via teleconference)

Division of Insurance Personnel

Commissioner Marcy Morrison
Julie Hoerner, Research Analyst
Dayle Axman, Supervisor, Life and Health
Mike Mawhinney, Assistant to the Commissioner

Public Attendees

Rep. Alice Madden, House Majority Leader
Sen. Brandon Shaffer
Betty Lehman, Autism Society of Colorado
John Miles, Department of Human Services
Susan Cox, Kaiser Permanente
Michael Huotari, Colorado Association of Health Plans
Christy Blakely, Family Voices
Linda Daniel, Daniel Public Policy Group

II. Welcome and call to order

Leo Tokar called the Commission to order and welcomed Committee members and guests.

III. Approval of the Minutes of February 2, 2007

The Minutes of February 2, 2007 were presented for approval and were adopted by acclamation without change.

IV. Announcements

Peg Brown reported that the Division of Insurance staff have been unable to locate Dr. Michelle Velkoff as she has closed her medical practice. The Division will post an announcement on the

website and after an appropriate period will ask the position to be declared vacant and available for an appointment to the vacancy in accordance with CRS 10-16-103.5(1)(b).

Ms. Brown also announced that Deb Higgins resigned her position on the Commission and she will contact the Governor's Office of Boards and Commissions about an appointment to fill this vacancy.

The vacancies to be filled are 1) a health care provider under CRS 10-16-103.3(1)(a)(III)(D); and 2) a business owner with less than 50 employees from a rural area under CRS 10-16-103.3(1)(a)(III)(F).

II. Referral of SB07-1253 and Commission Discussion

Representative Madden introduced this bill after being contacted by a constituent who, while living in Florida, was denied health care coverage because he was a member of the military reserves or National Guard. When the constituent moved to Colorado, he contacted the Colorado Division of Insurance and was told that there was no prohibition on being denied health care coverage because he was serving in the military reserves or National Guard. Representative Madden worked with Representative Joe Rice, Representative David Balmer, both officers in the Reserves, as co-sponsors.

Representative Madden stated that the term "uniformed services" is known in the military as applying to the four branches; however, she does plan of clarifying this term.

The Commission asked if it is the active and/or retired military personnel having problems obtaining coverage. Representative Madden stated that the bill was conceived to provide protection to the National Guard, Reserves and active military personnel.

One Commission member stated that when an individual is on active duty, the government is covering all of his/her needs, and questioned whether individuals on active duty have need of this coverage if the government is already providing coverage? Would there be some type of coordination of benefits between the two coverages? Representative Madden stated that there would not be any reason not to coordinate benefits if appropriate. She also indicated that the "gaps" appear to be individuals in the Reserves who have not been "called-up" for active duty.

Another Commission member noted that the Department of Defense is the primary payor for active duty. TRICARE allows the coverage to continue after military personnel return; however, due to federal legislation passed in 2006, TRICARE will always be considered the secondary payor. He also indicated that he didn't believe commercial group coverage was the problem area, but that it is conceivable that individual policies may be the problem.

One Commission member who is retired military confirmed the TRICARE would be a secondary payer. Yet another Commission Member stated that he believed that there would have to be another reason for ineligibility in an employer-based group plan other than military service.

In the fiscal assessment, it is believed that this would mandate would be rarely utilized so a significant cost is not anticipated. However, Representative Madden feels it is important to support military personnel in whatever manner possible.

The Commission members representing carriers were questioned if they were aware of individual carriers denying coverage. All replied that they were not aware of a carrier denying coverage, but it is conceivable that some carriers may be denying coverage.

One of the actuaries on the Commission noted that a carrier's underwriting guidelines may consider someone in the Reserves as participation in a "hazardous" activity.

The Commission believes that this may be an issue in the individual market and that carriers may be denying coverage or applying a rate-up. There does not appear to be an issue or conflict for coordination of benefits between coverage provided under this legislation and the military health coverage programs for active duty and retired military personnel.

Staff will draft a report on HB07-1253 and circulate it for comment by Commission members in preparation for issuing a final report on Monday, February 12, 2007.

V. Presentation of SB07-04

Senator Brandon Shaffer introduced SB07-04 after it was recommended by the Early Childhood and School Readiness Commission on which he sits. The bill is to provides for the coordinated funding and provision of services for children from birth to age 3 who have been identified to have severe developmental delays. Since the bill's introduction, a number of amendments have been collected and agreed to that are included in Amendment L.004 and the pre-amended draft of the bill. He asked the Commission members to refer to the "pre-amended" version rather than the "introduced" version.

Senator Shaffer indicated that the bill creates a "broker" role for the community-centered boards (CCB) to interface with providers and funding sources. This gives parents a single point of contact as they struggle to understand what services are available to them. The main goal of the legislation is to simplify the process for parents who are struggling with the fact that their child has received this diagnosis.

John Miles of the Department of Human Services helped draft the legislation. He reviewed the "Background" section of the Commission's assessment tool that was prepared for SB07-04. He stated that some states have identified 5%-7% of children with severe developmental delays; however, in Colorado, approximately 2% of children, birth to 3 years, are eligible under federal government's Individuals with Disabilities Education Act (IDEA) Part C criteria of a significant developmental delay. Part C has ICD-9 criteria for health conditions, but the services needed and that are identified under Part C are designed to assist in developing function and fit a child-appropriate definition of medical necessity.

Mr. Miles stated that both service coordinators and parents expend large amounts of time working with providers and the available payment sources to ensure that the needed services are provided. One of the problems with a process that takes a lot of time to coordinate is that the "window of opportunity" is very narrow for the children in this age category; delays in starting the services is very detrimental to the child. Families that have coverage through Medicaid or private insurers often have to go through lengthy denial and appeal processes when they attempt to receive payment for the services.

Mr. Miles said this legislation will help Colorado to achieve federal requirements that Colorado establish policies regarding:

- A common definition of "significant delay in development";
- A common set of service definitions for early intervention;
- A means of streamlining the administration of a coordinated system between providers and funding sources;
- Provide Colorado with the ability to access the 50% match of federal funds; and
- A directive that will provide consistency of providing insurance coverage for early intervention services.

It is estimated that approximately 5,000 children in Colorado would qualify under the Part C definition (2% of all children in the "birth to age 3" category). The federal law has 17 services, of which Colorado has selected 14 services for inclusion, but a number of these services are rarely used. Colorado would use a multi-disciplinary team to assess and work with children and families and rather than attempt to cover only some of the services, it was determined that a benefit cap

would be appropriate so that the services provided can be tailored to a specific child's needs. Although numbers are available from Medicaid, it is known that some children are already receiving some of the services that would be covered under this program from other sources.

A Commission member asked if this was an expansion of Medicaid's covered services. Mr. Miles indicated that it isn't for regular Medicaid, but would be for CHP+. He stated that the federal government defines the covered services for regular Medicaid.

Senator Shaffer reviewed the February 4, 2007 memorandum from the Colorado Legislative Council Staff regarding the fiscal impact. It eliminated coverage of non-emergency transportation services to reduce the cost impact to Medicaid; however, he said he was unsure why that was eliminated since it should still be covered. Betty Lehman indicated that a very small amount of costs is attributed to transportation ($400/year). Senator Shaffer indicated that this coverage would only apply to Part C eligible children only.

Betty Lehman provided some additional background information regarding the need for this legislation. She said that most people are unaware of CCBs and unaware of the programs and services available. She stated that the federal government determined that there is a cost-saving in providing early intervention services. She stated that the General Assembly has appropriated state funds to serve 2,072 infants and toddlers. Last year, the Department of Human Services, through the CCBs, served approximately 2,755 children per month and a total of 4,399 per year. John Miles indicated that Part C has reporting requirements and acknowledged that there is a "list" of Part C eligible children. He indicated that a program called "Child Find" and the public schools help identify the eligible children.

A question arose as to how public schools would be able to identify children in the birth to 3 years category. Mr. Miles indicated that public schools provide assessments and that physicians refer the children. Ms. Lehman indicated that physicians know about Child Find and who to refer the children to for assessment. A Commission member asked if there was an interaction between the CCBs and public schools and was told yes. Ms. Lehman indicated that Child Find does a multi-disciplinary evaluation and will determine if the child is eligible for Part C. The federal government has two programs: Part C for birth to age 3 and Part B for ages 3 to 21. The public schools are brought in to do assessments and to help with the transition from Part C to Part B.

Senator Shaffer stated that this legislation does not impact this assessment process. A Commission member asked if any of the "free" assessments will be pulled into the coverage to be provided by private insurers and was informed that the assessments would not be included under the services to be covered by insurance under the bill.

Another Commission member asked if the physician refers the child directly to the CCB. The reply was no, the physician will refer the child to Child Find. Mr. Miles indicated that physicians may refer the child to certain providers (hospitals, PT, OT, etc.) if the child is covered through private insurance. He also indicated that there is inconsistency in provider availability, particularly in rural areas.

Ms. Lehman reviewed the "Financial Impact". Early intervention services, by enhancing a child's development at a critical time, reduce the long-term costs to the state. The four metro CCBs have reported that 25% to 30% of children receiving services no longer qualify for further services or special education on or before their third birthday. The state-wide estimate of all CCBs is 10%-15%, which is a considerable cost-savings in future Special Education costs. However, children whose needs are not met or are under-served have a substantial risk of developing more severe disabilities and an inability to function without specialized care.

The JBC report to the Legislature of the Fiscal Year 2004-2005, indicated that only 12.7% of the individuals entering the Part C system used private insurance to cover a portion of their service needs even though 61% of Colorado's population has employer-based health insurance

according to the Kaiser Foundation. In 2003, the Douglas County program indicated that 71% of its families had private insurance and 20% were covered by Medicaid. Ms. Lehman reviewed the example provided in the assessment tool which demonstrated the cost barrier that exists for families that have insurance coverage for the services currently mandated by CRS 10-16-104(1.7). Ms. Lehman noted that $3.4 million of the Referendum C funds were used to help families.

In reviewing the Douglas County statistics provided regarding the number of services (342 of 457 physical therapy services) paid for by the CCB from Colorado's General Funds, a question arose whether the result of this bill be that fewer services will be paid for by the General Fund? John Miles indicated that any new monies that are received to cover services will not reduce General Fund expenditures.

Ms. Lehman continued with her presentation of the financial impact and stated that many health plans exclude coverage of "unspecified delay in development" (ICD-9 code 315.9), considering it to be an educational diagnosis instead of a medical one. These denials are a significant barrier to receiving these services in a timely manner during these critical years.

There are also provider barriers due to the variety of requirements imposed by the different health carriers, including the contracting and reporting requirements.

Ms. Lehman discussed the current coverage mandated by CRS 10-16-104(1.7) and discussed the allowable early intervention services under Part C. Mr. Mills stated that the original federal law identified 17 covered services. Colorado has provided more specificity to the federally-defined services. He noted that the "respite" service is provided while family members participate in programs that will help them to assist in the development activities required by their children.

A Commission member stated that the broker concept was a great idea, but wanted to know who pays for the broker services and what specific services are being added to the coverage that would be provided by both public and private payors? Senator Shaffer stated this process is difficult to understand unless you've been a parent that has had to work through this process. This legislation is attempting to give the CCBs assistance in finding funding sources. Senator Shaffer stated that common definitions of services will add to the consistency of coverage and enhance utilization of the services.

Asked if the bill was creating new coverage for services, Senator Shaffer said that the bill takes the Medicaid package of services and provides coverage for them through CHP+ and private insurance.

Mr. Miles stated that the Department of Human Services manages the funding for the CCBs and how much of it goes to administration overhead. Currently, the CCBs spend a lot of time tracking down funding sources.

A Commission member asked which services, considered most important, were not being provided. Mr. Miles indicated that pediatric physical therapy in rural areas is the greatest challenge. Developmental intervention services educates families to assist with the child's cognitive development. The trans-disciplinary approach provides the family with a protocol to use between visits.

Senator Shaffer stated that in order to receive Part C funds, Colorado is expected to ensure that all of the services identified in an "individualized family service plan" (IFSP) are provided. As stated previously, an additional $3.4 million from Referendum C funds were needed to prevent a wait list for the services. Part C funds are supposed to be used as a "payor of last resort".

Ms. Lehman said that the "heart" of this bill is the need to come into compliance with the federal requirements of Part C so that the state can continue to receive Part C funds. These requirements include:

- Development and implementation of a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services;
- Facilitation and coordination of payment for early intervention services between federal, state, local public and private resources; and
- Enhancement and expansion of the state's capacity to provide quality early intervention services.

Ms. Lehman identified the other states that have similar mandates (MA, CT, VA, NY, IN, RI) and was asked which of these states has similar requirements to the mandate being proposed ($0 deductibles, copays, etc.). Ms. Lehman indicated that Massachusetts' mandate is most similar and it was reviewed during the drafting of this bill.

Regarding the other possible alternatives for meeting the identified need, Ms. Lehman indicated that there is a struggle to fund the program and that there is a four year process in implementing a new "equity" formula to allocate Part C funds among the CCBs.

Ms. Lehman discussed the facts and assumptions presented in the assessment tool, indicating that the Division of Insurance provided numbers regarding the percentage of heath plans under the jurisdiction of the Division of Insurance. Deputy Commissioner Brown clarified that, actually, the general assumption used is that 35% of those individuals covered by health plans are subject to Colorado law and that half of the employer-sponsored coverage is subject to Colorado law.

Ms. Lehman indicated that the eligible children are those with significant developmental delays and are in need of a high level of services. She indicated that private insurers are already covering some of the services. She also indicated that according to testimony provided yesterday, it was estimated that this coverage would add $.49 per month to premiums. Mr. Miles indicated that most services aren't started until around age one due to the identification and assessment of the child.

Mike Huotari (Colorado Association of Health Plans) stated that he had just done a quick bit of math regarding the assumptions provided in the assessment tool: if 30% of the citizens covered by insurance are subject to this law, then 30% of the 4200 eligible children (1,260) will be covered and not the 770 provided in the assumption.

Susan Cox (Kaiser Permanente) provided information regarding Kaiser's Early Childhood Developmental Delay Center. She said that Kaiser will perform assessments that parents can take to CCBs so that they can receive services that Kaiser Permanente doesn't provide, such as home care, or they may choose to opt out of using Kaiser's providers.

She said that Kaiser Permanente has care coordination nurses who work with the families and Kaiser is concerned with the possible increase in administration costs for this program due to the requirements of this bill, which is money Kaiser would rather be spending on providing the actual services.

A Commission member asked Ms. Cox how this bill changes the current process. Ms. Cox indicated that there is some confusion surrounding some of the requirements so she is unsure of exactly how Kaiser will be impacted. Senator Shaffer stated that parents should have the final say in which providers are utilized for services and the bill is trying to keep the flexibility of current programs. A Commission member noted that carriers currently negotiate the rates they pay providers and asked if payments under this bill would replace the carriers' negotiated rates. Senator Shaffer said that if a carrier has a rate in place, then that is the rate it will pay. John Miles said that the CCB is a broker. For example: If the provider charges $70 and the carrier's

rate is $50, $50 is what it will pay. The CCB will make up the difference to the provider's registered rate of $70.

A Commission member asked if this is a "any willing provider" law. For example, if Kaiser can provide the service, but the parent can choose any provider. Mr. Miles indicated that the carrier would have to cover a non-network provider, but the carrier's cost is limited to the network provider's cost and the CCB will make up the difference.

A question was posed whether carriers' utilization review processes will come into play. If a carrier's medical director is not part of the "team", what happens if the carrier authorizes 5 visits, but a non-contracted provider indicates that 15 visits should be covered. Can the carrier limit coverage to 5 visits? No.

One of the Commission actuaries anticipates an increase to premiums due to $0 deductible and $0 copays for these services as well as a lack of medical review for utilization purposes since the care won't be managed the same way. Another Commission member expressed a concern about carriers giving up utilization review authority to a different provider group to determine medical necessity.

Mr. Miles indicated that the risk is capped due to the $5,725 maximum yearly benefit.

Susan Cox said that Kaiser is recommending an amendment regarding the definition of medical necessity. Kaiser is also concerned about the quality of care since any non-contracted provider being used may not have been credentialed by Kaiser and subject to their quality standards.

John Miles indicated that the state must provide the federal government with the provider qualifications. A Commission member noted that quality goes past someone being "certified" to perform services. Mr. Miles indicated that the Department of Human Services has a quality review team that reviews providers.

Mr. Huotari expressed a concerned about the possibility that this may be a "any willing provider" law. He also stated that he could find nothing in the bill that allows the carrier to pay a non-contracted provided its "contracted" rate and believes this may conflict with SB06-213 requirements.

He is also concerned about the credentialing of providers as the NCQA has specific requirements in this area. Additional concerns:

- The medically necessary wording;
- Unsure of the actual costs even though there is a benefit maximum; and
- Unsure of the unintended consequences of the bill.

The Commission members noted that the Commission does not "approve"/"disapprove" bills; the Commission attempts to balance the financial and social impact of mandates. Would there be an opportunity to ask additional questions as this is somewhat of a "moving target".

Senator Shaffer conceded that there are many dimensions to this bill and that it is important to put yourself in the position of a parent faced with the difficult challenges presented by a child with significant developmental delays. He said that a vote is scheduled on February 14, 2007.

Betty Lehman said that the bill intentionally does not address the operational issues so that those issues can be discussed and negotiated after it is passed. Mr. Miles said the bill is looking at the best way to streamline the process. One Commission member commented on the bill designing a healthcare delivery system versus mandating benefits.

Another Commission member said there is a need to separate out what the broker does versus the services provided. Actuaries must be able to understand the impact of services that aren't currently covered.

Ms. Lehman said that only four services are used primarily—most of the other listed services aren't used. Also, due to the shortage of early intervention providers, most of these providers have already contracted with the carriers. It is important to consider how much these services will save in the long run.

Ms. Lehman said this bill will achieve the "greater good".

The Commission believes there must be a cost benefit analysis. Services outside insurance coverage are being paid, but the savings are achieved by the school's special education program. Mr. Miles reminded the Commission that the cost-share piece is picked up by the state, which is why the deductibles and copays don't apply. However, a Commissioner stated that the bill language does not support that assertion.

Regarding the impact to the State of Colorado employee plan, it was noted that the State's contribution is fixed; therefore, any additional premium cost is borne by the employees. The reported increased premium for a single employee is $.50/month.

The Commission will provide a report to the Committee but recommends that it return to the Commission after it is heard in the House. Among the factors to be addressed in the report are:

- Size of population;
- Cap;
- Participating provider rate;
- How it overrides existing laws.

VI. Discussion of Commission's Objectives and Challenges

The Commission discussed the challenges with how the process on referral of bills and legislative deadlines. It was decided that the Commission will hold an unofficial meeting of the Commission to discuss how to improve the process and to make recommendations to legislative leadership about changes to the Commission's statute.

V. Adjournment

Commission on Mandated Health Insurance Benefits

March 9, 2007

Meeting Minutes

Commission Members in Attendance

The Honorable Lois Tochtrop
The Honorable Morgan Carroll
Richard Rush
Peg Brown (via teleconference)
Greg Dyson (via teleconference)
Chris Miller (via teleconference)
Pam Nicholson (via teleconference)

Division of Insurance Personnel

Julie Hoerner, Research Analyst
Dayle Axman, Supervisor, Life and Health
Mike Mawhinney, Assistant to the Commissioner

Public Attendees

Representative Bernie Buescher
Ned Calonge, M.D., M.P.H., Chief Medical Officer, CO Department of Public Health and Environment
Michael Huotari, Colorado Association of Health Plans

V. Election of a Chair

The Commission members decided to table this item. Rick Rush was selected by the Commission to act as a temporary chair for this meeting.

II. Approval of the Minutes of March 9, 2007

The Minutes of February 9, 2007 were presented for approval and were adopted by acclamation without change.

III. Referral of SB07-1301 and Commission Discussion

HB07-1301 establishes the Cervical Cancer Immunization Program to immunize women and girls against cervical cancer and provides a mandate for coverage of cervical cancer immunizations. Representative Buescher presented an overview of the bill. He stated that the bill is not a mandate to require the vaccine as a condition for school attendance; but it is to make the vaccine as widely available as possible. The four things it does:

1. It encourages federally qualified health centers to enter into agreements with local public health agencies to make the vaccine available to under-insured girls.

2. It establishes the Cervical Cancer Immunization Awareness Campaign Fund to increase public awareness.

3. It adds the cervical cancer immunization as an optional Medicaid benefit.

4. It mandates coverage for cervical cancer immunizations in all individual and group health plans.

Representative Buescher started working on this legislation last summer after conversations with his oldest daughter, who is a fourth year medical student. She had expressed her concern and frustration regarding the number of young women that were dying of cervical cancer when an immunization was available to prevent it. He stated that he met with representatives of every available carrier regarding coverage for the cervical cancer immunization, who indicated to him that they planned on covering it if the federal government approved it and they supported its use.

Representative Buescher indicated that Dr. Ned Calonge had completed the Commission's assessment tool and Rick Rush asked Dr. Calonge to review the information presented in the tool.

Dr. Calonge started by saying that he was impressed with the Commission's assessment tool. Dr. Calonge stated that the cost of the vaccine itself is estimated at $120 per shot, or $360 for the total course of three shots. The administration fee has been estimated at $20/shot which is based on data from the public health setting. Therefore, the total cost is $420 ($140 X 3), which makes it the most expensive vaccine available.

The Commission asked if there was only one manufacturer. Dr. Calonge indicated that Merck is currently the only manufacturer; however, GlaxoSmithKline will be joining the market.

One of the barriers to care is that if insurance doesn't cover the vaccine, it is possible that doctors will not stock the vaccine and patients may have to seek other care settings like public health clinics. He noted that pediatricians are concerned about the cost of the drug because they do not typically get reimbursed for the full cost of vaccines, which is not as much of an issue when they are providing less expensive vaccines.

A Commission member asked if Medicaid would receive reimbursement for the full cost. Dr. Calonge indicated that it would receive $97 per dose. He explained that the Vaccine for Children Program (VCF) provides vaccines for Medicaid recipients. The VCF will be able to buy the vaccine in bulk.

Representative Buescher stated that the reimbursement of Medicaid providers was reviewed yesterday and he realized that the stocking of the vaccine is expensive and there was discussion about making the reimbursement of the administration fee a percentage of the cost versus a flat fee.

In answer to what medical outcomes would likely result from a lack of treatment, Dr. Calonge stated that the Pap smear screening test reduced cervical cancer from the number one cause of death to somewhere beyond the top five. It is estimated that 40 Colorado women die each year due to cervical cancer. He stated that human papilloma virus (HPV) will infect up to 50% of women at some point in their lifetime. HPV causes abnormalities in the cervix that if left untreated will typically progress to cervical cancer. The Pap smear is an excellent screening tool for identifying these abnormalities, which is why cervical cancer is no longer the leading cause of death. However, there are a number of diagnostic and surgical procedures that are used to address the cervical abnormalities related to HPV infections. These include:

- Colposcopies;

- Cervical biopsies;
- Cervical conization procedures;
- Cervical cryosurgeries;
- Cervical loop electrical excision procedures (LEEPS); and
- Hysterectomies performed for cervical pathology.

It is estimated that 70% of cervical cancer cases are due to HPV infection; therefore, 28 women may be spared and 70% of all of the treatments performed following an abnormal Pap smear will be avoided.

Continuing his review of the assessment tool questions and the extent to which coverage is already available through specified entities, Dr. Calonge stated that Medicare coverage is not applicable since the vaccine is indicated for women at ages not eligible for Medicare. Regarding Medicaid coverage, he stated that it is already available because Medicaid covers all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) at the CDC and that it is unknown if the Federal Employee Health Benefit Plan or the Colorado State employee plans will cover it. He did state that Kaiser Permanente, which covers about 10% of the state's population, currently provides coverage for the vaccine.

One Commission member stated that TriCare has announced that it will cover the vaccine. Representative Buescher stated that when he met with representatives of Anthem, United HealthCare and Rocky Mountain Health Plans, they stated that they intended on covering it.

Dr. Calonge believes that the public demand for this immunization will be high because it prevents 70% of cervical cancer cases. He stated that since the vaccine has only recently become available, he is unsure of the coverage being provided in other states although there is a lot of publicity about requiring it for school entry, something this bill does not mandate. He believes that eventually, the market will drive insurers to provide coverage for the immunization due to the significance of it being able to protect women from most cases of cervical cancer.

Regarding the financial impact, Dr. Calonge provided the following assumptions to support a calculation of a per-member, per-month cost of $0.317:

- Disregarding "catch up", which is providing the immunization to females already over the age of 11, the steady state will require immunizing a single birth cohort (11 year olds)
- The 11 year old age cohort for a health plan population is 1% of the population and the female population will be ½ of 1%.
- The vaccine costs $360 for the series of three doses with an administration fee of $20 per dose.

He stated that there will be no indirect costs as this is a prevention vaccine.

The exact cost savings related to providing the vaccine is difficult to calculate because of the amount of data that would have to be aggregated regarding the savings from not providing the treatment for abnormal Pap smears through the treatment continuum for cervical cancer. However, national cost estimates indicate that the saved costs will more than cover the cost of the vaccine coverage mandate. He did note that the study was performed by the drug manufacturer.

Representative Buescher stated that the costs associated with the treatment do not account for the life years saved.

Regarding the savings indirectly related to the proposed mandate, Dr. Calonge stated that there should be savings due to averted time away from work due to medical treatment of cervical conditions. He provided that only looking at mortality, and ignoring the cost savings from averted

cervix procedures, the cost per year of life saved, based on Colorado numbers (and not accounting for future discounting) is $38,000, below the generally accepted benchmark of $40,000-$60,000 per year of life saved and better than many other mandated preventive procedures such as mammography.

Dr. Calonge stated that the three shot series will prevent 70% of the follow-up Pap smears, colposcopies, cervical biopsies, cervical conization procedures, cervical cryosurgeries, cervical loop electrical excision procedures and the hysterectomies done for cervical pathology so the overall cost savings will be greater than the vaccination costs.

A Commission member asked if this would replace the need for Pap smears. Dr. Calonge replied, no, that Pap smears are 95-98% effective in identifying abnormal cervical conditions. The vaccine will prevent 70% of the cervical conditions that are related to HPV infection and the vaccine is nearly 100% effective in preventing HPV infection.

In answer to a follow-up question regarding the possible change in the Pap smear screening guidelines, Dr. Calonge stated that annual screenings are not usually recommended in the absence of an abnormal result which is why the current guidelines recommend once every three years. He doesn't believe the recommendations will change and he also believes that it is difficult for individuals to remember to be screened every three years, which is a concern to him.

In response to whether the mandate will create a cost shifting between private and public payors of heath care, Dr. Calonge stated that the mandate should prevent cost shifting and that there is a concern that if private insurance does not cover this vaccine, parents will take their children to publicly-funded care sites for the vaccine series.

Dr. Calonge next discussed the medical efficacy. The ACIP has recommended this vaccine for all females under age 26, making it an acceptable medical treatment standard. The ACIP recommendations are always completely accepted by the American Academy of Pediatrics and the American Academy of Family Physicians, the two professional groups representing the major primary care providers for children nationally and in Colorado.

A Commission member asked, based on the age range for the immunization started at age 11 and ending at age 26, why age 26?

Dr. Calonge replied that infection rates begin to plummet from ages 23-26 due to monogamy in sexual relationships. The vaccine will work unless the female is already infected. It is believed that age 11 is early enough to catch most females prior to the beginning of sexual activity. The Commission asked if a 30 year old would be able to receive the vaccination. Dr. Calonge stated that the drug manufacturer sought FDA approval only up to the age of 26.

Representative Buescher stated that the proposed bill follows the ACIP recommendation.

Dr. Calonge stated that the criteria used to determine the appropriateness or medical necessity of the vaccine was the recommendation of the ACIP. Regarding the improved outcomes from providing the proposed mandated coverage, he stated that decreased HPV infections, decreased cervical abnormalities, decreased cervix procedures, decreased instances of cervical cancer and the decrease in the number of cervical cancer deaths are all improved and lasting outcomes.

In response to the medical, behavioral and lifestyle alternatives that exist for treating cervical cancer, Dr. Calonge provided:

- Medical: Continuation of the cervical cancer screening approaches in widespread use today. There is no other medical prevention alternative today. Early detection is considered "secondary prevention" and vaccines are considered "primary prevention".

The vaccine can prevent the need for cervical treatments that may result in other medical problems experienced by women, particularly when they become pregnant.

- Behavioral: 95% or more of the current 40 deaths/year in Colorado due to cervical cancer could be prevented if these women sought and obtained cervical cancer screening. It should be pointed out that the vaccine provides prevention, and Pap smears only provide early detection.
- Lifestyle: Life-long sexual abstinence or sexual activity exclusively with non-infected male partners (a status that can be difficult to assure) will prevent HPV infection. Current teen abstinence rates reported in Colorado, although improved, are still less than 50% (46%-48%).

Treatment costs don't typically start accruing until around age 22, which is the age that cervical abnormalities can begin occurring. Dr. Calonge believes that the vaccination saves money when considering the costs of cervical procedures.

A Commission member asked what would happen if a 21-year old would want the vaccine. Dr. Calonge indicated that the state (Medicaid) couldn't afford "catch up" immunizations; although one year "catch up" costs were built into the proposed bill.

Representative Buescher indicated that the funding for Medicaid is being provided by a separate bill and that as additional funds become available, it may allow for additional "catch up" immunizations.

The Commission asked if private insurers will be expected to provide for catch-up immunizations. Dr. Calonge stated that the private insurers will make that decision and that physicians will need to decide if it makes sense to vaccinate sexually-active females.

A Commission member commented that sexually-active females, particularly young females, may be in need of the vaccination to make sure they are immunized before exposure to HPV. Dr. Calonge stated that it is difficult to document the presence of HPV as it is not a currently part of the routine screening that is done. He mentioned that there is a new screening test available for HPV.

Representative Buescher stated that private insurers are not limited to the one year "catch up".

The Commission asked what the side effects of the vaccine are. Dr. Calonge stated that they are consistent with other immunizations: shot-site swelling and possible fainting. The same reactions were noted in both sides of the blind study that was done. The risks are no different or greater than other vaccines.

The Commission asked if a dead virus is used. Dr. Calonge stated that there are three forms of vaccines:

- Live virus (like polio)
- Segment of the dead virus
- Purified protein derivatives

This vaccine uses a purified protein derivative, which stimulates the immune system. In response to the Commission's question regarding long-term safety, Dr. Calonge indicated that the FDA determined that because this vaccine works in the same way as other vaccines, it used bridging studies of the other vaccines to determine long-term safety.

A Commission member asked if the vaccine also works on vaginal and anal warts. Dr. Calonge replied that it will if the warts are caused by HPV.

The Commission asked who will be responsible for the public awareness campaign. Representative Buescher replied that the CO Department of Public Health and Environment

would and that he already had an individual volunteer to do fund-raising for money to assist in the campaign. He also stated that physicians have testified in support of this bill.

A Commission member asked if the bill mandates the level of coverage as it was his understanding that the cost of the vaccine may be higher than the $120 per dose referenced today. Representative Buescher stated that the bill mandates full coverage. In response to a question regarding the drug manufacturer's pricing of the vaccine, Dr. Calonge stated that pharmaceutical pricing is both "an art and a science" and he is not surprised that the cost may fluctuate.

A Commissioner member commented that the Hepatitis B vaccine was expensive when it was first introduced but has come down in price, so is it possible that this will be true for this vaccine?

Dr. Calonge stated that when it was first introduced, the Hepatitis B vaccine was $180 for a three shot series. It fell to $120 when it was added as a school-entry requirement and now it is approximately $60. He would expect this to be true for this vaccine.

A Commission member asked if efficacy of the vaccine was similar to the varicella vaccine. Dr. Calonge stated that the varicella vaccine is 85% effective and 90% or better for attenuated situations. He also noted that it is approximately 50% effective when used for shingles. He noted that use of the varicella vaccine is up and it appears that children may need a booster shot at 11 years of age to maintain its effectiveness.

A Commissioner member noted that there was a lot of interest in the varicella vaccine when it was first introduced, that has diminished somewhat---any similarities with this vaccine? Dr. Calonge expects high demand for this vaccine to continue since it has been proven to be effective in the prevention of cervical cancer. It is the second vaccine to be used in the prevention of cancer (the Hepatitis B vaccine was first, in the prevention of liver cancer).

A Commission member asked if the federal government will mandate coverage. Representative Buescher stated that this is a Medicaid benefit, which occurs after the federal government approves it use. He also stated that the major carriers intend on providing coverage.

A Commission member noted that once an immunization is recommended by the ACIP, it becomes part of the coverage currently mandated by CRS 10-16-104(11), which provides mandated coverage for children up to the age of 13. Therefore, this mandate is adding coverage for females starting at the age of 13 and up until age 26.

Representative Buescher stated that the age range for private insurers is until 26 and for Medicaid, up to age 20.

The Commission asked if CHP+ will cover it. Dr. Calonge indicated that the CO Department of Healthcare Policy and Finance is still reviewing it, but probably will.

A Commission member noted that the bill, on page 6-7, specifies that insurers "shall provide coverage"—is that "full" coverage?

Representative Buescher indicated that this language has been amended to specify "full" coverage.

A Commission member expressed a concern that since there is only one drug manufacturer with a monopoly on supplying this vaccine that this might artificially raise the price. Another Commission member stated his concern that the requirement of "full" coverage may also raise the price.

Representative Buescher stated that if this becomes a problem that a cap or language regarding "reasonable and customary" may be added and agreed that this was an important observation.

This concluded Representative Buescher and Dr. Calonge's presentation.

Mike Huotari stated that he represents ten carriers and he conducted an informal survey of his members regarding the coverage of this vaccine. Nine of the ten carriers responded. Eight of the nine indicated that they currently cover this vaccine in accordance with the CDC guidelines. He also stated that he never collects information regarding the specific reimbursement rates due to anti-trust concerns.

The Commission asked Mr. Huotari if there was any discussion regarding catch-up immunizations. He stated that he didn't recall the specifics, but if the CDC guidelines provide for catch-up immunizations, then yes.

A Commission member asked if the CDC has already approved it, is it already covered by Colorado law. Dayle Axman stated that under the requirements of CRS 10-16-104(11), and as specified in Colorado Insurance Regulation 4-6-5, that this vaccine is covered because of the ACIP recommendation. The Commissioner member asked if this expands subsection (11). Julie Hoerner stated that this bill adds subsection (16) to CRS 10-16-104 and that subsection (11) is not expanded.

In discussing the benefits of this mandate, the Commission members believe that it is possible that the benefits outweigh the costs, but that it is difficult to quantify the treatment costs associated with cervical cancer. There is not quantifiable data available to review today. It may be possible to obtain general costs of the treatment of genital warts and cervical cancer, but it would be time and cost prohibitive to try to obtain specific data. There was a concern expressed that the true savings does not occur until 10 years after the effective date of this mandate since 11 year olds receiving the vaccine would not be expected to receive treatment for HPV-related cervical conditions until then. A Commission member noted that it may not just be females that benefit from this vaccine since it may reduce the number of males that are infected with genital warts, which is considered a sexually-transmitted disease (STD). The question was posed if the vaccine would prevent some STDs and a Commission member responded that it may stop as many males from being carriers; however, this particular question was not asked or answered during the presentation.

The Commission believes that general cervical cancer cost information may be available, and if so, should be included in its report. In response to a question about when the Commission's report is due, Ms. Hoerner stated that this bill had already been heard in Committee and had been referred to Appropriations. However, the Commission had agreed to provide a report within 3 business days, which is March 14, 2007.

A Commission member, in trying to do a calculation of the cost of vaccine program, stated that if there are 4 million people in Colorado, ½ of 1% thought to be 11 year old females would be 20,000. $420 X 20,000 = $8.4 million. $38,000/life saved would equal $1.064 million in savings. It was noted that the treatment costs of the women who do not die are not included in these savings. It was noted that not all of the 20,000 11 year olds would get cervical cancer. Ms. Hoerner reminded the Commission that this mandate only applies to individuals covered by health plans subject to the jurisdiction of the Division of Insurance.

A Commission member asked based on these calculations, if it appears that the cost of the vaccine outweighs the savings. The member providing the calculations stated yes and that the savings wouldn't be realized until 2018. Not all the Commission members were in agreement with this assessment. Another member stated that there is always a period of time before the true effect of an immunization is realized, but that the problem with numbers is that the true cost savings are from the treatment that is preventing death.

Another Commission member commented that one of the concerns is vaccinating children for conditions that don't appear until after age 25. Other comments include the fact that the vaccine is not limited in its use to 11 year olds---older females can also benefit from receiving the vaccine. Additionally, once a girl becomes sexually active, the health conditions can begin occurring right away, including STDs. It was noted that Dr. Calonge didn't provide the actual treatment statistics today. Is it possible to find out how often young people are receiving treatment for the related conditions? A Commission member thought that it might be possible to get information from a professional medical association regarding costs, but not information regarding frequency. Another member mentioned that hospitals might have some data available, but the concern was expressed that this would only be connected to end-stage treatment.

Mr. Huotari expressed his belief that it would be difficult to get this type of data in this short of time frame. It was offered that the Health Department may have information regarding the occurrence of genital warts since this is an STD and a 70% reduction estimate could be applied to the data. Dr. Calonge may be able to provide that information.

It was agreed that although it may not be possible to obtain strong, quantifiable data, the Commission may be able obtain some data that will be helpful to include in its report.

VII. Review of Draft Memo to Leadership

Only one comment was received and it was in reference to a formatting issue. It was noted that this document should have the approval of all the Commission members before it is sent to the leadership in the Legislature. It was decided that it would be sent again to all Commission members with a request to give it their immediate attention and request that comments be provided by March 16, 2007.

IV. Adjournment

Commission on Mandated Health Insurance Benefits

March 23, 2007

Meeting Minutes

Commission Members in Attendance

Rep. Morgan Carroll
Leo Tokar, Vice Chair
Richard Rush
Peg Brown
Pam Nicholson
Gail Lindley (via teleconference)
Chris Miller (via teleconference)

Division of Insurance Personnel

Julie Hoerner, Research Analyst
Dayle Axman, Supervisor, Life and Health
Mike Mawhinney, Assistant to the Commissioner

Public Attendees

Senator Moe Keller
Chris Habgood, Vice President of Public Policy, Mental Health Association
Tim Gilmore, Brownstein Hyatt Farber and Shreck
Erin Silver, United Healthcare
Susan Cox, Kaiser Permanente
Dr. Jean Milofsky, Kaiser Permanente
Michael Huotari, Colorado Association of Health Plans

VI. Call to Order and Introductions

Leo Tokar, Vice Chair called the meeting to order and asked the Commission members and guests to introduce themselves.

II. Approval of the Minutes of March 9, 2007

The Minutes of March 9, 2007 were presented for approval and were adopted by acclamation without change.

III. Referral of SB07-36 and Commission Discussion

Senator Keller described the documents being provided to the Commission and advised that the Pre-amended version of SB07-36 is the version that came out of the State, Veterans and Military Affairs Committee. The L.004 amendment will be offered in the Appropriations Committee. Other documents include a Price Waterhouse Cooper report containing information about eight other states with similar legislation; the

ICD9-CM list of Mental Disorders (290-319); the report prepared by The Mental Health Association of Colorado; the Commission's Assessment Tool; and the cost analysis for the State of Colorado employee plan.

Senator Keller provided an overview of the bill, which expands CRS 10-16-104(5.5) to require coverage for mental disorders as defined in ICD9-CM except for specific disorders as provided in the bill. She explained that Colorado first adopted mental health parity in 1997, which included six biologically based mental health conditions. Since then, there has been on-going discussion regarding the expansion of mental health parity: what conditions should be covered and how should the conditions be defined? It was determined that the ICD9-CM is the best source for defining the covered conditions. She also pointed out that this mandated coverage will not apply to employer groups with 50 or fewer eligible employees as it was determined that it would be difficult to pass this legislation if small groups were covered. Senator Keller also indicated that since the bill was drafted, additional mental health diagnosis codes have been excluded from the mandated coverage and she referenced the L.004 amendment. She explained that the amended language in lines 1-9 was added due to fear that the excluded codes would be denied under the non-parity mental health coverage and that the revisions in L.004 was done to add to the list of mental health diagnosis codes that would not be included in the mandate.

Senator Keller indicated the fiscal note provided by the CHP+ program should be reduced with the adoption of L.004's additional excluded codes. She stated that the Price Waterhouse Cooper report supports the fact that this mandate should have a minimal impact to premium costs. A Commission member asked about the inclusion of certain codes such as homosexuality and reading disorders in the mental health diagnosis codes and Senator Keller indicated that she had been surprised at the inclusion of certain conditions, but it is important that the correct version of the ICD9 listing be used. The ICD9 was first developed in 1977 and the version that is referenced in the bill is the ICD9-CM. She did note that there is an ICD10 version available, but it was not used since all of the insurers and payors use the ICD9 and the costs of reconfiguring claim payment systems to accept the ICD10 would have been a significant barrier to the bill.

A Commission member asked for further information regarding the exclusion of small groups from this coverage. Senator Keller reiterated that it was felt that the inclusion of small groups would have been a barrier to passage. Chris Habgood stated that small groups are more volatile and it was thought that this mandate might cause the small employers to drop health coverage.

The Commission asked if the discussion with carriers has been completed and Senator Keller replied no, that discussions are expected to continue as the bill moves through the system and on to the House.

The Commission pointed out that there are two mental health mandates: subsections (5) and (5.5) of CRS 10-16-104. Will subsection (5) be affected by this bill? Although mental health parity requires these conditions to be treated in the same manner as other physical illnesses and may provide some conflict between subsections (5) and (5.5), subsection (5) is still germane to small groups.

Chris Habgood reviewed the information provided in the Commission's Assessment Tool. In discussing "Social Impact", he stated, reading from the Assessment Tool, that according to the 1999 U.S. Surgeon General's Report on Mental Health, mental health disorders are the second leading cause of disability and premature death in the United States. That one in five adults (20%) will experience a diagnosable mental illness in any given year. Mr. Habgood stated that there is a disparity in people of Color in Colorado: Good mental health enables individuals from all racial and ethnic backgrounds to pursue healthy relationships, advance their education, succeed in the workplace and cope with adversity.

Additionally, according to the U.S. Surgeon General, one in five Americans experiences a mental health disorder each year and less than a third of these adults and even fewer children receive

any mental health services. The consequences of untreated mental illness are severe, resulting in job loss, disability, and economic and personal hardship.

The Commission stated that Colorado currently has two mental health mandates, one for biologically based conditions and the other for mental illness: what is being evaluated here? Mr. Habgood stated that most of this information applies to depression as it is the most prevalently studied and that only major depression is currently covered as a biologically based condition. He stated that chronic depression is very prevalent.

The Commission indicated that its challenge is to evaluate new coverage, not assess what may already be covered. Senator Keller stated that drug and alcohol abuse, post traumatic stress disorder (PTSD), and eating disorders are among the conditions that will be affected by this additional coverage.

Mr. Habgood stated that, each year in this country, businesses accrue: $116.6 billion in substance abuse costs, $205 billion untreated mental health costs, $43.7 billion for depression. The costs are high for lost productivity. In considering chronic depression only, and working with CO Department of Labor figures, it is believed that there is $886 million in lost productivity and $170 million in medical costs associated with untreated depression.

The Commission asked if this was in unpaid claims. Mr. Habgood stated that emergency room costs and employee absenteeism contribute to these figures. He stated that many emergency room costs associated with mental illness are not covered by health plans. A Commission member indicated that there is a high occurrence of mental illness in jails. Senator Keller replied that this was very true and that 84% of prison inmates suffer from alcohol and drug abuse and that 18-20% suffer from other forms of mental illness.

Mr. Habgood stated that mental health-related visits constitute a significant and increasing burden of care in U.S. emergency departments. From 1992 to 2001, there were 53 million mental health-related visits, representing an increase from 4.9 percent to 6.3 percent of all emergency department visits. These visits are typically mental health or alcohol/drug abuse related. Based on Colorado data, 292 emergency room visits per 1000 population = 1,352,850 *(Kaiser Family Foundation).* The American Hospital Association reports that 6.3% of emergency room visits are mental health-related visits, the total for Colorado would be 85,229 mental health-related visits. Mr. Habgood stated that not all of these visits are uncompensated care.

A Commission member stated that if the emergency room visit is coded outside of the biologically based conditions, the charges may not be covered. The Commission discussed that CRS 10-16-104(5) mandates some coverage for inpatient care and what types of care may not be covered with the current mandates. Senator Keller provided an example of someone who hurts himself while he is drunk: how would the emergency room visit be covered? A Commission member stated that it would depend on how the claim is coded by the hospital. It was also noted that CRS 10-16-104(5) does not provide a definition of mental illness, so what types of conditions are included is not defined. Additionally, the offer of alcoholism coverage is required by CRS 10-16-104(9). Additional discussion occurred regarding the current coverage of emergency room treatment under the current mandates.

A Commission member stated that there appeared to be two separate issues: (1) what are covered services and what the level of coverage is for mental health conditions under the current mandates; and (2) what is not working in CRS 10-16-104(5) to require this legislation. Another Commission member stated that the caps, particularly for outpatient services (20 visits or $1,000) may be too low and that without a definition of mental illness, some conditions may not have coverage. Senator Keller agreed that there is some disagreement about what insurers are using as mental illness diagnoses.

In regards to barriers to care, Mr. Habgood stated that a 2005 Colorado Health Institute survey of 640 community leaders in 23 communities around the state revealed that the top five health threats in communities are all directly or indirectly related to mental health. The top five health threats are: lack of access to mental health services, lack of affordable health insurance, low-paying jobs with no benefits, illicit drug use, and alcohol abuse. Additionally, in the absence of adequate insurance coverage and fully funded services and treatment, many people with mental illnesses increasingly find themselves warehoused in our prisons, jails and juvenile justice systems. It was noted that prisons are the leading treatment facilities in the state due to the number of individuals affected by mental illness or alcohol and drug abuse. In his opinion, early intervention will reduce costs.

Mr. Habgood stated that according to the Colorado Coalition for the Homeless: Colorado likely mirrors the following national estimates as determined by the U.S Conference of Mayors: 30% of Denver's homeless population suffers from mental illness; 50% battle substance abuse. On any given night, more than 9,725 people in Denver are homeless, one-third of who have a serious mental illness.

He believes the most significant impact will be on the suicide rates. At its worst, the consequences of inadequate insurance coverage result in a tragic loss of life. More than 90 percent of people who commit suicide have a diagnosable mental disorder, commonly a depressive disorder or a substance abuse disorder. Nearly 20 percent of persons diagnosed with bipolar disorder and 15 percent of persons diagnosed with schizophrenia die by suicide. People who die by suicide are frequently suffering from undiagnosed, under treated or untreated depression. Between 40 and 60% of those who die by suicide are intoxicated at the time of death. An estimated 18-66% of those who die by suicide have some alcohol in their blood at the time of death. Colorado's suicide rate is almost forty percent higher than the national average and we rank 8th highest in the nation for our suicide rate. Suicide is second leading cause of death for Coloradoans ages 10-34, and the leading cause of injury death for Coloradoans ages 35-74. The highest suicide rate in Colorado is among adults ages 85 and older. If more treatment was accessible, it could help prevent suicides.

The Commission asked if the lack of coverage in the policy or lack of insurance coverage (uninsured) was the reason. Mr. Habgood indicated that both are reasons.

Regarding the medical outcomes likely to result from a lack of treatment, Mr. Habgood stated that according to the May 2000 Center for Substance Abuse Treatment Brief, if people did not abuse alcohol the outcomes include: brain tumors would be reduced by 27%, breast cancer would be reduced by 13%, cardiomyopathy would be reduced by 30%, esophageal cancer would be reduced by 80%, and head and neck cancers would be reduced by 50%. Additionally, there is a definite relationship in the impact of depression alone on medical costs

In response to whether this coverage is provided through Medicare and Medicaid, Mr. Habgood stated that both do cover variations of the proposed mental health parity diagnoses, but the coverage itself is substantial. The Commission asked if Medicaid has a definition of mental illness. Mr. Habgood indicated that yes, but more so for children than for adults and he also stated that he is not a Medicaid expert. He also stated that the FEHBP provides full parity based on the DSM-IV diagnosis codes.

In answer to the question regarding public demand for appropriate insurance coverage, Mr. Habgood stated that 83% of Americans believe it is unfair for health insurance companies to limit mental health benefits and require people to pay much more out-of-pocket for mental health care than for other medical care, which is according to an Opinion Research poll commissioned by the National Mental Health Association. Seventy-nine percent said they support mental health parity legislation even if it results in an increase in their health insurance premiums.

Mr. Habgood stated that 38 states have some form of parity law, but that the laws vary from state to state. Eleven states have comparable laws to what would be covered in SB07-36. The only alternative to the legislation is to do nothing and encourage voluntary parity through the employer.

In discussing the *Financial Impact*, Mr. Habgood stated that the Price Waterhouse Cooper study found that the costs for mental health parity are real, and they are very low, increasing costs by less than 1%. Based on Congressional Budget Office's estimate, the increase to a Colorado employer would be $39 a year or $3.25 a month per employee if went from zero behavioral health care coverage to full coverage. However, Colorado law currently requires that the serious mental illnesses – "six biologically based mental illness" to be covered in insurance plans. According to the American Managed Behavioral Healthcare Association, 85% of behavioral health insurance costs are contributed to the treatment of serious mental illness, the six biologically based mental illnesses. Since Colorado already requires the treatment of the six biologically based mental illnesses, 85% of behavioral health care costs are currently being paid for. Therefore, the remaining total cost for expansion of full behavioral health care insurance coverage in Colorado would be $6.00 per person or $0.50 cents a month per employee.
The Commission, due to the time remaining, asked Mr. Habgood to provide a few additional comments. He stated that treatment standards or standard of care for mental disorders are the American Psychiatric Association practice guidelines. Regarding medical necessity, he stated that under the basic principles that guide the American health care system, decisions regarding which particular treatments, or the amount of treatment, are medically necessary are made by medical professionals in light of their patients' condition and desires, and the state of health care knowledge.

In conclusion, Mr. Habgood stated, in answer to how the need for coverage outweighs the costs of the mandate, that it is the $6 per year costs versus the savings made in recapturing lost employee productivity.

Susan Cox provided comments on behalf of Kaiser Permanente. She said that ever increasing health costs and increasing benefits add to health insurance costs. This is a concern because so many employers are currently struggling to provide coverage for their employees. She believes that "opening the door this wide" will make coverage totally unaffordable. Kaiser agrees that due to changing times, it would make sense to add four additional diagnoses to the six biologically based conditions:

1. Post-traumatic stress disorder (PTSD)
2. Social phobia
3. Agoraphobia with panic disorder
4. Chemical dependency

Kaiser believes, with the addition of these four conditions, that 95% of mental health conditions will be covered. Due to broad inclusion of the ICD9-CM diagnoses, there are a number of questionable conditions that will have coverage mandated. Dr. Jean Milofsky, the Chair of Kaiser's Psychiatric Department, said that she struggles with parity because it is difficult for her to testify against expanded coverage of mental health conditions. However, she said the data shows that for every $5 increase in premium, a certain number of individuals drop coverage. Additionally, there are some mental health disorders, such as narcissistic personality disorders, where people don't believe they have a problem and they won't seek care until these personality disorders develop into one of the biologically based conditions such as major depression. She believes coverage should only be provided for evidence-based diagnoses. For example, for eating disorders diagnoses there have not been consistent treatment protocols, and parents will seek treatment but the patient isn't interested in getting better. The inpatient confinements for eating disorders are very costly but the medical outcomes are poor. She also believes that chronic and major depression statistics have been blended inappropriately. Individuals suffering from chronic, borderline depression don't usually come in for treatment until the condition has developed into major depression.

A Commission member asked if these conditions are already being covered, then costs shouldn't increase. Additionally, it should be more cost effective to treat dysthymia before it develops into major depression. This is also true for eating disorders: by the time associated conditions develop, the treatment is much more expensive. Dr. Milofsky stated that Kaiser is already treating eating disorders on an outpatient basis, but if it was covered under parity, more patients would be demanding more extensive and expensive coverage.

The Commission asked why there is a concern that there would be abuse of treatment options for these conditions versus other illnesses as the medical necessity reviews that are in place for physical conditions would also apply to these conditions. Dr. Milofsky stated that 30% of healthcare dollars is wasted and she would recommend that a study be done before expanding the coverage so extensively. A Commission member stated that without protocols, it would be difficult to review medical necessity. Ms. Cox stated that eating disorders is one condition where the patient isn't motivated to get better and yet a lot of expensive care is provided.

A Commission member asked if "chronic depression" is a diagnosis. Mr. Habgood stated that this isn't the best term to be used. Dr. Milofsky stated that the correct term is dysthymia and an individual can have this condition for years without it being severe enough to treat. A Commission member stated that if someone's not responding to care, it should be cut-off and that it would be hard to wait for the statistics to support the care; it would be better to review medical efficacy.

Ms. Cox again stated that with the addition of the four diagnoses Kaiser is proposing, 95% of the conditions would be covered and it is difficult to expect carriers to cover everything. The addition of the broad range of codes will add a layer of administrative costs due to the appeal and review process and every $1 spent in administration is a $1 not spent on the patient.

Mr. Habgood stated that there is an 80% success rate for the treatment of depression. A Commission member asked if an individual is treated for major depression, would he/she always have the diagnosis or would it change to chronic depression. Mr. Habgood stated it is similar to a cancer diagnosis—once the occurrence is cured, the individual will always have an additional risk. A Commission member noted that there is a line between major depression and chronic depression (dysthymia), but chronic depression is not on the list.

Dr. Milofsky stated that at Kaiser, in its integrated care system, many times individuals with chronic depression are treated by their primary care physician. Ms. Cox also stated the four additional diagnoses have good treatment outcomes. Dr. Milofsky stated that attention deficit disorder (ADD) and bi-polar are often co-morbidities in children and she feels ADD should be treated in children. Ms. Cox stated that ADD is usually treated by the pediatrician.

Dr. Milofsky also stated that patients with vascular dementia will end up seeing a doctor due to behavioral issues, but that it is difficult to separate the patient into separate diagnoses.

Mike Huotari stated that the Colorado Association of Health Plans (CAHP) objects to the incorporation of the entire list and then carving out a few diagnoses. Mr. Habgood stated that it is important to ensure that the correct version of the ICD9-CM is reviewed. Mr. Huotari still believes it would be easier to add conditions then to "throw it all in" and them pull some conditions back out. A Commission member asked, in clarification, if CAHP recommends adding in specific conditions such as alcohol, depression, etc. Mr. Huotari replied yes to the concept, but not necessarily to the conditions mentioned specifically by the Commission member.

Senator Keller mentioned that some carriers have indicated a neutral position on the bill. There was some discussion about federal legislation. Senator Keller stated that there are two federal bills: one is looking at the DSM-IV codes, but it wouldn't supersede state law and that the second would allow the employer and insurer to decide what diagnoses to include and it would preempt

state law. Ms. Cox indicated that Medicare currently won't cover the 300 series codes, but does cover the 296 series of codes.

A Commission member expressed a concern regarding the exclusion of small groups from this coverage as it builds disparity between benefits offered by large and small groups; if this is a good mandate, it should be good for all size groups.

Senator Keller indicated her agreement; however, she felt including small groups would have been a significant barrier to passage of the bill. Another Commission member wanted to know how this bill will help recover the costs of lost employee productivity. Senator Keller stated the biggest help would be in the treatment of alcohol and drug abuse. Mr. Habgood stated that 65% of employee terminations are due to some type of mental illness and contributes to the uninsured problem. He also indicated that studies lump statistics together regarding what employers offer.

A Commission member asked what the actual problem is: is it someone who wants his/her 21st outpatient visit paid or someone who wants adult ADD covered? Is this too big of a fix for a small problem?

Mr. Habgood stated that part of the problem is in the definition of mental illness. Senator Keller said that insurers say they cover it, but they won't tell her how it's covered, which has been a source of frustration.

A Commission member stated that diagnoses that don't have evidenced-based outcomes may lead to waste. Providing parity for office visits could be a problem if there are no parameters for the number of visits. It would be helpful to have to have a "hurdle" to help ensure patient motivation. For example, a patient contemplating bariatric surgery must attend weight management classes. For a patient with an eating disorder, perhaps the first hurdle would be mental health treatment.

Another difference: a patient with cancer goes through a lot of different treatments, but the doctor will change the treatments that are ineffective. It was pointed out that cancer, with clinical treatment support, is not as much of an issue. The Commission wondered how many people would abuse treatment.

It was noted that mental illness improvements are more of a "soft" science where improvements in physical conditions based on specific treatment protocols is more of a "hard" science. It was asked if there are any studies tracking denials. Senator Keller and Mr. Habgood indicated that all they have is anecdotal—it is hard to get specifics. Senator Keller has heard from parents of mentally ill children and the barrier most often identified is for coverage of residential treatment as the children usually need longer periods of care. Many of the confinements are related to alcohol and drug abuse, but some are related to childhood schizophrenia although that is hard to diagnose.

Senator Keller thanked the Commission for its time and interest. The Commission asked when the report is due and Senator Keller indicated that the bill is scheduled to go to Appropriations on March 30, although there may be some delay.

The Commission will try to provide its report by March 28, 2007.

As part of the discussion, the Commission thought a $0.50 pmpm or 0.5% premium may be true in a managed care environment, but it is hard to determine if this would hold true in a non-managed care environment. The Commission wondered what the cost of the biologically based conditions when they were first introduced. It was noted that this may be hard to quantify, but these conditions were managed very aggressively so it didn't have a significant cost. Is there time to find out what insurers are covering now? It was decided that it would not be able to get

this information before the report is due. Although the current practices are unclear, the end result is clear. Again, the Commission wondered if it is the caps in CRS 10-16-104(5) or the lack of definition that is the issue. It is thought that the majority of policies currently exclude treatment for eating disorders.

IV. Review of Draft Memorandum to Leadership

A Commission member provided a brief overview of the memorandum and the group discussed the time commitment for providing the report. It was decided that the report will be provided within 5 business days following the meeting. The memorandum was approved as discussed.

V. Review of Representative Carroll's Draft Legislation

Representative Madden has indicated that since there is no consensus of the bill from Commissioner Morrison that the bill will not be introduced in this session. Some of the issues requiring additional discussion are the expansion of the scope of the Commission; member reimbursement as the bill would add two consumer members and it would be helpful to assist with their travel expenses; and, there was a concern that there would be an exacerbation of the quorum issue. Commissioner Morrison would like time for a more detailed discussion.

It was suggested that a meeting should be scheduled after the end of the current legislative session. It was noted that California has a mandates commission with a staff of eight and a budget of $3 million: should Colorado make more of a commitment to the process?

VI. Adjournment

Commission on Mandated Health Insurance Benefits

June 22, 2007

Meeting Minutes

Commission Members in Attendance

Leo Tokar, Vice Chair
The Honorable Morgan Carroll
The Honorable Lois Tochtrop
Richard Rush
Peg Brown
Greg Dyson (via teleconference)
Chris Miller (via teleconference)

Division of Insurance Personnel

Julie Hoerner, Director of External Affairs
Marcy Morrison, Commissioner of Insurance
Mike Mawhinney, Assistant to the Commissioner
Cameron Lewis, Director of Consumer Education

VII. Call to Order and Introductions

Leo Tokar, Vice Chair called the meeting to order and asked the Commission members and DOI staff to introduce themselves.

II. Discussion of Commission

A. Purpose and "mandate"

Deputy Commissioner Brown briefly reviewed the history and work of the Commission since its inception. She noted that more bills were referred to the Commission this year than at any other point in its history. The Commission heard and issued reports in 2007 on the following bills:

SB07-004 Sen. Shaffer and Rep. Todd – Early Intervention Serv Coordinated Pmt
SB07-036 Sen. Keller and Rep. Stafford – Mandatory Coverage Mental Disorders ICD9
SB07-078 Sen. Williams and Rep. Roberts – Restore Mandatory Offer Hospice Care
HB07-1253 Rep. Madden and Sen. Shaffer – Health Coverage Uniformed Services
HB07-1301 Rep. Buescher and Sen. Williams – Cervical Cancer Immunization

Ms. Brown reported that the Commission has been criticized, including by comments made at the Consumer Insurance Council, with assertions that referral of a bill to the Commission was intimidating to legislators and proponents, and that some perceive a bias by the Commission against mandated benefits. She noted that there has been suggestion by some legislators that the Commission violates separation of powers concepts, though the Commission was established by statute and the General Assembly has followed with internal rules about referral of legislation to the Commission.

Commissioner of Insurance Marcy Morrison noted that when she was in the legislature from 1993 to 2000 prior to the enactment of the legislation establishing the Commission, Legislative Council attached a form (cost benefit analysis), similar to the assessment tool, whenever a bill would have a mandate on it. The forms would be filed in all the legislator's file folders for their review.

One of the Commission's legislative members said the cost benefit analysis and the assessment tool were basically a duplication of work. She conveyed legislators' frustration of having their bills referred to the Commission as being an extra obstacle in trying to pass the legislation.

Another Commission member said he would like to see the Commission go back to its original purpose, that being assessing pricing or impact on premiums of a proposed mandate. He suggested review of the structure and work of other states with mandates review commissions. He noted that California has a commission, as well as several other states.

B. Value to process

A Commission member summed up the focus for discussion as responding to 3 questions:

1) Should the Commission on Mandated Health Benefits (Commission) exist?
2) How can the Commission be more effective?
3) How can the Commission be more supportive in balance?

It was also noted that with the Blue Ribbon (208) Commission for Health Care Reform in the process of establishing health care reform models for expanding coverage, especially for the underinsured and uninsured, the Commission should be prepared for upcoming legislation that could have several mandates. One of the legislative members of the Commission mentioned that the 2008 legislative session will mainly focus on health care reform, therefore, she feels that it may be a bit premature to consider repealing 10-16-103.3 and the Commission.

C. Membership

Ms. Brown reviewed the Commission's membership history noting that the Commission's membership is set at 11 members. Except for the legislative member, Commission members are appointed by the Governor for a 5 year term. Due to resignations, the current membership of the Commission is down to 8. The Division will notify the Governor's Office of Boards and Commissions about the vacancies. The vacancies to be filled are 1) a health care provider under CRS 10-16-103.3(1)(a)(III)(D); and 2) a business owner with less than 50 employees from a rural area under CRS 10-16 103.3(1)(a)(III)(F).

D. Procedures

The Commission noted that it had sent the legislative leadership a memo about procedures for referral of a bill to the Commission in March. This memorandum was

intended to provide a workable system for referral of legislation and to address the issues of the Commission's scheduling, ensuring a quorum for meetings, and providing sufficient time for the Commission to report back to the Legislature.

E. Proposals for change

To better understand the viewpoint of legislators, the Commission decided to have an interim meeting with legislators who are chair and vice-chairs of the referring committees, sponsors of bills that were referred to the Commission, and Legislative Council staff. Staff will establish a meeting date later in the year for this meeting and will draft a memorandum for the legislative members of the Commission to circulate to their colleagues inviting them to this meeting. Invitations should be extended to the Chairs and ranking Minority members of the Business and Health and Human Services Committees, and the prime sponsors of bills which were heard by the Commission in 2007. Staff will also draft a research request for the legislative Commission members to submit to Legislative Council about mandates commissions in other states.

III. Next Meeting for 2007

A. Date

Mike Mawhinney will send out an email to all Commission members on available meeting dates targeting later in September.

B. Agenda

No agenda has been drafted until a date has been confirmed

IV. Preparation of Annual Report

Staff will prepare a draft of the annual report for Commission members to review. The report is due to the General Assembly by December 1st of each year.

V. Adjournment

The Commission adjourned the meeting at 3:43 pm

Commission on Mandated Health Insurance Benefits

September 21, 2007

Meeting Minutes

Commission Members in Attendance

Leo Tokar, Vice Chair
The Honorable Morgan Carroll
The Honorable Lois Tochtrop
Richard Rush
Peg Brown
Chris Miller
Pan Nicholson
Greg Dyson (via teleconference)

Public Attendees

The Honorable Debbie Stafford
Betty Lehman, Autism Society of Colorado
Jerel McElroy, Kaiser Permanente
Susan Cox, Kaiser Permanente
Michael Huotari, Colorado Association of Health Plans
Jessica Morgan, Berry & Kirscht, LLC
Monica Griego, Colorado Consumer Health Initiative
Peggi O'Keefe, Axiom Strategies
Carly Dollar, Axiom Strategies
Hartman Axley, NAIFA – Colorado
Dede DePercin, Colorado Consumer Health Initiative

Division of Insurance Personnel

Marcy Morrison, Commissioner of Insurance
Julie Hoerner, Director of External Affairs
Cameron Lewis, Director of Consumer Education
Michael Mawhinney, Assistant to the Commissioner

I. Call to Order and Introductions

Leo Tokar, Vice Chair, called the meeting to order at 1:13 p.m. and asked the members of the Commission to introduce themselves.

II. Approval of the Minutes of June 22, 2007

Deputy Commissioner Peg Brown presented the minutes of the June 22, 2007 meeting of the Commission for approval. The minutes were approved by acclamation as presented.

III. Resignation of Gail Lindley

Deputy Commissioner Brown read Gail Lindley's resignation from the Commission and noted that this resignation leaves three vacancies on the Commission. Commissioners, with the exception of the legislative members, are appointed by the Governor. The Governor's Office of Boards and Commissions will be notified of the vacancies. The vacancies are for:

- a business owner with less than 50 employees located in the Denver metropolitan area
- a business owner with less than 50 employees located in a rural area
- a health care provider

CRS 10-16-103.3(1)(a)(III)(D and F).

IV. Discussion of Commission Role, Procedures, Operations

Deputy Commissioner Brown reviewed comments received from legislators in response to the invitation to attend the meeting. Senator Moe Keller wrote:

> I will not be able to attend the meeting this Friday, but I did want to pass on my thought that the commission was respectful and attentive during my presentation to you on SB 36. The committee's written report was thorough and balanced. I am somewhat in a fog about the role of the commission in the end: you do not have authority to actually recommend support or disapproval of the bill proposal before you. I don't think I would want the commission to have that authority either!

Representative Bernie Beuscher wrote:

> Thank you for the invite, and I would comment that I felt the committee dealt very thoroughly and fairly with my HPV bill. I wish I could attend the meeting on 9/21 to share my experience with the other members. . . .

Vice Chair Tokar then invited comment by the members of the public in attendance.

Betty Lehman – Autism Society of Colorado

Ms. Lehman explained her experience in presenting to the Commission on SB07-04 in February, 2007. Among the issues raised by Ms. Lehman were:

- Inability for proponents to obtain information to complete the Commission's assessment tool. Ms. Lehman particularly noted that information requested by the assessment tool is not publicly available as it requests information that is not collected by the Division of Insurance and requires actuarial analysis outside the purview of most groups proposing coverage mandates.
- Timeframe in which proponents are asked to prepare the assessment tool and present it to the Commission. Ms. Lehman said that she was notified that the bill had been sent to the Commission and she needed to prepare the assessment tool less than 20 hours prior to the Commission's meeting. Commission members noted that in most cases the Commission is given between 24 and 48 hours notice that it will need to meet on a piece of legislation, and that often the Commission's report is required to be presented to the Legislature within less than one working day from its meeting.
- Errors in the Commission's report arising from unreasonable timeframes for the report's preparation and submission, and that the report is not provided to proponents prior to its submission to the Legislature. Ms. Lehman said that five errors were contained in the Commission's report on SB07-04 and that these errors could have been alleviated had the report been provided to proponents prior to being sent to the Legislature. She also suggested that opponents be required to submit a report, possibly their own version of the assessment tool, for the Commission to consider along with that of the proponents.
- Lack of consumer participation on the Commission. Ms. Lehman posited that when consumers look at the Commission they should see themselves. She said the Commission was not representative of consumers, particularly as the scheduling of Commission meetings are inconvenient for consumers and the public. She suggested payment of monetary stipends to consumer members to encourage their attendance and participation. It was noted by the Commission that its membership is set by statute and that changing the membership requirements for the Commission would require a statutory change.

Ms. Lehman, in response to questions from the Commission, said her opinion is that the Commission is not needed.

Insurance Commissioner Marcy Morrison

Commissioner Marcy Morrison began by thanking Commission members for serving and taking the time to understand the implications and complexity of some of the legislation presented to the Commission. She has two concerns about the Commission:

- The Commission operates under serious constraints, particularly as compared to similar bodies in other states. She noted that Commissions in

other states have more access to information through resources for independent expert analysis and staff dedicated to the entity.

- It is unclear what the Commission's duties and responsibilities are. When bills are presented to the Legislature, a bill's proponents know what will be asked. Submitting similar information to the Commission is repetitious, though the Commission "drills down" and conducts more analysis in the implications and consequences of proposals than is typical of a legislative hearing.

The Commissioner noted she is troubled that anyone felt that they were not treated respectfully and feel that the process is unfair.

Commission members and the Commissioner discussed the history of the Commission with Senator Tochtrop noting that when the Commission was instituted there were a lot of mandate proposals and the question for each was whether it would have a positive impact. Commissioner Morrison noted that to have the Commission operate effectively and be the resource for the Legislature that it was intended to be, there must be investment in the Commission. She said that she does not believe the process is currently working, and that for the Commission to survive, serious changes need to be made in the process and that these will require additional resources to be provided.

Deputy Commissioner Brown inquired whether the research request to Legislative Council about other state's commissions had been submitted. As it apparently was not submitted, the Commission asked that an additional request be included for survey of other state's legislatures as to the usefulness of their commissions. Deputy Commissioner Brown will revise the request and send it to the Commission's legislative members for submission to Legislative Council.

Rep. Debbie Stafford

Representative Stafford said her memory of the inception of the Commission arose from the philosophical viewpoint of the legislative leadership that if a proposal included a health coverage mandate, that it could not be discussed. The Commission arose out of frustration by legislators seeking to propose mandates. She suggested that referral to the Commission has become a "litmus test" on mandate proposals, though the Commission noted it does not take a position in favor or against a legislative bill.

The Commission also discussed its ability to measure short-term costs vs. long term benefits and the business case vs. public interest. A Commission member noted that as it is easier to capture short term costs, the Commission may be skewed against mandate proposals. Further, the fundamental question of the analysis is the tension between coverage and affordability. Another Commission member noted that the Commission reviewed the existing mandates and did not recommend removal of any of them. It was also noted that Colorado has few mandates and that few employers exclude a Colorado mandated benefit if they choose to become self-insured.

DeDe DePerecin – Colorado Consumer Health Initiative

Ms. DePerecin questioned the process and procedures of the Commission and whether the Commission is, or should be subject, to the provisions of the Administrative Procedures Act. Ms. Lehman commented that if the Commission is going to look at revamping its procedures, one suggestion would be to require that a quorum be reached only with the presence and participation of the consumer members. She also suggested that the Commission permit alternates for the consumer members.

The Commission discussed meeting again later in the year after they have received the information requested of Legislative Council about other states' commissions and determined that a meeting in mid-November would be organized.

V. Preparation of Annual Report

Deputy Commissioner Brown noted the statutory requirement for the Commission to prepare an annual report and submit it to the Legislature by December 1, 2007. Staff will prepare a draft and circulate it for comment via e-mail with anticipated adoption of the final report at the November Commission meeting.

VI. Adjournment

It's business concluded, the Commission meeting was adjourned at 3:15 p.m.

Appendix D

Commission Reports for 2007

Commission on Mandated Health Insurance Benefits

Review of

SB07-78 – Concerning the Restoration of the Mandatory Offer of Hospice Care Coverage in Small Group Health Benefit Plans

February 2, 2007

Introduction

The Commission on Mandated Health Insurance Benefits exists to serve the people of Colorado and the Colorado General Assembly by providing objective information and recommendations on the impact and structure of current and proposed health insurance mandated benefits.

On February 2, 2007, the Commission met to review SB07-78 – Concerning the Restoration of the Mandatory Offer of Hospice Care Coverage in Small Group Health Benefit Plans. The bill had been referred to the Commission by Senator Hagedorn, Chair of the Senate Health and Human Services Committee on January 23, 2007 asking that the Commission report prior to February 8, 2007.

Due to the press of Senate business, the sponsor of SB07-78 was unable to personally present the bill to the Commission and asked that Edie Busam and Cordt Kassner, PhD., of the Colorado Hospice Organization present the bill.

From the information presented by Ms. Busam and Dr. Kassner, the Commission presents the following analysis:

Social Impact

The bill, as proposed, would reinstate the mandate of an offer of hospice coverage to small group Basic health benefit plans. In 2003, the offer of hospice coverage was one of the mandates included in the exclusions for the small group Basic "mandate lite" options. The other benefits excluded in the "mandate lite" Basic options are mammography and prostate cancer screenings, services for non-biologically based mental illness, general anesthesia for children undergoing dental procedures, and the offer of coverage for alcoholism treatment. Under the small group laws, insurance carriers are required to offer one of three Basic plans in the small group market. The three options are a mandate-lite plan, a mandate-lite high deductible health plan, and a high deductible health plan.

Hospice care is a package of coordinated health care services, including home care, to provide comprehensive and compassionate care at the end of life. Hospice care is available in 59 of 64 Colorado counties and provided care for more than 13,000 Coloradans in 2004. Hospice has been a covered benefit under the federal Medicare

program since 1983 and 83% of hospice services were reimbursed through that program. In 2004, 11% of the utilization of hospice services was covered by private insurance, including managed are.

Hospice has become a well recognized service for end of life care. The percent of all Colorado deaths preceded by hospice care has grown from 28% in 1997 to 46% in 2004, while the number of hospice patient days grew from 300,000 in 1997 to 800,000 in 2004. Hospice is a multi-disciplinary package of services generally reimbursed on a per diem basis including services such as home health care, pharmacologic services, chaplain care, psychological care, including bereavement counseling for family members.

This legislation restores the offer of coverage for hospice services for a limited subset of the population in small group health plans selecting either two of the three Basic plan options. At the end of 2005, only 6.7% of small group plans were one of the Basic plan options. Thus, this legislation would restore the offer of hospice to fewer than 3,200 employer plans and 25,000 Coloradans. The mandatory offer of hospice coverage remains in effect for most other small group, large group, and individual health insurance. The statutory mandate does not extend to health maintenance organizations, though the Commission expects that most HMOs provide coverage for hospice services. Moreover, in the experience of Commission members, the hospice benefit would add no additional cost to a small group's premium.

Financial Impact

As this bill restores an offer of hospice coverage, not coverage, it does not carry an immediate fiscal impact. However, as noted above, even the mandate of coverage of hospice services would not increase premium amounts in the experience of some of the actuaries serving on the Commission. The bill's proponents were questioned about why the bill was limited to restoration of the offer of coverage, as opposed to a mandate of coverage, and responded that SB07-78 is the first step of a process to seek a mandate of coverage based on information collected after the passage of SB07-78.

Information was provided the Commission referencing a Lewin-VHI study from 1994 concluding that Medicare saved $1.52 in Part A and B expenditures for every Medicare dollar spent on hospice care. A 2003 Milliman USA study reported that hospices save Medicaid approximately $282 million a year or $7,000 per Medicaid beneficiary utilizing the services. The Milliman USA report identified these cost savings as coming from: the avoidance of unwanted and unnecessary hospitalizations; provision of medications, durable medical equipment and home care visits within the hospice per diem; and long-term care room and board savings.

Balance

As noted, SB07-78 would restore the offer of hospice coverage to two of three Basic plans that small group carriers are required to offer. Because of the limited issuance of the Basic plans in the small group marketplace, this legislation will not have a significant

impact, if any, that would cause an increase in small group premiums. From the information presented, utilization of hospice services can result in savings in other areas of health care coverage and the balance weighs in favor of both the offer of such coverage and its utilization.

Recommendations

The following recommendations were discussed and mutually agreed to between the presenters and the Commission as being in the best interests of consumers and carriers:

The Commission would like to note that to avoid administrative costs and adverse selection, the offer required under this legislation should be made to the employer for the whole group, as opposed to permitting individual to select the additional coverage or not. There are substantial administrative costs associated with individual selection of a benefit within a group policy.

The Commission would further note that the statutory language of CRS 10-16-104(8) on the availability of hospice care coverage is potentially unclear in its inclusion of home health services without a direct requirement that such services are included, and not separate from, hospice care services. The Commission recommends that clarifying language be inserted that only home health services provided under a hospice care benefit are affected by this legislation.

The Minutes (unapproved) of the Commission meeting are attached.

Commission on Mandated Health Insurance Benefits

Review of

HB07-1253 – Concerning a Prohibition Against an Insurance Carrier From Denying Coverage to Persons Serving in the Uniformed Services of the United States

February 9, 2007

The Commission on Mandated Health Insurance Benefits exists to serve the people of Colorado and the State Legislature by providing objective information and recommendations on the impact and structure of current and proposed health insurance mandated benefits.

On February 9, 2007, the Commission met to review HB07-1253 – Concerning a prohibition against an insurance carrier from denying coverage to persons serving in the uniformed services of the United States. The bill was referred to the Commission on Thursday, February 8, 2007 by Senator Rosemary Marshall, chair of the House Business Affairs and Labor Committee, asking that the Commission report on the bill by Monday, February 12, 2007, when the bill is scheduled for hearing in the Business Affairs and Labor Committee.

Rep. Alice Madden, the sponsor of HB07-1253, presented the bill to the Commission. From the information presented by Rep. Madden, the Commission presents the following analysis:

Social Impact

The bill, as proposed, would prohibit individual and group health carriers from denying coverage to an individual solely on the grounds that the individual is serving in the U.S. military including reserve forces or National Guard.

Service members, including Reservists and National Guard who are placed on "active duty" for more than 30 days, and their dependents are covered under the military's TRICARE health coverage program. National Guard and Reservists who are not on active duty status are not eligible for TRICARE coverage, except in certain limited circumstances such as notification to report for active duty lasting more than 30 days. In addition, the military has established a plan (Triage Reserve Select) to "bridge" health insurance coverage for Guard and Reserve members entering or leaving "active duty" and who are not covered by their civilian employer's health coverage or other health insurance.

Generally, Reservists or National Guard who are not and have not been on active duty status for more than 30 days are not eligible for TRICARE OR Triage Reserve Select. The proposed legislation is intended to protect both active duty and Reservists or National Guard not on "active duty" from being denied individual or group health

insurance because of their military affiliation. It was noted that some individual health carriers may be turning down applications of these individuals on the basis that their Reserve or National Guard participation constitutes a hazardous activity. The Commission polled the representatives of insurance carriers on the Commission and it was their collective belief that this is not an issue in group insurance and may be limited to individual health insurance.

Financial Impact

The Commission assesses, as Rep. Madden stated she believes, this legislation addresses a relatively rare circumstance where an individual would be denied group or individual coverage solely due to the person's status as a member of the military, Reserves or National Guard. Because this prohibition would be rarely utilized to require coverage, it is anticipated that the additional cost across a carrier's covered persons would be negligible, if any.

Balance

This legislation will permit a very small number of individuals to access health coverage where they may otherwise have been denied coverage. As such, it is not expected to raise costs or premiums, other than negligibly. The Commission finds that the benefit of coverage for persons not on active duty but ready to serve the country outweighs the very small costs of this expansion of coverage.

Recommendations

The following recommendations were discussed with Rep. Madden as being in the best interests of consumers and carriers:

The terminology "membership in the uniformed services of the United States" appears to be a term-of-art that is not defined in Colorado insurance law. The Commission recommends, and Rep. Madden indicated her intent to amend this language to more completely define what individuals fall within the provisions of this bill and specifically exclude retired military personnel.

Commission on Mandated Health Insurance Benefits

Report On

SB07-04 – Concerning a coordinated system of payment for early intervention services for children eligible for benefits under Part C of the federal "Individuals with Disabilities Education Act," and, in connection therewith, requiring the Department of Human Services to develop a coordinated payment system and requiring coverage of early intervention services by public medical assistance and private health insurance

February 9, 2007

The Commission on Mandated Health Insurance Benefits exists to serve the people of Colorado and the State Legislature by providing objective information and recommendations on the impact and structure of current and proposed health insurance mandated benefits.

On February 9, 2007, the Commission met to review SB07-04 -- Concerning a coordinated system of payment for early intervention services for children eligible for benefits under Part C of the federal "Individuals with Disabilities Education Act," and, in connection therewith, requiring the Department of Human Services to develop a coordinated payment system and requiring coverage of early intervention services by public medical assistance and private health insurance. The bill was referred to the Commission on Thursday, February 8, 2007 by Senator Bob Hagedorn, chair of the Senate Health and Human Services Committee, asking that the Commission report on the bill by Wednesday, February 14, 2007 when the bill is scheduled for action by the Committee.

Senator Brandon Shaffer, John Miles of the Colorado Department of Human Services, and Betty Lehman of the Autism Society of Colorado presented information to the Commission about the legislation. Susan Cox of Kaiser Permanente and Mike Huotari of the Colorado Association of Health Plans also presented to the Commission on this bill.

Background

Federal Law

Part C of the Individuals with Disabilities Education Act (IDEA) was federally adopted to ensure that infants and toddlers, from birth to age 3 with disabilities or at risk of developing a disability, and their families, receive appropriate early intervention services. Part C focuses on enhancing the development of infants and toddlers with disabilities by providing services in a natural environment, such as the home or a child care center, and improve the capacity of the family to meet the child's needs and reduce educational costs

by minimizing the need for special education when the child is older. [1] To meet Part C goals, states develop a statewide, coordinated multidisciplinary, interagency system of early intervention services including a lead agency, preparation and dissemination on the availability of services, defining eligibility criteria, and delivering services. Once a child is referred as being suspected of having a disability, states are required to conduct an eligibility determination and have service coordinators work with parents to match children with services specific to the child's needs.[2] One of the purposes of the IDEA Part C act is "to facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources (including public and private insurance coverage)."[3] However, the federal law also defines "early intervention services" as developmental services that are provided under public supervision and are provided at no cost except where Federal or State law provides for a system of payments by families, including a schedule of sliding fees.[4]

SB07-04

SB07-04 would establish under the Department of Human Services and the Community Centered Boards (CCBs) a program by which early childhood intervention providers would "register" to provide services, the CCB would negotiate reimbursement rates with such providers, and providers' services would be billed for by the CCB to appropriate funding sources, including Medicaid and private insurance. *See* Pre-amended SB07-04, page 10 line 15 through page 11, line 7. The program is intended to coordinate the provision of services to very young children with developmental delays or at risk of developmental delays and access various funding sources for early childhood intervention services to treat such conditions.

Eligibility

In establishing the coordinated service delivery system, the bill establishes eligibility for the program as "an infant or toddler, from birth up to the child's third birthday, who . . . has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development" in accordance with the federal standards of Part C of IDEA. *See* Pre-amended SB07-04, at page 6, lines 4 through 10.

Services

Under the bill, the services "brokered" through the CCBs are to include the services identified in an eligible child's "individualized family service plan" (IFSP). *See* Pre-

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[1] U.S. Government Accountability Office, December, 2005, Individuals with Disabilities Education Act – Education Should Provide Additional Guidance to Help State Smoothly Transition Children to Preschool, Report to the Ranking Minority Member, Committee on Health, Education, Labor, and Pensions, U.S. Senate, GAO-06-26, at 7.
[2] Id. at 8 - 10.
[3] 20 U.S.C. 1431(b)(2)
[4] 20 U.S.C. 1432 (4)(b)

amended SB07-04, at page 5, lines 25 through 27. Colorado has included fourteen services which can potentially be included in the IFSP. They are:

1. Assistive Technology
2. Audiology Services
3. Developmental Intervention
4. Health Services
5. Nutrition Services
6. Occupational Therapy
7. Physical Therapy
8. Psychological Services
9. Respite Care
10. Service Coordination
11. Social Work
12. Speech-Language Pathology
13. Transportation, and
14. Vision Services

A multidisciplinary team assesses a child referred to the program and develops the IFSP. According to the Government Accountability Office, in Colorado, speech language, physical, and occupation therapy are the most frequently provided services. GAO Report – Individuals with Disabilities Education Act, Education Should Provide Additional Guidance to Help States Smoothly Transition Children to Preschool, December, 2005, GAO-06-26, at 17.

SB07-04 defines early intervention services as "medically necessary" for purposes of Medicaid and private health insurance. *See* Pre-amended SB07-04, page 5, line 27 through page 6, line 3.

Providers

SB07-04 defines qualified providers as "a person or agency . . . who provides early intervention services and is listed on the registry of early intervention service providers" established by a CCB. *See* Pre-amended SB07-04, at page 7, lines 5 through 10. There is apparently no licensure or certification requirement to be a service provider.

Reimbursement

Currently, early intervention services are paid for through a variety of sources and it is not uncommon for services to be partially reimbursed from a patchwork of payors. Most services are covered under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program, a voluntary Medicaid program, and Medicaid currently covers the cost of early intervention services for Medicaid eligible children. The Children's Basic Health Plan (CBHP) does not cover the same array of services as Medicaid, and SB07-04 amends the CBHP to cover the early intervention services. *See* Pre-amended SB07-04, at page 13, line 25 through page 14, line 3.

Private Insurance Coverage

Currently, for private health insurance, under CRS 10-16-104(1.7) **Therapies for congenital defects and birth abnormalities**, all individual and group health benefit plans are required to "provide medically necessary physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age." The benefit level is to be at least twenty therapy visits, spread as appropriate throughout the policy year, for each of physical therapy, occupational therapy, and speech therapy. These services are subject to copayment, coinsurance and deductible requirements, medical necessity determinations, provider network requirements, claims payment and appeal processes.

SB07-04 would amend CRS 10-16-104(1.7) to cover children only from their third birthday through their sixth birthday for the 20 visits each of physical, occupational and speech therapy. *See* Pre-amended SB07-04 at page 16 line 24 through page 17, line 4. SB07-04 would add a new subsection requiring all individual and group plans to cover early intervention services as set forth above (and adding case management) up to a cap of $5,725 per calendar or policy year. The $5,725 amount is annually indexed by the Denver-Boulder-Greeley Consumer Price Index for following years. Pre-amended SB07-04 as drafted indicates that, except for high deductible health plans, coverage "is not subject to deductibles or copayments, and any benefits paid under the coverage . . . shall not be applied to an annual or lifetime maximum benefit contained in the policy or contract," Senator Shaffer and the proponents of the bill said that the intent was for the state program to pay any deductibles and copayments. A question that arises is if the state pays the deductibles and copayments are they included in the capped amount or in addition to it.

Social Impact

The families of children who are diagnosed as being, or at risk of being, developmentally delayed face a complex matrix of needs, services, and resources to work through. Children with developmental delays who do not receive adequate and appropriate treatments and therapies have substantial risk of developing more severe disabilities, including inability to function without specialized care, and potentially expensive surgeries for correction of deformities exacerbated by the developmental delays. The avoided cost of not providing early intervention services is recognized, but no information was provided to the Commission to quantify the future health cost avoidance to the state or families. The bill's proponents did provide information about the cost avoidance from early intervention services to the school and educational system.

According to the bill's proponents, federal estimates of children eligible for a Part C IDEA program are about 2% of the population or 4,199 children in Colorado. Historically, in Colorado, the Division of Developmental Disabilities estimates the rate as 1.8% and the federal Government Accountability Office found Colorado serving 1.7% of

the population.[5] The Joint Budget Committee reports that 3,920 children had IFSPs as of June 1, 2006, while the GAO report identifies 3,484 children as being served under Part C.[6]

Among the purposes of SB07-04, proponents say that the bill will help Colorado meet federal requirements by:

- Establishing a common understanding as to the definition of a significant delay in development and that timely and appropriate early intervention services are needed;
- Setting a common set of service definitions for early intervention regardless of the source of funding or reimbursement for such services;
- Creating a means by which the State and other early intervention providers and funding sources can streamline administration for an effective, efficient, and coordinated system;
- Permitting Colorado to access federal matching funds for Part C services under Medicaid;
- Requiring consistency for insurance coverage for families with children needing early intervention services.

Financial Impact

Currently, the Department of Human Services receives $6.9 million in federal Part C funds and an additional $11.6 million from the General Fund to coordinate and provide payment for early childhood intervention services according to the fiscal note on the bill. This works out to approximately $4,406 for each of 4,199 children (2% of population) or $5,310 for the lowest count of children served identified above (GAO – 3,484).

Proponents of SB07-04 provided a complex analysis of the increased costs to be absorbed by private health insurance under the legislation. The proponents noted that approximately 61% of Coloradans have employer-provided insurance. For purposes of this analysis, the Division of Insurance estimates that approximately half (50%) of this 61% of employer provided insurance is through Colorado regulated health plans, or 30.5% of the population. An additional 6% of the population is covered under individual health insurance. Thus, roughly 37% of Coloradans have insurance that would subject to the requirements of this legislation.

Assuming 4,199 as the eligible population, with 37% covered by a Colorado regulated health plan subject to the requirements of SB07-04, approximately 1,554 children between the ages of birth and age 3 would have commercial insurance coverage for the early intervention services under this legislation. Information about the current program shows indicates that most children receive services for slightly more than a year, and that a relatively small percentage of eligible children are identified before they are 18 months

[5] GAO-06-26, at 3.
[6] Id. at 3.

or older. However, if each of the potentially children received the maximum capped benefit of $5,725 per year, the total insurance cost for these services would be $8,896,650 per year. Carriers are currently providing under the congenital defect and birth anomaly mandate in CRS 10-16-104(1.7) some amount of these early intervention services. Using proponents' methodology, this is estimated this to be approximately $5,307,200. Thus, the estimated *maximum* annual additional cost to health plans would be $3,589,450. This calculates to an additional annual benefit payment of $2,310 for each of the estimated 1,554 eligible children covered by Colorado regulated insurance above what carriers are already covering. Another financial estimate, of the Department of Personnel and Administration on the state employees health plans estimated that its cost would increase by $202,763.94 over 50,748 members, or $4 per member per year (PMPY). These amounts may be tempered or exacerbated by the following additional factors which the Commission is unable to quantify:

- The legislation adds several services to be covered by insurance beyond the current requirement physical, occupational and speech pathology services.
- The current law permits a cap of 20 visits for each of the 3 services, while the legislation requires services in accordance with the child's IFSP established by the multidisciplinary team under the CCB. It can be anticipated that without the visit cap, utilization of these services may increase. The GAO study identified that speech therapy was the most frequently provided service at 20%, with physical and occupational therapy at 14% each.[7]
- The majority of eligible children appear to enter the system closer to their third birthday. According to the GAO study, children under age 1 were 14% of those served, while 2 to 3 year olds were 54%.
- The availability of these services in the fully insured market may cause migration of families needing such care from other plans (e.g. self-funded) into Colorado regulated plan offerings.
- This represents a cost-shift from the government to employers.

Issues Raised by the Health Plans

Mike Huotari of the Colorado Association of Health Plans and Susan Cox of Kaiser Permanente raised concerns with the legislation at the Commission meeting.

Ms. Cox was most concerned about the impact of the legislation in supplanting Kaiser Permanente's existing Early Childhood Development Center services. She additionally raised the issue of whether carriers may manage their provider network for quality purposes under the proposal. She noted that Kaiser Permanente, in particular as a group model HMO, uses a limited set of providers to ensure quality of care and efficacy of treatment. The bill as presented raises the questions of whether Kaiser Permanente and other carriers may credential and use their contracted providers to provide services, or whether the legislation creates an "any willing provider" situation in which the carrier

[7] Id. at 17.

must pay claims for early childhood intervention services submitted by any provider for an eligible child.

The legislation does not clearly address whether a carrier can maintain and utilize their own network of service providers for early childhood intervention services, or whether the CCB becomes a "sole source" for the registry of providers on whose behalf they have negotiated reimbursement rates. *See* Pre-amended SB07-04 at page 10, line 15 through page 11, line 16. The "sole source" issue arises from proponents' responses to the Commission's Assessment Tool where they state: "SB07-04 creates "one-stop" direct services with service coordination and delivery based on the child's needs, not dictated by funding resources. . .." *See* Assessment Tool submitted to the Commission on February 9, 2007 at page 8 – 9. In contrast, the proponents at the Commission meeting stated that the intent is for the CCB to develop a list of service providers which parents can select from (including selecting providers contracted with their insurance carrier for reimbursement below that negotiated by the CCB). What has not been calculated or estimated, is the increased additional administrative cost of utilizing the CCB model either as a sole source or broker design.

This discussion also raised the potential for conflict with CRS 10-16-704(3) on participating and non-participating provider reimbursement rates. Under this provision, when a consumer receives services at a network facility, they are to be held harmless from additional costs due to a facility provider not being a contracted provider with the consumer's health plan. Under these circumstances, the Division of Insurance requires the insurance carrier to hold the consumer harmless by paying the provider up to full billed charges, as opposed to the network discount or percentage for out-of-network services. SB07-04 should be clarified so as to not create an unintended consequence of CCB registered providers asserting CRS 10-16-704(3) to raise their reimbursement above the CCB's negotiated rate.

Additional concerns raised by the health plans include:

- the "deeming" of medical necessity as to early intervention services authorized by an IFSP which may be developed, in part, by unlicensed and unregulated service providers. *See* Pre-amended SB07-04, at page 5, line 25 through page 6, line 3; and
- the language in the proposed CRS 10-16-104(1.3)(b) that the coverage is not subject to deductibles and copayments, and benefits paid cannot be applied to annual or lifetime benefit maximums, *see* Pre-amended SSB07-04 at page 16, lines 4 to 9. At the Commission meeting, the proponents said their intent is for the state (or the CCB) to pay the deductibles and copayments. However, the plain language of the bill draft does not comport with this intent. It is unclear how the state or CCB would assume this responsibility and what changes would have to be made in health plans' claims handling processes to accommodate this. These types of process changes have an cost, sometimes substantial, in changing

computer programming, work processes, and necessitating more manual processing to accommodate the exception.

Issue Raised by the Commission

The Commission is concerned that by amending CRS 10-16-104(1.7) to restrict its application for ages three to five, this bill may deny children who suffer a physical defect or abnormality, but not a developmental delay, from having physical, occupational and speech therapy covered. There are any number of physical birth defects for which these services are medically necessary and appropriate.

Balance

The Commission recognizes that there is a demonstrated social benefit from the proposed legislation and that the overall benefit from early intervention services may outweigh the short-term costs. However, it should be noted that while the benefits of early intervention may outweigh the short-term costs, the institutions that have to pay the short-term costs (e.g., employers and employees), aren't necessarily the same institutions directly receiving the longer-term benefits (e.g., public education and affected families). Benefits of the proposal include more consistency and predictability of services to children needing early intervention services. It would assist families in obtaining a range of services for their child.

However, the long-term savings in health care costs, vis a vis education costs, were not quantified. Certainly, this bill relies on short-term costs for health care services to achieve long term savings, some possibly in health care, but the lion's share in educational and opportunity costs. Moreover, increased utilization due to additional diagnoses or even just more knowledge of the availability of services under the proposed program have not been considered or calculated.

This uncertainty brings with it concern about the administrative costs if this bill overrides current systems, and whether current system inefficiencies will be remedied or replaced by other systems equally inefficient and ineffective.

The uncertainty around these issues has made it difficult for the Commission to clearly identify the cost-benefit of this legislation and prohibit the it from presenting a conclusive impact assessment of the bill as presented.

Recommendations

The Commission would respectfully request that this legislation be referred back to the Commission for an updated analysis as the bill progresses through the legislative process and we anticipate that some of the issues identified above are resolved.

Commission on Mandated Health Insurance Benefits

Review of

HB07-1301 –Concerning increasing the availability of cervical cancer immunizations, and, in connection therewith, establishing the cervical cancer immunization program, encouraging federally qualified health centers to contract with local health agencies to administer cervical cancer immunizations, requiring a cervical cancer immunization public awareness campaign, specifying that cervical cancer immunization is a benefit for Medicaid recipients, and requiring that certain health insurance policies provide coverage for cervical cancer immunizations.

March 9, 2007

Introduction

The Commission on Mandated Health Insurance Benefits exists to serve the people of Colorado and the Colorado General Assembly by providing objective information and recommendations on the impact and structure of current and proposed health insurance mandated benefits.

On March 9, 2007, the Commission met to review HB07-1301 – Concerning increasing the availability of cervical cancer immunizations, and, in connection therewith, establishing the cervical cancer immunization program, encouraging federally qualified health centers to contract with local health agencies to administer cervical cancer immunizations, requiring a cervical cancer immunization public awareness campaign, specifying that cervical cancer immunization is a benefit for Medicaid recipients, and requiring that certain health insurance policies provide coverage for cervical cancer immunizations. The bill had been referred to the Commission by Representative McGihon, Chair of the House Health and Human Services Committee on March 2, 2007 asking that the Commission report by March 14, 2007.

Representative Bernie Buescher attended the Commission meeting with Ned Calogne, M.D., M.P.H., the chief medical officer for the Department of Public Health and Environment.

Mike Huotari was present and represented the Colorado Association of Health Plans.

From the information presented by Representative Buescher and Dr. Calonge, the Commission presents the following analysis:

Social Impact

The bill establishes the Cervical Cancer Immunization Program to immunize women and girls against cervical cancer and provides a mandate for coverage of cervical cancer immunizations.

The bill is not a mandate to require the vaccine as a condition for school attendance; but it is to make the vaccine as widely available as possible. The four things it does:

1. It encourages federally qualified health centers to enter into agreements with local public health agencies to make the vaccine available to under-insured girls.

2. It establishes the Cervical Cancer Immunization Awareness Campaign Fund to increase public awareness.

3. It adds the cervical cancer immunization as an optional Medicaid benefit.

4. It mandates coverage for cervical cancer immunizations in all individual and group health plans.

In June 2006, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) voted to recommend the vaccine developed to prevent cervical cancer and other diseases in females caused by certain types of genital human papilloma virus. Human papilloma virus is the name of a group of viruses that includes more than 100 different strains or types. Some human papilloma virus strains are communicated through sexual contact and these strains affect men as well as women. The ACIP has recommended this vaccine for all females under age 26, making it an acceptable medical treatment standard. The ACIP recommendations are accepted by the American Academy of Pediatrics and the American Academy of Family Physicians, the two professional groups representing the major primary care providers for children nationally and in Colorado.

The federal Food and Drug Administration recently licensed this vaccine for use in girls and women, ages 9 to 26 years of age. The vaccine is given through a series of three shots over a six-month period. The vaccine is only produced by one manufacturer currently. A second manufacturer is working on a similar vaccine that is scheduled to be approved by the Food and Drug Administration and entering the market within the next two years.

The cost of the vaccine itself is estimated at $120 per shot, or $360 for the total course of three shots. The administration fee has been estimated at $20/shot which is based on data from the public health setting. Therefore, the total cost is $420 ($140 X 3), which makes it the most expensive vaccine available.

One of the barriers to care is that if insurance does not cover the vaccine, it is possible that doctors will not stock the vaccine and patients may have to seek other care settings like public health clinics. Dr. Calogne noted that pediatricians are concerned about the cost of the drug because they do not typically get reimbursed for the full cost of vaccines, which is not as much of an issue when they are providing less expensive vaccines.

Dr. Calonge indicated that Medicaid would purchase the vaccine $97 per dose. Further, he explained that the Vaccine for Children Program[8] provides vaccines for Medicaid recipients and that this vaccine would be included in this program. The vaccine is already available through Medicaid because it covers all vaccines recommended by the ACIP at the CDC. Insurance plans under the jurisdiction of the division of insurance require coverage of this vaccination until the age 13 years pursuant to section 10-16-104 (11), C.R.S., because the vaccine is recommended by the ACIP at the CDC. Last, it is unknown if the Federal Employee Health Benefit Plan will cover it, but that Tricare could provide coverage.

Dr. Calonge stated that Medicare coverage is not applicable since the vaccine is indicated for women at ages not eligible for Medicare.

In answering what medical outcomes would likely result from a lack of treatment, Dr. Calonge stated that the Pap smear screening test reduced cervical cancer from the number one cause of death to somewhere beyond the top five. It is estimated that 40 Colorado women die each year due to cervical cancer. It is estimated the human papilloma virus will infect up to 50% of women at some point in their lifetime. Human papilloma virus causes abnormalities in the cervix that if left untreated will typically progress to cervical cancer. The Pap smear is an excellent screening tool for identifying these abnormalities, which is why cervical cancer is no longer the leading cause of death. However, there are a number of diagnostic and surgical procedures that are used to address the cervical abnormalities related to human papilloma virus infections. These include:

- Colposcopies;
- Cervical biopsies;
- Cervical conization procedures;

[8] The vaccines for children programs are administered through local health departments.

- Cervical cryosurgeries;
- Cervical loop electrical excision procedures (LEEPS); and
- Hysterectomies performed for cervical pathology.

It is estimated that 70% of cervical cancer cases are due to human papilloma virus infection; therefore, 28 Colorado women may be spared and 70% of all of the treatments performed following an abnormal Pap smear will be avoided.

Financial Impact

The proponents believe that the public demand for this immunization will be high because it prevents 70% of cervical cancer cases. The market will drive insurers to provide coverage for the immunization due to the significance of it being able to protect women from most cases of cervical cancer.

Regarding the financial impact, the proponents provided the following assumptions to support a calculation of a per-member, per-month cost of $0.317:

- Disregarding "catch up", which is providing the immunization to females already over the age of 11, the steady state will require immunizing a single birth cohort (11 year olds)
- The 11 year old age cohort for a health plan population is 1% of the population and the female population will be ½ of 1%.
- The vaccine costs $360 for the series of three doses with an administration fee of $20 per dose.

Regarding the savings indirectly related to the proposed mandate, the proponents expect that there should be savings due to averted time away from work due to medical treatment of cervical conditions. Further, only looking at mortality, and ignoring the cost savings from averted cervix procedures, the cost per year of life saved, based on Colorado numbers (and not accounting for future discounting) is $38,000, below the generally accepted benchmark of $40,000-$60,000 per year of life saved and better than many other mandated preventive procedures such as mammography.

The proponents believe that the three shot series will prevent 70% of the follow-up Pap smears, colposcopies, cervical biopsies, cervical conization procedures, cervical cryosurgeries, cervical loop electrical excision procedures and the hysterectomies done for cervical pathology so the overall cost savings will be greater than the vaccination costs.

Pap smears will not be replaced by this vaccination. Pap smears are 95-98% effective in identifying abnormal cervical conditions. The vaccine will prevent

70% of the cervical conditions that are related to human papilloma virus infection and the vaccine is nearly 100% effective in preventing human papilloma virus infection. However, the protocols for frequency of Pap smears may continue to change to a three-year cycle from annually. Dr. Calonge commented that the full cost of implementing coverage for this vaccine could be paid for if physicians and patients would only follow the recommendation of Pap smears every three years rather than annually.

In addition, Michael Huotari, President of the Colorado Association of Health Plans, made reference that out of his 10 member associates, 9 responded to a survey, with 8 of those 9 associates cover the vaccine.

Balance

As noted, HB07-1301 establishes the Cervical Cancer Prevention Immunization Program. Based on the costs presented, this legislation will not have a significant impact on health insurance premiums. From the information presented, utilization of this vaccine will be high, but the cost avoidance from the treatment of cervical cancer will create a cost savings.

Unfortunately the bill sponsors and supporters did not provide actuarial analysis as to the probable longer term cost savings associated with this coverage of this new vaccine. That is, not only the reduction in mortality, but also the cost savings associated with fewer surgical treatments and other services associated with this virus. While the sponsors and supporters did not quantify the expected reductions in the number of procedures, based on data from a Commission member for standard costs for a preferred provider organization for the following surgical treatments are:

Colposcopy:	$160
With a biopsy	$200 – $225
With a loop electrode biopsy	$500
With a loop electrode conization	$550
Cervical conization	$400
With a loop electrode excision	$450
Cervical biopsy	$200
Cervical cryosurgery	$200
Total abdominal hysterectomy	$1,650

Vaginal hysterectomy	$1,250

Staff does not have access to the ancillary costs related to these surgical procedures nor to treatment guidelines for human papilloma virus and, therefore, is unable to determine the combination of treatments that may be appropriate. However, the relative cost of most of the procedures indicates the vaccination series to be more cost effective than treatment based on .317 cents per individual per month

Recommendations

Some members of the Commission expressed concerns about the monopoly of the current manufacturer of the vaccine and the possibility of price gouging with mandatory coverage.

The cost savings may not be demonstrated until treatment costs are incurred. Specifically, the proponents noted treatment costs do not typically start accruing until around age 22, which is the age that cervical abnormalities can begin occurring. However, Commission discussion indicated the disregarded "catch-up" for girls after 11 year of age may not be appropriate. Information from the Mayo Clinic indicates vaccination of girls after the age of 11 is recommended regardless of sexual activity.

The Minutes (unapproved) of the Commission meeting are attached.

Commission on Mandated Health Insurance Benefits

Review of

SB070-36 – Concerning the Inclusion of certain Additional Mental Disorders in the Mandatory Health Insurance Coverage for Mental Illness, and, In Connection Therewith, Defining Mental Disorder as a Condition Classified as a Mental Disorder in the Ninth Revision of the International Classification of Diseases and Excluding Specified Conditions Defined as Mental Disorders Therein.

March 23, 2007

Introduction

The Commission on Mandated Health Insurance Benefits exists to serve the people of Colorado and the Colorado General Assembly by providing objective information and recommendations on the impact and structure of current and proposed health insurance mandated benefits.

On March 23, 2007, the Commission met to review SB07-36 -- Concerning the Inclusion of certain Additional Mental Disorders in the Mandatory Health Insurance Coverage for Mental Illness, and, In Connection Therewith, Defining Mental Disorder as a Condition Classified as a Mental Disorder in the Ninth Revision of the International Classification of Diseases and Excluding Specified Conditions Defined as Mental Disorders Therein. The bill had been previously been referred to the Commission by Senator Groff, Chair of the Senate State, Veteran's and Military Affairs Committee on February 1, 2007 asking that the Commission report by February 5, 2007. Due to the press of Senate business, the sponsor of SB07-36 was unable to present the bill at the Commission meeting on February 2, 2007 and the Commission issued a report noting such. The Senate State, Veteran's and Military Affairs amended SB07-36 and referred it to the Senate Appropriations Committee. Senator Keller requested that the Commission meet to hear the bill on March 23, 2007 in advance of the bill's hearing in the Appropriations Committee.

Senator Moe Keller attended the Commission meeting with Chris Habgood of the Mental Health Association of Colorado. Also in attendance at the meeting were: Tim Gilmore of Brownstein, Hyatt, Farber and Schreck; Erin Silver, representing United Healthcare; Susan Cox and Dr. Jean Milofsky of Kaiser Permanente; Michael Huotari of the Colorado Association of Health Plans; and Charles Malick, also representing the Mental Health Association of Colorado.

Senator Keller and Chris Habgood presented the bill, requesting that the Commission consider the bill as amended by the Senate State Affairs Committee, and with an amendment Senator Keller will be proposing for the Senate Appropriations Committee. From the information presented by Senator Keller, Chris Habgood, Susan Cox, Dr. Jean Milofsky, and Mike Huotari, the Commission presents the following analysis:

Current Law

Colorado law currently contains three mandates in the areas of mental health conditions and services.

1. *Mental Illness Mandate – CRS 10-16-104(5)*

CRS 10-16-104(5) requires that group health coverage provide benefits for at least 45 days of hospitalization (or up to 90 days of partial hospitalization) and outpatient mental health services. The outpatient services may have a 50 percent copayment or coinsurance requirement that may differ from the copayment or coinsurance requirement for physical illnesses. The outpatient services may have a deductible for mental illness, but the deductible must be the same as for physical illness. In addition, benefits may be limited to not less than $1,000 per year or 20 visits per year. CRS 10-16-104(5)(c). Certain other requirements concerning the type of entities and professional who can provide and be reimbursed for services are contained in this section. "Mental illness" is not defined in this statute, except that it does not include autism. CRS 10-16-104(5)(h). Accordingly, "mental illness" has been subject to governance via contract language, industry standards and related court rulings.[9]

2. *Biologically Based Mental Illness – CRS 10-16-104(5.5)*

This paragraph establishes six conditions as "biologically based mental illness" and requires that group insurance benefit coverage for them be "no less extensive than the coverage provided for any other physical illness." The six conditions are identified in the statute as:

(1) Schizophrenia
(2) Schizoaffective disorder
(3) Bipolar affective disorder
(4) Major depressive disorder

[9] It should be noted that for purposes of the small group Basic mandate-lite option, coverage under Paragraph (5) is not included in such policies. CRS 10-16-105(7.2)(b)(III). According to information in the 2005 Small Group Activity Report, only 6.7% of small group plans were one of the three Basic option plan designs. SB07-36 has been amended such that it does not apply to small group plans.

(5) Specific obsessive-compulsive disorder, and
(6) Panic disorder

The statute requires that preauthorization or utilization review used to determine coverage under this section be "the same as, or no more restrictive than, that used in the determination for any other physical illness." CRS 10-16-104(5.5)(a)(I). However, benefits under this section are not required to be provided if they duplicate the benefits under CRS 10-16-104(5) above. CRS 10-15-104(5.5)(b).

3. *Availability of Coverage for Alcoholism – CRS 10-16-104(9)*

Under this mandate, when group health insurance is purchased, the purchaser must be offered coverage for alcoholism and alcoholism treatment services of at least the following:

A. 45 days per year of inpatient treatment in an alcohol treatment facility, which confinement would reduce the total days available for all other illnesses, and specifically reduces the days available under the mental illness benefit in 1. above;
B. $500 of outpatient benefits per year.

Copayment requirements under this section for alcoholism treatment cannot exceed 50% but may differ from those for physical illness, but deductible amounts may not differ between alcoholism and other conditions. However, a further limitation in imposed that "benefits will not be payable unless the patient having the coverage . . . has completed the full continuum of care, including detoxification and rehabilitation." CRS 10-16-104(9)(d)(III).

Federal Law

It should further be recognized that under the Mental Health Parity Act of 1996 (and several annual extensions of it), the U.S. Department of Labor Employee Benefits Security Administration has extended interim final rules through December 31, 2007. Under these interim final rules, sponsors of health insurance plans that provide mental health coverage must offer plan participants the same level of mental health benefits as to annual or lifetime dollar limits compared to the other medical coverage in the plan. This federal law applies to health plans sponsored by employers (including self-funded plans), but does not apply to small employers with between 2 and 50 employees. Legislation is currently pending in Congress to extend and expand these requirements to deductibles, copayments, out-of-pocket expenses, co-insurance, hospital stays, and outpatient visits.

SB07-36 Provisions

The bill amends the current biologically based mental illness mandate (CRS 10-16-104(5.5)) to define "mental disorder" to include most diagnoses contained in the International Classification of Diseases, Ninth Revision, Clinical Modification 2006 (ICD9-CM). Pre-amended SB07-36 at page 3, lines 12 through 14. The bill specifically excludes 14 diagnoses as follows:

1. 299.0 – autistic disorder
2. 302.0 – ego-dystonic sexual orientation
3. 305.1 – tobacco use disorder
4. 306 – physiological malfunction arising from mental factors
5. 307.3 – stereotypic movement disorder
6. 307.9 – other and unspecified special symptoms or symptoms not elsewhere classified
7. 309.29 -- culture shock
8. 310 – specific nonpsychotic mental disorders due to brain damage
9. 312.31 – pathological gambling
10. 313.1 misery and unhappiness disorder
11. 315 – specific delays in development
12. 317 – mild mental retardation
13. 318 – other specified mental retardation
14. 319 – unspecified mental retardation

Pre-amended SB07-36 at page 3, lines 14 through 19, and incorporating Senator Keller's proposed Appropriations Committee amendment, L.004 at page 1, line 14 through page 2 line 1.

The bill makes minor wording changes to CRS 10-16-104(5.5)(a)(I) which requires group health carriers (except certain ones defined in CRS 10-16-102(21)(b) pertaining to specialized coverages such as credit, dental, vision, short-term (bridge) policies, etc.) to provide coverage for the six biologically based mental illnesses "that is no less extensive than the coverage provided for a physical illness." *See* Pre-Amended SB07-36 at page 2, line 4 through 10. The bill, then adds a new subparagraph (II) which requires large group carriers (the specialized coverages and small groups are exempted) requiring coverage for the ICD9-CM conditions with the 14 exceptions listed above. Subparagraph (II) also contains a provision to require coverage of a mental disorder associated with a physical illness for which coverage is provided, and where one of the 14 exclusions is considered a physical illness.

Social Impact

There is strong evidence of the prevalence of mental illness and disorders in the U.S. population. Among the general statistics provided by the bill's proponents (not specific to SB07-36 and related populations):

- Mental health disorders are the second leading cause of disability and premature death in the U.S. Untreated mental health disorders cost the U.S. economy $80 billion in lost productivity, sick leave, and unemployment, including: 217 million days of work lost and 65% of job terminations. The costs are high for lost productivity. In considering chronic depression only, and working with CO Department of Labor figures, it is believed that there is $886 million in lost productivity and $170 million in medical costs associated with untreated depression.
- One in five adults (20%) will experience a diagnosable mental illness in any given year, and less than a third of the adults and even fewer children receive any mental health services. Extrapolated to the Colorado labor force, this means that approximately 361,870 Colorado workers would have a diagnosable mental illness in a given year, and approximately 120,623 or fewer of them would receive services. Polling statistics show that 87% of Americans cite lack of insurance coverage as the reason they don't see a mental health professional.
- Mental health is an increasing component of emergency room visits with approximately 85,229 visits in Colorado being related to mental health issues. This may include some portion of $57.6 million in attempted suicide costs.
- Colorado taxpayers pay substantial costs due to the prevalence of mental illness and substance abuse in persons in the correctional system and among the homeless. One in five (20%) Colorado prison inmates have a serious mental illness and will remain incarcerated from 15 months to twice as long as the normal population. In Denver, approximately 3,241 seriously mentally ill homeless persons roam the streets on any given night.
- Substance abuse, including alcohol abuse, is a significant problem in our society including up to $116.6 billion in costs to businesses nationally, with over 5 million people needing treatment for severe drug abuse, but only 2.9 million receiving treatment. It is estimated that 50% of the homeless battle substance abuse and that 40 to 60% of suicides are intoxicated.
- Colorado likely mirrors the following national estimates as determined by the U.S Conference of Mayors: 30% of Denver's homeless population suffers from mental illness; 50% battle substance abuse. On

any given night, more than 9,725 people in Denver are homeless, one-third of who have a serious mental illness.

Much of the information provided in the assessment tool and other materials provided by the proponents addressed depression, substance abuse, and mental illness in general. The information presented was not specific to the conditions added by the bill, and thus over-generalized the impact of the proposed legislation. The Commission has some concern that the analysis presented did not take into account the existing non-biologically based mental illness coverage and mandated substance abuse offer of benefits in assessing the expected benefit and impact from this legislation.

Financial Impacts

Certain of the costs of mental disorders, including substance abuse, are identified above. The bill's proponents provided some information about cost savings attributable to mental health treatment as follows:

- According to the National Advisory Mental Health Council, coverage for severe mental disorders that is equal to that provided for physical illnesses can result in a 10% decrease in use and cost of medical services for these persons. For persons who receive outpatient alcohol treatment, their medical services use is approximately 40% lower.
- Medical sequelae due to alcohol abuse might be reduced by 27% for brain tumors, 13% for breast cancer, 30% for cardiomyopathy, 80% for esophageal cancer, and 50% for head and neck cancers.
- Approximately $170 million in medical costs due to untreated depression is absorbed by Colorado industry. When depressed workers are treated with prescription medicines, their absenteeism dropped by 9 days and medical costs declined by $882 per employee per year. For some employers, mental health treatment has had a four to one return on investment, or a reduction in medical costs of 48.9 %.
- Conversely, where employer-sponsored behavioral health services were limited, employers found an increase in medical costs of as much as 37%.

The Congressional Budget Office (CBO) has conducted several analyses of federal mental health parity legislation. Most notably, the CBO estimate on S.543(2001) would increase group health insurance premiums by an average of 0.9 percent. This estimate was a weighted average of both affected and unaffected plans. The federal bill exempted approximately 30% of private sector employees working for small businesses. For employers in the several states which already imposed similar requirements, "firms would face little or no additional cost." However, for

firms that use the benefit designs prohibited by the bill such as different day or visit limits, deductibles, coinsurance, or copayments for mental health different from those for medical surgical benefits, such firms "would experience increases in premium costs higher than 0.9 percent." The CBO then found that affected plans would experience an increase of between 30 and 70 percent in their mental health costs. *See* CBO Memorandum of July 12, 2002 on Estimate of S. 543, the Mental Health Equitable Treatment Act.

Because Colorado law already requires "parity" for the six biologically based mental illnesses, the 0.9 percent cited by the CBO would overstate the premium increase required. There was testimony presented to the Commission and it was noted in the information provided to the Commission that 85% of the cost of treating serious mental illness is already encompassed by coverage of the six biologically based mental illnesses. As part of the discussion, the Commission thought a $0.50 per member per month or 0.5% premium may be true in a managed care environment, but it is hard to determine if this would hold true in a non-managed care environment.

Mandated benefits commissions in other states have reviewed legislation similar to SB07-36. From what we can ascertain, neither of the bills discussed below was enacted.

In New Jersey, the Mandated Health Benefits Advisory Commission contracted with an actuarial firm to review the impact of their Assembly Bill 333 in 2005. The assessment found that the legislation would result in average premium increases of 0.3 percent to 0.7 percent, with a certain number of people, up to 5,000, losing coverage as a result of the increased cost. The study found that it was "unable to definitely quantify the extent to which the mandate would actually increase the amount of mental health, alcoholism, and substance abuse treatment obtained by covered individuals, or whether it would simply make the financial impact of that treatment more affordable." *See*, A Study of Assembly Bill A-333, A Report to the New Jersey State Assembly the Mandated Health Benefits Advisory Commission, February 1, 2005. It should be noted that the New Jersey legislation would have applied to individual, small and large group, and the state employees plan. In addition, the New Jersey legislation utilized the Diagnostic and Statistical Manual of Mental Disorders (DSMD) rather than the IDC9-CM. The New Jersey preexisting biologically based mental illness mandate consists of eight conditions, two more than in Colorado -- paranoia and other psychotic disorders and pervasive developmental disorders or autism.

The California Health Benefits Review Program presented a report to the California Legislature on April 16, 2005 analyzing their SB572. SB 572 proposed to expand "parity" in California beyond the nine conditions that California had

previously identified as "severe mental illnesses" for comprehensive coverage. The nine "severe mental health conditions" in California add to the Colorado biologically based conditions – anorexia nervosa, autism, and bulimia. SB 572 proposed to add "parity" coverage for psychoses and neuroses, personality disorders, sexual disorders and other conditions. The California report concluded that SB 572 would increase costs by 0.2115 percent and premiums would increase by 0.3151 percent, with large fee for service plans experiencing an increase of $2.24 per member per month, while large group HMOs would experience the smallest increase of $0.17 per member per month. The California legislation imposed the parity requirement across all types of coverage, individual, small and large group, and indemnity and managed care plans (which in California are regulated by different entities).

Kaiser Permanente presented to the Commission that the addition of post traumatic stress disorder, social phobia, agoraphobia with panic disorder, and chemical dependency to the list of the six biologically-based conditions would encompass 95 percent of conditions and presumably treatment costs. Kaiser Permanente is concerned that a number of the diagnoses included under SB07-36's incorporation of the ICD9-CM do not have an agreed upon treatment regimens, limiting their ability to assess medical necessity, and opening the potential for unnecessary and excessive utilization with attendant costs. The Commission questions whether "agoraphobia with panic disorder" may already be covered under the panic disorder listing of the biologically based mental illnesses in CRS 10-16-104(5.5).

Using the information from the CBO, the proponents peg the increased premium cost of expansion of mental health coverage proposed by SB07-36 at $6.00 per person or $0.50 per person per month. It should be noted that proponents cite the $0.50 as a per employee per month increase, it is more likely to be $0.50 per person per month and may result in larger premium increases due to the number of family members covered.

Proponents testified that eight states which have imposed laws similar to SB07-36 have realized premium increases of one percent or less. They also indicated in their written materials that eleven states have comparable laws to that proposed in SB07-36.

Balance

The Commission recognizes that mental health conditions are prevalent and costly to American society, and Colorado taxpayers, citizens and employers. The Commission commends Senator Keller and Representative Stafford for trying to address the significant problems that mental illness presents to our state.

To the extent that expansion of mental health coverage as proposed by SB07-36 would address these some of these issues, it would be good for our society. The Commission's concern, however, is that SB07-36 is being touted as solving problems that it does not reach through the regulation of employer sponsored, fully-insured health insurance.

The Commission is concerned that there was no clear identification of the specific problem that SB07-36 is intended to solve. Among the questions raised:

- How are the current mandates of CRS 10-16-104(5) and 10-16-104(5.5) insufficient?
- Is there regularly care beyond the caps of CRS 10-16-104(5) resulting uncovered expenses?
- Does "mental illness" need to be defined in statute, and if so, how broadly?
- Do all "mental illnesses" have recognized and beneficial treatments?
- What is the role of the "medical necessity" requirement, and the requirement that the patient is progressing?
- There are standard exclusions for custodial care: how does that play into certain mental illness conditions and treatments?
- Is there coverage for the condition but the treatment approach is not recognized as appropriate?

A substantial portion of the data used to support the "need" for this legislation did not take into account Colorado's existing coverage mandates nor even the role of commercial employer-sponsored coverage. The Assessment Tool contains many references to costs due to untreated depression, but there is no reference that major depression is already covered under the biologically based mental illness mandate. Review of the information presented indicates the problem may be that people are not seeking treatment, not that treatment of major depression is already covered.

The Commission also notes that this legislation would provide expanded benefits for mental health conditions to only a small proportion of Colorado's population. As presently structured, the legislation would expand mental health coverage only for the 15 percent of Coloradans who are covered by a Colorado-regulated large group plan.

Testimony and information presented by the bill's proponents stated that 85 percent of the cost of treating mental illness is already covered under the biologically based mental illness provisions of CRS 10-16-104(5.5). The bill's proponents did not address how much of the additional 15 percent of costs are

covered by the "other" mental illness coverage under CRS 10-16-104(5) or by employer provided health plans that already provide mental health coverage up to the level required by this legislation.

Recommendations

Some members of the Commission are concerned that small employer plans are excluded from the legislation thereby setting a possibly uncomfortable precedent for two tiers of mandates – small employer and large employer – and also possibly encouraging large employers to self-fund in order to receive the same treatment afforded small employers. The bill's proponents indicated that small employer plans were not included for political reasons and because the expansion or addition of the mandate in SB07-36 may affect coverage decisions by businesses on the margin of providing employee health insurance. If these coverage decisions might be affected by this mandate, there could be similar experience with large employers.

Regardless of some of the issues raised regarding definitions and approaches, the Commission agreed that there would be some corresponding increase in premiums associated with this new mandate. And even when the relative cost is small as potentially with this expansion, the number one reason why the uninsured do not have coverage is the perceived affordability of insurance and anything that raises premiums increases the chances that fewer employers will offer coverage and fewer employees will choose to enroll.

The Commission recommends that further analysis be conducted as to what the effect of this legislation would be in the context of the three existing mandates. It may be that the existing mental illness mandate, which does not contain a definition of mental illness, should be amended to utilize the ICD9-CM list, with the specific exclusions. In the alternative, it might be that the biologically based mental illness mandate be amended to include the four conditions identified by Kaiser Permanente which might raise parity coverage from 85 to 95 percent of treatment costs. Further, it might be appropriate to look at how many employers are exercising the mandated offer of alcoholism treatment coverage and make changes to this coverage requirement.

The Minutes (unapproved) of the Commission meeting are attached.

Appendix E

Memorandum to Legislative Leadership

To: Speaker of the House Andrew Romanoff
Majority Leader Alice Madden
Minority Leader Mike May
Health and Human Services Committee Chair Ann McGihon
Business Affairs and Labor Committee Chair Rosemary Marshall

Senate President Joan FitzGerald
Majority Leader Ken Gordon
Minority Leader Andy McElhany
Health and Human Services Committee Chair Bob Hagedorn
Business Affairs, Labor and Technology Committee Chair Jennifer Veiga

From: Mandated Health Insurance Benefits Commission

Date: March 26, 2007

RE: Commission Procedures

The Mandated Health Insurance Benefits Commission (Mandates Commission) is statutorily established to review proposed health insurance mandates, the existing mandated health insurance benefits, and to provide advice and counsel to the General Assembly and Division of Insurance about health insurance benefit issues. *See* CRS 10-16-103.3(5). The statute and legislative rules provide that the chair of committee of reference is to refer a bill to the Mandates Commission for analysis prior to a bill's hearing in the committee. CRS 10-16-103.3(6)

As there has been substantial confusion over the process for referral of bills to the Mandates Commission, the Commission would like to offer the following as suggested processes and procedures for referral of bills to the Commission, scheduling of Commission meetings, and reports from the Commission.

Referral of Bills to the Commission

Both the statute and rule vest the referral of a bill to the Mandates Commission for analysis in the chair of the committee of reference. Because the Commission's charge covers health insurance mandated benefits pursuant to CRS 10-16-104, the committees that handle most of these bills are the Health and Human Services or Business Affairs Committees. On some occasions, other committees handling health insurance mandate bills have referred them to the Mandates Commission.

The practice has been that a bill is referred to the Mandates Commission via a brief memorandum from the committee chair referring the bill to the Commission. The memorandum generally is forwarded by Legislative Council staff to the Division of Insurance to organize the Commission meeting on the bill.

Schedule of Mandates Commission Meetings

The challenge for the Mandates Commission has been to receive timely referrals of bills so that the Commission has a chance to meet and "hear" the bill, analyze it, and prepare its report. The Mandates Commission has tried to accommodate "short fuse" requests for it to meet, hear and report on bills. However, this process has proved frustrating for both bill sponsors and the Commission.

To remedy this frustration, the Mandates Commission proposes that it have regularly scheduled meetings on an every-other-week basis through the end of the legislative session. The dates for these meetings would be March 30, April 13, and April 27, 2007. The Commission meetings are scheduled for 2 to 4 p.m. on these dates in the hearing room at the Division of Insurance. On some occasions, some Commission members participate in the meeting via teleconference.

We would appreciate the referral of any bills for these meetings by noon the Wednesday before the meeting date. Thus, the referral dates would be March 28, April 11, and April 25, 2007. Receiving the referral 2 days before the Commission meeting permits the Division of Insurance staff to confirm a quorum for the Commission meeting, prepare agendas, and distribute copies of the legislation and materials prior to the Commission meeting. In addition, this timeframe permits the Division to post the meeting as a public meeting and inform interested parties of the meeting. The Division maintains an e-mail list of interested parties, though we also appreciate bill sponsors, committee chairs, and others assisting to inform persons interested in specific legislation of Commission meeting dates and times when such bills will be considered.

Assessment Tool

Since its inception, the Commission has requested bill sponsors or advocates to prepare and complete an Assessment Tool. A copy of the Tool is attached. The Assessment Tool is designed to provide the Commission with information about the social and financial implications of the legislation so the Commission may provide a report with the costs and benefits of the legislation for the committee of reference's consideration. The Tool is also designed to track the requirements of CRS 10-16-103 requiring a report to the committee of reference by a bill's proponents on the social and financial impacts of the legislation. In some cases, the Commission finds that bill sponsors and advocates utilize the Commission's assessment tool to fulfill the requirements of a report to the committee of reference.

It is helpful for the Division of Insurance to receive an electronic copy of the completed Assessment Tool prior to the Commission meeting so that it may be provided via e-mail to Commission members who may be participating in a meeting by teleconference.

Commission "Hearing"

The Commission has been privileged to have several legislators come and present their bills to the Commission. The meetings are fairly informal. Usually, the bill sponsor is asked to review the legislation and "hit the high points" of the Assessment Tool. Commission members often ask questions about the legislation to clarify understanding of the bill and how it would be put into practice. If there are other individuals interested in the legislation, either supporting or opposing the legislation, they are asked to briefly discuss their position on the legislation.

Commission Report

The Commission does not vote on the legislation or recommendations. Rather, the Commission asks that the Division of Insurance personnel who staff the Commission to prepare a written report on the bill providing analysis of the costs and benefits, social and financial, of the legislation, and include any technical suggestions to clarify the bill's language or effect.

Because it takes time to prepare these reports, the Commission requests that it be provided 5 to 7 business days depending on the complexity of the legislation to file its report. The Commission realizes that the General Assembly works under certain deadlines and would ask that where necessary, these deadlines be waived for a short period to permit the Commission's report to be prepared, reviewed and submitted.

Conclusion

The Commission believes that it can provide a valuable service to bill sponsors and the General Assembly by providing social and financial, costs and benefits analysis to the committees of reference on proposals to require specific health insurance benefits. We hope that this memorandum and mutual understanding of our responsibilities, constraints, and processes will alleviate any misconceptions about the role, purpose and procedures of the Commission. We further hope that our suggestions as to scheduling, referral and time frames for us to report back to the Legislature work within the legislative processes and schedules.

If you have any questions, please contact Leo Tokar, acting Chair of the Commission, at 303-344-7242 or leo.tokar@kp.org, or Peg Brown, Deputy Insurance Commissioner for Consumer Affairs and member of the Commission, at 303-894-7501 or peg.brown@dora.state.co.us.

Appendix F

Legislative Council Report

Colorado
Legislative
Council
Staff

Room 029 State Capitol, Denver, CO 80203-1784
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MEMORANDUM

Pursuant to section 24-72-202(6.5)(b), research memoranda and other final products of Legislative Council Staff research that are not related to proposed or pending legislation are considered public records and are subject to public inspection. If you think additional research is required and this memorandum is not a final product, please call the Legislative Council Librarian at (303) 866-4011 by November 1, 2007.

October 25, 2007

TO: Senator Lois Tochtrop
Representative Morgan Carroll

FROM: Jeanette Chapman, Research Associate, 303-866-6136

SUBJECT: State Mandated Benefit Evaluation Programs

This memorandum responds to your request for information about mechanisms used in other states for review and analysis of proposed mandates for health insurance benefits. Specifically you asked for identification of different types of structures for review and location; budget and staffing information for the review entity (if applicable); and a description of the process for review. Twenty-five states, including Colorado currently provide some mechanism for assessing the impact of proposed mandates for health insurance benefits. In most states, there is not a separate entity responsible for review and evaluation of proposed benefit mandates. This memorandum provides detail about those the six states that have a task force or commission charged with assessing proposed mandates for health insurance benefits including the social, medical and financial impact of those mandates — Colorado, Indiana, Maryland, New Jersey, New York, and Virginia. A summary of each task force or commission including the membership and assessment processes of those states are detailed in Table 1.

According to staff in Indiana, the Indiana Mandated Benefits Task Force has not produced an assessment as required by state statute due to lack of funding. An attempt by the task force to repeal their statutory responsibilities was unsuccessful in 2007. Arkansas, North Carolina, and South Carolina repealed their benefit mandate assessment statutes during the 2007 legislative session. All three states had a commission established to advise the general assembly on the social, medical, and financial impact of current and proposed mandated health insurance benefits.

Table 1
States with a Task Force or Commission to Evaluate Proposed Mandated Health Benefits

	Colorado	Indiana	Maryland	New Jersey	New York	Virginia
Type of Entity	Commission on Mandated Health Benefits	Mandated Benefits Task Force	Health Care Commission	Mandated Health Benefits Advisory Commission	State Health Care Quality and Cost Containment Commission	Special Advisory Commission on Mandated Health Insurance Benefits
Membership	There are 11 commissioners. 9 members appointed by the governor: • 1 employee of the Division of Insurance; • 1 representative of the health insurance industry; • 1 representative of a health maintenance organization; • 2 representatives of health care providers; • 2 private citizens; and • 2 small business owners (less than 50 employees). The Senate president appoints a member of the Senate Business, Labor, and Technology Committee. The Speaker of the House appoints a member of the House Business Affairs and Labor Committee.	10 members appointed by the governor: • 2 members representing the insurance industry; • 2 members representing consumers; • 2 members representing health care providers; • 2 members representing business; • 1 independent actuary; and • commissioner of insurance or designee.	13 members appointed by the governor, two of whom must be licensed physicians.	There are 17 commissioners. Commissioner of Health and Senior Services Commissioner of Human Services Commissioner of Banking and Insurance 2 public members appointed by the Senate president; 2 public members appointed by the Assembly speaker; 8 members appointed by the governor: • medical educator from the University of Medicine and Dentistry of NJ with expertise in the study and evaluation of the cost of health care and insurance; • a representative of the NJ Association of Health Plans; • a representative of the NJ Hospital Association; • a representative of the NJ State Nurses Association; • a representative of the NJ Dental Association;	There are 21 commissioners. 13 members appointed by the governor. 6 members appointed on recommendation of legislative leadership: • 2 members recommended by the Senate president; • 2 members recommended by the Assembly speaker; • 1 member recommended by the Senate minority leader; and • 1 member recommended by the Assembly minority leader. Superintendent of Insurance Commissioner of Health	There are 18 commissioners. 6 legislative members 10 members appointed by the governor: • 1 physician; • 1 chief executive officer of a general acute care hospital; • 1 allied health professional; • 1 representative of small business; • 1 representative of major industry; • 1 expert in the field of medical ethics; • 2 representatives of the accident and health insurance industry; and • 2 nonlegislative citizen members. 2 ex officio nonvoting members: • commissioner of health, or designee; and • commissioner of insurance, or designee.

Table 1
States with a Task Force or Commission to Evaluate Proposed Mandated Health Benefits (Cont.)

	Colorado	Indiana	Maryland	New Jersey	New York	Virginia
Membership (cont.)				• a representative of a consumer advocacy organization; and • two public representatives with expertise about health benefits plans. The Senate president and the House speaker appoint two non-voting members each (one from each political party).		
Member Compensation	Reimbursed for expenses	Per diem and reimbursement for travel and other expenses	Per diem and reimbursement for travel expenses.	Reimbursed for expenses	Reimbursed for travel expenses	Per diem and reimbursement for expenses.
Time line for Report	Bills proposing a mandate are referred to the commission for an assessment of the social and financial impact of the mandate by the chair of the appropriate standing committee. The committee chair may determine the time period within which the assessment is conducted.	At the request of a legislator or the task force, the task force must assess at least one mandate per year and report to the legislative council no later than Nov. 1.	The commission must annually assess any legislatively proposed mandated service prior to July 1 of the year after the bill is introduced. Beginning January 2004, the commission must assess the cost of all existing health insurance mandates every four years. The report is required by December 31.	The chairman of a committee of reference to which a bill proposing a mandate is referred must request a proposed written assessment. The assessment must be completed and provided to the bill sponsor, the committee chair, and the presiding officer to the house of origin within 180 days of the request. However, the commission may receive an extension of up to 90 days.	The governor, the chair of the Senate insurance committee, or the chair of the Assembly insurance committee may request in writing that the commission evaluate a proposed mandated benefit. The commission may then vote whether to undertake an evaluation. No time line is indicated in statute.	The legislature refers introduced bills with mandates to the Commission, which meets during the interim and provides a report to the legislature prior to the start of the next legislative session.
Budget	Not to exceed $20,000 per year.	None	$300,000 for FY 2007-08	Information not available.	$300,000 for FY 2007-08	None
Staff	Division of Insurance provides staffing.	Department of Insurance provides staffing.	The Commission has staff. However, the mandated benefits analysis is done by a private actuarial firm under contract with the commission.	Department of Banking and Insurance and the Department of Health and Senior Services provide staffing.	Department of Insurance may provide staffing or may contract with independent organizations for services.	Bureau of Insurance provides staffing. Joint Legislative Audit & Review Commission staff and Department of Human Resources staff may provide background and research.

Table 1
States with a Task Force or Commission to Evaluate Proposed Mandated Health Benefits (Cont.)

	Colorado	Indiana	Maryland	New Jersey	New York	Virginia
Assessment Process	The commission shall: • review and evaluate the state mandatory health care coverage provisions; • advise and assist the Division of Insurance on matters relating to mandated insurance benefits rules; • request information and prescribe the format, content, and timing of the information to be submitted to the commission for the assessment of proposed and existing mandated benefits; • assess proposed mandated benefits and other bodies of mandated benefits laws as requested by the legislature; • provide information and recommendations relating to any system of mandated health insurance benefits to the governor and any standing committee of the legislature on request; • make recommendations to the legislature regarding a standard health benefit plan; and • report annually on the activities of the commission to the legislature by December 1.	The task force is charged with examining social, medical, and financial impacts of proposed mandates as follows: Social impacts: • whether the proposed service is used by a significant part of the population; • whether the coverage is already available; • if not generally available, whether the lack of coverage results in unreasonable financial hardship; • the level of public demand for the service; • the level of public demand for coverage of the service; and • whether the service is covered by self-funded health plans provided by employers with at least 500 employees. Medical impacts: • whether the service is recognized as effective in patient treatment; • whether the service is recognized by peer review literature and the medical community; and • whether the service is available to and used by physicians.	The commission is charged with examining social, medical, and financial impacts of proposed mandates as follows: Social impacts: • whether the proposed service is used by a significant part of the population; • whether the coverage is already available; • if not generally available, whether the lack of coverage results in individuals avoiding necessary treatment; • if not generally available, whether the lack of coverage results in unreasonable financial hardship; • the level of public demand for the service; • the level of public demand for coverage of the service; • the level of interest of collective bargaining agents in negotiating for inclusion of the coverage; and • whether the service is covered by self-funded health plans provided by employers with at least 500 employees.	The commission is charged with examining social, medical, and financial impacts of proposed mandates as follows: Social impacts: • whether the proposed service is needed by, available to, and used by the population; • whether the coverage already exists, if not, whether the lack of coverage results in inadequate care or financial hardship; • whether there is a public demand for and/or public opposition to the proposed benefit; • relevant findings bearing on the social impact of the lack of the benefit; and • other information related to the social impact as the commission deems appropriate. Medical impacts: • whether the service is recognized by peer review literature and the medical community; • if the benefit mandates coverage of services provided by an additional class of practitioners, the results of a trial comparing results achieved by the additional practitioners;	The commission shall: • investigate the current practices of health plans with regard to the proposed benefit and, to the extent possible, self-funded health plans; • investigate the potential premium impact of the benefit on all segments of the insurance market, as well as the potential for avoided costs through early detection and treatment of conditions, or more cost-effective delivery of medical services; and • analyze the current medical literature regarding the proposed benefit to determine its impact on health care quality.	The commission shall: • develop and maintain a system and program of data collection to assess the impact of mandated benefits including costs to employers and insurers, the impact of treatment, cost savings in the health care system, number of providers, and other appropriate information; • advise and assist the Bureau of Insurance on matters relating to mandated insurance benefits and provider regulations; • prescribe the format, content, and timing of information to be submitted to it in the assessment of proposed and existing mandates; • provide assessments of proposed and existing mandated benefits and providers as requested by the legislature; • provide additional information and recommendations relating to any system of mandated benefits to the governor and legislature;

Table 1
States with a Task Force or Commission to Evaluate Proposed Mandated Health Benefits (Cont.)

	Colorado	Indiana	Maryland	New Jersey	New York	Virginia
Assessment Process (Cont.)		Financial impacts: • whether the proposed coverage will increase or decrease the cost of service; • whether the coverage will increase the appropriate use of the service; • whether the service will be a substitute for a more expensive service; • whether the coverage will increase or decrease the administrative expenses of health insurers and HMOs and premium and administrative expenses of covered individuals; • impact of the coverage on the total cost of health care, including potential savings; • impacts of all mandated benefits on the ability of employers to purchase coverage that meets employee needs; • whether the financial impact of all mandated benefits will affect employee wages and compensation; and • whether the financial impact of all mandated benefits will affect hiring practices of employers.	Medical impacts: • whether the service is recognized as effective in patient treatment; • whether the service is recognized by peer review literature and the medical community; and • whether the service is available to and used by physicians. Financial impacts: • whether the proposed coverage will increase or decrease the cost of service; • whether the coverage will increase the appropriate use of the service; • whether the service will be a substitute for a more expensive service; • whether the coverage will increase or decrease the administrative expenses of health insurers and HMOs and premium and administrative expenses of covered individuals; • impact of the coverage on the total cost of health care, including potential savings; and • impacts of all mandated benefits on the ability of employers to purchase coverage that meets employee needs.	• the results of other research; • the impact of the benefit on the general availability of coverage in the state; and • other information with respect to the medical efficacy as the commission deems appropriate. Financial impacts: • whether the benefit will increase or decrease the cost of treatment; • whether similar mandated benefits in other states have affected charges, costs, and payments for services; • whether the benefit will increase the appropriate use of the service; • the impact of the benefit on total costs to carriers and on administrative costs; and • the impact of the benefit on total costs to purchasers.		• report annually on its activities to the legislature's joint standing committees that have jurisdiction by December 1 of each year; and • review and evaluate benefits and provisions of essential and standard health benefit plans.

States With a Mechanism to Review Mandated Benefits Other Than a Commission or Task Force

Eighteen states either require proponents to prepare an assessment of the impact of their bill proposing a mandate, or require a state legislative agency or the state department of insurance to prepare an assessment. California's mandate benefit assessment law requires the University of California to assess legislation proposing a new mandated benefit or service or repealing an existing mandated benefit and provide a written analysis to the legislature. All states without a mandate review commission are listed in Table 2.

Table 2
States Without a Mandate Review Commission or Task Force

Proponents Prepare Assessment	State Legislative Agency Prepares Assessment	State Department of Insurance Prepares Assessment	State University Prepares Assessment
Arizona Florida Kansas Oregon Washington	Hawaii North Dakota Ohio Tennessee	Georgia Kentucky Louisiana Maine Minnesota New Hampshire Texas Wisconsin	California