1 OFFICIAL TRANSCRIPT PROCEEDINGS

2 HEARINGS ON HEALTH CARE AND COMPETITION

3 LAW AND POLICY

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5 FEDERAL TRADE COMMISSION

6 June 25, 2003

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26 FEDERAL TRADE COMMISSION

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24 P R O C E E D I N G S
25 - - - - -
26 MS. MATHIAS: Why don't we go ahead and get
27 started. I do apologize for starting late but it does
28 appear that there are traffic issues outside. And we are

1 actually missing one of our panelists but I am certain he
2 will be here momentarily.
3 My name is Sarah Mathias and I would like to
4 welcome you to the FTC-DOJ Health Care Hearings on
5 Competition Law and Policy. This has been a series of
6 hearings which we started in February.
7 We will have another group of hearings tomorrow
8 talking about pharmaceuticals, formulary issues in the
9 morning and then in the afternoon we will be looking at
10 prospective guidance from the FTC, DOJ and other entities.
11 This afternoon, however, we are going to consider
12 issues on mandated health insurance benefits. I hope
13 that's why you're here. We are interested in learning and
14 this whole series of hearings is to help FTC and DOJ learn
15 what's going on more in the health care arena in various
16 issues. So if you go to our Web site, www.ftc.gov or the
17 DOJ, www.usdoj.gov you will see the various agendas that
18 we've been working with throughout this year so far
19 starting in February.
20 But again, today we are looking at mandated
21 health insurance benefits. And the fact that various
22 states and the federal government do consider quite often
23 mandating services and pharmaceuticals from time to time
24 that affect how our benefits are provided to us can affect
25 competition.
26 We're interested in learning what the effects of
27 those mandates are, to what extent do they increase health
28 care costs and coverage. What are the benefits of some of

1 the mandates that have been put forward up to this point
2 and could also be put forward in the future.
3 We are all joined by a panel of distinguished
4 panelists today. I'm very excited with the group that we
5 have. We do short introductions here because we like to
6 spend more time delving into the issues rather than reading
7 everyone's outstanding resumes. So we actually do have a
8 bio handout in the hallway out in front of me where you can
9 pick up the bios and get everyone's extensive résumé.
10 But I will introduce them briefly and start on my
11 right hand side, your left. And this will be the order of
12 presentation as well. Dan Gitterman, to my right, far
13 right, is an Assistant Professor of Public Policy and
14 Political Science at the University of North Carolina at
15 Chapel Hill. We will be joined soon by Tom Miller who is
16 at the Cato Institute and he's Director of Health Policy
17 Studies. Rob Ibson, to my immediate right is the Vice
18 President for Government Affairs for the National Mental
19 Health Association.
20 To my immediate left is Stephanie Kanwit who is
21 sitting in today. We originally were scheduled to have
22 Karen Ignagni who could not make it. But fortunately,
23 Stephanie was able to come. So we're very pleased with
24 that and Stephanie is the General Counsel and Senior Vice
25 President of the American Association of Health Plans.
26 Further on down is Rachel Laser. She is Senior
27 Counsel in the Health and Reproduction Rights Group at the
28 National Women's Law Center here in Washington, D.C.

1 Further down on my left is Anthony Knettel. He is Vice
2 President of Health Affairs at the ERISA Industry
3 Committee.
4 And finally, is David Hyman at my far left. He
5 is a Professor at University of Maryland and he is also
6 Special Counsel here at the FTC. And I have the great
7 pleasure of working with David on just about a daily basis.
8 So I'm very pleased I can harass him now on a panel.
9 MR. HYMAN: But only for the next two hours and 47
10 minutes.
11 MS. MATHIAS: Correct.
12 MR. GITTERMAN: I want to know why he's to your
13 left and I'm to your right.
14 MS. MATHIAS: I'm not even going to try to answer
15 that. Anyway, we do have Cecile Kohrs who is sitting
16 directly in front of us. She will be keeping time for
17 everyone. She has nice little time cards so that you can
18 tailor your remarks so that we can keep the ball moving
19 forward. And we do request that everybody respect the
20 property rights of others so that we have time for the
21 question and answer later.
22 Rules of procedure. What we will do is we'll
23 have the presentation period, some people have PowerPoints.
24 Our presenters and panelists are welcome to either go up to
25 the podium or stay at their seats, whatever is most
26 comfortable for them.
27 When we get into the -- we will take a break at
28 one point during the presentations just so that everybody

1 can get up and move around and come back refreshed. We
2 will move directly into a moderated roundtable and my
3 questions are usually general questions directed at
4 everybody.

5 And the way that it helps me to know when a
6 panelist wants to answer a question is if you just tilt
7 your name tent sideways that way I'll know to call on you
8 and I don't miss you. And with that, Dan, I'll get you
9 started and start your presentation for you.

10 MR. GITTERMAN: Okay. Thank you very, very much.
11 Today I want to talk to you about "Applying the Brakes on
12 Mandated Benefits," question mark. I got into the topic of
13 mandated benefits through the topic of the minimum wage,
14 something that economists have very clear opinions on and
15 politics gives us a very different result.

16 So while I teach in a policy department my
17 training is political science and these comments should
18 have that spin. And I apologize that my PowerPoint slides
19 have a lot of text. I have an 18-month-old at home who's
20 keeping me up most of the night and so there was probably a
21 little bit more cutting and pasting than thoughtful bullet
22 points that I should have allowed.

23 Just some brief background. Everybody knows that
24 the majority of health insurance regulation is at the state
25 rather than the federal level although some standardization
26 insures operating numerous states subject to separate and
27 nonuniform requirements.

28 The formal definition of mandated benefits,

1 provisions that regulate or specify the particular benefit
2 content of health insurance policies. Why policymakers
3 like it? Well, they tend to like mandates and mandated
4 benefits because they are able to deliver benefits to
5 constituents with no public expenditures.
6 But as political economist Uwe Reinhardt warns us
7 just because of physical flows triggered by mandated
8 benefit do not flow directly through the public budget
9 doesn't detract from the measure's status of a bona fide
10 tax. Someone will bear the cost.
11 For many policymakers these mandates allow them
12 to find a creative way both to finance and expand benefit
13 coverage. Academic proponents, and this is from the
14 literature of market failure, suggest that insurance
15 markets may fail to provide the appropriate level of
16 benefits so that requiring inclusion in all plans can be
17 welfare increasing.
18 Opponents suggest that the inclusion of an
19 expensive benefit increases the premium cost to the
20 employer and raises the probability that some employers may
21 opt to offer no insurance, health insurance, at all,
22 sometimes referred to as why mandate Cadillac coverage when
23 purchasers just want a Chevy.
24 Some of the comments today that I want to address
25 is to sort of look beyond just the economic justifications
26 and to understand some of the political motivations for why
27 we have the number of mandated benefits that we do.
28 And in the handout that was made available when

1 you came in there are three tables. The first table has a
2 list of all the states and the number of mandated benefits
3 they have.
4 The range is Maryland, David's great state, which
5 has 52 mandated benefits and that other side of the range
6 is Idaho with ten. And for more information on that I will
7 refer you to the handout.
8 For political scientists economic explanations of
9 market failure or some political economist's explanations
10 that mandated benefits are efforts, are captured by
11 provider groups to get their benefit in.
12 To understand a little bit about the politics and
13 what motivates state legislators to mandate benefits is
14 they are able to, through regulation, through statutory
15 regulation, able to deliver concentrated benefits to
16 providers or suppliers of goods and services. So every
17 provider group wants to be included as a mandated benefit.
18 The benefits sometimes accrue to a small group
19 and the costs are usually spread across a broad number of
20 workers, consumers and purchasers. And exactly who bears
21 the cost, I think, is somewhat of an open question.
22 Policymakers prefer this financing scheme because
23 the incidence is confused. It's hard for any voter,
24 consumer or worker to know for sure how he or she is being
25 affected by what ends up being a confusing tax. This helps
26 policymakers foster the illusion that benefits can be
27 provided and no one bears the cost.
28 Another important point that I refer to former

1 Treasury Secretary Larry Summers about is a certain
2 unredistributed character of mandated benefits, the fact
3 that workers usually pay directly for the benefits they
4 receive, a point I'll get back to in my concluding remarks.
5 One of the trends that I want to talk about and
6 it is certainly a solution Dave and I talked about at
7 lunch, is not a perfect solution and has plenty of
8 problems, but in states like Maryland and other states
9 which began to accumulate a very high number of mandated
10 benefits the motivations for policymakers being clear to
11 mandate more and more benefits was some self-enforcing
12 mechanism to stop them, stop legislators from mandating
13 again. One trend we're seeing is increasing concern among
14 policymakers about costs of coverage in health care, higher
15 premiums, more uninsured Americans.
16 Part of the response has been for both Congress
17 and various state legislatures around the country to
18 examine the cost and benefits of mandates and to require a
19 social and financial impact of those mandated benefits.
20 The trend we have seen is something called
21 mandate review statutes which establish a formal
22 legislative process for the proposal, review and
23 determination of mandated benefit necessity. And the
24 definition of necessity and how you weigh the costs and
25 benefits of the social versus the fiscal impacts, et
26 cetera, really vary quite widely across the states.
27 There's also a great deal of variation in these
28 state mechanisms in terms of the credibility and the

1 independence of the review as well as the objectivity and
2 the quality of the regulatory impact analyses.
3 The review processes also vary a great deal in
4 terms of their enforcement rules, that is, whether a review
5 is actually mandated, whether it’s up to the discretion of
6 a particular legislative committee and whether there are
7 statutory thresholds that need to be met. For example, in
8 Maryland I believe it was 14 percent, if the mandates were
9 more than 14 percent of the premium cost that would require
10 an immediate review.
11 Some of the trends that I just want to speak to
12 briefly and the three mandates that we saw coming out of
13 the Congress, the only three mandated benefits, i.e.,
14 mental health parity, HIPAA, and the maternity stays all
15 went through the Unfunded Mandate Reform Act where the CBO
16 Health and Human Resources division provided a formal
17 statement about the costs of the mandate, these particular
18 mandates, on the private sector.
19 The CBO reports, and it shouldn’t surprise you,
20 that they believe it’s given members of Congress a whole
21 lot more information about mandates and their costs. We
22 all know that policymakers don’t always listen to good
23 information and there's a wonderful article called “Why
24 Congress Doesn’t Listen to Economists,” which is something
25 else that we should say, that good analysis doesn't always
26 translate into policy outcomes.
27 I wanted to give you a sense of the different
28 types of review models we are seeing across the states.

1 One model is the standing independent commission.
2 Maryland and Pennsylvania are examples of states that have
3 done that where the mandates are referred over to an
4 independent commission to make recommendations to the
5 legislature. These tend to be costly. Seven states are
6 currently doing it. Maryland has basically contracted out
7 with Mercer Consulting to do those analyses for them
8 yearly.
9 The second model is basically just charging an
10 administrative agency, usually the Department of Insurance,
11 to evaluate the mandate and make recommendations to the
12 legislature. In many states that have tried this route; it
13 shouldn't surprise you that it has gotten somewhat
14 politicized based on who was in control of the executive
15 branch. Nine states use the administrative agency
16 approach.
17 The third model is basically to have legislative
18 staff analyze the impact of mandates before any legislative
19 consideration. One of the ways that I got into looking at
20 mandated benefits and their reviews was I was approached by
21 the California Health Care Foundation who was actually
22 approached by the Senate Insurance Committee to actually
23 pay for the cost of reviewing a number of mandated benefits
24 that were coming through the California legislature.
25 And the foundation really needed to think long
26 and hard about whether they wanted to provide the money to
27 play that analytical role or contract out for that type of
28 analysis. But there was a concern that the staffers in the

1 California state legislature didn’t have the substantive or
2 analytical expertise to make those type of judgments. Nine
3 states currently use the legislative staff option to
4 mandate these, to review these mandates.
5 The final model is that the proponents themselves
6 submit information and in these states what you see are the
7 various proponents of a particular mandated benefit trying
8 to make their best case of why it should be included as
9 part of health insurance coverage. Six states currently
10 are using that. This model doesn't seem all that much
11 different than advocates and opponents submitting testimony
12 to a committee basically really is just no different than
13 that despite them passing formal legislation to require
14 that.
15 On the question of whether these mandated reviews
16 have improved policy outcomes, and policy outcomes being
17 whatever you think should be the right policy on mandated
18 benefits, what we see is actually wide variation and
19 credibility in the quality of the impact analysis which
20 obviously has a great deal of implications for their
21 objectivity and usefulness in the legislative decision-
22 making process.
23 Few would obviously argue against improving the
24 quality of information available to state-level
25 policymakers but these review statutes have really faced
26 mixed success. Getting them started is very difficult
27 because there's a standard politics for and against any
28 type of cost-benefit review depending on your perspective

1 on this form of regulation.
2 A great deal of trouble with a lack of
3 independence of the review entity. Sometimes they take the
4 form of full commissions where the governor and each House
5 and Senate get to put forward appointees.
6 The lack of internal legislative or executive
7 staff, analytical capacity, limited data to make judgments
8 about the potential costs, sporadic funding of the actual
9 evaluation process and also very tight legislative
10 timetables. Sometimes, these mandated benefits are added
11 at the end of the session, sometimes amended to another
12 piece of legislation and there's actually no time for a
13 formal analysis of any kind.
14 What are some of the types of questions if we are
15 actually going to introduce an analytical capacity into
16 what is a pretty political process? And I do this in the
17 form of a David Letterman top ten.
18 One is the issue of structure, who should oversee
19 the review process. If it's in the form of an independent
20 commission how can the independence and credibility be
21 maximized.
22 Two is procedure. Is the review mandatory?
23 Should legislators create a commitment mechanism which
24 forces them to have this subject to review or should it be
25 any proposal, should any committee actually have complete
26 discretion of whether to refer this or not to refer this
27 for review.
28 Should the entity review existing data or

1 contract for new studies. Should existing staff or
2 external consultants do the analysis and how can the
3 credibility of consultants or external analytical sources
4 be maximized.
5 One of the things that you have seen in the 1996
6 mental health parity debate is the incredible wide range of
7 estimates from each of these different consulting groups.
8 I think the costs were somewhere between zero and 8
9 percent. And even sort of relying on expert opinion has
10 given you a wide range of estimates. What types of costs
11 and benefits and social factors should be included in an
12 impact analysis?
13 Number five, how can we assure full disclosure of
14 the data methods and assumptions? How should the various
15 stakeholders submit their opinions on the legislation?
16 How can assessment or reform of the review process be built
17 into a structure?
18 Number six, how can the timeliness of analysis
19 during active sessions be assured? Recently, Bill Roper
20 who's the dean of the public health school and I talked to
21 some North Carolina legislators and basically tried to
22 offer some of the analytical capacity of the University of
23 North Carolina at Chapel Hill which they laughed at because
24 academics run on yearly schedules and legislatures need to
25 know by tonight. And so we left somewhat disappointed
26 about sort of the role that academics or a university
27 research apparatus might play.
28 The big issue here is also the funding.

1 Evaluations are expensive and some states have done it in
2 the form of legislative appropriation in an era of budget
3 constraints at the state level. Many of those
4 appropriations have dried up.
5 Some states, California, Maryland have a
6 regulatory assessment fee where, I believe, in Maryland
7 it's one-third from the clinicians and two-thirds from the
8 payers towards the evaluation. And California, I believe,
9 it's the Association of Health Plans and some of the other
10 groups that have agreed to do it.
11 The other obvious place is when you have the type
12 of funding that's available from the Robert Wood Johnsons
13 and the California Health Care Foundations, whether they're
14 willing to step up and play a role here.
15 One of the things that California Health Care
16 Foundation has done is establish a partnership with the
17 National Conference of State Legislatures to try to play
18 that role of delivering quality information.
19 Another example of a potential public-private
20 partnership that has been pointed out to me several times
21 is something called the Health Effects Institute, which is
22 a joint U.S.-UPA industry collaboration to look at some of
23 the impacts of the health effects of pollutants, and people
24 are looking for models about those types of partnerships.
25 This is one that is somewhat related.
26 How will the real-life economics drive the future
27 politics? And there are a variety of claims on both sides
28 of this debate about mandated benefits, one of the most

1 powerful being that state-mandated benefits by raising the
2 minimum cost of providing any coverage make it impossible
3 for smaller firms which would have the desire to offer
4 minimal health insurance at a low cost.
5 That claim from the economics literature is
6 clearly driving the move to bare bones policies and other
7 types of things that exempt small employers from mandated
8 benefit requirements.
9 Two is this claim from the economic literature
10 that the employee will end up bearing the cost in some form
11 or another. And the two options either are in less take-
12 home wages or that they are paying more and more cost of
13 the premium.
14 And these claims that come from the economics
15 literature with empirical data to show them, I think,
16 haven't sort of made their way out into the populace. When
17 you have a financing mechanism that is so complex how do
18 you have everyday consumers, workers, patients understand
19 exactly what these trade-offs are.
20 Indeed, if at some point they begin to feel the
21 pain that mandated benefits are or aren't posing in terms
22 of cost, whether we're likely to see some type of backlash.
23 But I think in the political world these causal claims
24 about who bears the cost are still very much up for grabs.
25 And as you will see from some of the other
26 panelists, there are very persuasive arguments on both
27 sides and very persuasive evidence on both sides. But it's
28 yet to be, I think, viewed by the broader public as a

1 plausible, credible causal story which will sort of
2 interject policy change.
3 Perhaps my final comment is sort of more of a
4 hope than anything else, and that is how can we get beyond
5 the marketeers and the mandaters, which is how I see the
6 two camps divided right now. And maybe it makes me someone
7 with no opinion or a pragmatist, but some final points.
8 One is how did we get here? And if you look at
9 the variety of the minimum benefit legislation from the
10 early '70s a lot of it had to do with adverse selection and
11 real market failure here and ways to intervene in the
12 insurance market. I think it's important not to lose sight
13 of what some of these minimum benefit and mandated benefits
14 were set out to do.
15 Two is let's be careful not to discredit any
16 state regulatory role. I don't think that is what we're
17 doing. Mandated benefits are on the table but let's not
18 forget the important role that state regulators play in
19 issues of financial solvency and market conduct, et cetera.
20 Finally, whether this cycle of reform and those
21 who take the long view of health politics every ten years
22 are so we are sort of revisiting a number of the debates
23 about higher premiums and more uninsured as we did in the
24 early '90s. And I think it's important as we face these
25 problems yet again that we don't recreate the problems of
26 an earlier era in our rush to judgment.
27 Finally, as is appropriate for any gathering at
28 the FTC is that for competition truly to work there

1 obviously needs to be a reasonable degree of
2 standardization of benefits and of the rules across
3 competitors. And obviously, much of our challenge is to
4 find out what those rules are if we are to capture any of
5 the benefits from competition in markets. Thank you.
6 (Applause.)
7 MS. MATHIAS: Thank you. Ralph is next since we
8 don't have Tom.
9 MR. IBSON: Good afternoon. I appear before you
10 this afternoon on behalf of the National Mental Health
11 Association. National Mental Health Association is an
12 organization who's symbol is a bell. It's a bell cast
13 quite literally from the chains and shackles that held
14 people with mental illnesses in state institutions earlier
15 in this country.
16 I won't offer a history of the cruel treatment of
17 people with mental illness over the years but suffice it to
18 say that that history is marked by ignorance, loathing and
19 fear. The shackles and chains are gone but the ignorance
20 and loathing is not.
21 A landmark report by the Surgeon General in 1999
22 offered the nation a new vision of mental illness. It was
23 a vision that explained the intertwined relationship
24 between mental health and general health, between mental
25 illness and other illnesses.
26 It was a report that underscored that mental
27 illnesses are readily diagnosable, treatable, that those
28 treatments are as efficacious generally as treatments for

1 other illnesses and in some instances more efficacious.
2 The Surgeon General bemoaned the fact that even
3 with great scientific gains there remain vast disparities
4 in access to services and formidable financial barriers
5 that blocked mental health care from people regardless of
6 whether they had health insurance or didn’t.
7 Mental illness is the second leading cause of
8 disability and premature death in this country. And it’s
9 staggering to consider the findings of President Bush's New
10 Freedom Mental Health Commission who’s interim report in
11 October noted that one of every two people in this country
12 who need mental health treatment do not receive it.
13 The commission noted that those statistics are
14 even worse for minorities and ethnic groups and the quality
15 of care they receive is even poorer.
16 We note at the same time that some 30,000 lives
17 are lost each year to suicide and some 650,000 people visit
18 emergency rooms as a result of failed suicide attempts. In
19 90 percent of those cases mental disorders were implicated.
20 Although the Surgeon General and other scientists
21 have made it clear that mental illness and so-called
22 physical illnesses are not really different health
23 insurance routinely treats them very differently. Some
24 employers outright do not offer mental health benefits. The
25 more common pattern though is for policies to single out
26 mental health disorders and impose restrictive limits on
27 care. Typically those limits are in the form of limits on
28 the number of outpatient visits, limits on the number of

1 covered days of hospital care and far stricter, far more
2 onerous cost sharing burdens.
3 In our view, that is, the National Mental Health
4 Association, we contend that discrimination against people
5 with or at risk of mental disorders is arbitrary and
6 capricious, imposes huge costs on society and taxpayers and
7 should be impermissible as a matter of federal law.
8 Many states require coverage of mental illness
9 but permit insurers to limit mental health benefits or to
10 impose cost sharing and other requirements on the
11 beneficiary that don't apply to coverage of other
12 illnesses.
13 The majority of states have enacted mental health
14 parity laws, though they vary in scope and reach. The
15 enactment of the Mental Health Parity Act of 1996, which
16 Dan alluded to, had a marked effect on state activity
17 around enactment of parity laws. In a number of states it
18 actually expanded those laws since 1996. None have
19 contracted them.
20 It's important to note that parity legislation
21 now pending in Congress is not a benefits mandate; it
22 simply attempts to close the loopholes in that 1996 law,
23 loopholes that have been exploited by employers and
24 insurers.
25 I trust we will hear discussion today about the
26 costs of parity legislation. The Congressional Budget
27 Office, in a projection in 2001, which was reiterated in a
28 number of follow-up memos is to the effect that the

1 anticipated cost of enacting the then Domenici-Wellstone
2 parity law or the Wellstone parity legislation now pending,
3 which is substantively identical, would on average involve
4 premium increases of less than 1 percent.
5 Other studies done in 2001 and 2000,
6 PricewaterhouseCoopers in particular, as well as the
7 National Advisory Mental Health Council, essentially affirm
8 those findings, those projections. The experience of the
9 Federal Employee Health Benefits Plan, which adopted mental
10 health and substance abuse parity effective in January
11 2001, also bears out the relatively minimal cost increases
12 associated with mental health parity.
13 The experience of the states, likewise, mirrors
14 the projections offered regarding expansions of the federal
15 law. PricewaterhouseCooper, for example, in 2000, stated
16 that there are no examples where mental health parity has
17 been enacted in a state and costs have dramatically
18 increased and no examples where a measurable increase in
19 the uninsured has been detected.
20 Those who question the costs associated with
21 mental health parity look at cost in a very narrow way,
22 ignoring offsetting savings that come from improved access
23 to mental health care. And CBO is guilty of the same.
24 In that regard it's critical to consider the cost
25 of not providing mental health benefits. Consider the
26 recent NIMH study, for example, released this month. It
27 appeared on the front page of the New York Times, I think,
28 on June 18th, which found that depression alone costs

1 employers $44 billion in lost productivity each year.
2 A study cited in the Surgeon General's report of
3 1999 is to the effect that the indirect cost of mental
4 illness imposes a nearly $79 billion cost on the U.S.
5 economy and that is in 1990 dollars.
6 The Surgeon General observed that even that $79
7 billion figure does not take into account the pain and
8 suffering experienced by the individual and his family.
9 The persistent injury regarding the cost of
10 mental health parity ignores the profound benefits that
11 flow from it. What are those benefits? Well, reduced
12 employer costs, as I indicated, in increased productivity,
13 less sick leave, et cetera.
14 Studies have shown that providing workers with
15 mental health benefits substantially reduces other medical
16 costs as well as yielding reduced absenteeism, increased
17 productivity and lower disability claims.
18 Studies have also found that for each dollar
19 invested in mental health treatment there were $4 to $7
20 cost savings in crime and criminal justice costs.
21 Unquestionably, the benefits to the families and the
22 individuals involved are immeasurable.
23 One often reads opponents of parity and finds an
24 argument made that this is a benefit that employers should
25 undertake voluntarily. An interesting response to that
26 premise was offered by one of a small number of employers
27 who have offered mental health parity, who testified last
28 year before the Energy and Commerce Committee. That

1 individual, Jim Hackett, the CEO of Ocean Energy
2 Incorporated, a Houston firm, stated, I think this is
3 useful and helpful to hear Hackett's perspective, so I'll
4 quote him, "While I personally believe as a business leader
5 that providing mental health benefits on par with physical
6 health benefits makes not only economic but moral sense
7 there is a need for governmental intervention to end
8 insurance discrimination against mental illness."
9 "Too few businesses have really examined mental
10 health parity, typically because of misunderstanding
11 regarding mental illness and the erroneous belief that
12 parity means additional cost, and misperceptions about the
13 efficacy of treatment."
14 "I was one of those business leaders until my
15 personal circumstances made me see what was going on in our
16 own company. Today more than ever managers of every
17 business have the opportunity to support their employees
18 while at the same time reducing the cost to their companies
19 of mental health-related productivity costs."
20 Hackett went on to speak further about the issue
21 of cost indicating that in 2002 when his company
22 voluntarily established parity they took the step along
23 with other Houston companies, namely Weingarten Realty
24 Investors and the Houston Chronicle. There has since been
25 an additional corporation in Houston who took that step.
26 Of the three, he says, each of us estimated that
27 any increase in cost due to parity will be minor and more
28 than offset by avoided cost of lost employee productivity.

1 It is somewhat troublesome to discuss this issue
2 because it is often an issue discussed in abstraction. And
3 it’s an issue that pits fairness on the one hand perhaps
4 with costs on the other. And we operate at a level that
5 doesn't really take into account the impact on the
6 individual and the family.
7 And with your indulgence, I’d like to just close
8 by offering you just a few capsules of the many, many
9 people who have written to our organization attesting to
10 the importance of parity to them and the despair they
11 experience with the insurance benefits or lack of benefits
12 they had met.
13 I’ll read a few lines from Dottie, a woman who
14 wrote to us that her insurance has both yearly and lifetime
15 limits on mental health care. Her employer was self-
16 insured and thus does not have to follow the state’s parity
17 law.
18 She reported that she's $30,000 in debt due to an
19 episode of hospital care for severe clinical depression
20 that exceeded the yearly insurance limit. But she also has
21 a lifetime, lifetime outpatient cap and will reach it soon.
22 She said, quote, without the assistance from my doctors,
23 therapists, I am suicidal. While the yearly limit is hard
24 enough to deal with the lifetime cap, to me, is the same as
25 a death sentence, close quote.
26 A gentleman from Illinois named Tom who wrote,
27 quote, my wonderful 16-year-old son, Mark, who inherited my
28 manic-depressive genes is not here anymore. Six years ago

1 he came from school early on Valentine's Day and hung
2 himself in his bedroom closet. Several months before his
3 suicide the insurance we had stopped coverage of mental
4 health benefits. Mark died of bipolar disorder complicated
5 by inadequate health insurance coverage.
6 Finally, from Ann in Oregon. Ann writes, quote,
7 my husband's insurance has always been more than adequate.
8 Two years ago my son had a head injury. He got the care of
9 the best pediatric neurologist in the state's best trauma
10 unit. Everything was covered by insurance. Shortly after
11 that he started exhibiting psychotic symptoms and now more
12 than a year later has been diagnosed with bipolar disorder.
13 After a trying six months of testing and visits
14 we were told our maximum benefits had been used up and
15 insurance would not pay for anything for 18 months. We
16 were shocked that doctor-provided care could be denied just
17 because it is a mental illness.
18 We have had to limit our son's access to doctor
19 visits and just hope the medication works to avoid another
20 breakdown. We pay out of pocket for each visit, close
21 quote. Thank you very much.
22 (Applause.)
23 MS. MATHIAS: Thank you. Stephanie.
24 MS. KANWIT: Thanks so much, Sarah. I appreciate
25 it. Is it up? There we go. Just being too quick here.
26 I'm Stephanie Kanwit not Karen Ignagni. She sends her
27 apologies. She's up on the Hill dealing with Medicare,
28 prescription drug bills today.

1 I want to talk a little bit about the topic here
2 today and the title of this presentation is "Toward a More
3 Accountable Regulatory System." And our first slide here
4 talks about context. Where are we right now? I want to
5 add to Professor Gitterman's thoughtful presentation.
6 Basically, this slide talks about the fact that
7 our whole health care system is at a very critical
8 juncture. You have heard about some of it already,
9 increasingly unaffordable, inaccessible.
10 The second bullet talks about only a small amount
11 of care provided to patients is evidence-based by which we
12 mean that there is technological assessment that it
13 actually works, that it's safe and efficacious. And by the
14 way the RAND Corporation today, later today, is coming out
15 with a study that talks about exactly that. We have to
16 address that.
17 Third is the issue of underuse, overuse and
18 misuse of health care services which place patients at
19 risk. The fourth talks about the regulatory system is
20 transactional and not performance-oriented. And we talk
21 about this concept in the underlying bullet of good
22 intentions gone awry.
23 In other words, mandates, what we're talking
24 about today, may have been enacted on all levels with the
25 very best of intentions to provide consumers care that
26 legislators, regulators thought they should be provided
27 with, but without systematic analysis the unintended
28 consequences may, in fact, overwhelm the system.

1 And finally, we need a change in direction and we
2 need a change in the areas of what I call the three A’s,
3 affordability, access and accountability.
4 One of the issues that we deal with all the time
5 at the American Association of Health Plans is how mandates
6 affect these three A’s, the affordability, accountability
7 and accessibility. Clearly, clearly mandates make health
8 care less affordable.
9 The question is which ones, how, when? Which are
10 the mandates that do a little and cost a lot? Which are
11 the ones that actually work? Which are the ones that
12 provide things that are helpful and which harmful to make
13 it in a very simple way.
14 In fact, as you heard from Professor Gitterman,
15 mandates often are enacted without accountability, based on
16 anecdote not evidence, with no rigorous analysis of costs
17 and benefits and no look back. That’s a real problem. No
18 look back at the cost of the mandate.
19 You may hear people in state legislatures and
20 Congress talk about the fact that such and such a benefit
21 will only add per month to each member's medical bill the
22 cost of a Big Mac hamburger. But that really isn't the
23 test. We need to look at a cumulative cost test. Each
24 mandate added on top of each other. And some of our slides
25 talk about those quite specifically.
26 In fact, the bottom line for this slide is really
27 that we need to be careful to ensure that in pursuit of the
28 perfect health care system where everybody gets everything

1 they need for specific individuals that we don't destroy
2 the very good health care system we have in place right now
3 because of the issues of affordability, accountability and
4 access.
5 This is probably the key slide in terms of what I
6 believe the Federal Trade Commission and the Department of
7 Justice want to talk about today or at least start some
8 dialogue. The issues of when mandates can be
9 anticompetitive. Obviously, they may not be but in some
10 cases they are.
11 Five points that we have listed here, they drive
12 up costs for employers and consumers. They may end up
13 restricting consumer choice, not increasing but
14 restricting.
15 Number three, they may discourage competition
16 among providers. I'm going to be talking a little bit
17 about mandates, it's a little bit broader than Professor
18 Gitterman's in terms of provider mandates, not just benefit
19 mandates, which is why that third bullet there.
20 And, in fact, some of these mandates create a
21 presumed right of providers meaning hospitals and doctors
22 to contract. They may hinder non-price competition, in
23 other words, create a benefit design. And last but not
24 least, very important, they may stifle innovative medical
25 advances in treatment and diagnosis because they freeze
26 current practice.
27 This you've heard again from Professor Gitterman
28 -- volume of mandate continues to rise. We have a

1 patchwork of state and federal mandates affecting all
2 aspects. This figure just boggles my mind, the 25-fold
3 that mandates have grown from 1976 to 1996. And the
4 hundreds of new mandates that continue to be proposed. The
5 federal patients' bill of rights legislation which, as many
6 of you know, has been debated in Congress for many years
7 now would have proposed 84 new mandates. So mandates can
8 be federal as well as state.
9 These are just a bar chart of the same concept of
10 how mandates have grown up to 2002 in terms of the number
11 of mandated health benefits out there. So this is a
12 graphic illustration.
13 Further to my point that mandates can be federal
14 and not just state, I would add to Professor Gitterman's
15 list some of the mandates that are contained in HIPAA which
16 as many of you know the revolutionary Health Insurance
17 Portability and Accountability Act of 1996. It was
18 revolutionary because it was the first time that the
19 federal government, the Congress, actually put mandates in
20 health insurance benefits.
21 And remember, HIPAA applies not just to insured
22 plans which is what the states are regulating. It applies
23 to self-insured plans and it applies to individual health
24 insurance. So it's everybody. Everybody is covered by the
25 HIPAA mandates. And for those of you who know HIPAA there
26 were issues in there related to many, many issues of health
27 care, portability, accountability, privacy issues, time
28 frames, a nondiscrimination provision that says you can't

1 discriminate against anyone based on health status, health
2 status-related factors including genetic information and
3 claims history. So HIPAA really was revolutionary.
4 And the Department of Labor claims rules, my
5 second bullet, very, very extensive regulation as many of
6 you know, by the federal Department of Labor. And recently
7 they have promulgated new claims rules that provide
8 specific time frames for claims and appeals, expanded what
9 they call SPDs, Summary Plan Description Disclosure, et
10 cetera. So really specific.
11 Then, of course, the issue of mental health
12 parity which we've been discussing, the maternity length of
13 stay in the Newborn and Mothers Health Protection Act and
14 the post-mastectomy reconstructive surgery in the Women's
15 Health and Cancer Rights Act. These are the federal
16 mandates and, as I mentioned, across the board
17 applicability.
18 Now, state mandates, we have been discussing
19 benefit mandates but often people think of mandates as just
20 benefit mandates, in other words, my right to have my
21 insurer pay for autologous bone marrow or in vitro
22 fertilization or something else.
23 I wanted to make this a little bit broader and
24 talk about process mandates, for example, the one I just
25 described: the 48-hour minimum stay following child birth
26 or formulary requirements; what you have to do to get
27 drugs; when you get drugs; what you have to do to appeal.
28 If you have a three-tier formulary in your health insurance

1 or health benefit plan how you get third-tier drug, what
2 kind of co-pays you have to pay. Many of those are
3 prescribed as well.
4 And last but not least, one of my favorite
5 categories which is the provider mandates. In other words,
6 first mandated coverage for select classes of providers,
7 massage therapists, counselors, and naturopaths in some
8 states.
9 And last but not least, contracting mandates
10 which truly may have anticompetitive effects in given
11 circumstances. In other words, any willing provider laws,
12 prompt payment laws, collective bargaining laws which the
13 Federal Trade Commission has been quite out front in
14 opposing state laws that allow providers to collectively
15 bargain, allegedly to counteract the power of insurance
16 companies, and mandated definitions of medical necessity.
17 All of those are mandates that have been inscribed in law
18 at the behest of provider groups, hospitals and doctor
19 groups.
20 Patchwork system. This is a serious, serious
21 problem the proliferation of mandates creating a patchwork
22 system. We do not have, in a nutshell, a rational,
23 consistent and cohesive regulatory system. We have, for
24 example, and this is just a 20,000-foot view here,
25 inconsistent state mandates.
26 One example, 42 different standards for
27 independent medical review. Our health plans love
28 independent medical review. We support it. It’s cost

1 effective. It’s efficient. It gets the person the benefit
2 if they’re entitled to it under the contract quickly but
3 when a health plan has to comply with 42 different state
4 mandates, has to figure out to comply cost effectively, the
5 administrative costs and the hassle involved in that is
6 really a serious problem.
7 Also a serious problem, no state, no state on
8 independent review uses a standard based on the best
9 available medical and scientific evidence. This goes back
10 to the point I made on the initial part which is that we in
11 the United States do not use a system of technical
12 assessment to see what is safe and to see what’s effective.
13 And then on top of all the different state
14 mandates you have the federal mandates overlapping and
15 conflicting in many cases. My favorite example was the
16 HIPAA privacy rules. I know health plans who have spent
17 literally millions and millions of dollars trying to comply
18 with those rules because the rules allow more stringent
19 state laws to apply so they have to figure out in each
20 given case which law should apply, which law might apply,
21 et cetera.
22 It’s a very complicated procedure which I won’t
23 go into here but it is a very -- I would venture to say it
24 has cost the American health care system billions, billions
25 to comply with HIPAA privacy rules which are good laws, a
26 good concept in and of itself.
27 Now, Sarah, if I hit this -- oh, wow. I’m
28 impressed. I simply had to show you this today and Sarah

1 promised me it would come up on the screen. I know you
2 can't read it. What it is is a really nice color chart.
3 One of our crackerjack policy analysts at AAHP did this at
4 our behest about a year ago and what it is is it talks
5 about the complexity of just privacy laws.
6 And she took the State of Virginia and did in a
7 chart what the laws of the State of the Virginia required a
8 health insurer or a health company to comply with and then
9 went to the federal level and looked at HIPAA privacy rules
10 and then looked at the federal law known as Gramm-Leach-
11 Bliley, which many of you are familiar with.
12 And what that company, that insurer, and it could
13 be a Taft-Hartley insurer, it could be a union insurer or
14 self-funded plan had to comply with in all these various
15 different privacy rules all of which add to the cost and
16 complexity of trying to comply.
17 I describe it to lay audiences just driving down
18 the highway and having to figure out what the speed limit
19 is because it's never posted. You need a lawyer to figure
20 out what rules to comply with to start with which should
21 not be the case.
22 Cost crisis. We all know about this. I won't
23 dwell on this except to say from the third bullet that we
24 had PricewaterhouseCoopers, AAHP, do a study for us last
25 Spring which was really eye opening. It found that
26 mandates and regulation accounted for 15 percent of the
27 premium increase in one year, the period 2001 to 2002. In
28 other words, $10 billion was mandates and regulation. And

1 that's what it is costing.

2 And these are some other numbers out there that
3 we have found from respectable groups trying to talk about
4 what is going on in the cost crisis in health care.

5 Health care spending expected to increase. This
6 is no surprise to any of you. These are CMS figures from
7 the National Health Statistics group and it's a mind
8 boggling, $9000 per person, per capita, in 2010.

9 The impact of mandates on cost, we found some
10 statistics. They are a bit old but they're still useful to
11 look at. The Barents Group from 1997 and 1998 talking
12 about some of these provider mandates that I mentioned
13 before and what they cost.

14 For example, any willing provider state laws that
15 allow any willing provider, any willing chiropractor,
16 pharmacist, you name it, to join a network would add a 9
17 percent average cost increase. A lot of money. Medical
18 necessity mandates, mandated point of service, et cetera.
19 All of the numbers there and it really adds up to a lot of
20 money.

21 Who's paying for this? Obviously, as Professor
22 Gitterman said, working families and here's some statistics
23 from LECG on the cost of these mandates.

24 The issue of mandates fueling the uninsured
25 crisis and the whole issue of what happens, why do we have
26 41 million people uninsured in this country. In fact,
27 we're citing you some data here that show if not for
28 mandates 18 percent of uninsured businesses in '99 would

1 have sponsored, according to Jensen and Morrisey, uninsured
2 coverage.
3 And the last but not least, the last bullet down
4 there, very important point, state mandates, as I think
5 you’ve heard, don't apply to Medicare, Medicaid, federal
6 employees, the FEHBP plans or self-insured or ERISA group
7 health plans. So what you’ve got out there is a very
8 uneven playing field where they apply to some people and
9 don’t apply to others and increase costs and skew the
10 market competitively.
11 Issue of limiting choice and stifling
12 competition. I think my favorite example is any willing
13 provider, the any willing provider laws that are in effect
14 in about 22 states in the country depending on how you
15 define them. And basically, those laws restrict innovation
16 and flexibility to design products tailored to consumer
17 needs because they require that you have certain numbers of
18 providers in each individual, in each plan. And they
19 create a presumed, quote, right to contract that does not
20 exist in any other industry. Am I out of time down there?
21 I’m watching this thing. Sorry about that.
22 This just shows you that we believe that in many
23 cases mandates are for provider protection and not consumer
24 protection with examples cited of prompt pay laws and the
25 AMA model contract is worth pointing out.
26 This is a wish list that the AMA has had in place
27 since 1997, I believe. And they are asking basically that
28 states enact mandated disclosure of provider payments

1 which, quite frankly, I believe is anticompetitive in the
2 extreme, and restrictions on the ability of health plans to
3 correct and collect unwarranted overpayments to providers.
4 ABMT is probably the most cautionary tale that
5 anyone has. It's really quite a nightmare. As many of you
6 know it was mandated in ten states and for all federal
7 employees covered by the federal employees plan. There
8 were no clinical trials.
9 The result was that not only did many women die
10 on the table but ABMT was no more effective than standard
11 therapy. We cannot go down this road. We have to get tech
12 assessment here. We have to weigh costs and benefits of
13 medical treatments in this country.
14 Stifling innovation. I use as examples length of
15 stay and the 48-hour maternity stay mandates. And I cite
16 the New England Journal of Medicine, for example, an
17 article that basically said it didn't help infant health
18 to ensure that women got to stay in the hospital for 48
19 hours. I hope, again, that legislators look at these kinds
20 of cost-benefit analyses before enacting mandates such as
21 that.
22 Many of you know the IOM had a call to action
23 with four things that they wanted to do. And again, the
24 last bullet is critical, allowing payment incentives with
25 delivery of safe and effective care and deal with the
26 issues that I have been talking about, safety and
27 effectiveness.
28 Road map for policy. Greater accountability and

1 transparency. I think we all agree with that. The Federal
2 Trade Commission has been very, very active in that area as
3 well. Deal with the moratorium on mandates until costs and
4 benefits can be assessed. Provide flexibility,
5 affordability and choice for employers and consumers.
6 Last but not least, how do we promote greater
7 accountability. How do we get policyholders and the public
8 to understand the anticompetitive effects of provider and
9 benefit mandates in many cases, to make sure they
10 understand it before they enact it.
11 To ensure full and accurate disclosure and to
12 take enforcement action if anyone is intentionally
13 misleading the public about effectiveness or health care
14 products. Thank you.
15 (Applause.)
16 MS. MATHIAS: Thank you, Stephanie. We will
17 actually go to Rachel next and then for everybody to keep
18 their attention, we'll take a break after Rachel and then
19 move on to Tom Miller.
20 MS. LASER: I feel like I'm following a very
21 impassioned talk and I hope that I can offer a slightly
22 different perspective in an equally impassioned fashion.
23 And with due respect, I'd like to start by saying
24 that requiring health insurance coverage for basic health
25 care for women, like contraceptive coverage, should not be
26 subject to a competition analysis in our view. And
27 moreover, for all employees covered by federal
28 antidiscrimination law, contraceptive coverage is actually

1 required by law.
2 That said, I will briefly discuss how critical
3 contraceptive coverage is to women's health, the specifics
4 of federal antidiscrimination law and its application to
5 contraceptive coverage and other policy reasons why
6 contraceptive coverage must be provided regardless of the
7 activity of an unregulated marketplace.
8 I'll start by offering some basic facts about
9 women's health. Most women have the biological potential
10 to become pregnant for about 30 years of their lives and
11 they spend approximately three-fourths of their
12 reproductive lives trying to postpone or avoid being
13 pregnant.
14 To date, over half of pregnancies in the United
15 States are unintended. We all know that how often you
16 become pregnant, what the spacing is between your
17 pregnancies and even just plain becoming pregnant is a
18 matter of life and death for many women in our country.
19 Unfortunately, our maternal mortality stats are
20 bad and haven't changed in decades. Right now, it's 7.5
21 per 100,000 women are dying in our country every year. And
22 the Healthy People 2010 goal is for 3.3 of 100,000 women to
23 die from maternal mortality. And obviously, this doesn't
24 take into account the many incidences of maternal
25 morbidity.
26 And it is important to point out the extreme
27 racial disparities that still exist around pregnancy and
28 pregnancy related illness. Black women are still four

1 times more likely to die from pregnancy related conditions
2 than white women. Hispanic women are 1.7 times more likely
3 to die.
4 Some women can't become pregnant because of pre-
5 existing medical conditions, and, of course, there are the
6 emotional and economic impacts for women who can't continue
7 schooling and who have to sometimes and often foot the cost
8 of having a kid by themselves. So I think it should be
9 pretty clear to most people why many people today, at
10 least, why pregnancy prevention is a crucial component of
11 women's health.
12 It is also clear that prescription contraception
13 is the most effective kind of birth control for women and
14 there are five different kinds of FDA-approved, reversible
15 methods currently on the market which include an oral
16 method, the birth control pill, barrier method, injections
17 like Depo-Provera, implants like Norplant, and IUDs.
18 For some women certain types of prescription
19 birth control are contraindicated. Women who have a
20 history of strokes in their family might not be able to
21 take the birth control pill safely and might be advised to
22 use the IUD. But the IUD would be once off cost of $500
23 and the birth control is roughly $25 a month. So they
24 might be using the wrong kind of birth control if they
25 don't have help in paying for it.
26 And then of course there are the medical reasons
27 that are not related to pregnancy prevention that women use
28 birth pills including dysmenorrea, premenstrual syndrome

1 and ovarian cancer prevention.
2 Insurance coverage of contraceptives is also a
3 matter of equity for women. Pregnancy is a condition that
4 is still unique to women last I checked and the only forms
5 of prescription contraception that are available today are
6 for women still.
7 Failure to cover contraceptives forces women to
8 bear higher health costs and, in fact, one study showed
9 that women's out-of-pocket health care costs during their
10 reproductive years are 68 percent higher than a man's.
11 Some of which is certainly attributable to reproductive
12 health care costs which have not been traditionally covered
13 by insurance plans.
14 And finally the failure to cover contraceptives
15 exposes women to the unique physical and economic risks
16 that we have discussed before surrounding unintended
17 pregnancy.
18 But federal law fortunately does require
19 employers who cover prescription drugs to include coverage
20 for prescription contraception. Title VII of the Civil
21 Rights Act of 1964 prohibits sex discrimination by private
22 employers with at least 15 employees and by public
23 employers. And the Pregnancy Discrimination Act of 1978,
24 which is now incorporated into Title VII, says that
25 discrimination on the basis of pregnancy is sex
26 discrimination and it requires equal treatment of women who
27 are affected by pregnancy, child birth or related medical
28 conditions in all aspects of employment and explicitly

1 including fringe benefits.

2 EEOC is the agency responsible for enforcing
3 Title VII and, fortunately, the EEOC in 2000, and now the
4 courts, have found that under Title VII singling out
5 prescription contraceptives for exclusion violates the
6 Privacy Discrimination Act because it is disadvantageous
7 treatment of pregnancy related conditions which is women's
8 capacity to become pregnant and consequent need to have
9 access to contraception.

10 I think I will just read you one quote from the
11 Erickson decision which was a federal district court
12 decision that came down in 2001 which summarizes nicely how
13 the federal courts, just like the EEOC, really got the
14 importance of contraceptive coverage for women's basic
15 health needs.

16 There the judge wrote that, quote, the exclusion
17 of prescription contraceptives creates a gaping hole in the
18 coverage offered to female employees leaving a fundamental
19 and immediate health care need uncovered.

20 The judge also got that contraceptive coverage is
21 part of basic preventive health care for women. The
22 Erickson judge called contraceptive coverage a fundamental
23 and immediate health care need. And he likened
24 contraceptives to other preventive drugs in Bartell Drug
25 Company, the defendant's, plan, such as blood pressure and
26 cholesterol lowering drugs, hormone replacement therapies,
27 prenatal vitamins during pregnancy and drugs to prevent
28 allergic reactions, breast cancer and blood clotting.

1 The EEOC also compared contraceptives to other
2 provided coverage in the respondent's plan which included
3 vaccinations, preventive dental car and some of the ones
4 that I listed in Erickson.
5 The Washington Business Group on Health, an
6 organization that represents 160 national and multinational
7 employers, I think, did a nice job of fitting contraceptive
8 coverage into the trend in insurance to cover preventative
9 care. I think I'll just let you read the quote since you
10 can see it and also I do have copies of the PowerPoint
11 presentation out in the front.
12 More than that, contraceptive coverage saves
13 insurers and employers money. And here I think I'll
14 actually start at the end of the slide, talking about the
15 Federal Employee Health Benefits Program.
16 Fortunately, the Federal Employee Health Benefits
17 Program -- I don't think I mentioned it before -- in fiscal
18 year '99 started including a mandate for contraceptive
19 coverage. And it has been passed every year in the
20 Treasury bill, the appropriations bill. And when the FEHBP
21 requirement was implemented the Office of Personnel
22 Management, which administers the program arranged with the
23 health carriers to adjust the 1999 premiums in 2000 to
24 reflect any increased insurance cost due to the addition of
25 contraceptive coverage. No adjustment was necessary and
26 the Office of Personnel Management reported in a letter
27 which I have that, quote, there was no cost increase due to
28 contraceptive coverage.

1 There are a number of studies that talk about how
2 the savings of contraceptive coverage outweigh the costs.
3 I have some of them listed here. The savings come from
4 fewer pregnancies, fewer deliveries, and healthier
5 newborns. And those are just some of them not to mention
6 indirect savings in the workplace of increased productivity
7 and less leave, increased morale. There's lots of indirect
8 savings there.
9 So now I'll talk a little bit about the history
10 of contraceptive coverage. It wasn't until the early 1990s
11 that the Alan Guttmacher Institute really was at the
12 forefront of conducting studies that looked at sort of the
13 gaps in the coverage for prescription contraceptives in
14 health plans.
15 AGI found that roughly half of typical large
16 group plans do not routinely cover any contraceptive method
17 at all. And only 15 percent covered all five FDA-approved
18 reversible methods. It's also noteworthy that before the
19 FEHBP contraceptive coverage mandate passed, 81 percent of
20 plans under FEHBP, the Federal Employee Health Benefits
21 Program did not cover all reversible forms of contraception
22 and 10 percent did not cover any of these methods.
23 Why has contraceptive coverage been excluded?
24 Traditionally, there has been less prevention focus in
25 health insurance and contraceptive coverage has this unique
26 attribute where, like some of the other mandates that we're
27 talking about, there are stigmas that are attached and
28 privacy concerns. So it's hard for women to articulate

1 their need to their HR departments or to Congress and
2 different folks.
3 Women have been paying out of pocket for
4 contraception and for many women, not including lower
5 income women, the costs haven't been prohibitive. We
6 talked earlier about how the birth control pill might cost
7 $25 a month.
8 And finally there has been a history of sex
9 discrimination in health care. It wasn't until Senator
10 Mikulski in the early '90s passed a law that required that
11 there be more drug testing on women because it was found
12 that drug testing hadn't traditionally included women at
13 all. There was a lack of maternity benefits and so this
14 sort of fit into that pattern.
15 But now there does seem to be a renewed, or a new
16 I should say, momentum for prescription contraceptive
17 coverage. Why? We think because of the 1990s survey that
18 sort of brought it into the spotlight, and then, of course,
19 Viagra, which was covered 40 seconds after it was
20 introduced into the market even though contraception has
21 been available for four decades. So that's when a lot of
22 people started speaking up more about it.
23 The public supports requiring contraceptive
24 coverage. A 2001 poll found that 71 percent of Americans
25 support laws requiring health insurance plans to cover
26 prescription contraception and a Kaiser Family Foundation
27 poll found that 75 percent of Americans believe that it
28 should be required even if it adds to costs.

1 So what is the current status of contraceptive
2 coverage? It’s spotty. A 2002 Kaiser Family Foundation
3 survey found that 99 percent of covered workers have
4 coverage for prescription drugs and 78 percent have
5 coverage for oral contraceptives. So we can assume that
6 coverage for the other methods wouldn’t be as high as that.
7 There has been this recent clarification of
8 federal antidiscrimination law through the EEOC and in
9 federal courts that I referred to and it is beginning to
10 change policy voluntarily and based on lawsuits.
11 DaimlerChrysler, under pressure, joined auto makers Ford
12 and GM in adding coverage in June 2002. Dow Jones you may
13 have read about in the Wall Street Journal settled after
14 charges were filed at the EEOC in December 2002. Others
15 have added it voluntarily.
16 There is this bill that has floated around
17 Congress, although it hasn’t been reintroduced this
18 session, called EPICC, the Equity in Prescription Insurance
19 and Contraceptive Coverage Act and that bill is important
20 because, like we’ve talked about, these state mandates,
21 even where they exist, don’t cover all employers and
22 insurance companies necessarily, that EPICC would cover
23 self-funded plans.
24 It would cover small companies that aren’t
25 covered by Title VII because they have fewer than 15
26 employees. And it would also cover an estimated -- well,
27 let’s see, it would cover a lot of women who are included
28 in an estimated 16 million Americans who obtain health

1 insurance from private insurance other than employer
2 provided plans.
3 And women tend to be disproportionately
4 represented in this population because it includes people
5 who are self-employed, people who are employed by employers
6 who offer no health insurance and part-time, temporary and
7 contract workers.
8 And skipping back up to the 25 states, 25 states
9 are currently requiring some form of contraceptive
10 coverage. We call these the state EPICCs. And they vary a
11 little bit. I mean, some of them require that all the five
12 methods be covered. Some of them explicitly refuse to
13 cover emergency contraception. Some of them explicitly
14 include emergency contraception even though it is actually
15 an FDA-approved method now.
16 Some of them require that insurers offer at least
17 one plan with contraceptive coverage and others require
18 that every plan has to include contraceptive coverage. But
19 unfortunately, many employees still don’t receive this
20 benefit of contraceptive coverage because companies and
21 insurance companies are not voluntarily choosing to provide
22 it and/or the relevant federal and state laws don’t reach
23 them or aren’t being enforced.
24 This was my effort at explaining a flawed
25 marketplace in the context of contraceptive coverage and
26 why this public preference that we’ve heard about for
27 contraceptive coverage isn’t necessarily reflected yet in
28 the policies that are available.

1 Firstly, to the extent that companies are making
2 self-funded plans and putting those together women haven’t
3 traditionally been at the top of the hierarchy in companies
4 so they haven’t necessarily been in those small rooms that
5 are deciding which benefits should be included and which
6 shouldn’t.
7 In the context of state mandates women are still
8 disproportionately represented in the state legislatures
9 and it’s not surprising that the foremost champion of
10 contraceptive coverage in the federal Congress is a woman,
11 Senator Snowe from Maine. And perhaps this is a
12 coincidence but the Commissioner for the EEOC, when they
13 issued their ruling in 2000, was a woman.
14 And we've talked about the privacy concerns, the
15 stigma, and also the fact that there are minimal costs so
16 women often don’t speak up.
17 Let’s see where I am. I’m on my last slide. To
18 conclude, regardless of a competition analysis it is
19 crucial to cover prescription contraceptives because it is
20 a fundamental and basic women’s health need and therefore
21 good public policy and because in many cases federal law
22 requires it. Thanks.
23 (Applause.)
24 MS. MATHIAS: We will take a ten-minute break and
25 then reconvene.
26 (Whereupon, a short recess was taken.)
27 MS. MATHIAS: If we could go ahead and get started
28 we will start with Tom and then move back in order to

1 Anthony and finish up with David and move into a moderated
2 roundtable.
3 MR. MILLER: Thank you very much, Sarah. I
4 apologize for being here. I don't know whether -- well,
5 actually, I picked a bad week to try to end Medicare as we
6 know it in the other part of my job. But I don't know
7 whether I was the victim of profiling by Security
8 downstairs or just the victim of forced switching of over
9 the counter Claritin as you can tell from my voice now.
10 I'm just one of those unfortunate folks who just doesn't
11 have a steady supply like I used to. But I would have to
12 pay for it out of pocket.
13 Let's talk about today's hearing, which is
14 mandated benefits. I'm going to focus mostly on the state
15 end because I think Stephanie had done a good job on the
16 federal end.
17 Taking some material that's already out there,
18 Lewin Group from Blue Cross Blue Shield in the fall of 2002
19 gave some general ranges in terms of the number of mandated
20 benefits. The growth rate, I think in some earlier
21 presentations have gone through that so I'm going to slide
22 over that pretty quickly. In the same way, kind of the
23 most common benefits you see a favorite, there's always
24 cancer screening but that's kind of dominance in terms of
25 states. And there's a variance.
26 Blue Cross really follows this very closely in
27 terms of tracking it. You can pull all this stuff I'm
28 going to show you on the web off of the Blue Cross site. I

1 haven't seen it updated since the 2000 survey of the state
2 benefits but at that time it was indicated although there
3 were a lot of efforts to increase the mandated benefits the
4 rate of increase seems to be slowing down if not completely
5 going away in its full strength version.
6 There are some favorites still going on at that
7 time and again, it looked like mental health and clinical
8 trials were the favorites within the last couple of years.
9 This is kind of a look at the big map. It's not
10 Bush versus Gore in red and blue. The lighter colored blue
11 toward the bottom, like Florida and Texas, those with more
12 than 40 mandates in the state.
13 The white ones, like Iowa, I think, is probably
14 the lowest mandated state, are the ones that are less than
15 20 and in between is the 20 to 40. Again, this is from
16 about December 2002 -- 2000 data that Blue Cross has.
17 They count up about 716 benefit mandates at the
18 state level. There are different ways to count these
19 things and then I'm going to fly through these. You can
20 find these online. This is going to be actual benefits,
21 state by state, the year they're enacted. There's always a
22 little difference in terms of the strength in which they go
23 through it but it indicates kind of that's how you get up
24 to 716 through the various states.
25 There's also mandates to require coverage of
26 providers or certain persons to be covered by insurance.
27 And about 687 of those back when this was calculated in
28 2002 scene, and again we can go through the various states

1 in terms of that. And I can provide this to you later but
2 again the online site pretty much defines it.
3 And this is just a quick listing of some of the
4 most recent additional mandates in the last few years of
5 the most popular ones and the years they were enacted in
6 different states that didn't show up on that chart.
7 Let's talk though about the labor market effects
8 of state mandated benefits on employment. The study that's
9 most often cited from almost a decade ago is John Gruber's
10 work at American Economic Review looking at maternity
11 benefits. His finding then was that it significantly
12 reduced wages but not employment. There are some
13 differences of opinion on that.
14 There was another Michigan state study which
15 compared small group versus the ERISA-protected larger
16 group plans in terms of what the mandate effects were on
17 employment but Bill Vogt's not here today and David Hyman
18 summarized some of his work, in essence, in a paper --
19 actually it's 2001 not 2000 -- that Bill Vogt did with Jay
20 Bhattacharya.
21 They went through the methodology and said
22 basically he hadn't proved anything. Could be more. Could
23 be less. Could be the same but the underlying study didn't
24 really kind of make a dent in that in a positive
25 statistically significant way.
26 Why is this? Well, there are other ways in which
27 people move around to reshuffle the compensation portfolio
28 to take into account the higher costs of particular

1 mandated services. It’s all part of compensation portfolio
2 so you get a little bit less of something else in return
3 for the higher cost benefits.
4 The negative effects though are, of course, you
5 are banning what are in effect the low cost health
6 insurance contractual alternatives and that should, in
7 theory, begin to decrease insurance coverage at least on
8 the margin particularly for price sensitive buyers.
9 You can’t really increase employment by
10 increasing mandates. I think we can prove that pretty
11 effectively so it does raise the cost of hiring. And
12 again, that’s a summary not only of Vogt and Bhattacharya’s
13 work but some work by Sloan and Conover both in Inquiry and
14 in our publication a couple of years ago, Regulation. Mike
15 Morrisey has also done a lot of work in this area. It’s an
16 older AEI conference study.
17 The cost effects of state mandated benefits on
18 health insurance premiums. Now, this is different. This
19 work is not yet in the literature. Got a working draft
20 that may be, get another updated draft in a couple of
21 weeks. It will be submitted later this year.
22 These are some economists down at Baylor
23 University, Jim Henderson, Allen Seward, Beck Taylor. What
24 they’re finding from taking a different approach it’s
25 hegemic pricing as opposed to the standard actuarial
26 approach or the cost ratio expenditure prediction approach
27 that it's not the absolute number of mandates that matters,
28 it’s which ones you apply.

1 Some mandates have a real significant effect in
2 raising premium costs for insurance, others marginally at
3 least can save some costs. So it's not a single walk.
4 They used also city level data as opposed to state data
5 which cleans up some of the noise in the information and it
6 was real market prices in terms of the marginal effects,
7 what the actual purchasers were doing as you added
8 particular mandates in particular places.
9 Some more in this regard. One mandate they said
10 broke into three categories, mandates on providers,
11 mandates for benefits and mandates to cover particular
12 people.
13 Let's take a look at the providers first. The
14 average state mandate from their data set, probably in the
15 mid-'90s, I think, was about 8.5 mandates. The effect they
16 found was requiring coverage of additional providers would
17 actually lower HMO premiums and in our methodology, back
18 then, HMOs were HMOs and fee-for-service or indemnity meant
19 something different, but there was no significant impact on
20 indemnity premiums. Today we would probably call that a
21 loose PPO.
22 There were some possibly offsetting effects in
23 having this coverage of additional providers. Even though
24 you would get more claims frequency, higher spending for
25 the services that previously weren't available you would be
26 perhaps able to substitute lower-cost alternatives.
27 Depends which providers you're adding to the coverage, such
28 as a nurse practitioner, some other examples in that regard

1 and then that actually reduced the severity of claims
2 overall and lowered total spending.
3 The mandates that tended to lower premiums by
4 adding on providers, as I mentioned nurse practitioners,
5 dentists, psychologists -- I wonder what they meant by
6 that?
7 Mandates raising premiums, social workers and
8 podiatrist and the agony of defeat for health insurers.
9 They did have a more statistically significant premium
10 effect on indemnity plans in this regard though than HMOs.
11 That’s on the positive side.
12 Mandating benefits. Again, from the particular
13 data they used the average state there had about seven
14 mandates. It does raise premiums. I’m leaving off the
15 actual hard numbers and percentages because the paper’s
16 being modified. I talked to Jim Henderson this morning.
17 They’re going to resubmit.
18 So the direction is right but -- I have the real
19 numbers. I just don’t want to kind of quote them at this
20 point because they’re going to change a little bit over the
21 next couple of months. But there’s a premium raising
22 effect by mandating benefits and again it’s more
23 significant on indemnity plans -- think PPOs rather than,
24 you know, old style, than HMO premiums.
25 The seven most common benefits they have
26 different effects. The one that was the real killer in
27 terms of prices and in costs of insurance was drug abuse
28 treatment. Significant there. I give you a ballpark of

1 about 10 percent. We can argue about the exact number in
2 that regard as a premium increase.
3 Off label drug use. That means if you get to get
4 prescription drugs even though it's not an FDA-approved use
5 as kind of part of your insurance coverage that tends to
6 increase premiums.
7 Alcoholism treatment though, surprisingly, if you
8 do it right, and kind of cut off the other later stage of
9 the illnesses and diseases and effects that come out of it,
10 could lower premiums the most out of the mandated benefit
11 required.
12 Then you get into the screening effects. You get
13 kind of a slight rise for the cervical cancer screening,
14 mammography screening. There's a lot of dispute in the
15 literature anyway on mammography screening, at what point.
16 Well-child care does lower indemnity premiums. I wouldn't
17 go overboard on it but there is some effect in that regard.
18 Minimum maternity stays pretty much no significant effect.
19 Now, this is the mandates on persons to be
20 covered. Again, there the average was a little bit less
21 than five mandates per state. It does lower premiums.
22 It's a narrow area.
23 Basically, the main effect is in guaranteeing
24 conversion from group to nongroup plans, lowers premiums
25 probably because it cuts down on some additional
26 administration and marketing costs and makes a little bit
27 more, slightly more seamless transition.
28 Well, if some of these mandates are good why

1 don't insurers already have them in the package? Now,
2 there's a traditional bugaboo about adverse selection. I
3 tend to be a little skeptical about it being overstated.
4 There are regulatory problems with not being able
5 to price insurance properly to prevent adverse selection
6 from occurring but it's not as much adverse selection in
7 terms of the positive mandates the positive benefits it's
8 been there's a lot of turnover particularly in small group
9 plans. So there's no guarantee that if you offer a
10 particular benefit that you're going to capture the
11 benefit; the gain of that benefit is lost for both the
12 policyholder and the insurer if the policyholder isn't
13 going to stay in the plan long enough and in a couple of
14 years maybe go off with someone else or need to change
15 because of employer judgments.
16 So the other element here is that other mandates
17 may simply not be binding if, in fact, standard policies
18 will generally provide them. Well, there's a little
19 dispute on that.
20 A different way of looking at mandates is in the
21 aggregate. We're in the process of publishing a pretty big
22 study later this summer looking at the overall costs of
23 health services regulation working with Professor Chris
24 Conover of the Fuqua School of Business down at Duke
25 University.
26 This aggregates all the kind of overall costs of
27 health services. We did this also for mandated benefits
28 both at the state and federal level. This kind of divides

1 it up into the cost without transfers which is kind of the
2 real baseline effect and then the costs with transfers.
3 I'll use other simple words, rent-seeking behavior,
4 extraction costs of extra costs and subsidies. We pass
5 checks back and forth between ourselves.
6 So the baseline estimate for the cost of state-
7 mandated benefits is about $7 billion by Conover and there
8 is a lower bound, which is the Henderson work, which might
9 be about $5.4 billion. An upper bound is in 1992 work by
10 AGS, which has been updated, about $8.5 billion.
11 Now if you throw in the transfer costs, which are
12 real losses to our overall economy, I suppose, that's
13 almost $29 billion so that brings it up a bit.
14 And again, there's a wide range between the lower
15 bound at $9 billion and the upper bound of $48 billion.
16 Again, if you have some questions about the Henderson work
17 and the Conover work I'll talk to you afterwards about it
18 but that's kind of the streamlined version.
19 The lack of insurance is an effect of mandated
20 benefits. Again, older work by Conover with Frank Sloan at
21 Duke had in 1998 estimate, I think it was an Inquiry
22 article, said about 20 to 25 percent of the uninsured was
23 due, the effects were due to mandated benefit costs.
24 And that means, in effect, one-fifth to one-
25 fourth of what was then about the 15, 16 percent uninsured.
26 So it's a fraction of a fraction. But in later looking at
27 it Chris thought that perhaps you need to kind of move that
28 down about half as much because again this was treating

1 mandates kind of as statewide as opposed to the fact that
2 there may be some variations and also that no state is
3 actually the polar case of no mandate versus every mandate.
4 So that may water it down to some degree. But we know it
5 has an effect on coverage of insurance.
6 Some other effects, of course, in the labor
7 markets and insurance, employers -- this happened more in
8 the 1990s -- they have a greater propensity to self-insure.
9 You take advantage of the workings of ERISA in order to
10 avoid the worst versions of counterproductive state
11 insurance regulation including mandated benefits. You can
12 also have offsetting effects in terms of lower wages,
13 decreased employment, reduced generosity of fringe benefits
14 as well.
15 Let me try to rocket ahead a little faster here.
16 Why do we have these mandated benefits? Well, the simple
17 answer is it's off budget. It doesn't look like it costs
18 anybody anything so that's always going to be popular with
19 the state legislature.
20 However, this only affects some folks in the
21 labor market. Remember ERISA pulls out a lot of the big
22 employer plans. The individual market sometimes doesn't
23 have as binding a set of mandates so you're really
24 affecting less than half of a state's population when you
25 throw these mandates onto small group insurance in smaller
26 firms. Again, it's 33 percent of the population used to
27 private plans. If you get some mandates it also hit onto
28 the individual purchase policy so you should make it up to

1 42 percent of the insured population. This is mostly work
2 done by Gail Jensen and Mike Morrisey for Health Insurance
3 Associates of America about four years ago.
4 And the disproportionate effect also means on
5 small firms. These are the firms that are the most price
6 sensitive, the most likely to be on the margins of dropping
7 coverage when they can't afford it. Also given the nature
8 of the demand, often their workforce isn't crazy about
9 elaborate insurance coverage.
10 Now, again there was the argument before about
11 aren't these mandates pretty much requiring what's already
12 done by other folks? It's hard to draw the lines exactly
13 but you do need to compare peers to peers.
14 Using data from self-insured employer group plans
15 our larger employers already have more resources on the
16 table, more ways to, in effect, not only swallow these
17 benefits but also manage them. In fact, their workforce
18 may want them and may be the overall balance but the small
19 employers below that end who are going to be hit with this
20 are the ones who are not subject to all the regulation and
21 have a much greater sensitivity to the cost of the extra
22 insurance.
23 On the federal side, again, I'm just going to
24 touch on it very briefly. The federal regulation by body
25 part, which was a trend in the mid-'90s to about the late
26 '90s has begun to slow down if we took about three of them.
27 I'd say largely it was distracted by the patients
28 bill of rights, multiyear war in which the Congress tried

1 to pass the kidney stone of managed care regulation and
2 threw it back out.
3 So we may see if there's kind of a new taste for
4 pending regulation at the federal and after that was kind
5 of pause for four years. But thus far there aren't any
6 immediate signs of it except for prescription drugs for
7 seniors, which is a different category.
8 The politics is that these type of mandates
9 federal or state are going to be promoted and supported by
10 both -- different types of interest groups, the providers
11 who think they'll get paid a little bit more for providing
12 the services and the particular groups that cluster around,
13 an aggrieved group with a particular condition or disease
14 and say we must have coverage for this and someone else
15 should pay for it.
16 There has, however, been a little take up for the
17 bare bones insurance policy alternatives which were tried
18 in the early 1990s. We have a minimum benefit for more
19 affordable coverage. They tended to move toward the
20 catastrophic side. That's Morrisey and Jensen's work in
21 '96. More recent there's been an effort to do more limited
22 policies which, in effect, give you a couple of doctor
23 visits and prescription drugs and not much more. I think
24 Arkansas is experimenting with that.
25 More on the politics. My old professor at Duke
26 Law School, Clark Havighurst, I think has it pretty well
27 figured out -- the rest of the political world has a little
28 problem with it. The political market for consumer

1 protection in regulation of health care.

2 Well, who are the folks asking for the consumer
3 protection? Generally speaking, the worried middle class,
4 the folks with the greatest preference for regulation, the
5 most aware, the most politically active, the most
6 influential. They're the folks who'd like to kind of
7 guarantee a minimum standard which is pretty high for the
8 health insurance they're going to get and look around for
9 it.

10 And you get this coalition of the upper middle-
11 class voters and the special health industry interests who
12 want the industry interest want to use high standards
13 perhaps to squeeze out the lower-cost competition and also
14 increase demand for their services as long as they can get
15 paid more than it costs which isn't always the case in some
16 years.

17 The income and elasticity of health care
18 indicates as people get wealthier they want more health
19 care and, of course, we all think that it's being paid for
20 by someone else.

21 What are some alternatives and some remedies to
22 get around this? Well, there's been efforts to do things
23 like state-level mandated benefits review laws. They tend
24 to look more at the mandates and maybe slow the new ones
25 and roll the old ones back but more states are beginning to
26 pick up in this direction.

27 The other way is to, in effect, make insurance
28 less important. And we're at the early stages of these

1 consumer-driven health plan options with this less
2 comprehensive insurance, a little bit more of a front-end,
3 cost-sharing deductible and they're given ways to package
4 this together. The full strength version is a medical
5 savings accounts.
6 Health reimbursement accounts are kind of a toe
7 in the water which have a lot of growth among the employer
8 groups. Flexible spending accounts say you've got the
9 money, why don't you spend it on whatever you want but not
10 mandated for the extra rounds.
11 Bill Thomas is trying to get something I guess in
12 the House this week on health savings accounts, which kind
13 of blend these together, and the pure strength version will
14 be defined contribution but there's been some regulatory
15 barriers to that and employers are a little reluctant to go
16 whole hog without knowing what's out there in the
17 individual market.
18 A different way to get around it is tax parity
19 for all individual health insurance purchasers as well as
20 group purchasers. If you control the money, you control
21 your mandates and you can go ahead and buy what you want or
22 at least what you can find in the market.
23 I've argued for a form of competitive federalism
24 which would allow you to get out of the geographical box of
25 monopoly regulation by a single state insurer. That would
26 allow you to buy insurance from other states across the
27 border if they offered a different deal. That would begin
28 to break up some of this log jam over particular mandates.

1 If people want it they'll pay for it but otherwise they'll
2 go somewhere else.
3 You could experiment with carve outs such as
4 mandate free insurance if it's provided through the
5 Internet, more of a national market or a virtual market if
6 you will. Another bypass might be for some of these multi-
7 state purchasing groups. I'm not talking about the
8 Association Health plans, a little bit better version of
9 it, but, in fact, they could operate on a multistate basis
10 and have someone else, the prudent buyer, in between. Or
11 just bypass for any type of individual-tax-credit-eligible
12 policy saying you can mandate that which doesn't have state
13 mandates in it.
14 A real over-the-edge point would be to say let's
15 have no unfunded mandates at the state level. It would be
16 a little hard to work this out so in effect you'd say you
17 can mandate it at the state level but you have all this
18 stuff included in a group policy but if someone wants to
19 opt out of it, they immediately get a rebate back from the
20 state government which forced them to pay for this and then
21 the state government has to find the money from the insurer
22 who ought to be able to take a little bit of a nuisance
23 charge for going through the whole hassle.
24 The ultimate nuclear weapon would be federal
25 preemption. Likelihood of those thing occurring my usual
26 capper on these things. Thank you.
27 (Applause.)
28 MS. MATHIAS: Thank you, Tom. Next we have

1 Anthony.

2 MR. KNETTEL: Thank you very much. You've had a
3 lot of really good information pumped at you at very high
4 speed over the last couple of hours so I'd like to give you
5 a little bit of a break and step back and talk a little bit
6 more conceptually about some issues. And in particular
7 talk to you about an employer perspective on mandated
8 benefits since employers pay the lion's share of the
9 premiums for the coverage that we have been talking about
10 for employees in the private marketplace.

11 I think it's an important contribution to the
12 debate to think about how employers think about these
13 issues not just all the really excellent studies that we
14 have heard and talked about so far today. So I'm going to
15 take a little bit more of a conceptual approach, I think,
16 from some of the previous discussants.

17 First of all, I need you to know who the ERISA
18 industry truly is so you know a little bit more about the
19 perspective you're hearing. ERIC represents 110 of the
20 largest employers in the U.S. A typical ERIC member has
21 about 50,000 domestic employees.

22 While a large proportion of our members sponsor
23 self-funded plans I think they sponsor more insured health
24 care coverage than most people tend to assume. That's
25 especially true for companies that have their employees
26 distributed all over the country rather than concentrated
27 primarily in a couple of geographic regions.

28 It's also the case that, for example, to the

1 degree that an employer has focused its health care
2 offerings in terms of integrated health care delivery
3 systems has a much higher propensity to offer an insured
4 arrangement rather than a self-funded arrangement.
5 So you've heard several times today about the
6 ability of large employers to escape a lot of the state-
7 level mandates that we've been talking about. That's true
8 but only up to a point. And, in fact, even when
9 technically legally those mandates may not apply as we'll
10 see in a minute there are reasons why those employers may
11 wind up indirectly being subject to those requirements
12 anyway.
13 And in addition to providing health care coverage
14 for active employees, many of our members provide retiree
15 health coverage as well which helps to heighten and
16 concentrate some of the economic and cost issues that come
17 to play in the discussion of mandates and how it interacts
18 with benefit plan design.
19 So I'd like to really talk about three general
20 areas, one, what the current benefit design environment is
21 for large employers, how mandates impact plan sponsors,
22 benefit design decisions.
23 And then I'll kind of focus because of the
24 limitation on time, I decided to focus primarily on
25 mandated mental health parity in terms of giving you some
26 feedback from a large employer point of view on that
27 particular issue.
28 And we'll still only be able to scratch the

1 surface because there are a lot of very complicated legal
2 and policy issues involved. But I'll do my best to address
3 at least some of them.
4 In terms of the current benefit design
5 environment it's not at all an exaggeration to say that
6 ERIC member companies today face unprecedented pressure to
7 contain health care benefits. And it's not just because of
8 the double digit health care premium increases that we have
9 all been seeing.
10 And a typical ERIC member has seen a premium
11 rates increase of about 15 percent over the last two years.
12 For many small employers it's at least double that although
13 I was in a meeting in a room yesterday with somebody where
14 their year-to-year premium increase last year was 100
15 percent. So the scale of the cost increase pressure is
16 enormous. I don't want to minimize that at all.
17 But there are other things going on that
18 influence an employer's benefit design decision behavior.
19 One of them is the fact that our member companies are
20 subject to domestic and global competition on a scale that
21 is also historically unprecedented.
22 And because of the rapid transformation of a
23 number of our major industries in recent years in many
24 cases they're competing against companies that provide much
25 less or in some cases no health care coverage at all.
26 And so there's a real zero sum game going on in
27 terms of how much money companies are willing to spend.
28 And the current state of the economy certainly adds to that

1 situation as well.

2 As a result, the budgeting and planning processes
3 within companies with respect to the coverage they provide
4 has also been completely transformed. As a result, that
5 means that in the current fiscal environment when either
6 the federal government or in the case of an insured product
7 a state government enacts a benefit mandate those mandates
8 do not result in net increases in coverage.

9 As somebody expressed earlier, they result in
10 reallocation of coverage between different individuals
11 depending on their health status and what their particular
12 conditions are. Or maybe to put that another way,
13 employers have a pie that has a limited number of dollars
14 that they are going to spend on health care coverage.

15 And that pie is not growing. If anything, it's
16 shrinking. And so when their health plan becomes subject
17 to a benefit mandate the pie doesn't grow, the pieces of it
18 just get reallocated between the coverage.

19 And that may be higher cost sharing for all
20 individuals in the plan. It may be a new mandated benefit
21 is offset by the elimination of some other benefit from the
22 coverage.

23 In essence, there is now a competitive
24 environment where individual covered services or whole
25 categories of covered services are literally competing with
26 each other to either stay in the most favored level of cost
27 sharing under the plan or even to remain a covered service
28 in the plan at all.

1 And not only that, not only do various kinds of
2 covered services compete with each other within the health
3 plan as somebody else mentioned they compete with other
4 forms of benefits with separate benefits provided under
5 vision, dental, life, disability, pension plans, stock
6 ownership plans. There’s a compensation pool.
7 And so in terms of employers design choices
8 covered services that have a poor perceived value to a
9 company’s employees is very likely to be subjected to
10 higher deductibles, co-pays, insurance, or possibly left
11 out of coverage altogether because what the employer is
12 trying to do is take a limited pie and allocate it in a way
13 that is going to provide the greatest perceived value to
14 their employees.
15 And as a result, as I said earlier, just as a way
16 of wrapping up, basically each time a benefit is mandated
17 by the state government or the federal government that
18 mandate is going to be offset by a benefit reduction of
19 equal or greater cost in some other area. So that is
20 really the context that we are talking about in terms of
21 trying to assess the impact of these various policy-making
22 requirements.
23 How do mandates impact plan design decisions?
24 Let’s talk first about the insured arrangements. And as I
25 said, a lot of people assume that large employers provide
26 their coverage largely through self-funded plans. I mean,
27 in fact, the measures are really pretty bad but in fact
28 something under 50 percent of the marketplace, possibly as

1 little as 40 percent of the marketplace is actually covered
2 provided through self-funded plans. So there's a big chunk
3 of the market that remains fully insured. And that is true
4 even among our members for the reasons I mentioned earlier.
5 But in some respects the potential impact of a
6 benefit mandate on a large employer can be even greater
7 than it is on a small employer that only does business in a
8 single state because if a large nationwide company, like
9 many of our members, wants to contract with a national
10 carrier or wants to provide uniform benefits across its
11 entire workforce by contracting with a multiple number of
12 carriers they are forced to adopt the coverage that
13 aggregates the most restrictive provisions of all of the
14 related state benefit mandates in all of the states in
15 order to ensure that what they offer complies with all of
16 the states simultaneously. So there's kind of this
17 aggregating and magnifying effect of the mandates for large
18 national employers.
19 The alternative is that they abandon providing
20 uniform coverage to their employees and then instead cope
21 with the administrative hassle and cost and complexity of
22 trying to comply with overlapping and inconsistent state
23 mandates.
24 So the cost of the mandate is not just the cost
25 of the mandate itself but how it interacts with other
26 competing states and how the employer organizes itself in
27 terms of trying to comply with all of those competing
28 requirements.

1 On the self-funded side, even though technically
2 state law cannot impose a benefit mandate directly on an
3 employer-provided plan there's frequently leakage from the
4 insured side to the self-insured side where a large company
5 is contracting with a large national carrier on
6 administrative services only, an ASO basis.
7 If, in fact, the self-funded plan were to operate
8 exempt from all of those big mandates that ASO would have
9 to maintain a separate management system for the benefits
10 separate from their insured business. And in many cases,
11 especially with respect, for example, to claims review
12 requirements and external review, it's simply too much of a
13 hassle to do that, and so the ASO providers actually wind
14 up administering self-funded plans in ways that are
15 consistent with the state law mandates simply because it
16 would be too expensive to maintain a separate parallel
17 system. So there is a substantial amount of indirect
18 leakage even where the state law doesn't directly, legally
19 apply.
20 Let me talk for a couple of minutes, just as an
21 example of some of these issues about mandated mental
22 health parity since that's one of the issues that has been
23 raised today.
24 First of all, there's a very, very wide range of
25 what people mean by parity or what parity applies to. In
26 some cases it's as narrow as a specified list of six or
27 seven serious disorders that have to be covered.
28 In other cases it's full parity across the board

1 with respect to both cost sharing and treatment limitations
2 between mental health and medical and surgical benefits.
3 So we’re talking about a very, very broad range,
4 conceptually, of mandates.
5 Mandated coverage of a specified list of serious
6 disorders has really had, I think it's fair to say, a very
7 modest impact on ERIC members. Our member companies
8 because they’re very large tend to offer comprehensive
9 coverage to begin with. I’m not aware of any of them that
10 exclude any of these specific disorders, and because of the
11 nature of the mandate doesn’t directly go to benefit plan
12 design issues it’s really relatively easy to comply and so
13 there’s not a lot of disruption that’s associated with it.
14 Full parity, however, is an entirely different
15 matter and has the potential to be exceedingly disruptive.
16 On the state level there have been a number of states that
17 have mandated requirements that purport to be full parity.
18 Flexible interpretation and enforcement by the state
19 regulators has perhaps made the impact of those
20 requirements to be tolerable. Although from the policy
21 perspective of our members it still doesn't, just because
22 it's tolerable doesn’t make it acceptable.
23 But all it takes is one litigant and one court to
24 completely change the equation if you have a restrictive
25 and literal interpretation of what constitutes broad-based
26 mental health parity.
27 And, for example, we had reference earlier to the
28 federal mental health parity bill, the Domenici-Kennedy

1 Bill. That particular bill applies parity not just to cost
2 sharing like deductibles and co-pays and so forth but it
3 also applies it to treatment limitations.
4 Well, what constitutes a treatment limitation?
5 Well, a lot of our member companies provide their mental
6 health services through managed behavioral carve out
7 arrangements. That means that those services are provided
8 through a completely separate vendor, through a completely
9 separate network.
10 And those networks are typically different from
11 networks that provide coverage for medical and surgical
12 benefits. They frequently don't have an out-of-network
13 option. They are frequently a much tighter benefit, a much
14 tighter network, much smaller percentage of the total
15 providers in the service area included in the network.
16 They frequently use much more vigorous
17 utilization management and review. So as a result, the
18 level and intensity of management of the mental health
19 benefits is not the same as it is for medical and surgical
20 benefits.
21 Well, in the context of a bill that prohibits
22 differences in treatment limitations, all of these more
23 intensive techniques place greater limits on access to
24 treatment than would be the case for medical and surgical
25 benefits under the less intensively-managed companion
26 coverage. That means that under the Domenici and Kennedy
27 Bill many of, if not all of, the managed behavioral carve
28 out arrangement that I'm aware of that have been touted as

1 making mental health parity affordable would, in fact, be
2 illegal under the bill.
3 So what I’m saying is that functional parity, in
4 terms of trying to achieve the end of providing appropriate
5 health care coverage for mental illnesses, functional
6 parity is not equivalent to legal parity. And it’s very,
7 very important when we talk about these mandates and we
8 talk about the impacts of the mandates or the potential
9 impact of mandates to focus on what these requirements
10 actually say, not what is being said as to what their
11 intended effect is intended to be.
12 For example, reference was made earlier to a
13 number of studies that have said the cost of mental health
14 parity would be relatively low including a number of
15 studies, including a Pricewaterhouse study.
16 And ERIC was one of the organizations that
17 financed an earlier Pricewaterhouse study that found that
18 the cost would be about 8.6 percent. And the reason for
19 the difference between the two is the difference in the
20 assumption of the legal interpretation of how parity would
21 work. And specifically the studies that have found that
22 the cost would be low assume that these managed behavioral
23 carve out arrangements would be able to exist in the
24 marketplace and keep costs low rather than requiring that
25 the mental health services be provided on the same basis as
26 the fee-for-service medical and surgical benefit they are
27 coupled with.
28 If that assumption doesn't apply because the

1 legal interpretation of the mandated benefit has not been
2 correct then the validity of the cost estimate goes out the
3 window in terms of the cost effectiveness of mental health
4 parity.
5 At that point -- I see my time is up. I think
6 maybe I would make just one last comment about mental
7 health parity and then conclude, which is there's been a
8 lot of discussion over whether the treatment of mental and
9 behavioral conditions are, in fact, fully equivalent to
10 treating medical conditions. I've forgotten now -- some of
11 the other panelists may be able to remind me -- there's
12 been even a recent article talking about the medicalization
13 of mental and behavioral health care. Even if you accept
14 that the two are clinically equivalent to each other, there
15 still are legitimate reasons for making distinctions
16 between mental health and other services.
17 For example, the elasticity of demand for mental
18 health services is much higher than for medical and
19 surgical services. And it's been found by one study, for
20 example, to be 50 percent higher. What that means is that
21 if you lower the cost sharing for mental health services
22 the same amount you lower them for medical and surgical
23 services you can expect a 50 percent greater increase in
24 utilization of mental health services than non-mental
25 health services.
26 So I'm not talking about the clinical equivalence
27 of the treatment. I'm talking about the consumption
28 behavior of individuals when faced with that kind of a cost

1 sharing. And one of the reasons why my member companies
2 have higher cost sharing with respect to mental health
3 services in many cases is to counterbalance this greater
4 propensity to consume services when cost sharing is lower.
5 So there are other reasons other than the stigma
6 associated with mental health that I think can explain some
7 of the reasons for differential treatment even among
8 companies who have publicly stated their support for mental
9 health parity. So with that let me conclude and I look
10 forward to our panel discussion later on. Thank you.
11 MS. MATHIAS: Thank you, Anthony. And finally we
12 have David Hyman.
13 (Applause.)
14 MR. GITTERMAN: Maybe we should just skip you,
15 David.
16 MR. HYMAN: Well, I was going to say the principle
17 virtue of the last speaker is to finish as quickly as
18 possible, either so you can have discussion of the
19 tremendously rich presentations that we've already had or
20 so that everybody can go home or both. Not saying which
21 order.
22 I've got my academic affiliation up here. I'm
23 actually Special Counsel here at the Federal Trade
24 Commission and so I'm required to make a standard
25 disclosure that nothing -- or disclaimer.
26 MS. MATHIAS: Disclaimer.
27 MR. HYMAN: Disclosure and disclaimer, Sarah, that
28 nothing that I say represents the views of the Federal

1 Trade Commission or any of the Commissioners.
2 This is an interesting topic from both
3 theoretical and practical perspectives. I think you've
4 certainly heard enough to make that point so I'm not going
5 to belabor it. There is a rich academic literature both --
6 not just both -- economic, legal and political science on
7 these issues and I've listed four articles that much of my
8 remarks are drawn from, the last of which is obviously
9 mine.
10 Let me just start with, I think, the best case
11 scenario for why you ought to mandate benefits, why it
12 makes sense to think about mandating benefits even in an
13 extremely competitive market.
14 The first is information asymmetry. Patients may
15 know a lot about their condition but they may not, but they
16 don't know a lot about insurance. I teach insurance law
17 and I ask my students has any of them read their insurance
18 contracts. And most of them have a whole variety of
19 insurance contracts even as law students, maybe especially
20 as law students, and I think even in that highly selected
21 group there's at most one or two people that have ever
22 gotten past the first paragraph or so of an insurance
23 contract.
24 And that's not a circumstance that leads you to
25 believe that the contracts are going to reflect tightly
26 people's preferences. Leaving that aside they're
27 incomplete contracts. That is, they say things like we'll
28 cover all medically necessary services but they're not

1 incredibly specific about what that means. They defer
2 until after services need to be provided and paid for the
3 decision as to what's actually going to be covered and
4 which won't. And that's a circumstance that's really ripe
5 for misunderstanding about the scope of coverage and their
6 potential benefits in just getting some mandates to specify
7 what that would be.
8 Related subject is the problem of adverse
9 selection that's been mentioned by several people. Let me
10 give this a very practical spin. Any given employer is
11 going to be extremely reluctant to offer a benefit that
12 will disproportionately attract high cost employees or high
13 cost beneficiaries. So there's a collective action
14 problem.
15 None of them have the incentive to offer that
16 benefit even if they think it makes sense for them to do so
17 because they're going to get selected against and suffer
18 economic consequences as a result. So you don't see people
19 saying we do a great job treating AIDS. Feel free to come
20 and enlist in our program. And that's why you see mandates
21 that sometimes are driven off of specific high dollar-cost
22 conditions.
23 The second reason why you might think it makes
24 sense to mandate benefits or the problem related to the
25 first but distinct, cognitive bias. People are not perfect
26 rationalizing machines as economists like to think they
27 are. They operate with inadequate information under
28 pressures of time and so they use hunches and intuitions to

1 make their decisions.

2 And the more complex those decisions are the more
3 likely you'll see systematic biases developing. When they
4 are emotion-laden decisions like health care consumption
5 the stakes go up even more. And then as if that weren't
6 enough we're all optimistically biased. Each and every one
7 of us lives in Lake Woebegone. We all think we're above
8 average and we're not going to list to ourselves all the
9 conditions that we might get and then try and contract for
10 coverage that maps onto that. Instead, we systematically
11 discount low probability events and as a result it never
12 makes it onto your agenda and you don't contract for it.

13 Third is even if you could contract you're not in
14 a very good situation to do so. Individual patients in
15 dealing with insurers don't have much bargaining power.
16 When you add employers to the mix there are reasons for
17 thinking they're good agents but not perfect agents in
18 dealing with insurers. That, just so everybody is clear,
19 is paternalism dressed up in slightly different clothes but
20 nonetheless that's a common reason why people think
21 benefits should be mandated.

22 The fourth reason is a different form of
23 paternalism but a distinct issue as well, to view health
24 care as a merit good. That is, it's not subject -- it
25 shouldn't be subject to market constraints and
26 circumstances. It should be something you get just because
27 you're a human being. And I think both Ms. Laser and Mr.
28 Ibson nicely articulated elements of that view in their

1 presentation. And it's a widely shared perspective.
2 Fifth is externalities, the decision as to what
3 you cover and don't cover may have adverse financial or
4 health-related consequences for people not subject to the
5 contract. And again, I think we heard nice descriptions of
6 that from both Mr. Ibson and Ms. Laser in the context of
7 the particular mandates that they were arguing for.
8 The sixth, with all due apologies to Stephanie,
9 is that managed care made lots of people nervous about the
10 scope of coverage. Rather than rely on goodwill and
11 relational contracts, you started to see states pushing for
12 specific mandates so that things wouldn't be subject to the
13 vagaries of case-by-case determination. Instead you just
14 make it an across-the-board rule.
15 Now, I'm a law professor and law professors do
16 models. So this is a model and it's just to show you that
17 there are different kinds of mandates that track different
18 types of relationships. There are really three entities
19 that are relevant here, the patient, the physician and the
20 insurer.
21 And you can have mandates that affect each of
22 those three relationships. And so I just unimaginatively
23 call them Type I, II and III. And I've just given you some
24 examples of this so you see the different things that you
25 could call mandates, not just benefit mandates as several
26 speakers have commented but mandates more broadly.
27 So any willing provider is a Type I mandate. It
28 affects the relationship between the insurer and the

1 physician. And I'm giving you some of the variance there.
2 Freedom of choice, due process, mandatory admittance.
3 There are others. The gag clause issue that everybody was
4 excited about a few years ago is a similar Type I mandate
5 and then the whole array of restrictions on compensation
6 are also Type I.
7 Type II, physician-patient relationship mandates.
8 There's been a lot less activity here but there has been a
9 little bit forcing physicians to disclose the economic
10 incentives that they operate under. The interesting, from
11 a consumer information perspective, requiring them to
12 disclose their results and what their qualifications are to
13 perform particular interventions. And then not
14 surprisingly the economic one, a prohibition on balanced
15 billing that some of the states have opted for in dealing
16 with Medicare.
17 Type III mandates are where most of the action
18 has been in terms of actual total numbers of mandates. If
19 you look at individual states, and it's this whole array of
20 direct access to specialists, mandatory point of service
21 options, a variety of specific coverage issues and we've
22 talked about some of these but by no means all of these
23 today.
24 Expedited appeal of coverage and liability
25 issues. And just so everybody remembers Type III is the
26 relationship between the insurer and the individual patient
27 with respect to coverage.
28 Now, six questions to ask yourself about any

1 mandate and I'll ask them and then try to answer them.
2 It's the sort of standard who, what, where, why we all
3 learned in grade school as to what goes into a newspaper
4 article.
5 Who benefits from the mandates? I think the
6 general rule is the people receiving the services benefit
7 but so do the providers of those services. And not
8 surprisingly that has predictable consequences on the
9 coalitions that arise seeking to get these things into
10 effect at both the state and federal level.
11 Who pays for it? Well, we've heard about this
12 from several speakers. It's not the beneficiaries who pay
13 for it, it's the aggregated insurance pool that pays for
14 it. It's essentially a tax but it's a tax not on the
15 general population even though it's imposed by the state
16 legislature or the federal legislature. It's a tax on
17 everybody in the insurance pool.
18 What is the cost of those benefits, of the
19 mandate? And here I identify two distinct costs. One is
20 the simple cost of the mandate itself for the people who
21 receive those services. The second is what the literature
22 calls displacement or I would call crowding out. Some
23 people, when the choice is pay $10 extra for the service or
24 go without, go without. So they drop insurance coverage.
25 They lose their job. Displacement is a possible outcome of
26 benefits at the margins.
27 Third, where are we going with this? What's the
28 sort of logic driving this mandate as opposed to all of the

1 other mandates and how do we think about them collectively?
2 Do we really believe that the state legislature is the
3 optimal circumstance for specifying coverage.
4 When do we decide whether we're actually making
5 things better or things worse? Not every action undertaken
6 by state and federal legislatures has the desired
7 consequences and so some mechanism for looking
8 retrospectively is going to be quite helpful in deciding
9 whether to reverse course.
10 Why is it worth doing? The sort of cost-benefit
11 trade-off often informed by hindsight will tell you that
12 you maybe leaving well enough alone was the right thing to
13 do and maybe not. It depends on the specifics and the
14 mandate and the consequences that followed.
15 And finally, how does the particular mandate that
16 you've opted for fare against the other alternatives that
17 are available? It is always comparative. Compared to what
18 should be the question you ask about mandates or any other
19 regulatory action.
20 Now, let me give you six reasons why you ought to
21 be skeptical of mandated benefits and then I'm going to
22 follow up with five reasons why you ought to be skeptical
23 of those six reasons.
24 The first is if you look both in theory and in
25 practice our experience with mandates is really not all
26 that reassuring. With respect to theory for the mandate to
27 outperform private contracting or whatever the other
28 alternatives are the people doing the mandating need a lot

1 of information. They need good information. They need it
2 on a real-time basis and they need to use that information
3 instead of ignore that information.
4 Second, they have to have the right incentives.
5 They have to trade off costs against benefits in a way that
6 makes sense for the people who they're trying to protect by
7 mandating the benefits. And they have to know what those
8 people's preferences are, that sort of information as well.
9 And the problem is if you actually look there
10 doesn't seem to be much evidence to suggest that state or
11 federal legislatures do all that well on any of those
12 parameters, on information incentives or preferences.
13 Not surprisingly, if you look at mandated
14 benefits and Stephanie has already talked about autologous
15 bone marrow transplant. I've added drive-through
16 deliveries a subject I've looked at in considerable detail
17 and wrote about in even more tiresome detail.
18 These are nobody's idea of mandated benefits that
19 resulted in the consequences that people thought they
20 would. Bone marrow transplant we basically mandated
21 coverage of a procedure that affirmatively harmed women.
22 Drive-through deliveries, thankfully, doesn't
23 appear to be harming women although it essentially has a
24 whole series of additional consequences, some of them not
25 so clearly desirable. They crowded out alternative
26 arrangements for the delivery of postpartum care and it
27 cost a fairly significant amount of money for a population
28 that really, some of them need it and lots of them don't.

1 And I'm happy to share the 100 page article I
2 wrote about this if you really want to read it. And
3 Stephanie cited the New England Journal article on this. I
4 think the report that Congress required be prepared came to
5 the same conclusions. Pediatrics did an article about it
6 that came to the same conclusions. It still happens to be
7 the mandate in effect for postpartum care.
8 The second problem I mentioned earlier is:
9 capture of provider protection. This is the public choice
10 problem. Mandates are principally the consequence of
11 provider protection more so than consumer protection.
12 There are exceptions but the general trends are
13 unmistakable.
14 The third problem is institutional competence.
15 People may not make good decisions but state legislatures
16 and Congress don't necessarily make good decisions either.
17 Now, you know why I had to make the disclaimer at the
18 outset.
19 They're not very good making cost-benefit trade-
20 offs. And they're not very good at differentiating what
21 real quality is from pseudo-quality. By that I mean things
22 that end up on the front page of the newspaper as a
23 horrific outcome but that don't necessarily track onto what
24 real quality is.
25 They also tend to be extremely anecdote driven
26 and they're much more interested in issuing good press
27 releases than trying to get a handle on what the data is.
28 And it's hard to get the data. I mean, Dan has already

1 mentioned the fact that the timescale for figuring out the
2 data is often a year or more. The timescale for deciding a
3 mandated benefit is this week.
4 The final problem is coordinating oversight and
5 we have heard a little bit about this. Each state goes off
6 and mandates its own benefits. And it doesn't think very
7 much about the benefits it has mandated before. It doesn't
8 think very much about coordinating those mandates with the
9 mandates that other states have thought sensible. And when
10 you add into that the complexities of ERISA and Medicare
11 things get very complicated very quickly which creates its
12 own transaction costs.
13 The next problem is moral hazard. When you cover
14 something -- this is the if you build it they will come.
15 When you mandate a benefit people use that benefit and they
16 disproportionately show up and use that benefit and that
17 can drive up costs in its own right.
18 And if you view their obtaining access as the
19 principal virtue that doesn't bother you in the slightest.
20 If you're worried about trading off coverage, one against
21 another, you start to get very concerned because the
22 mandate itself is not necessarily very finely grained.
23 The fifth problem is costing out mandates. We've
24 heard about this a little bit. Each mandate is viewed in
25 isolation. Nobody asks what's the aggregate cost of
26 mandates. A related strategy is to express each mandate in
27 terms of the dollar per member per month or per day or less
28 than the cost of a Big Mac. I mean, these are all ways of

1 dividing a big number by an even bigger number to get a
2 smaller number that makes it look very reasonable to do the
3 mandate. That's not really a very effective way of asking
4 the question which is is the money you're spending worth
5 the benefit you're getting from the perspective of the pool
6 as a whole.
7 The final reason to be skeptical is because it's
8 voted on by people who don't typically bear its costs; they
9 treat it as a free lunch but it isn't. It has to be paid
10 for by the beneficiaries of the services.
11 Now, let me turn around and give you five
12 problems with the critique I just made. The first is that
13 the figures that get thrown around about the costs of
14 mandates are systematically skewed upward. And the reason
15 is they focus on the aggregate costs of all mandates and
16 mandates often replicate what is covered in the private,
17 i.e., unregulated market.
18 So figures that say 18 or 20 or 30 or even higher
19 percentage of the cost of health insurance is attributable
20 to a mandate doesn't tell you anything if many of those
21 mandates simply parallel what's already provided in the
22 market and would exist even were there not mandates. So
23 that's not really a fair comparison.
24 The second is displacement. Trading off coverage
25 or not and employment or not is usually presented as a
26 binary choice, either you have insurance or you don't.
27 It's more often a continuous function. You trade off the
28 content of the policy rather than lose the insurance

1 outright.

2 At the margins people do walk away but it is not
3 so clear that mandates are driving people not having
4 insurance. In fact, the experience with bare bones
5 coverage where when you offer coverage without any of these
6 mandated benefits people don't actually take it very
7 frequently suggests that what's going on is not really
8 necessarily the result of the mandates alone.

9 The third is there are benefits to
10 standardization. Mandates do make it harder for
11 imperfections in the market to result from ignorance about
12 the substantive content of the terms. They make people --
13 they set some terms and then they force people to compete
14 around those terms, principally on price rather than on
15 both price and coverage benefits. And if you want to
16 encourage that kind of competition that's what you do.

17 Fourth is don't discount the symbolic benefits of
18 legislation. It is unrealistic to expect legislators to
19 walk away from motherhood and apple pie issues on the basis
20 of theoretical law professor type arguments about why they
21 should. I mean, Dan mentioned Congress doesn't listen to
22 economists. The good or bad news is they don't listen to
23 law professors either.

24 Finally, there's the issue of federalism. All of
25 the states are busily mandating things but that's part of
26 which states are supposed to. That's the virtue of the
27 federalist system is to allow each state to go off and be a
28 laboratory for democracy.

1 So where does that leave us? Well, the pessimist
2 view is our old standby, I'm from Washington and I'm here
3 to help you is what's going on with mandates. The
4 pessimist redux, which a prominent health economist said to
5 me when I told him we were looking at a different but
6 similar subject was, yeah, maybe this would work if it was
7 done by angels but failing that you might as well just
8 scrap it entirely. The optimist version of this is the
9 private market isn't going to give people what they want
10 and mandates can actually fix this at no on-budget cost.
11 So let me give two slightly more intermediate
12 formulations that I think will give you my bottom line.
13 This is from Russell Korobkin's Cornell article that I have
14 referenced in the second slide. And as Russell points out
15 in some circumstances, critical language "some," consumers
16 might prefer to pay for benefits that the market for health
17 insurance doesn't provide rather than enjoy a reduced level
18 of benefits at a lower price.
19 We have to pay for all the benefits that we wish
20 to receive but we can use government mandates to ensure
21 that we receive all the benefits for which we are willing
22 to pay. So mandates can actually be a market correcting or
23 supplementing form of regulation.
24 And then last was the article I wrote pointing
25 out that not surprisingly horror stories do give rise to a
26 demand for regulation but any way of approaching this is
27 going to create its own imperfections. And the issue we
28 should focus on is getting the institutional arrangements

1 right rather than trying to specify individual coverage.
2 As the last line in the article points out this strategy
3 lacks the moral certainty of stringing up a few managed
4 care desperados in black hats, but it’s going to do more to
5 improve the status quo than any ten patient bills of rights
6 or mandates. Thank you.
7 (Applause.)
8 MS. MATHIAS: Thank you, David. I have a ton of
9 questions but we are somewhat limited on time, and I think
10 as the panelists have listened those that come early or
11 start at the very beginning don't have a chance to respond
12 unless I give it to them at this point. And so I have seen
13 various panelists scribbling notes and I think it makes
14 sense to give them an opportunity to kind of raise some of
15 the issues or address some of the issues that have been
16 raised by others. And then, time allowing, we will move on
17 to some questions. So I’ll start with Dan and see if
18 there’s anything he would like to comment on that was
19 raised so far.
20 MR. GITTERMAN: I’ll pass.
21 MS. MATHIAS: I’m going to skip over you Tom and
22 come to Ralph.
23 MR. IBSON: I’m afraid it would probably end up
24 being largely inside baseball for me to walk you all
25 through the niceties of mental health parity legislation.
26 As I hear criticism, suggestions that there is, that we
27 will encourage undue consumption of services, that
28 provisions of pending legislation will result in managed

1 behavioral health care organizations not being able to
2 manage care, I could certainly share with you the flaws in
3 those arguments.
4 Indeed, I can confidently say that mental health
5 advocates would be more than happy to sit down with
6 opponents of this legislation to arrive at language that
7 addressed those kinds of concerns if those conversations
8 were to result in the enactment of legislation.
9 I fear that many of the arguments are strained at
10 best and believe that, fundamentally, the disparity in
11 coverage is so pervasive and so troublesome not simply for
12 the insured but for society at large, taxpayers, business
13 people, communities, that to establish in law that at a
14 minimum there be parity in terms of financial requirements
15 and treatment limitations subject to maintaining, as the
16 bills do, the opportunity for managed care to manage in the
17 manner, in the more intense manner that it does the medical
18 side, is desperately needed. Thank you for the opportunity
19 to comment.
20 MS. MATHIAS: Stephanie?
21 MS. KANWIT: Two quick comments. One on the
22 mental health parity. I think everyone in the audience
23 knows that we, in fact, have a mental health parity bill
24 that has been enacted in 1996. And in fact the American
25 Association of Health Plans, which I don't know if people
26 know, has been supporting many of the provisions of that.
27 I think to Mr. Ibson's point, one of the only
28 things we commented about we wanted to make sure that the

1 things that were covered in the bill were allowed the
2 managed care, the utilization management review, et cetera,
3 so that the employers, as Mr. Knettel pointed out, would
4 have the ability to do that.
5 And secondly, that disorders such as jet lag or
6 religious diffusion would not be part of it. In other
7 words, everything in the DSM-IV wouldn't be covered, that
8 there would be some limits on that, obviously for cost
9 reasons. But that there is a consensus, I think, that we
10 must be working to get appropriate mental health care.
11 Secondly, to David Hyman's very excellent summary
12 of all the issues -- he raised some of the issues why
13 mandate benefits, for example, informational asymmetry and
14 cognitive bias, all of which are terrific. I think we also
15 have to remember that we already have many mandates out
16 there that cover some of the problems that David raised.
17 For example, HIPAA, as I believe I mentioned, has
18 a prohibition on health status-related discrimination. The
19 Americans with Disabilities Act has provisions that many
20 have interpreted as not allowing people to carve AIDS out,
21 for example, when you pay for cancer and whatever but you
22 wouldn't pay for AIDS.
23 So we already have many laws on the books that
24 solve some of those problems rather than going into it on a
25 benefit mandate by benefit mandate basis. And I think
26 that's important to remember.
27 MS. MATHIAS: Rachel?
28 MS. LASER: Really enjoyed everyone's

1 presentations and think I learned a lot. I really don't
2 have much to say except that the argument that states
3 getting to mandate coverage for certain benefits creates a
4 system of disuniformity and asymmetry isn't a persuasive
5 argument, I guess, for me. Just because if there's a
6 mandate that would be good public policy and corrects a
7 flawed marketplace that certain states are passing but
8 other states haven't gotten to because of their politics it
9 still seems like it's a better solution and a more
10 equitable solution than having none of these state
11 mandates.
12 MS. MATHIAS: Actually, I want to jump back to Tom
13 because I think that was my original order.
14 MR. MILLER: The fundamental political economy
15 will have as many mandates as you can get away with and you
16 can afford. When you hit the ceiling, the limit, it will
17 bounce back.
18 Mental health's a classic example of that. Sure
19 there's a mandate there but it didn't have much of an
20 effect. There was Swiss cheese throughout it. It made
21 everybody happy. They got to do the symbolic mandate and
22 they went home and then come back in another five years and
23 argue about the next round of it.
24 So some of this is somewhat shadow boxing to say
25 we did the symbolic thing and we cared. We showed that we
26 cared but we didn't do much more than that. Not that I'm
27 in favor of it in particular.
28 David's point about the costs of the mandates

1 being imposed upon the insurance customers in the pool --
2 you've got to remember which pool you're talking about.
3 There's often this idea that there's this grand pool where
4 you know it's like wetlands, no dollar ever escapes the
5 health care system. No net loss because if that dollar
6 escaped we'd have less health care.
7 But, in fact, different people pay these amounts
8 in different types of insurance pools. It could be at the
9 small employer level. It could be a pooling of the small
10 group as a whole. It could be the self-insured employer.
11 It could be the individual buying individual policies and
12 it could be very different in terms of the income effects
13 as to whether or not, yeah, it costs a little bit more but
14 I kind of like that as opposed to someone who's really
15 scratching and clawing to cover a lot of their needs in
16 life and can't afford that extra premium in order to have
17 coverage where their employer can't as well.
18 Again, in terms of federalism, we need a more
19 dynamic concept of federalism than just, ah, we can close
20 the borders. You can't get out so I guess this is the one
21 you're stuck with until you get a U-Haul and move out.
22 There are ways in which different state
23 governments can compete as true laboratories of democracy
24 but we do have a concept although you can stretch it too
25 far of the dormant commerce. I know the FTC doesn't want
26 to stray in this direction with insurance. You've had
27 enough of your jurisdiction clipped in that regard.
28 Nevertheless, the idea of actually having real

1 competition which serves the customer is the right type of
2 federalism and the state governments could be proxies as
3 regulators to engage in regulatory competition as well as
4 competition among providers.
5 Standardization is important but we always forget
6 that we can have standardization of more than one standard.
7 There is nothing wrong with saying maybe there's three or
8 four boxes of the standards to choose from as opposed to
9 one size always must not fit anyone but that's the only
10 thing we can get through the legislature.
11 MS. MATHIAS: Anthony?
12 MR. KNETTEL: Well, I would just reiterate one of
13 the points, I think it was Stephanie, originally made which
14 is that in the current federal policy-making context we are
15 no longer talking about uniform federal standards versus
16 state standards but now the incredibly complex interaction
17 of federal floors with state flexibility to provide
18 additional standards on top, which, in some respects, is
19 the worst of all possible worlds because you get the very
20 large compliance, and HIPAA is an example, you get the very
21 large compliance costs with the federal standard but then
22 all of the additional potential liability and compliance
23 costs related to the absolutely impossible task of trying
24 to reconcile all of the divergent state privacy laws with
25 the federal standards.
26 So it isn't just -- I'm not sure exactly what you
27 would call that in terms of federalism terminology where
28 you have this hybrid but in many respects the hybrid

1 situation is the most difficult of all.
2 MS. MATHIAS: David?
3 MR. HYMAN: I would call it full employment for
4 lawyers. And as someone who trains lawyers I'm devastated
5 to hear that. Just two quick additional points. I think
6 it's important to realize that there are cognitive biases
7 that are going to operate with regard to the purchase of
8 things like insurance but it's also important to recognize
9 that state legislatures are subject and federal
10 legislatures are subject to cognitive biases as well.
11 So the comparative institutional issue turns out
12 to be much more complicated than just saying private
13 market, bad; regulation, good. End of discussion.
14 The second point is although there are
15 informational asymmetries in coverage issues the benefit,
16 the circumstances where you get the mandates are precisely
17 where there is enough information out there for people to
18 organize and lobby in favor of mandates.
19 So the irony is the things you don't mandate are
20 the things that you would be worried about getting left out
21 of insurance coverage, and the things that you do have the
22 lobby and mandate are the things that are probably going to
23 be handled perhaps not at the level of the merit good that
24 the advocates might want but nevertheless will at least be
25 salient to the people who are negotiating these contracts
26 for coverage.
27 MS. MATHIAS: One of the comments that we have
28 been hearing today and just now during the free-flowing

1 comments is the possible need for, well, the complexity of
2 dealing with the mandates as they grow across the 50 states
3 and are implemented.
4 And one of the early comments on Professor
5 Gitterman's presentation was that maybe there is some need
6 for standardization. I think we've kind of talked about
7 that, but that raised the question in my mind of how would
8 that really work? Would there be a federal steering
9 committee that kind of created some sort of standards or
10 would there just be more federal mandated benefits and try
11 to get rid of some of the state benefits that we have.
12 And the third question on that to raise to the group
13 is how does that actually improve competition or does it
14 improve competition and benefit the consumers? So
15 hopefully there'll be at least one taker for that question.
16 MR. HYMAN: That would be Dan.
17 MS. MATHIAS: Very good.
18 MR. GITTERMAN: Well the standardization I was
19 talking about was not of regulation; it was of benefit
20 packages. And I agree with his point that there could be
21 different standards across these different markets.
22 You know, the compliance issues are huge here and
23 it probably would be very important to this debate if we
24 had better information from the plans and industry about
25 the actual administrative costs that are involved with this
26 multilevel of compliance. That's not a number or debate
27 that I think we've had other than anecdotally.
28 MS. MATHIAS: Stephanie.

1 MS. KANWIT: You could do this in a couple of
2 ways, Sarah. One, you could make everything federally
3 regulated the way we do under ERISA and somebody said that
4 at the end, who was it?
5 MS. MATHIAS: Tom.
6 MS. KANWIT: It was Tom. You just make everything
7 come under. You have some sort of an optional system where
8 health insurers or health plans or TPA's, third-party
9 administrators, all go under a federal level, get only
10 regulated by the Department of Labor, Department of
11 Treasury, HHS, pick your regulator, but you just have one
12 regulator and everybody is subject to the same kinds of
13 rules. That’s one of the ways you’d get some sort of
14 uniformity.
15 On the cost issue. Those costs are really hard
16 to pin down, Dan. I think one of the problems has been
17 getting data on how much it costs to comply with this
18 administrative complexity. I know in the HIPAA privacy
19 area one of our plans, Highmark, which is in Pennsylvania,
20 which is not an enormous plan like an Aetna or a Cigna,
21 enormous health insurer, basically said it cost them $150
22 million to date to comply with HIPAA privacy regulations.
23 Just one insurance company in Pennsylvania. So you
24 multiply that among everybody just as Anthony made the
25 point.
26 The worst of all possible worlds in HIPAA you
27 don’t know what regulation is supposed to apply and you
28 have to figure it out. That is not a way to run a

1 railroad. We can't have a system where you don't even know
2 which rules are supposed to apply.
3 MS. MATHIAS: Tom?
4 MR. MILLER: The problem with centralized
5 regulation at the federal level is it is one-stop shopping
6 but not one-stop shopping for the health care consumer.
7 It's one-stop shopping for the lobbyists and the interest
8 groups. And they've become much more effective and
9 efficient in dealing in kind of a Washington Inc. Witness
10 the Department of Education since it federalized as opposed
11 to kind of balkanizing it out through the states.
12 And it's always the second best case scenario but
13 in most cases it is better to have 50 small mistakes, even
14 if that seems like too many, than one really big one. And
15 in thinking of HIPAA it sounds like a pretty good example
16 in that regard.
17 We have got a complex set or rules. I know it's
18 not the exclusive rules because you can actually do
19 something else on the state level but we've got kind of the
20 appearance of protecting privacy which didn't deliver that
21 but what it delivered was a lot of costs, a lot of
22 nuisance, and a lot of confusion.
23 So that's pretty much what happens when you route
24 this through the centralized bureaucracy to square a circle
25 that couldn't be handled politically because, in fact,
26 people thought of it in different ways as to what they
27 would want.
28 Markets standardize but they only standardize to

1 a certain degree that's justified. I mean, you don't go
2 into a store and find 500 brands of everything that's
3 different prices throughout. At a certain point there's a
4 limitation on choice because that's where the dollars are
5 and that's how people decide.
6 We can't handle every choice every minute in a
7 spot market but it does narrow down to the reasonable range
8 of choices if, in fact, people are controlling the
9 resources and voting with their dollars.
10 MS. MATHIAS: One of the comments that David made
11 earlier was the fact that the employment-based insurance
12 decisions that are made are somewhat paternalistic. It
13 seems to me that, likewise, state and federal mandates are
14 paternalistic as well.
15 And one of the areas that seems to be developing
16 right now is consumer-driven health care plans. And I'm
17 just kind of asking for some education here, whether or not
18 -- it's my understanding that under some of the consumer-
19 driven health care plans or the idea of it is the consumer
20 is given an amount of money to spend on their health care
21 as they think it's necessary which would allow some
22 choosing and self-analysis of what kind of care they need
23 and don't need.
24 How would that fall under the umbrella of some of
25 the mandated benefits or does it fall outside of it like
26 some of the self-funded and ERISA plans? I don't know if
27 anybody has the answer to this question but it's kind of an
28 idea that arose as the presentations were going on.

1 MR. MILLER: I've been doing some work in that
2 area and will probably have a paper out in the fall. It is
3 a little confusing -- first of all, there's a lot more
4 rhetoric about consumer-driven insurance than experience.
5 They're taking off and doing fairly well and the early
6 experience which is not, you know, definitive in terms of
7 cost savings seems to be pretty good and the selection
8 concerns are knocked down.
9 But remember this is consumer-driven with a
10 governor on the speed at which they can drive. There's
11 always kind of someone sitting next to them with a
12 learner's permit. They've only got a learner's permit.
13 They only get to kind of drive so much with so much of a
14 tank of gas.
15 It tends to be kind of a narrow range in most of
16 the HRA health reimbursement account plans within it you're
17 dealing with about $1000 up for grabs in terms of cost
18 sharing, maybe a $1000 to $2000 in the individual account.
19 And there's a lot of kind of remaining employer steering to
20 make sure they do the right thing and they cover all the
21 early benefits.
22 So we are well short of kind of the wild west
23 frontier that people would have imagined and had horrors
24 about of a pure defined contribution where you've got your
25 check in the mail and you're out there wandering through
26 the jungle of the individual market not knowing what you'll
27 find.
28 It's also still the regulatory environment for

1 turning folks loose in a better individual market is not
2 fully worked out and we’re still straddling in that regard.
3 Having said that, the experience with medical
4 savings accounts was with most of the states, the HIPAA
5 qualified MSAs, they got past the problems with the
6 mandated benefits for the early dollar coverage. There are
7 a few states who were outliers on that and held on for
8 awhile. I think Connecticut just went the other way.
9 So to a large degree if you have a deductible,
10 they call it a deductible, then you’re in effect paying
11 cash with this some type of tax advantage account that
12 bypasses most of the early dollar -- and most of these
13 mandates tend to focus upon early dollar coverage
14 decisions. It’s more the discretionary care that gets
15 mandated.
16 People are not mandating that you have to get
17 intensive care when you have a life-threatening illness. I
18 think we’ve got that one figured out that if you buy
19 insurance or if you get into the hospital in some other way
20 it will pretty much be covered. But over time this might
21 kind of redirect the way in which if people are willing to
22 kind of live with the consequences of their choice and
23 spend their own money then they can get what they want if
24 they’re willing to pay for it.
25 MS. MATHIAS: Does anybody else have a comment to
26 that question?
27 MS. KANWIT: Many of the products being marketed
28 out there all have preventive care as a freebie if that's

1 the right word. In other words, it doesn't count against
2 your assessment allotment.
3 MS. MATHIAS: As a general question and maybe it
4 provides kind of a wrap-up but I'm interested to hear what
5 each of the panelists thinks our role of the FTC and the
6 Department of Justice is in looking at health insurance
7 mandates. Should we be promoting transparency? Should we
8 be promoting better economic or better information going to
9 the legislators before they make a decision? Should we --
10 one person suggested we propose that there might be a
11 moratorium for a period of time to allow people to assess
12 the mandates that exist. Should we be making
13 recommendations maybe that mandates should be re-evaluated
14 every certain number of years because certain things may
15 get mandated? The examples were given earlier about the
16 bone marrow treatment so that treatments that may be
17 thought as good initially turn out to be bad with
18 unintended consequences should they be revisited? Should
19 there be some sort of sunset clause to these because it
20 just seems to be that we keep growing mandates and maybe
21 some of them need to be put to bed? So it's a series of
22 questions just to kind of open it up and see if I can get
23 any answers.
24 MR. KNETTEL: I'll start off. I think among our
25 members their principal priority, and you'd be in a better
26 position to answer than I, what FTC's particular
27 contribution should be. But their number one priority
28 right now is trying to put in place the infrastructure

1 that’s needed to provide for a much more transparent health
2 care purchasing decision-making.
3 You can put an individual at financial risk with
4 a spending account and catastrophic coverage but that
5 doesn't mean you have given them the tools to make a
6 meaningful or appropriate decision.
7 We have known for 20 years that putting moderate
8 and low-income individuals at higher economic risk will
9 reduce utilization but we also know that they're just as
10 likely to forego needed care as unnecessary or
11 inappropriate care. And so simply putting people at
12 financial risk is not the full answer.
13 What we have been focusing on a lot with our
14 members and despite my comments about state-level
15 policymaking at both the state level and the federal level
16 is trying to increase the availability of information with
17 respect to performance standards across the board, health
18 care providers, both clinical outcomes and process
19 performance, health plans in terms of their operations and
20 so forth.
21 And so whatever within its role FTC could do to
22 try to make much more transparent decision-making possible
23 I think would be a huge step forward in terms of bringing
24 out a lot of the unnecessary and inappropriate care we’re
25 all paying for.
26 MS. MATHIAS: Tom.
27 MR. MILLER: Well, since you can’t change the
28 taxes last time I checked the legislation around the FTC

1 that's a bit of a barrier to really straightening out some
2 of this. More information is better although some
3 information becomes in effect redundant or nuisance or
4 bypasses people.
5 It would be nice if, in fact, folks could share
6 information without being threatened with it being called
7 price fixing or other types of coordination under the
8 antitrust side of it. So sometimes it's a little hard to
9 get that information out there.
10 I've suggested perhaps we might be able to get
11 some information out by way of state government health
12 plans where it's a little bit more of a public like a
13 baseline and you can anchor this stuff also to some of the
14 Medicare fixed payment rates as a conversion factor where
15 you can know what other folks are charging.
16 Regulatory, again you're not going to have a
17 regulatory override among what the states are doing last
18 time I checked our system of government but the idea of a
19 sunset provision is reasonable. Not just look at these
20 things but actually have kind of have to force some action.
21 It'd be nice to kind of actually have a self-
22 actuating rule which was a zero sum game. You will add no
23 mandate until you get rid of one. Trade them off. No net
24 loss, no net gain. Which mandates do you want but you
25 don't kind of inflate the bubble further.
26 I would disagree to some extent with the
27 suggestion that by making lower or moderate income workers
28 more sensitive to the cost of their care that somehow this

1 has massive deleterious effects upon their health care.
2 Folks have been living off of kind of a minor
3 factoid in the RAND study in the mid-1970s which found out
4 that folks who suffer from hypertension didn't get screened
5 enough when they had a deductible and in fact that could be
6 easily fixed. And there wasn't very serious evidence
7 beyond that of any type of impairment of the quality of
8 care by having some reasonable significant cost sharing in
9 terms of the health insurance that people were
10 experiencing.
11 MS. MATHIAS: Ralph.
12 MR. IBSON: Just a very quick comment, I guess,
13 and a very modest one at that and take it from my parochial
14 view of the world. I guess I would just urge that you not,
15 that the Commission and the Department not look at mandates
16 as a generalized whole assuming that they are problematic
17 generally but recognize the flaws in the marketplace.
18 Recognize at least from my view of the world the enormity
19 of the problems of stigma, fear, loathing of mental illness
20 and the role that we believe that plays in the kind of
21 insurance coverage that's made available to people with
22 mental illness such that, in our view, there is great need
23 for mandates like mental health parity.
24 Those mandates shouldn't be dismissed and lost in
25 the greater notion that somehow there is this large problem
26 that has to be dealt with en masse.
27 MR. GITTERMAN: I was just going to add that I
28 guess a suggestion when you begin to frame whatever your

1 findings are from this hearing and a variety of the others
2 is much of the complaints have been about the multiple
3 entities that are involved in the regulatory picture and
4 another beast wants a piece of it.
5 One is, I think, in the different type of
6 mandates that David talked about, the Type I versus the
7 Type III, mandated benefits, the Type III is what many of
8 us talked about. It sounded like those other types are
9 more usual types of things that the FTC would be interested
10 in.
11 But I think sort of being very up front about
12 what current jurisdiction is and what are areas that you
13 think amenable to further jurisdiction it would be very,
14 very important because I, since you called and David e-
15 mailed and most of the ride down on Amtrak, I was thinking
16 what does the FTC have to say about mandated benefits. And
17 I think sort of putting that out on the front end it would
18 probably be very useful.
19 MS. MATHIAS: I'm actually going to let Dan have
20 the last word there and call it a day since we are a little
21 bit past 5:00 at this point. I do want to try to keep a
22 promise to you that we would end at 5:00.
23 I did want to recognize that comments and written
24 comments are very welcome on the record. They can be
25 submitted. The FTC and DOJ websites give directions on how
26 they can be submitted. We welcome comments and we will use
27 them as part of our analysis. We will reconvene tomorrow
28 morning at 9:15 here at 600 Pennsylvania.

1 And finally, the FTC and Department of Justice
2 greatly thank our participants for taking the time today to
3 help us and taking the time before today to think about
4 what they could add to the whole analysis. So a round of
5 applause to our wonderful panelists.
6 (Applause.)
7 (Whereupon, the hearing concluded
8 at 5:04 p.m.)
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15 I, Deborah Turner, CVR, do hereby certify that
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