



Effects of Government Mandated Benefits on Health Care Costs

A White Paper Detail on
Higher Health Care Costs from Well-Intentioned Laws



*Part of a Series of Special Industry Reports
From BlueCross BlueShield of Tennessee*

Additional White Paper Reports
in this series from
BlueCross BlueShield of Tennessee include:

Rx for Pharmacy Costs in Tennessee
Health Plan Affordability in Tennessee
Assessing the Value of Health Care in Tennessee

Bill Cecil
Director, Health Policy Research

Published September, 2004

This series of white paper reports is also made available on the
BlueCross BlueShield of Tennessee Web site at www.bcbst.com.
Additional information also is located at www.TennesseeHealth.com.

When Health Care is Mandated, Costs Go Up

Our goal in this paper is to illustrate, using data, the degree to which well-intended government policies have adversely impacted health insurance premiums in the private market. While the intention of state and federal health care mandates is usually good, they have significantly increased the cost of health care in Tennessee and the nation, almost always for those that are privately insured. The purpose of government intervention in health care is twofold: 1) to reduce government outlays for the Medicare or Medicaid programs and 2) to assure that patients seeking health care receive that care and that it is paid for. Sounds good at face value, doesn't it? However, when costs are reduced for government programs, they are shifted to private insurance. When health care is mandated, the cost for everyone goes up.

An internal analysis of the cost impact of 18 state or federal government interventions or mandates shows a total cost prescribed by the mandates of just over \$20 per insured person per month (*See Table 1 on page 2*).¹

¹ Internal analysis conducted by the Actuarial, Product Development and Health Policy Research departments of BlueCross BlueShield of Tennessee.

Table 1
The Cost of 18 State and Federal Health Insurance Benefit Mandates

| <i>Mandate</i> | <i>Description</i> | <i>Annual Privately Insured Cost in Tennessee</i> |
|--|--|---|
| HIPAA | Health Insurance Portability and Accountability Act | \$29,586,115 |
| COBRA | Continue coverage after employment disruption (Congressional Omnibus Budget Reconciliation Act) | \$8,136,182 |
| State Mandate 56-7-2301 | Newborn coverage from moment of birth | \$15,902,537 |
| Federal Mandate | Pregnancy recognized as illness | \$258,878,508 |
| State Mandate 56-7-2401,2,3 | Health plans must pay for optometrists, psychologists, podiatrists, social workers, licensed counselors and school psychologists | \$48,077,437 |
| State Mandate 56-7-2404 | Health plans must pay for chiropractors | \$96,154,874 |
| State Mandate 56-7-2302 | Dependents covered to age 24 | \$57,692,925 |
| State Mandate 56-7-2407 | Health plans must pay for certified nurse midwife services | \$739,653 |
| Mothers Health Protection Act of 1996 | Raised the length of stay for vaginal deliveries and c-sections | \$18,121,496 |
| State Mandate 56-7-2504 | Coverage for high dose chemotherapy and bone marrow transplantation | \$369,826 |
| State Mandate 56-7-2506 | Coverage for bone mass measurement and other services related to osteoporosis | \$13,683,578 |
| State Mandate 56-7-2407,8 | Health plans must pay for services received from Nurse Practitioners | \$17,751,669 |
| State Mandate 56-7-2803/HIPAA | Must give credit for previous group coverage to pre-existing conditions cases | \$52,885,181 |
| Women's Health & Cancer Rights Act of 1998 | Coverage for breast reconstruction for mastectomy | \$2,958,612 |
| State Mandate 56-7-2354 | Coverage for prostate screening | \$23,299,066 |
| Screening Mammography Act of 1999 | Coverage for annual screening | \$30,695,595 |
| Emergency Ambulance/ Prudent Layperson | Any visit to ER must be covered if it falls within the "prudent laypersons" definition of emergency | \$141,643,527 |
| Mental Health Parity | Changes coverage limits to service rather than dollars | \$9,245,661 |
| | Total | \$825,822,441 |

Costs alone are not so bad except that higher health care costs generally mean more companies and more people will not be able to afford health coverage, adding to the uninsured ranks. Higher health care costs will push some companies out of business or cause them to reduce their workforce. According to the Health Care Cost Calculator, a 1 percent increase in health care costs in Tennessee would result in 304 lost jobs, and 5,725 more uninsured.²

Because of the mandates listed in Table 1 you cannot purchase health insurance without the built-in cost of administering and paying for the mandates, no matter how unlikely you are to experience any of the health issues related to the mandates.

Four examples are reported in detail in this paper. In addition to the mandates shown in Table 1, these examples demonstrate an unintended cost resulting from government intervention. The government intervention examples are:

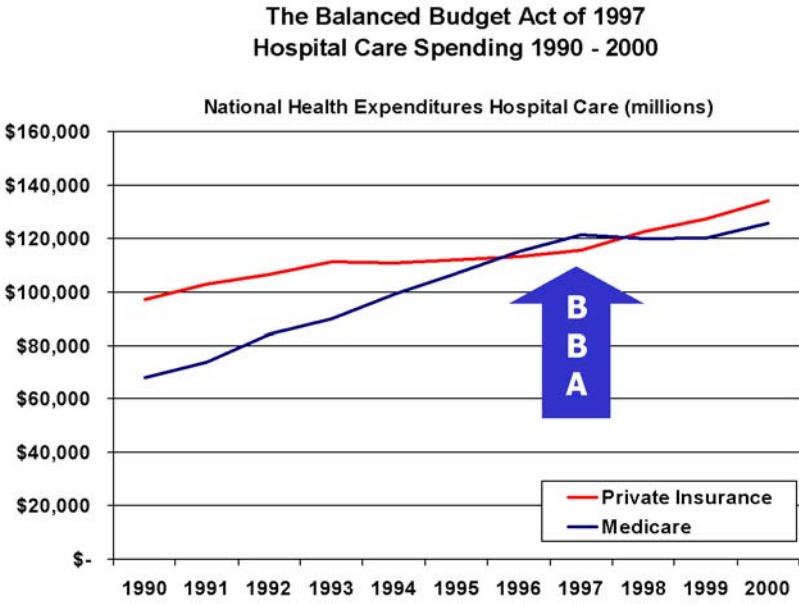
1. The Balanced Budget Act of 1997;
2. TennCare;
3. Emergency Medical Treatment and Active Labor Act (EMTALA) and prudent layperson laws governing utilization of emergency room services and payment for emergency room services; and
4. Mothers Health Protection Act of 1996.

1. The Balanced Budget Act of 1997

The Balanced Budget Act (BBA) was signed by President Bill Clinton in 1997 and was enacted in November 1997. With respect to health care costs, the law was designed to reduce federal government expenditures for hospital care in the Medicare program. The BBA succeeded; in 1998 Medicare hospital expenditures were \$1.45 billion below 1997 levels. Figure 1 graphs the relationship between Medicare hospital spending and private insurance hospital spending from 1990 through 2000.

² American Association of Health Plans. Available at: <http://aahpcostcalculator.org/index.php>

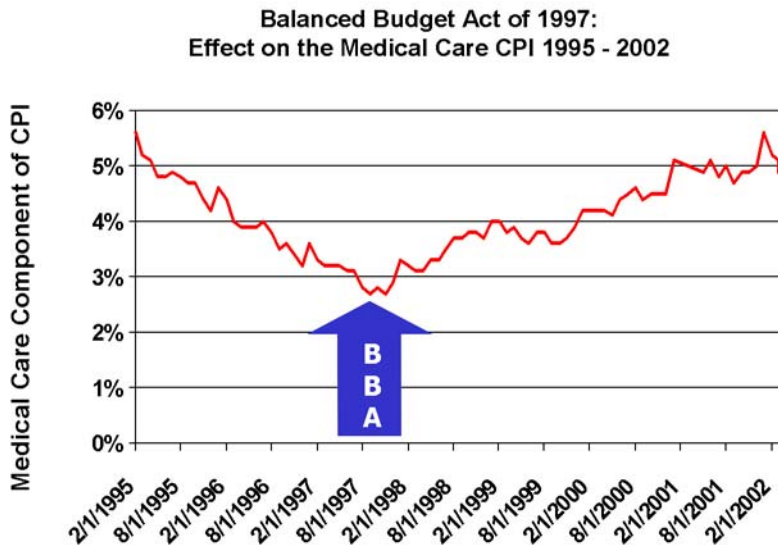
Figure 1
The BBA of 1997: National Health Expenditures for Hospital Care



Source: Centers for Medicare and Medicaid Services

Figure 1 illustrates Medicare spending for hospital care rising at a significant rate up until 1998 when spending flattened for two years. Private insurance hospital expenditures were essentially flat for five years and began to rise substantially again in 1998, the first government fiscal year that the Balanced Budget Act of 1997 was in effect.

Figure 2
BBA of 1997: Medical Care Consumer Price Index



Source: Bureau of Labor Statistics

Figure 2 graphs the medical care consumer price index (CPI) from 1995 through 2002 and affirms the finding of cost shifting from Medicare to the privately insured and self-pay segment. According to the Centers for Medicare and Medicaid Services the medical care CPI reflects consumer out-of-pocket costs for medical services and insurance premiums.³ As costs were shifted from Medicare to the privately insured and self-pay segments both insurance premiums and out-of-pocket costs for hospital care rose. The CPI shows the mechanism of the increased costs: an increase in prices – not an increase in utilization of services.

³ The Impact of Medicare and Medicaid Policy on the CPI and PPI. Centers for Medicare and Medicaid Services. Available at: <http://www.cms.hhs.gov/statistics/health-indicators/trends.asp>

Figure 3
BBA of 1997: The Hospital Services Producer Price Index

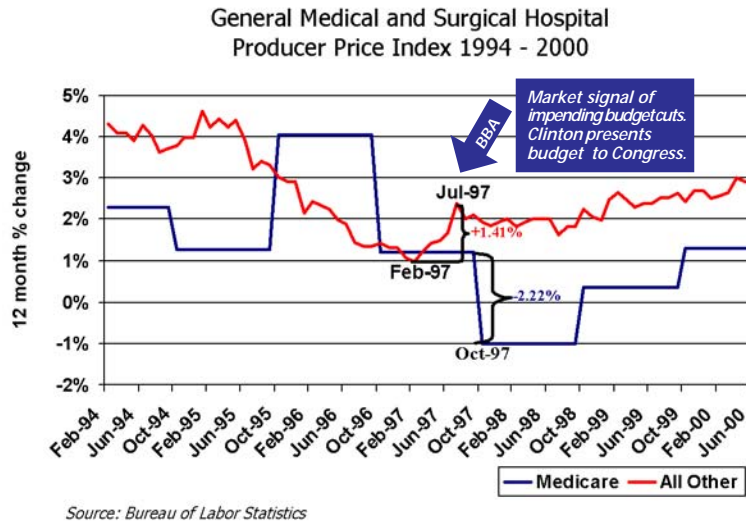


Figure 3 graphs the producer price index (PPI) for hospital care over the 1994 through 2000 period and illustrates the cost shift to private payers from Medicare because of changes in pricing. In February 1997, President Clinton presented his budget proposal for 1998 to Congress showing the Medicare hospital payment cuts that were included in the Balanced Budget Act. Figure 3 illustrates the increase in hospital pricing to the all other payer category (all other includes private insurance and every other wholesale purchaser of hospital services other than Medicare and Medicaid) that occurred in response to the notification of impending cuts. The price to private insurers increased by +1.41 percent between February and July 1997. The PPI trend for private payers (all other) declined consistently for several years prior to the notice that Medicare was reducing hospital payments; following that announcement, the PPI trend reversed upward.

Did the Balanced Budget Act save money? No! Instead of saving costs, the Balanced Budget Act of 1997 shifted costs from Medicare patients to privately insured and self-pay patients in order to reduce government expenses. The cost impact is about \$0.98 per privately insured person per month, or \$45.6 million for the private employers in the state of Tennessee.⁴

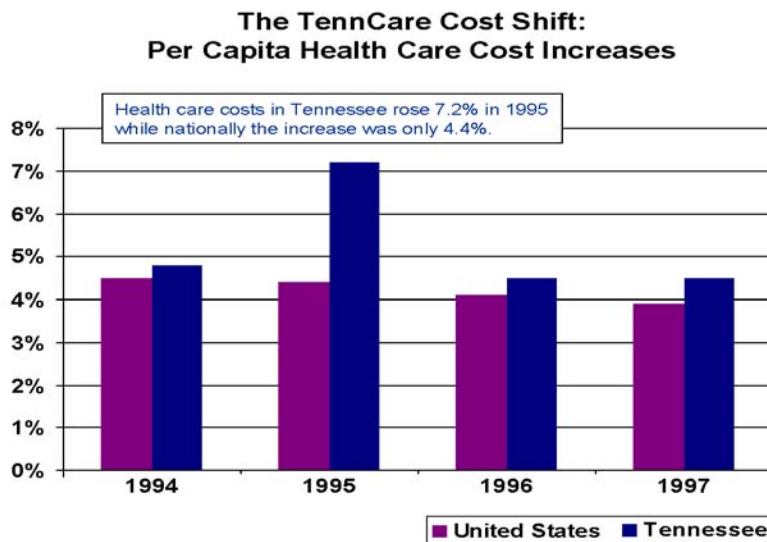
⁴Based on Internal BlueCross BlueShield of Tennessee cost estimates.

2. TennCare

TennCare has been lauded as a program that saves money.⁵ *The Tennessean* newspaper reported in 2001 that the state government's estimate of savings for 1999 showed that the state saved about \$485 million compared to the cost of operating a traditional Medicaid program, as in other southern states.⁶

TennCare's first full year of operation was in 1995, which included an expansion of beneficiaries and a reduction in provider payments in order to achieve program savings to justify its existence. Enrollment rose by 56 percent while TennCare per capita spending on physician and other professional services declined by \$137. Figure 4 shows the health care cost increases in Tennessee and nationally during the TennCare implementation and just after. The graph illustrates the spike in health care costs that occurred in Tennessee with the implementation of the TennCare program and tees up the question: How can a program that is supposed to save money result in higher overall health care costs for Tennessee?

Figure 4
Increase in Total Per Capita Personal Health Expenditures

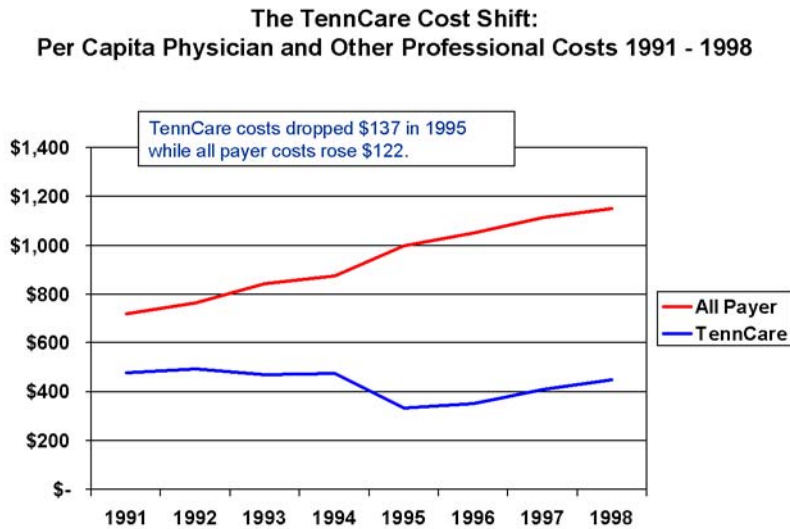


Source: Centers for Medicare and Medicaid Services

⁵ de la Cruz, Bonna. Report: TennCare cost-effective; Medicaid would cost state more. *The Tennessean*. 8/23/01.

⁶ Op Cit.

Figure 5
The TennCare Cost Decrease and the All Payer Cost Increase



Source: Centers for Medicare and Medicaid Services

Figure 5 helps answer the question of how overall costs could rise. In 1995, Tennessee all payer per capita costs for physicians and other professionals rose 13.9 percent, about twice the 1991-98 average of 6.9 percent. At the same time, TennCare costs for the physician and other professional category fell 29 percent. All payer per capita health care costs should have risen about 4.2 percent based on previous year increases in Tennessee and the nation (4.3 percent).⁷

If no cost shifting occurred from the TennCare attempt at cost savings, the all payer per capita expenditures would have reflected the \$137 per capita decline that occurred in TennCare – that is, there would have been an overall reduction in all payer per capita spending for physician and other professional services. That reduction did not happen.

If just cost shifting occurred, the all payer per capita expenditures would have increased at the previous trajectory or about 4.2 percent, in line with the national increase and previous years in Tennessee. That level of increase did not happen.

The level of increase in the all payer physician and other professional category of expenditures shows that increased costs for the privately insured more than made up for the TennCare reductions—it added \$445.8 million to the total cost of health care

⁷ All Payer includes privately insured, uninsured, Medicare, Medicaid and every other payment source for health care.

paid for by Tennessee consumers above that which would have been paid if TennCare had not been enacted. The privately insured, Medicare and the uninsured had to bear this additional cost and the cost shift of \$200.8 million (to make up for the TennCare savings). The additional cost burden in one year totaled approximately \$647 million!

Because of the TennCare expansion, fewer people are covered by private insurance. Between 1994 and 1995, the population grew by 134,000. If the rate of coverage by private insurance had remained the same in 1995 as in 1994, 3.838 million would have been covered, an increase of 89,000. Instead the number of privately insured declined by 35,000 for a total of 124,000 persons not covered by private insurance that otherwise would have been.^{8,9} The \$647 million has to be borne by this now smaller number of privately insured and uninsured. Since payments for Medicare enrollees are set by the federal budget and the uninsured are usually less capable of paying, most of this increase was borne by the privately insured population in Tennessee. The net effect is an increased cost of approximately \$174 per privately insured person per year.

3. EMTALA and Prudent Layperson

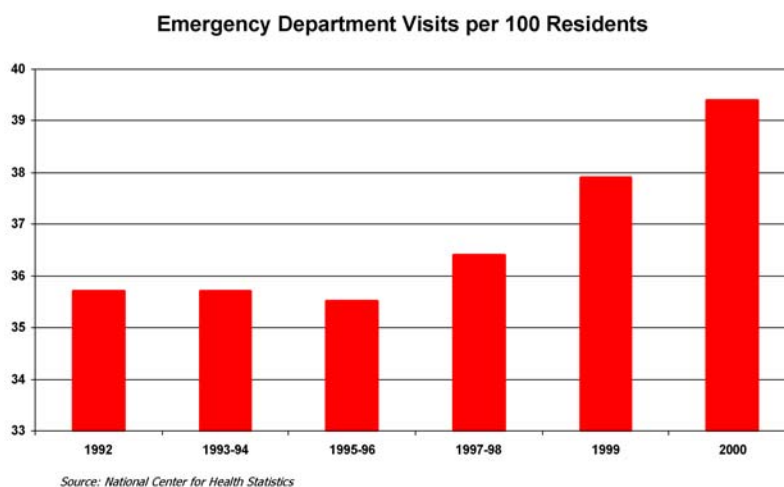
The federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the state Prudent Layperson legislation has contributed to an increase in inappropriate but highly costly emergency room use. Designed principally to address the issue of patient dumping of the poor and uninsured who could not pay for services, EMTALA was enacted in 1986. EMTALA was prompted by several highly publicized incidents where, based only on the patients' ability to pay, hospitals reportedly failed to medically screen patients or take the same steps they would have afforded a paying patient prior to their discharge or transfer. The effect of EMTALA was to force hospitals to provide health care for any patient that arrived at their doorstep. An important change in how EMTALA is enforced today came in November 1998 when the Centers for Medicare and Medicaid Services changed the enforcement level to "aggressive."

Prudent Layperson legislation required that health insurance companies pay for emergency room visits for their members in most instances whether the visit was an actual emergency or not. The effect of Prudent Layperson was to make certain that hospitals were paid for visits made by insured patients without regard to whether the visit was necessary.

⁸ Historical Health Insurance Tables. U.S. Census Bureau. Available at: www.census.gov/hhes/hlthins/historic/hihist4.html

⁹ The 1995 Tennessee population is reported by the March Supplement of the Annual Demographic Survey of the Census Bureau to be 5,483,000. In 1994, based on the same Census Bureau report, 70.1 percent of the population was covered by private insurance. If 70 percent coverage continued in 1995, 3,838,000 would have been covered; instead 3,714,000 were covered by private insurance in 1995, a decline of 35,000 from 1994 and a difference of 124,000 from that portion of the population that would have been covered had the coverage rate remained at 70 percent.

Figure 6
Emergency Department Visits per 100 Residents



These two laws together resulted in an increase in emergency room visits as shown in Figure 6. Beginning in 1998, the aggressive enforcement of EMTALA and adoption of Prudent Layperson had caused the emergency visit rate to rise by seven percent after having been stable for several years.^{10,11}

During the same 1992 through 1999 period, the emergency room visit rate from injuries remained flat while the visits diagnosed as having “ill-defined symptoms” rose 45 percent.¹² Ill-defined symptoms include “chest pain,” “abdominal pain” and “headache” in addition to “other” – all without a significant final diagnosis. Fully 54 percent of the emergency department visits in 2000 were not triaged as either emergent or urgent.¹³ From 1997 through 2000, the rate of emergency department visits that were considered emergencies declined by 17 percent.¹⁴ Of the total increase in emergency department visits from 1992 through 2000, 66 percent were due to ill-defined symptoms.

¹⁰ Burt CW, McCaig LF. Trends in hospital emergency department utilization: United States, 1992–99. National Center for Health Statistics. Vital Health Stat 13(150). 2001.

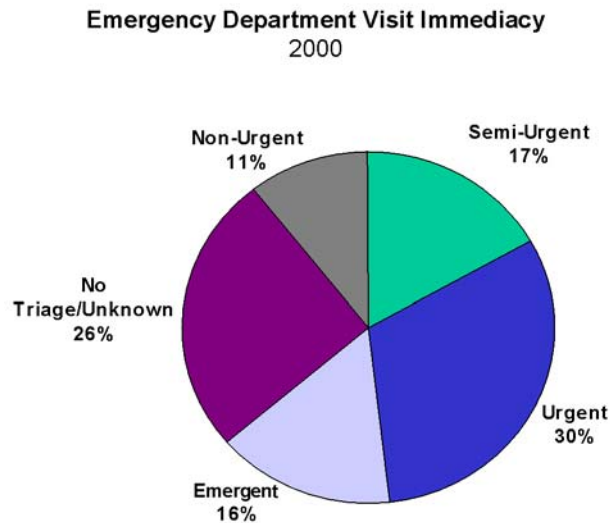
¹¹ McCaig LF, Ly N. National Hospital Ambulatory Medical Care Survey: 2000 emergency department summary. Advance data from vital and health statistics; no. 326. Hyattsville, Maryland: National Center for Health Statistics. 2002.

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

Figure 7
Emergency Department Visit Immediacy 2000



Source: National Center for Health Statistics

The result of intervention through EMTALA and Prudent Layperson is that the case mix or the immediacy of care requirement of emergency department visits is decreasing while the number of visits is increasing.^{15,16} More primary care is being delivered in the emergency room than ever before. Because emergency rooms are expensive to build, staff and maintain, allocating resources in this manner represents a potentially significant system inefficiency; that is, additional costs are incurred, but without additional benefit. The cost impact is about \$46 per privately insured person per year or about \$179 million in additional costs for employers and employees in Tennessee.¹⁷

4. Mothers Health Protection Act of 1996

In the mid-1990s, state governments began implementing legislation designed to require health insurers to pay for longer lengths of stay for maternity cases. In most instances, the mandates included the requirement for payment for two days for a vaginal delivery and four days for a cesarean-section at the discretion of the mother and provider. The effect was to limit the ability of managed care organizations to

¹⁵ Immediacy of care requirement refers to how necessary immediate health care is. Patients deemed emergent would have the most immediate health care needs and those deemed non-urgent would have the least immediate health care needs.

¹⁶ Case mix is the resource use intensity requirement for the type of patients in question. A high case mix means that the patient(s) is likely to be higher cost and is likely to be more seriously ill. A lower case mix means that the patient(s) is likely to be lower cost and less seriously ill.

¹⁷ Internal BlueCross BlueShield of Tennessee cost estimates.

aggressively manage the length of stays for obstetric cases. The theoretical advantage of this act was that mothers and babies would not be required to leave the hospital early to satisfy a cost management strategy. In 1995 and 1996, the Institute of Medicine's report on medical errors had not been released nor had the Centers for Disease Control and Prevention's study on hospital acquired infections showing just how hazardous hospital environments are.

There is no evidence that short-stay admissions resulted in any effect on newborn health status. Edmondson and others reported in 1997 that early discharge appeared to have little or no independent effect on the risk of rehospitalization.¹⁸ Kotagal and others studied the safety of early discharge of newborns in the Ohio Medicaid program and concluded that reductions in length of stay did not result in an increase in rehospitalizations.¹⁹ Madden et al reported in the *New England Journal of Medicine* that early postpartum discharge policies did not appear to have affected the health outcomes of newborns.²⁰ Mandl and others surveyed women who delivered and were insured by Harvard Pilgrim Health and found no differences in the sense of maternal competence, depressive symptoms, or satisfaction with care among women who participated in the reduced stay program and those that did not.²¹

Policy makers were unaware that there could be unintended consequences to the new policy of requiring payment for longer lengths of stay in the form of higher c-section rates, induction rates and neonatal mortality rates. The reality of this mandate was that costs rose for four reasons instead of just one: 1) higher lengths of stay for delivering mothers, 2) higher c-section rates, 3) higher complication rates, and 4) higher readmission rates.

Since mother-baby protection acts were implemented by most states at about the same time, both national and Tennessee data is helpful in appreciating the downstream effects.

¹⁸ Edmondson MB and others. Hospital readmission with feeding-related problems after early postpartum discharge of normal newborns. *JAMA*. 1997;278:299-303.

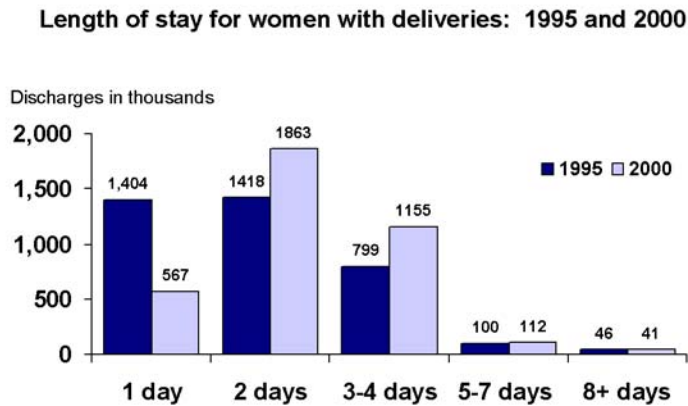
¹⁹ Kotagal UR and others. Safety of Early Discharge for Medicaid Newborns. *JAMA*. 1999;282:1150-1156.

²⁰ Madden JM and others. Effects Of A Law Against Early Postpartum Discharge on Newborn Follow-up, Adverse Events, and HMO Expenditures. *NEJM*. 2002;347:2031-2038.

²¹ Mandl KD and others. Maternal and infant health: effects of moderate reductions in postpartum length of stay. *Arch. Pediatr Adolesc Med* 1997;151:915-21.

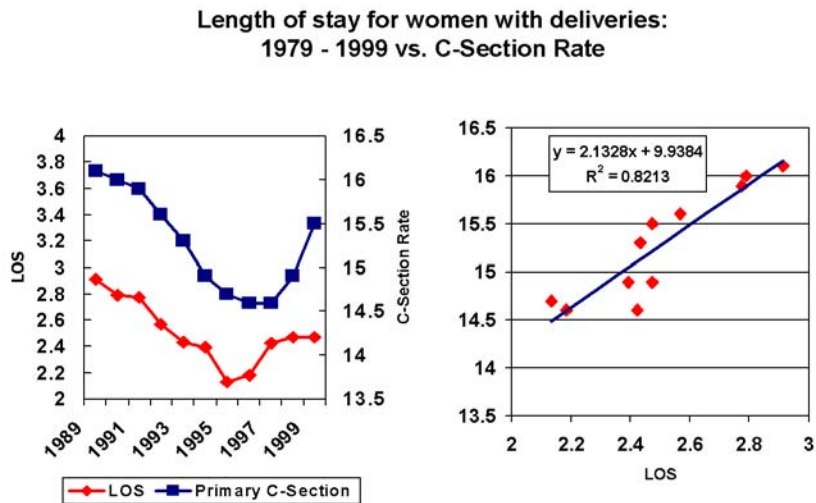
The expected effect of the mother-baby protection acts is shown in Figure 8. The inpatient hospital lengths of stay for delivering women shifted to longer lengths of stay as prescribed in the acts.

Figure 8
Length of Stay for Women with Deliveries: 1995 and 2000



Source: Lola Jean Kozak, Ph.D. *Analytic Issues (things you need to know about NHDS data)*, Centers for Disease Control, National Center for Health Statistics, 2002.

Figure 9
Length of Stay for Women with Deliveries: 1979 - 1999 vs. C-Section Rate

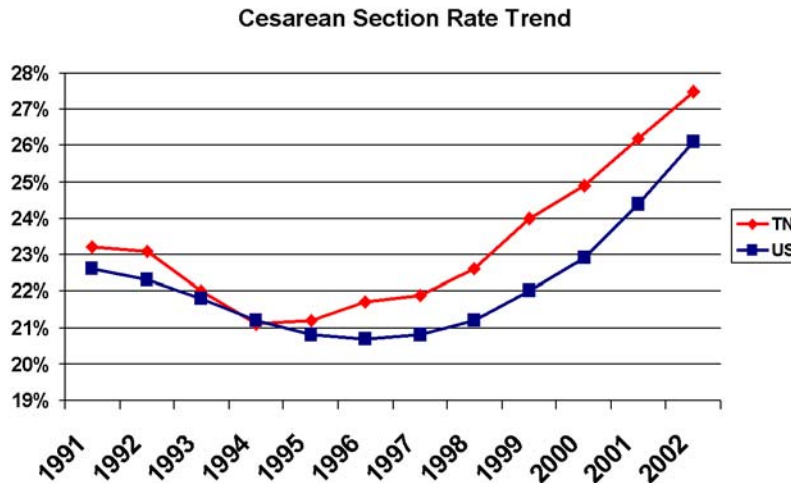


The left panel of Figure 9 shows the primary c-section rate in blue (use the right axis) and the average length of stay in red (use the left axis) for all deliveries nationally over time.²² It is easy to appreciate that the timing of the changes in

²² Primary c-section rate is the percentage of mothers whose first delivery is by cesarean section.

c-section and length of stay are associated. The right panel of Figure 9 shows the dependence of length of stay on c-section (the graph axes are rotated for convenience of display).

Figure 10



Source: National Center for Health Statistics

Figure 10 shows the c-section rate over time for Tennessee in red and the U.S. in blue; the beginning of the rise in the c-section rate is associated with the enactment of the mother-baby protection acts both in Tennessee and elsewhere. Why is there an association between the timing of the implementation of the mother baby-protection acts and the increase in the c-section rate? There are a number of possible reasons:

1. The increase in respect for maternal autonomy in the mode of delivery decision. It is likely that this is part of the reason for the increase. That is, since payment for c-section is now guaranteed by law if a mother is firm in her position that c-section be the mode of delivery for her child, it is acceptable.
2. Defensive medicine. With respect to childbirth, the question comes down to the medical need for early delivery. The newborn mortality rate for disorders of short gestation has increased from 100 per 100,000 live births to 115 per 100,000 live births from 1997 to 2002. The newborn mortality rate for disorders of long gestation remained at zero from 1997 through 2002.
3. The four days of a c-section delivery provide an economic incentive as opposed to the two days of a vaginal delivery.
4. Convenience. C-sections can be scheduled at a time when both the mother and health care providers know that the delivery will be completed.

Other reasons for higher c-section rates are likely, but none of them would be possible without a permissive mother-baby law. In fact, there are some indications that a higher c-section rate is not optimal. BlueCross BlueShield of Tennessee internal data shows that the complication rate for delivery by c-section is 29 percent while the complication rate for vaginal delivery is 18 percent.

The cost of the mother baby law is approximately \$0.49 per person per month.

In Summary...

Unintended Consequences Cost Us All

While not always bad, government intervention frequently has unintended consequences in the health care marketplace. Initiatives to push down costs in one area frequently result in a cost bubble somewhere else. This paper highlights several examples of the unintended consequences of government intervention. The total cost impact of the government mandates and interventions discussed in this paper for Tennesseans is \$37.82 for each privately insured person per month; a family of four incurs a cost of \$151 every month or \$1,815 every year due to government intervention in the health care marketplace alone. Government mandated benefits in health care are responsible for causing:

1. Approximately 10 percent of average per person health care costs in Tennessee,
2. 18 percent of the average health insurance premium, and
3. Over 30 percent of the increase in health care costs since 1995.²³

There are differences in the kinds of government interventions discussed in this paper. Reasonable societal actions do include providing appropriate access to health care when health care can contribute to improving health. However, the cost of health insurance is one of the barriers to access. Our goal in this paper has been to illustrate, using data, the degree to which those well-intended government policies have adversely impacted health insurance premiums in the private market. It is our belief that the problem of health care costs can only be solved by informed persons working together for a solution that is fair and equitable to all.

²³ Internal BlueCross BlueShield of Tennessee analysis.



801 Pine Street
Chattanooga, TN 37402

www.bcbst.com

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

* Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

This document has been classified as public information.