FAIRNESS VERSUS WELFARE IN HEALTH INSURANCE CONTENT REGULATION

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Regulating the content of health insurance contracts, where the government determines which medical treatments and services must be covered, creates tension between principles of fairness and principles of welfare economics. Principles of fairness, after all, may require that all medical losses be shared within a community, while principles of welfare economics would advocate regulation only where there is some form of market failure that leads to an inefficient or suboptimal result. As part of recently enacted federal health care reform, the federal government will, for the first time, have the primary responsibility of regulating the content of privately financed health insurance policies, although the federal government is given the statutory option to borrow heavily from existing state regulation. This Article provides the first comprehensive study of the state legislative process with respect to health insurance content regulation. In the states studied, the author finds that both fairness and welfare claims influence mandate passage, with little reliance by legislators on outside evidence substantiating welfare claims. In contrast to theoretical writings on health insurance content regulation, which emphasize market failure as the primary justification for mandates, this current study finds that mandates were rarely premised on correcting defects in the insurance market. Rather, the justifications provided tend to be more paternalistic in orientation, often based on a desire to increase suboptimal utilization of a particular medical treatment or service regardless of the reason why individuals lack coverage. Even where there is an independent, expert commission providing robust data on proposed regulation, bills with virtually no impact on either health insurance coverage or treatment utilization are passed. Given these

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findings, this Article argues that the federal government should be hesitant to rely upon existing state-level regulation when it defines "essential health benefits" as part of health care reform.

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I. INTRODUCTION

Regulating the content of health insurance through state-mandated benefit laws, where the government determines which treatments and services a health insurer must cover, has always generated controversy. This area of legal policy presents a very clear tension between principles of fairness on the one hand, and welfare economic principles on the other. Fairness,[1] after all, might require that certain types of medical losses be shared within the insured community. Fairness concerns are likely to pull in the direction of broad coverage terms under health insurance contracts. Welfare economics,[2] on the other hand, discourages market intervention, except where there is market failure. Even in cases of market failure, if the welfare gain that would result from requiring health insurance contracts to cover a particular service is less than the welfare loss that would result, the law should not be passed. And in this area, the welfare loss that results can be significant. After all, when government regulates the content of health insurance, premiums typically rise in order to reflect the fact that more types of losses must now be covered by

1. While concepts of fairness (and justice) are notoriously ambiguous and difficult to define, I refer to fairness in this Article to represent a normative principle in health care that requires that certain types of medical losses be shared within a political community, that is unfair for the political community to spread the risk of losses for common conditions while refusing to do so for rare conditions, and that equally deserving conditions affecting equally situated individuals must be treated equally. While "fairness" is often used to refer to John Rawls's theory of justice, I am using the term in this Article more broadly. *See generally* JOHN RAWLS, A THEORY OF JUSTICE (1971) (exploring the concept of fairness).

2. I use the term "welfare economics" in its classic sense, to refer to a market-based utility and efficiency-maximizing norm. There is a third possible frame, libertarianism, which tends in the mandated benefit debates to be subsumed in the welfare economic framework. Given the frequent overlap between welfare economic concerns and libertarianism in this area, I have kept the debate two-sided. *See infra* note 143.

the contract. And as premiums rise, fewer individuals are able to afford coverage, leading to a reduction in the number of individuals with health insurance.[3] In a welfare economic frame, the trade-off, then, is often between covering the greatest number of individuals versus providing comprehensive coverage to those who are covered. Fairness, on the other hand, tends not to focus on cost, but rather focuses on a fair distribution of health care access, treatment, and resources.

Historically, it has been left to the individual states to resolve these tensions. As part of the Patient Protection and Affordable Care Act of 2010[4] (ACA), however, the federal government will, for the first time, take the primary role in regulating the content of privately financed health insurance.[5] The statute itself does not provide the relevant coverage provisions, but rather delegates to the Department of Health and Human Services (HHS) the responsibility for defining so-called "essential health benefits."[6] Congress gave relatively little guidance to HHS; aside from putting in place a few prohibitions[7] and providing ten broad categories of coverage that must be included, the statute otherwise states simply that HHS shall ensure that the scope of essential health benefits is "equal to the scope of benefits provided under a typical employer plan."[8] With this requirement, Congress implicitly provided that HHS will in some way take into account existing state regulation, since over forty percent of workers are covered by plans that are regulated at the state level.[9] The statute, however, is worded generally enough that HHS has

3. *See, e.g.*, David M. Cutler, *Employee Costs and the Decline in Health Insurance Coverage*, 6 F. FOR HEALTH ECON. & POL'Y 27, 48 (2003).

4. Pub. L. No. 111-148, 124 Stat. 119 (2010); *see also* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

5. *See* Patent Protection and Affordable Care Act of 2010 (ACA) § 1201, 124 Stat. at 154, 161 (to be codified at 42 U.S.C. § 300gg-6) (adding section 2707 to the Public Health Services Act). States have the ability to require benefits in addition to those mandated by the federal government, but states would be required to pay any premium increase that results from such requirements. *See id.* § 1311(d)(3), 124 Stat. at 176 (to be codified at 42 U.S.C.§ 18031). The federal government is, however, responsible for determining coverage under Medicare, the program of health insurance for the elderly. Nevertheless, the task under Medicare involves both a markedly different patient population, payer, and statutory coverage definition. For an overview of the Medicare coverage decision process, see Michael S. Kolber, *Opacity and Cost Effectiveness Analysis in Medicare Coverage Decisions: Health Policy Encounters Administrative Law*, 64 FOOD & DRUG L.J. 515 (2009).

6. ACA § 1302, 124 Stat. at 163–68 (to be codified at 42 U.S.C. § 18022).

7. For example, the Secretary is directed to "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life" and also to "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life." *Id.* at § 1302(b)(4)(B), (D), 124 Stat. at 164 (to be codified at 42 U.S.C. § 18022).

8. *Id.* § 1302(b)(2)(A).

9. *See* THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 155, ex. 10.1 (2010) [hereinafter EMPLOYER HEALTH BENEFITS 2010], http://ehbs.kff.org/pdf/2010/8085.pdf (finding that forty-one percent of workers are covered by plans that are fully insured and therefore subject to state insurance regulation). For further discussion, see *infra* Part II.A.

tremendous discretion in how to apply the "typical employer plan" standard.

The result is that HHS faces a critical decision regarding the extent to which existing state mandates should be taken into account in defining essential health benefits.[10] For example, if thirty states have mandates requiring coverage for autism therapies, should the federal government simply adopt that position?[11] The advantages of such an approach are that it is easy to implement, and it can be said to merely aggregate the preferences already expressed through the state legislative processes. Nevertheless, the state legislative processes that produced such content regulation have been subject to a significant amount of criticism.[12] There are those that oppose such state laws because they do not reflect the opinion holder's normative disposition regarding fairness or welfare. The most vocal critics, particularly in the popular press, tend to be those who oppose state laws because they appear to run afoul of welfare economic principles.[13] There are also those who believe that more regulation of the content of health insurance is necessary in order to achieve fairness in health care distribution.[14] On top of such normative concerns is the lingering suspicion that the institutional design of the state legislative process leads to less-than-ideal outcomes.[15] In part, this is because health insurance content regulation appears to be a perfect candidate for rent seeking, with a small group of intensely interested individuals who stand to economically benefit from the legislation, along with a very small cost imposed on the larger public. Operating under this dynamic, it is plausible that legislatures will "overproduce" mandated benefit laws.[16]

While this paints a bleak picture regarding the perception of state health insurance content regulation—suggesting that the federal government may not, in fact, want to borrow heavily from such state regula-

10. Not surprisingly, this is one of the issues on which the HHS secretary has requested guidance from the Institute of Medicine committee tasked with developing a framework for essential health benefit determination. *See Determination of Essential Health Benefits*, INST. MED. NAT'L ACADS., http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx (last visited Nov. 9, 2011).

11. Earlier versions of federal health reform legislation were in fact explicit that HHS should use the majority state position in defining essential health benefits. While that specific language was not included in the final bill, the final bill language certainly leaves leeway to rely on the majority state position in defining essential health benefits.

12. *See, e.g.*, RICHARD A. RETTIG ET AL., FALSE HOPE: BONE MARROW TRANSPLANTATION FOR BREAST CANCER 169–74 (2007); David A. Hyman, *Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 N.C. L. REV. 5, 26 (1999).

13. *See, e.g.*, VICTORIA CRAIG BUNCE & JP WIESKE, COUNCIL FOR AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES 2010; David A. Hyman, *Health Insurance: Market Failure or Government Failure*?, 14 CONN. INS. L.J. 307, 319–23 (2008); David R. Henderson, Op-Ed., *Terminatorcare*, WALL ST. J., Jan. 10, 2007, at A17.

14. *See, e.g.*, Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 J.L. MED. & ETHICS 652 (2008).

15. *See, e.g.*, Jessica Mantel, *Setting National Coverage Standards for Health Plans Under Health Care Reform*, 58 UCLA L. REV. 221, 233 (2010).

16. *See* MAXWELL L. STEARNS & TODD J. ZYWICKI, PUBLIC CHOICE CONCEPTS AND APPLICATIONS IN LAW 250–63 (2009) (providing an overview of the Wilson-Hayes model of legislative procurement).

tion in establishing its own requirements—nearly all of the literature in this area is theoretical in nature. Without a better understanding of how the state legislative process actually plays out in this area, the federal government has no idea what it would be adopting if it were to adopt the majority state position on a given regulation. There are unanswered foundational questions, such as whether state regulation tends to reflect a fairness or a welfare economics approach. And there are additional questions with respect to what states consider, and are persuaded by, in the health insurance regulatory context. One primary concern is whether, and to what extent, the state process is evidence-based.

Regulating the content of health insurance pursuant to federal health care reform is a high-stakes affair. Under ACA, federal premium tax credits are provided for qualified individuals who purchase coverage in the individual market.[17] The tax credit amount is not fixed, but rather fluctuates with the cost of coverage. As a result, if broad coverage requirements drive premium prices up, the cost of health care reform to the federal government will increase as well. This is in contrast to state governments that could generally regulate the private insurance market at no direct cost. In addition, the requirement under ACA that individuals purchase health insurance coverage or face a monetary penalty (the so-called "individual mandate") does not apply to individuals if available coverage is unaffordable.[18] As a result, if substantive regulation pushes premium prices higher, fewer individuals will be subject to the individual mandate, which has significant implications for the success of health care reform.[19]

Despite these high stakes, little is empirically known about existing state-mandated benefit laws and therefore the role that such laws should play in the federal regulatory process. This Article attempts to begin filling the informational gap that exists with respect to state mandates. In this Article, case studies from two states that have been very active in regulating the content of health insurance are presented. The studies look at all proposed mandated benefit laws over a ten-year period from 1999 through 2008 in California and Connecticut. These states were chosen both because they are "high-mandate" states, meaning that their legislatures both propose and pass a large number of health insurance mandates, and also because they offer contrasting institutional designs with respect to the decision-making process. Connecticut utilized a standard legislative process during the entire study period.[20] Approximately four years into the study period, California moved from a standard legislative

17. *See* ACA, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213–20 (2010) (to be codified at 26 U.S.C. § 36).

18. Coverage is unaffordable if the premiums exceed eight percent of the individual's household income. ACA § 1501, 124 Stat. at 246–47 (to be codified at 26 U.S.C. § 5000A).

19. *See* Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 131–32 (2011).

20. *See infra* Part III.B.2.

process to a new, innovative model that relies on an independent academic center for information gathering and dissemination.[21]

The studies presented here analyze proposed mandates in a given state using both quantitative and qualitative methods. The bill file for each proposed mandate was coded for various factors in order to determine the types of arguments and evidence that were presented in favor of the mandate. This data set was then analyzed for the frequency with which various types of arguments were made and, using a technique known as Qualitative Comparative Analysis (QCA), the impact of various arguments and types of evidence on committee and legislative passage were analyzed. The bills that passed during the study period are then examined in detail. The analysis also includes a general discussion about the evidence contained in the bill files. The findings suggest that legislators appear motivated by a mix of fairness and welfare concerns, and they act to paternalistically protect individuals from poor insurance purchasing decisions or poor medical treatment decisions. Interestingly, the studies show quite clearly that these state laws are *not* aimed at "traditional" insurance market failures such as adverse selection. Without a specific structure in place to provide legislators with appropriate data (for example, on costs or medical effectiveness), very little evidence is provided to legislators. And even when there is a structure in place to ensure that such data are available, those data appear to have only a modest impact on bill passage.

Part II of the Article provides background on health insurance content regulation, its current structure, and the changes that ACA will make to that regulatory structure. Part III presents the study, providing an overview of the study design and case selection as well as the data. Finally, Part IV discusses the implications of the study for defining "essential health benefits" and for the fulfillment of health reform goals.

II. BACKGROUND

For purposes of this Article, the terms "mandated benefit" or "mandated benefit law" are used to refer to laws that regulate either (1) which medical treatments or services must be covered by a health insurance policy, or (2) which medical providers must be eligible for reimbursement under a health insurance policy. For example, laws that require health insurance contracts to cover mental health treatment or medically necessary services provided by chiropractors would both be considered mandated benefit laws. This Part will provide an overview of how the content of health insurance contracts is currently regulated, the policy debate surrounding mandated benefits laws, and how ACA will change the regulatory structure of mandated benefits once its provisions become fully effective in 2014.

21. *See infra* Part III.B.1.

A. Current Regulation

Privately financed health insurance can be obtained either through the individual market or through an employer-provided plan.[22] The regulation of the content of health insurance coverage differs based on the market through which the coverage is purchased.

Health insurance purchased on the individual market is regulated at the state level. While Congress has the authority to regulate insurance pursuant to the commerce clause,[23] Congress has legislatively granted states the ability to engage in such regulation.[24] The grant of state authority, however, is not absolute. Congress may, at any time, exercise its authority to regulate insurance provided it is clear in its intent to do so.[25]

Employer-provided health insurance is subject to a more complex regulatory regime due to the federal Employee Retirement Income Security Act of 1974 (ERISA).[26] ERISA broadly regulates nearly all employer-provided welfare and retirement plans.[27] Based in large part on a desire to allow nationally uniform administration of such plans, ERISA preempts any state law that "relates to" an employee benefit plan.[28] Nevertheless, ERISA specifically "saves" from preemption laws that regulate insurance.[29] Because "insurance" could be interpreted broadly to include even self-financed arrangements and therefore render ERISA's broad preemption provision meaningless, ERISA also specifically provides that states may not, under the guise of "insurance" regulation, regulate self-insured plans.[30]

As the name implies, a self-insured plan exists where an employer does not purchase a group insurance policy to pay plan claims but rather retains the risk of loss itself.[31] In the simplest case, a self-insured plan would simply pay any claims out of the employer's general assets. Given the possibility of large and unpredictable medical claims, however, many self-insured employers purchase a form of reinsurance, known as stop-loss insurance, to provide reimbursement to the employer when medical

22. The majority of nonelderly Americans (56.5 percent) receive health insurance through an employer-sponsored plan, while 5.2 percent purchase individual coverage and 19.4 percent receive Medicaid or some other form of governmental coverage. The remaining 18.9 percent of nonelderly Americans are uninsured. THE HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER 29 (2010), http://www.kff.org/uninsured/upload/7451-06.pdf.

23. United States v. Se. Underwriters Ass'n, 322 U.S. 533, 552–53 (1944).

24. McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011 (2006).

25. *See id.* § 1012(b).

26. *See* Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974).

27. The definition of "welfare plan" is broad and includes, among other things, employer-provided health insurance and medical care. *See* 29 U.S.C. § 1002(1) (2006).

28. *See id.* § 1144(a).

29. *See id.* § 1144(b)(2)(A) (commonly referred to as the "savings clause").

30. *See id.* § 1144(b)(2)(B) (commonly referred to as the "deemer clause").

31. *See* Troy Paredes, Note, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 247 (1997).

plan claims exceed a certain threshold.[32] Purchasing a stop-loss policy, even a very generous one, does not subject a self-insured plan to state regulation.[33] The plan continues to be treated as a self-insured plan and therefore any state law that "relates" to the plan, such as a requirement that the plan cover specific treatments or services, is preempted under ERISA.

The end result of this regulatory structure is that individual insurance policies are regulated at the state level, insured employer plans are regulated both by the state and by ERISA, and self-insured employer plans are regulated solely by ERISA. Having different regulators results in dramatically different content regulation for these different types of plans. On the one hand, states have been very active in content regulation. States average eighteen mandated benefit laws,[34] with a high of thirty-five in California and a low of two in Idaho.[35] On the other hand, ERISA mandates coverage of only four benefits: minimum hospital stays following childbirth, breast reconstruction following mastectomy, mental health parity, and a limitation on the exclusion of preexisting conditions.[36] The end result of this complex regulatory scheme is that individual insurance policies must comply with an average of eighteen state mandates, insured employer plans must comply with both state mandates and ERISA's substantive requirements, while self-insured employer plans need comply only with the four requirements contained in ERISA.

B. The Policy Debate

The U.S. system of health insurance is unique in many ways. Unlike many other industrialized countries, the vast majority of nonelderly citizens in the United States receive health care coverage through privately financed insurance rather than through a public program.[37] In countries with national health care in one form or another, determinations of what treatments and services are covered are often determined as part of a comprehensive benefits package. For example, in Canada, the National

32. *See id.* at 248–49.

33. *See, e.g.*, Bill Gray Enters., Inc. Emp. Health & Welfare Plan v. Gourley, 248 F.3d 206, 214 (3d Cir. 2001); Am. Med. Sec., Inc. v. Bartlett, 111 F.3d 358, 364 (4th Cir. 1997); United Food & Commercial Workers v. Pacyga, 801 F.2d 1157, 1161–62 (9th Cir. 1986).

34. U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-96-161, HEALTH INSURANCE REGULATION: VARYING STATE REQUIREMENTS AFFECT COST OF INSURANCE 9 (1996) ("On average, states have enacted laws mandating about 18 specific benefits."); Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1364.

35. Monahan, *supra* note 34, at 1364.

36. 29 U.S.C. §§ 1181, 1185–1185b (2006). ACA will add a fourth mandate requiring plans to reimburse routine patient care costs associated with participation in specific types of clinical trials, effective in 2014. *See* ACA, Pub. L. No. 111-148, § 10103, 124 Stat. 119, 892–93 (2010) (to be codified at 42 U.S.C. §§ 300gg, 300gg-8) (adding section 2709 to the Public Health Services Act).

37. *See* Gerard F. Anderson & Bianca K. Frogner, *Health Spending in OECD Countries: Obtaining Value Per Dollar*, 27 HEALTH AFF. 1718, 1721–22 (2008).

Health Care Act defines the services that must be covered in all provincial health plans but leaves to the provinces discretion whether additional services will be covered. In the United States, the basic benefit package is instead determined by private insurance companies and their consumers, with the government occasionally stepping in to modify the package through legislation. It is both a reactionary[38] and ad hoc process that has been the subject of much criticism and debate.

Justifications for mandated benefit laws are typically grounded either in fairness claims or welfare economic claims (and sometimes, both). Welfare economic rationales are typically used to support the proposition that mandated benefits can effectively address various types of market failure that can affect the health insurance and medical treatment markets. Health insurance markets, particularly markets for individual health insurance policies, are known to suffer from a wide variety of market failures.[39] For example, sometimes the market fails to provide insurance coverage that an individual desires to purchase because of a problem known as adverse selection. Adverse selection has been defined as "the process by which insureds utilize private knowledge of their own riskiness when deciding to buy or forgo insurance."[40] Individuals often have private knowledge of a health condition or health risk that is either difficult or impossible for the insurance company to obtain. Assume, for example, that an individual has been trying unsuccessfully to conceive a child for a number of years and therefore has reason to believe that she will utilize medical treatment for infertility. The insurance company cannot discover this information about her likelihood of utilizing infertility treatment.[41] Therefore, if the insurer were to offer two policies, one that covered infertility treatment and one that did not, the individual would, subject to certain pricing assumptions,[42] purchase the policy that covered infertility treatment. The problem, of course, is what happens to the market when everyone behaves in this manner. When the policy that covers infertility treatment is adversely selected by all those with reason to believe they will utilize infertility treatment, the insurer must increase the price of the policy accordingly. In short order, the premiums associated with the policy that covers infertility treatment would be greater than the premiums associated with the policy that did not offer such coverage by the full expected cost of infertility treatment. Because the policy would then effectively cease to function as insurance, the insurer

38. Reactionary in the sense that legislation responds to current market conditions.

39. *See, e.g.*, George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 492–94 (1970).

40. Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1223 (2004).

41. This is true assuming that the individual had not sought prior medical treatment for her infertility.

42. The price increase associated with the policy with infertility coverage would have to be lower than the expected cost of treatment in order for the individual to rationally select the policy that covered infertility treatment.

would simply stop offering coverage for infertility.[43] Essentially, adverse selection would have eliminated that coverage option from the market.

A mandated benefit law can remedy the situation by requiring that every health insurance policy sold within the state cover the benefit at issue. By doing so, insurance coverage for the treatment, which would not otherwise be available, is preserved, and is available to affected individuals at an average cost. The mandated benefit law in this way solves the adverse selection problem.

This is but one example of the many forms of market failure that might justify a mandate. Others include increasing suboptimal utilization of a medical treatment or service, overruling undesired insurance company coverage determinations, addressing decision-making shortcuts and problems of risk assessment and cognitive bias, as well as overcoming preference aggregation problems in the group market.[44]

Putting welfare economics aside, certain theories of fairness might also support various mandated benefit laws. After all, mandating coverage for a specific treatment or service essentially requires that the entire insured community bear the risk of that loss—and theories of fairness in health care are often concerned with which medical risks should be compulsorily shared. For example, John Rawls's work on fair equality of opportunity might translate into covering medical losses that are suffered through no fault or responsibility of the individual.[45] Or we might want to cover all those expenses that restore "normal species functioning."[46] These and other theories of fairness might demand that medical care be distributed according to medical need and not the ability to pay.[47]

While fairness theorists are likely to object to any regulatory regime that does not reflect their conception of fairness, objections grounded in welfare economics are much more common in the literature. Welfare-based objections to mandated benefit laws fall into two primary categories. First, there are those who object to mandated benefit laws simply because they interfere with the freedom of two willing parties to contract and are therefore welfare decreasing.[48] For example, imagine that an individual desires to purchase insurance coverage that protects only against

43. This is particularly true given the effect of overhead costs on health insurance premiums. In the individual market, overhead costs can contribute as much as forty percent of the cost of premiums. *See* Mark Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons*, 18 HEALTH AFF. 28, 34 (1999); Mark V. Pauly & Len M. Nichols, *The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes*, HEALTH AFF., Dec. 23, 2001, at W325, W326, http://content.healthaffairs.org/content/early/2002/10/23/hlthaff.w2.325.full.pdf. As a result, the addition of infertility treatment to a health insurance policy may raise the cost of the benefit *above* the expected cost of treatment once overhead costs are taken into account.

44. For a fuller discussion of these types of market failure, see Amy B. Monahan, *Value-Based Mandated Health Benefits*, 80 U. COLO. L. REV. 127, 133–48 (2009).

45. *See* RAWLS, *supra* note 1, at 311–12.

46. *See* NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 147–55 (2008).

47. *See, e.g.*, Stone, *supra* note 14, at 653.

48. *See* CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 18 (1995).

the risk of loss associated with hospitalization. The individual budgets and saves for other forms of medical care, such as routine preventive care and imaging tests. The individual correctly assesses that his or her risk for nonhospitalization medical care that would exceed the individual's budget, such as mental health or substance abuse problems, is low. Mandated benefit laws interfere directly with the desired bargain by preventing the individual from obtaining the desired coverage.[49] For example, in a state with preventive care or mental health mandates, the individual would essentially be forced into subsidizing other individual's desired coverage, even where it is rational for the individual to forgo certain coverage, thereby decreasing the individual's welfare.

The second, and most prominent, argument against mandated benefit laws is that the price of such laws is simply too high. This view is based on the relationship between health insurance premiums and coverage rates. We know that as health insurance premiums rise, fewer individuals elect coverage.[50] Even though many mandates have a relatively modest cost to individual subscribers, even small increases in price potentially contribute to the problem of uninsurance. The argument is that it is better to protect health insurance coverage rates than to broaden the scope of health insurance coverage. In other words, the welfare gain associated with many individuals having incomplete health coverage is greater than the welfare gain associated with having fewer individuals with more comprehensive coverage.[51]

Each of these sources of opposition is then further exacerbated by public choice concerns regarding the institutional design through which mandated benefits become law. Mandated benefit laws are in many ways a striking example of public choice concerns in that they involve, in nearly all cases, narrowly conferred benefits and widely distributed costs.[52] Take, for example, a law requiring health insurers to cover hearing aids. The group that potentially benefits from such legislation is the eight percent[53] of the population that is hearing impaired, whereas the costs are distributed among the entire insured population. When such a mandate

49. *See, e.g.*, Henderson, *supra* note 13.

50. For an overview of the literature on the price elasticity of demand for health insurance, see Jonathan Gruber, *Health Insurance and the Labor Market*, *in* 1A HANDBOOK OF HEALTH ECONOMICS 645, 696–97 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

51. It is, of course, incredibly difficult to calculate even the pure income gains and losses associated with mandate passage. It is difficult to estimate what effect a mandate will have on health insurance premiums and even harder to isolate what effect a small marginal increase in premiums will have on health insurance coverage rates. *See, e.g.*, TEX. DEP'T OF INS., HEALTH INSURANCE REGULATION IN TEXAS: THE IMPACT OF MANDATED HEALTH BENEFITS 25–37 (1998) ("For example, a recent news article quotes one large Texas insurer as saying mandates raise the price of insurance by as much as 20%. In the same article, another large insurer estimates the cost to be only about 2%.").

52. *See* MANCUR OLSON, JR., THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS 143–44 (1965); Robert D. Tollison, *Rent Seeking*, *in* PERSPECTIVES ON PUBLIC CHOICE: A HANDBOOK 506, 520–24 (Dennis C. Mueller ed., 1997).

53. NAT'L ACAD. ON AN AGING SOC'Y, HEARING LOSS: A GROWING PROBLEM THAT AFFECTS QUALITY OF LIFE 1 (1999), http://ihcrp.georgetown.edu/agingsociety/pdfs/hearing.pdf.

comes before the legislature, the interested individuals are likely to lobby extensively in favor of the bill, because, assuming they desire to use a hearing aid, they stand to gain a financial benefit of several thousand dollars. On the flip side, few members of the general public are likely to find it worthwhile to oppose such legislation given its likely small impact on their health insurance premiums.[54] The result may be that legislatures oversupply such legislation.[55] So even if many proposed mandates represent excellent policy choices, if the institution charged with making decisions regarding what becomes law and what does not is poorly suited to make such determinations, the outcomes of mandated benefit laws may be suboptimal.

C. How ACA Will Change Mandated Benefits

Given the complex regulatory structure and significant policy concerns described above, it is unsurprising that mandated benefit reform was on the table in the lead up to health care reform. In the end, among its many changes, ACA reserves for the federal government the ability to regulate the content of health insurance contracts offered on the individual and small group markets.[56] Large employer plans will remain subject to state regulation, while self-insured plans retain their relative freedom from substantive regulation.

Specifically, ACA provides that all individual and small group plans must provide "essential health benefits."[57] Despite the central importance of how "essential health benefits" are defined, the specifics of coverage are not specified in the statute. Rather, the statute grants HHS the authority to define essential health benefits.[58] ACA provides guidelines for such determination, stating that such benefits shall include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and chronic disease management, as well as pediatric services (including oral and vision care).[59] HHS is further directed to ensure that the scope of essential health benefits is "equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary."[60] Additional required elements for consideration in determining essential health benefits are

54. Insurance companies are an additional source of opposition, but the political cost to legislators of disregarding such opposition on a particular mandate may not be sufficient to deter legislators from passing a mandate that is not opposed by the public at large.

55. *See* STEARNS & ZYWICKI, *supra* note 16, at 251.

56. *See* ACA, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 154–61 (2010) (to be codified at 42 U.S.C. § 300gg) (adding section 2707 to the Public Health Services Act).

57. *Id.*

58. *Id.* § 1302, 124 Stat. at 163–68 (to be codified at 42 U.S.C. § 18022).

59. *Id.* § 1302(b)(1).

60. *Id.* § 1302(b)(2)(A).

also provided. For example, HHS is directed to "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life" and also to "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life."[61]

ACA specifies that states can continue to regulate the individual and small group market by mandating benefits in excess of "essential health benefits."[62] At first glance, this suggests that the essential health benefit requirements merely set a floor, which states may exceed at will. ACA, however, goes on to provide that if a state enacts benefit mandates that exceed essential health benefit requirements, the state must "defray the cost" of any additional benefits for those individuals who are enrolled in "qualified health plans" within the state.[63] Given that all health plans offered within the state's insurance exchange will by definition be qualified health plans, the subsidy that would be required would often be substantial. As a practical matter, this direct cost to the state of mandated health benefits that exceed essential health benefit requirements makes it highly unlikely that states will regulate the content of coverage in the individual and small group market.

D. What ACA Will Not Change

ACA leaves a significant part of the health insurance market unchanged with respect to mandated benefits. Even once ACA's major reform provisions become fully effective in 2014, states will continue to regulate the large group market (which is unaffected by the "essential health benefit" requirements detailed above). Similarly, the content regulation of self-insured plans remains nearly unchanged.[64] Such plans remain subject only to ERISA's limited substantive requirements. Table 1 briefly summarizes the sources of substantive regulation once ACA becomes fully effective.

61. *Id.* § 1302(b)(4).

62. *Id.* § 1311(d)(3)(B), 124 Stat. at 176 (to be codified at 42 U.S.C. § 18022).

63. *Id.*

64. ACA does add one substantive mandate to all forms of health insurance, including self-insured plans. ACA requires such plans to reimburse routine patient care costs associated with participation in specific types of clinical trials. *Id.* § 10103, 124 Stat. at 892–96 (to be codified 42 U.S.C. § 300gg) (adding section 2709 to the Public Health Services Act). Note that the statement in the text assumes that Congress takes no further action to regulate self-insured plans, but that there may be good reason for Congress to take such action. *See* Monahan & Schwarcz, *supra* note 19, at 196–97 (arguing that regulating self-insured plans in the same manner as insured plans would eliminate the ability of employers to "dump" their less healthy employees onto the individual insurance market).

TABLE 1:
SOURCES OF CONTENT REGULATION UNDER ACA[65]

Type of Coverage	Federal Regulation	State Regulation
Individual	Essential health benefits, preventive care, and clinical trial expenses	States must subsidize mandates that exceed essential health benefits[66]
Small Group	Essential health benefits, preventive care, and clinical trial expenses + ERISA[67]	
Large Group	Preventive care and clinical trial expenses + ERISA	States may mandate additional benefits, no subsidy required
Self-Insured Group	Preventive care and clinical trial expenses + ERISA	None

III. STUDYING THE STATE PROCESS: CASE STUDIES OF CALIFORNIA AND CONNECTICUT

Given the critical importance of regulating the content of health insurance under both the current regime and under the forthcoming federal health care reform, it is disappointing how little is known about how the current state processes actually work. The studies presented in this Article attempt to fill this gap by providing a detailed look at the types of arguments used to support proposed mandates, the extent to which evidence is provided to substantiate such arguments, and the effect that different factors and evidence have on mandate passage. This Part provides a brief overview of previous studies in this area, before providing the study methodology and results.

65. Amy B. Monahan, *Initial Thoughts on Essential Health Benefits*, *in* NEW YORK UNIVERSITY REVIEW OF EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION–2010, at 1B-1, 1B-7 (Alvin D. Lurie ed., 2010).

66. While ERISA's substantive provisions would also generally apply to an employer-sponsored small group plan, ACA appears to provide that plans need only comply with the substantive requirements of "essential health benefits," and that this requirement trumps other law with respect to the substantive requirements that apply to a plan within an exchange. *See id.* § 1311(d)(3)(A).

67. *See* ACA § 1311(d)(3), 124 Stat. at 176 (to be codified at 42 U.S.C. § 18031) (requiring the state to pay either the individual or the health insurance company directly for any increased premium costs that result from state requirements that exceed essential health benefits for any individuals enrolled in a qualified health plan).

A. Previous Studies

1. Economic Studies

Not surprisingly, many economists have studied the issue of mandated benefit laws. Such studies have looked at a diverse array of topics, such as the influence of mandated benefit laws on the decision of small firms to offer insurance,[68] as well as the effect such laws have on health insurance coverage rates[69] and premiums.[70] Economists have also studied the labor market effects of state mandates.[71] In general, the economic studies have focused on the effects of mandates post-passage.

2. Health Policy Studies

Health policy studies are perhaps the most common type of study in the existing literature. In most cases, these studies examine the health-related outcomes associated with the passage of a single mandate. For example, one study examined whether a state mandate requiring coverage of outpatient breast cancer surgery caused payors not covered by the mandate to change their practices.[72] Other studies have looked at how mandated benefit requirements change patient and physician behavior post-passage.[73] While some of these studies have found positive im-

68. *See, e.g.*, Gail A. Jensen & Jon R. Gabel, *State Mandated Benefits and the Small Firm's Decision to Offer Insurance*, 4 J. REG. ECON. 379 (1992).

69. *See* JOHN C. GOODMAN & GERALD L. MUSGRAVE, FREEDOM OF CHOICE IN HEALTH INSURANCE, NCPA POLICY REPORT NO. 134, at 20–21, app. A (1988) (using an econometric model to estimate that as many of one out of every four uninsured people lack health insurance because state mandates have increased the price of insurance); Jonathan Gruber, *State-Mandated Benefits and Employer-Provided Health Insurance*, 55 J. PUB. ECON. 433, 435 (1994) (finding that mandates have little effect on the rate of insurance coverage and that most firms offer the benefits at issue even in the absence of regulation).

70. Stephan F. Gohmann & Myra J. McCrickard, *The Effect of State Mandates on Health Insurance Premiums*, 24 J. PRIVATE ENTERPRISE 59 (2009) (estimating that some mandates can increase premiums by up to sixteen percent).

71. Robert Kaestner & Kosali Ilayperuma Simon, *Labor Market Consequences of State Health Insurance Regulation*, 56 INDUS. & LAB. REL. REV. 136 (2002) (finding no strong evidence that insurance regulations affected labor market outcomes, although they appear to cause a small decrease in private coverage).

72. John Bian et al., *Spillover Effects of State Mandated Benefit Laws: The Case of Outpatient Breast Cancer Surgery*, 46 INQUIRY 433 (2009).

73. *See, e.g.*, Melinda B. Henne & M. Kate Bundorf, *Insurance Mandates and Trends in Infertility Treatments*, 89 FERTILITY & STERILITY 66 (2008) (finding that infertility mandates are associated with higher utilization rates of assisted reproductive technology and lower rates of births per cycle and multiple births per cycle); Renee Y. Hsia et al., *Do Mandates Requiring Insurers to Pay for Emergency Care Influence the Use of the Emergency Department?*, 25 HEALTH AFF. 1086 (2006) (failing to find evidence that "prudent layperson" mandates for emergency room coverage increased use of emergency services); Jonathan Klick & Thomas Stratmann, *Diabetes Treatments and Moral Hazard*, 50 J.L. & ECON. 519 (2007) (finding the diabetes mandates generate moral hazard, with diabetics exhibiting higher BMIs after the adoption of these mandates); Barak D. Richman, *Insurance Expansions: Do They Hurt Those They Are Designed to Help?*, 26 HEALTH AFF. 1345 (2007) (finding that comprehensive insurance coverage for pharmaceuticals and mental health care does not equalize utilization rates, suggesting that privileged classes extract more health care services even in the face of equal coverage); Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Cov-*

provements in outcomes following mandate passage, others have found that mandates actually harm certain health outcomes.[74] Like the economic studies, health policy studies tend to focus on outcomes post-passage.

3. Political Science Literature

There is, of course, a vast literature regarding the political process, issues of institutional design, and the use of information by legislators, but none of it is specific to mandated benefit laws. Work on public choice theory is particularly relevant here because, as previously mentioned, mandated benefit laws are likely to involve concentrated benefits and diffuse costs. In general, this work suggests that not only should there be strong motivation by interested parties to lobby in favor of a benefit mandate,[75] there is likely to be no strong opposition to such bills,[76] with the end result being that such legislation is "oversupplied."[77] Also of particular relevance is the literature on the use of information by legislators.[78] Studies of the state legislative process have documented that state legislators often do not believe they have adequate information available to them,[79] and also that outside information is not frequently relied on during the decision-making process.[80] There is also a substan-

erage Mandates, 2002, 36 PERSP. ON SEXUAL & REPROD. HEALTH 72 (2004) (finding that plans in states with mandates are significantly more likely to cover prescription contraceptives than those in states without mandates).

74. *See, e.g.*, Klick & Stratmann, *supra* note 73, at 532–33.

75. There is some evidence that suggests that health insurance coverage issues are frequently raised by individuals to their state representatives. For example, one survey found that three percent of the insured population in California (around 200,000 individuals) had contacted an elected official about problems with their health plan, including lack of coverage for certain benefits. *See* 2 MANAGED HEALTH CARE IMPROVEMENT TASK FORCE, IMPROVING MANAGED HEALTH CARE IN CALIFORNIA: FINDINGS AND RECOMMENDATIONS 17 (1998).

76. While insurers do typically oppose all benefit mandates, their opposition is unlikely to be very strong to any one bill because of the typically low marginal cost of a single mandate. After all, insurers typically oppose mandates because they increase the cost of health insurance, which in turn decreases the number of individuals that purchase insurance and therefore decreases the insurer's profits (assuming, of course, that the mandate is not valued by the typical consumer). A single mandate, however, might increase the annual premiums for health insurance by only a few dollars. Thus, while it is true that insurers typically oppose mandates, their opposition to any one single bill is likely, in most cases, to be fairly weak.

77. *See, e.g.*, OLSON, *supra* note 52, at 141–48; STEARNS & ZYWICKI, *supra* note 16, at 69–72; Tollison, *supra* note 52, at 520–24.

78. *See, e.g.*, Paul Sabatier & David Whiteman, *Legislative Decision Making and Substantive Policy Information: Models of Information Flow*, 10 LEGIS. STUD. Q. 395 (1985); Edward Schneier, *The Intelligence of Congress: Information and Public-Policy Patterns*, ANNALS AM. ACAD. POL. & SOC. SCI., Mar. 1970, at 14.

79. H. Owen Porter, *Legislative Experts and Outsiders: The Two-Step Flow of Communication*, 36 J. POL. 703, 708 tbl.1 (1974) (finding that legislators most often cited "[g]etting adequate information; becoming knowledgeable on proposals, understanding the effects of legislation" as the most difficult part of their job).

80. *See* Christopher Z. Mooney, *Information Sources in State Legislative Decision Making*, 16 LEGIS. STUD. Q. 445, 452 tbl.1 (1991) (finding relatively low rates of outside written information use among state legislators).

tial amount of literature regarding institutional design and competence, which explores why legislatures may not be well suited to certain tasks.[81] Of particular relevance to mandated benefits, this literature has explained why legislators may not undertake an optimal amount of research prior to making decisions.[82] Both public choice theory and the literature regarding the use of information by legislators has significant implications for mandated benefit laws. They tend to confirm the suspicions of those commentators who believe that mandated benefit laws result from rent seeking by interested parties and are not likely to be well-grounded in evidence.

4. Evidence-Based Critiques

Mandated benefit laws have been criticized, often by those in the medical profession, on the basis that the substance of such laws is not based on clinical best practices.[83] For example, in a commentary about mandates for cancer screening services, Dr. Helen Halpin Schauffler notes that:

> [M]ost state legislatures are not using evidence-based guidelines and recommendations as the basis for defining cancer-screening benefits. Policymaking in state legislatures seems influenced more by interests with a direct stake in the outcome and the desire for everyone to be screened for everything every year, regardless of the cost, effectiveness, or relative cost-effectiveness of the cancer-screening tests. Allowing politics to trump science in the design of benefit mandates results in potential overuse of screening services, is an inefficient use of health care resources, and produces an even greater divide in access to preventive care between those who have health insurance coverage and those who do not.[84]

In several instances, mandates have been passed that are of dubious clinical value. Well-known examples include state mandates requiring coverage for high-dose chemotherapy and autologous bone marrow transplant[85] as well as mandates requiring coverage for hormone replacement therapy.[86] In addition, mandates sometimes have been proposed based on "clinical practice guidelines" of independent physician groups, not

81. *See, e.g.*, NEIL K. KOMESAR, IMPERFECT ALTERNATIVES: CHOOSING INSTITUTIONS IN LAW, ECONOMICS, AND PUBLIC POLICY (1994).

82. *See* Matthew C. Stephenson, *Information Acquisition and Institutional Design*, 124 HARV. L. REV. 1422 (2011) (exploring the role of institutional arrangements in the production of information useful to government decision makers).

83. *See, e.g.*, Monahan, *supra* note 44, at 128; Helen Halpin Schauffler, *Politics Trumps Science: Rethinking State-Mandated Benefits*, 19 AM. J. PREVENTIVE MED. 136 (2000).

84. Schauffler, *supra* note 83, at 136.

85. *See* RETTIG ET AL., *supra* note 12, at 3, 152.

86. *See* Peter D. Jacobson, *Transforming Clinical Practice Guidelines into Legislative Mandates: Proceed with Abundant Caution*, 299 JAMA 208, 209 (2008) (discussing Massachusetts's continuing mandate to cover hormone replacement therapy despite new evidence regarding the risks involved in such treatment).

those of a national medical association or practice group. These practice guidelines, developed by an independent physician group, were not subject to the normal peer-review process.[87] These examples of where politics have apparently "trumped science" have important implications for mandated benefit laws.[88] To the extent that state legislators are not well-informed regarding clinical best practices, the mandates that they pass may negatively impact both clinical outcomes and health spending.

5. Legal Literature

The legal literature on mandated benefit laws has looked at both the efficacy of specific mandates[89] and engaged in broader, theoretical discussions of the efficacy of such laws in general.[90] Professor Russell Korobkin has examined the theoretical underpinnings of state-mandated benefit laws in depth.[91] Professor Korobkin, accepting the efficiency premise—"that health care is a consumer good that must compete with other goods for society's scarce resources, and that it should be provided only to the extent that people prefer it to alternative goods that they could purchase with the same dollars"—argues that benefit mandates can enhance efficiency under certain circumstances.[92] Professor Korobkin uses both game theory and behavioral decision theory to demonstrate that the strategic interests of health insurers and the cognitive limitations of purchasers are likely to result in the "underprovision" of certain health insurance benefits.[93] Professor Korobkin is not, however, an unqualified supporter of mandates, being very clear that while such mandates can be efficiency enhancing, they are by definition a second-best solution.[94] Professor Korobkin's work also provides a comparative institutional analysis of courts, legislatures, and specially appointed expert commissions in order to determine which is best suited to the task of regulating the substance of health insurance.[95] Professor Korobkin acknowledges that legislatures are better suited to the task than courts

87. *See id.* at 208–09 (discussing the proposal in Texas to mandate coverage for a cardiac screening method developed by an independent group of cardiologists, despite the lack of scientific evidence that the benefits of following the guidelines outweigh the harms).

88. The tension between science and law is certainly not unique to the mandated benefits arena, or even the broader health law field. *See, e.g.*, J.B. Ruhl & James Salzman, *In Defense of Regulatory Peer Review*, 84 WASH. U. L. REV. 1 (2006) (discussing the interplay between science and administrative law).

89. Angela Barner, *Unlocking Access to Insurance Coverage for Autism Treatment*, 6 J.L. ECON. & POL'Y 107 (2009); Jessica L. Hawkins, *Separating Fact from Fiction: Mandated Insurance Coverage of Infertility Treatments*, 23 WASH. U. J.L. & POL'Y 203 (2007); Hyman, *supra* note 12.

90. *See, e.g.*, Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1 (1999); Monahan, *supra* note 34; Monahan, *supra* note 44. *See also* Hyman, *supra* note 13.

91. *See* Korobkin, *supra* note 90.

92. *Id.* at 8.

93. *Id.* at 8–9.

94. *Id.* at 66.

95. *Id.* at 74–87.

(which must evaluate coverage ex post rather than ex ante).[96] There are, however, two primary drawbacks to legislative decision making identified by Professor Korobkin: (1) small but well-organized interest groups are likely to have too great an influence on the legislative process and (2) vocal consumer support necessary to mandate a benefit means that the benefit is important and salient enough that the market is likely to provide the benefit without the mandate.[97] Professor Korobkin concludes that expert administrative bodies are more likely than either legislatures or courts to produce efficient benefit mandates.[98]

Professor David Hyman has also explored the difficulty of the task of regulating the substance of health insurance.[99] In his work, Professor Hyman acknowledges that difficult trade-offs must be made with respect to what is covered and what is not, but questions whether the government is well suited to this task.[100] In studies of particular mandates, he has found the political process to be fueled by "bad anecdotes and popular appeal" rather than good science and evidence.[101] Professor Hyman's work on laws requiring health insurance coverage for postpartum hospital stays lends support to these theories by chronicling the lack of evidence supporting the medical efficacy of such stays.[102] In other work discussing Congress's "overruling" of the National Institutes of Health recommendation concerning mammogram screening Professor Hyman states:

> It is implausible that our elected representatives knew or cared about the scientific merits of the arguments for and against routine mammograms for women in their forties. Legislative second-guessing was instead attributable to the political gain from embracing the issue—particularly when the cost of the recommended mammograms would be the responsibility of private insurers.[103]

Compounding the problems associated with an anecdote-driven and non-evidence-based process is the fact that states can make these decisions with little to no direct cost to the state, argues Professor Hyman.[104] In a study of laws regulating insurance coverage for postpartum hospital stays, Professor Hyman notes that of the twenty-nine states with such

96. *Id.* at 80.

97. *Id.* at 80–82 (mandating benefits when the market already provides them is of course "unnecessary or inefficient").

98. *Id.* at 83–84, 87.

99. Hyman, *supra* note 12, at 13 ("Because insurance only shifts and spreads risk for which the policy provides coverage, the specification of such coverage necessarily implies a series of tradeoffs within the common pool, with significant distributional implications within and across identifiable groups.").

100. *See* David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 235 (2000).

101. *See id.* at 236; *see also id.* at 237 (stating that health insurance regulation is premised on a "foundation of anecdotes").

102. *See generally* Hyman, *supra* note 12, at 18–24.

103. Hyman, *supra* note 100, at 263.

104. *See id* at 249; Hyman, *supra* note 12, at 18–24.

laws, eighteen of them do not provide equivalent coverage for Medicaid beneficiaries—suggesting that state legislatures are compelled to pass such regulation only when it does not come at a direct cost to the state government.[105] Professor Hyman also echoes Professor Korobkin's conclusion that coverage issues that are salient to consumers will be handled through normal market mechanisms, as long as consumers are willing to pay for the desired coverage.[106] The result is likely to be that the regulated coverage duplicates what is already available in the market.[107]

In my own work on mandated benefit laws, I have examined whether states or the federal government should be tasked with such regulation, arguing that it should take place at the federal level, in part in order to bring self-insured plans within its purview.[108] In later work, I explored the theoretical justifications for mandated benefit laws, presenting a model of permissible justifications.[109] I argued that the initial impetus for a benefit mandate should be some type of market failure, broadly construed.[110] The market failure might be a failure to provide the desired insurance coverage, or it could be a failure involving the utilization of the treatment or service.[111] In part, this responded to the concerns of both Professors Hyman and Korobkin that the legislative model makes it likely that the benefit mandates will mirror what is already available in the market. Even where a market failure is identified and supported by evidence, there must still be some means of distinguishing which treatments will be required to be covered and which will not. Because our health care resources are limited, and our potential health care demands are not, we must have some additional threshold that must be met before coverage for a particular treatment or service is mandated. I argued that in addition to market failure, a potential mandate must either be supported by a justice claim about which there is consensus, or a positive cost-benefit or cost-effectiveness analysis.[112] I acknowledged that state legislatures may not be the ideal decision makers for the well-known reasons cited by others, but argued that following the justification framework I established would help to control some of the weaknesses inherent in the state legislative process.[113] It would give legislators a better decision-making guide than relying on anecdote and would result in mandates that are better able to achieve their policy goals.[114]

Overall, the legal literature expresses a fair amount of skepticism of the efficacy of regulating the content of health insurance contracts

105. *See* Hyman, *supra* note 12, at 25–26.
106. *See* Hyman, *supra* note 100, at 248.
107. *Id.*
108. *See* Monahan, *supra* note 34, at 1361–64.
109. *See* Monahan, *supra* note 44.
110. *Id.* at 132–33.
111. *Id.* at 136–40.
112. *Id.* at 148.
113. *Id.* at 153.
114. *Id.* at 151–54.

through state legislatures, even among those otherwise sympathetic to the theoretical rationales for such regulation.

B. Case Selection and State Background

The study in this Article examines all of the proposed mandated benefit laws within a state over the ten-year period from 1999 through 2008. The time frame was selected in order to study the most recent legislative efforts but also to include a sufficient number of bills for meaningful analysis. Included in the study were any proposed laws that would have required health insurance contracts to cover (1) specific medical treatments or services or (2) medical services provided by specific providers, where the inclusion of such providers could be reasonably expected to increase the scope of coverage.[115] Bills that attempted to regulate other aspects of health insurance (such as pricing regulation) were excluded, as were bills that merely changed cost-sharing requirements for specific benefits and bills to remove or repeal existing mandates.[116] The inclusion criteria were drafted in order to isolate the types of bills that feature most prominently in the relevant debates—those that expand insurance coverage and therefore increase costs. It is these bills that create the most controversy, because of their potential role in decreasing the affordability of health care coverage. Identical bills that were introduced during the same session in different houses were combined for purposes of the analysis. Where a single bill contained multiple, distinct mandates each mandate was treated as a separate bill.[117]

Two states, California and Connecticut, were included in the study. As part of the initial selection, states that frequently regulated the substance of health insurance policies (so-called "high-mandate" states) were identified in order to ensure sufficient data for analysis.[118] From there, the goal was to select states that utilized different institutional designs to make mandated benefit decisions, but this choice was con-

115. Provider mandates do not always expand the *type* of services that are covered by the insurance policy. For example, a mandate to cover the services of a nurse-midwife on the same basis as a medical doctor would not expand the type of care a covered individual could receive. A mandate that requires coverage for medically necessary services provided by a chiropractor does, however, expand coverage as no other type of provider typically provides chiropractic care. Requiring reimbursement of chiropractors essentially requires coverage of medically necessary chiropractic services.

116. While bills to repeal existing mandates have much in common with bills proposing new mandates, repeal bills were excluded from the study in order to limit its scope, and also because such repeal bills are almost never successful.

117. For example, Senate Bill 325, introduced in Connecticut in 2001, contained mandates requiring coverage for clinical trial expenses, hearing aids for children, Pap smears, colorectal cancer screening, mammograms, and psychotropic prescription drugs. For coding purposes, this bill was treated as six different bills. S. 325, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001).

118. By one recent estimate, California and Connecticut were among the top ten states in terms of number of enacted mandates, with fifty-six and fifty-nine enacted mandates respectively. *See* BUNCE & WIESKE, *supra* note 13, at 3 tbl.1 (finding a high of sixty-nine mandates in Rhode Island and a low of thirteen in Idaho).

strained by the lack of legislative record in many states. Further background on each selected state is provided below.

1. California

California was selected for inclusion because of its status as a high-mandate state, the accessibility of the relevant legislative history, and the presence of a unique institutional design with respect to mandated benefits decision making. During the first four years of the study, California utilized a standard legislative process to reach decisions on proposed mandates. Under that process, a legislator would propose a mandate, which would then be referred to a legislative committee with subject matter jurisdiction for further fact finding and public input.[119] The committee could either vote to approve the bill, in which case it returned to the legislature and could be scheduled for a vote, or the committee could decline to take action or vote against the bill, in which case the bill died in committee after which no further legislative action was possible.[120]

In 2002, the California state legislature passed a law funding a center at the University of California to assess legislation proposing a mandated health benefit or service[121] by preparing a written analysis with the relevant data.[122] The center, which has come to be known as the California Health Benefits Review Program (CHBRP), is directed to include in its report various public health impacts, medical impacts, and financial impacts of the proposed mandate.[123] The details of the factors required to be included in CHBRP reports are provided in Appendix A. The reports are to be provided to the relevant legislative committees within sixty days after receiving a request to prepare a report.[124] The center is funded through an annual fee that is assessed on health insurers, but the total amount assessed on all insurers cannot exceed two-million dollars annually.[125] Staff is housed at the University of California, but CHBRP also relies on a task force with members at each of the medical schools within California, as well as outside actuarial consultants.[126] The law es-

119. *See* State of Cal. Legis. & Couns., *Overview of the Legislative Process*, OFFICIAL CAL. LEGIS. INFO., http://www.leginfo.ca.gov/bil2lawx.html (last visited Nov. 9, 2011).

120. *See id.*

121. The definition of mandated benefit used in the legislation authorizing the California Health Benefits Review Program is slightly different than the definition of mandated benefit law used in this study. *See* Act of Feb. 15, 2002, 2002 Cal. Stat. 795.

122. *Id.* During the study period, California was the only state to follow this independent, prospective, data-gathering model. *See* Nicole M. Bellows et al., *State-Mandated Benefit Review Laws*, 41 HEALTH SERVS. RES. 1104, 1112 (2006). Interestingly, Connecticut is the first state to follow California's innovation regarding an academic advisory panel for mandated benefits. Connecticut's adoption of such a system, however, took place in 2009, outside of the study period. *See* Act of June 30, 2009, No. 5018 § 1(b)(2), 2009 Conn. Acts 179 (Reg. Sess.).

123. *See* § 2, 2002 Cal. Stat. 795 (amending section 127660(a) of the Health and Safety Code).

124. *See id.* (amending section 127660(b) of the Health and Safety Code).

125. *See id.* (amending section 127662(b) of the Health and Safety Code).

126. Susan Philip, *Overview and Commentary*, 41 HEALTH SERVS. RES. 991, 992–95 (2006).

tablishing CHBRP became effective during the 2003–2004 legislative session, and was originally scheduled to sunset on January 1, 2007. It was subsequently renewed in 2006[127] and 2009,[128] and it is currently scheduled to sunset in 2015.[129] CHBRP's role is to provide data only. It does not make recommendations regarding bill passage, nor does it "discuss the merits or drawbacks of specific bill provisions."[130] In all instances during the study period, CHBRP provided the required report within the sixty-day time frame.

California's legislature had a consistent Democratic majority in both houses during the entire study period. The governor was a Democrat, Gray Davis, from 1999–2003. Late in 2003, Arnold Schwarzenegger, a Republican, became governor and held that position for the remainder of the study period.

2. Connecticut

Connecticut was selected for inclusion due to its status as a high-mandate state, the accessibility of the relevant legislative history, and the presence of a traditional institutional design with respect to mandated benefits decisions, which provides a contrast to California's system of independent information provision. The Connecticut state legislature considers bills that propose mandated benefits through the standard legislative process. Once the bill is introduced, it is referred to committee, in this case typically the Insurance and Real Estate Committee. The committee holds a public hearing where interested parties can testify in favor of or in opposition to a bill.[131] In order for the bill to move forward in the legislative process, it must receive a favorable committee report.[132] If the committee issues a favorable report, the bill will then be placed on the legislative calendar for a vote.[133] During the study period, there was no formal mechanism in place for the committee to receive expert information regarding proposed mandates. Rather, the information received during the legislative process was limited to committee testimony presented by interested parties.

127. Act of Feb. 24, 2006, 2006 Cal. Stat. 684.

128. Act of Mar. 4, 2009, 2009 Cal. Stat. 298.

129. *Id.*

130. Philip, *supra* note 126, at 993.

131. *Legislative Process in Connecticut*, CONN. ST. LIBRARY, http://www.cslib.org/legtutorial/ (follow "Onward to the Committee" hyperlink; then follow "Public Hearing" hyperlink) (last visited Nov. 9, 2011).

132. *Id.* (follow "Onward to the Committee" hyperlink; then follow "Committee Decisions" hyperlink; then follow "Unfavorable Report" hyperlink) (last visited Nov. 9, 2011).

133. *Id.* (follow "Onward to the Committee" hyperlink; then follow "Committee Decisions" hyperlink; then follow "Favorable Report" hyperlink) (last visited Nov. 9, 2011); *id.* (follow "Floor Action in the House and Senate" hyperlink; then follow "Readings" hyperlink) (last visited Nov. 9, 2011). Upon redrafting by the Legislative Commissioners Office and two readings, a favorably reported bill will then be placed on the legislative calendar for a vote.

Like California, the Connecticut state legislature was at all times during the study period controlled by the Democratic Party. Connecticut, however, had a Republican governor during the full study period.

C. Study Design

The first step in the study process was to identify each of the bills to be included in the study. Comprehensive electronic databases of all proposed legislation in the relevant states were searched for relevant terms[134] and the full text of all potentially relevant bills was obtained for further review. The text of all identified bills was then reviewed to ensure the substance of the bill met the criteria for inclusion in the study. After this initial process was complete, various secondary sources that identify state-mandated benefit bills were referenced in order to verify complete bill inclusion. A complete list of the bills included in this study is contained in Appendix B. Once all of the proposed mandates were identified, the legislative history (or "bill file") for each bill was obtained. The bill file included committee reports, public testimony, and any expert reports that were prepared. A large percentage of the bill files were available online through official sites maintained by the respective state governments. Connecticut, however, maintains hard copy transcripts of public hearing testimony, and the relevant transcripts were obtained for those bills through the Connecticut State Library.

Each bill file was then coded for multiple factors. The factors attempt to capture a very broad range of fairness and welfare-economic-based arguments, in order to determine which framework, if any, is prevalent in supporting proposed mandates.[135] Within the welfare economics category, there are two distinct subgroups. The first subgroup includes claims of market failure. In other words, various claims that the existing market for health insurance or medical treatment is in some way flawed.[136] Each of these claims is framed in reference to the status quo, alleging a failure of some type in an existing market. There were three such market failure claims present in the data. The first, and in many ways the classic, market failure claim is one that involves the effects of adverse selection. As discussed above, adverse selection occurs when in-

134. Search terms included "health insurance," "insurance policy," "contract of insurance," and variants thereof.

135. These broad categories are based in part on my previous theoretical work on justifications for mandated benefit laws. *See* Monahan, *supra* note 44. While my previous work served as an initial guide to establishing coding variables, this work was also modified based on interviews with CHBRP staffers regarding their observations of the mandate process, and also based on an initial coding of a sample group of bill files.

136. There are three types of market failure claims identified in the bill files; additional types of market failure claims are included as coding variables, but do not have any occurrences in the data. Evidence or claims of market failures stemming from cognitive bias, decision-making shortcuts, and group market preference aggregation do not appear in any of the bill files in the study. Those variables are omitted from discussion for obvious reasons.

surance purchasers take advantage of private information regarding their health status in making their insurance purchasing decisions. Mandated benefit laws can solve the problems caused by adverse selection by eliminating the ability of insurers to offer plans that do not cover the benefit that is affected by adverse selection.

The second type of market failure claim is one based on suboptimal utilization of a medical treatment or service. Such a claim is premised on the idea that a medical treatment or service is currently underutilized, and that insurance coverage for the treatment or service will increase rates of utilization and therefore improve health outcomes. In other words, a suboptimal utilization claim assumes that people are, for various reasons, declining beneficial medical treatment, that mandated insurance coverage will lower the cost of that treatment, and that the result of a mandate would be more individuals utilizing the service and health outcomes therefore being improved. Note that while this is considered a market failure claim, it is a failure with respect to medical treatment decisions, not a failure in the private insurance market. It is perfectly possible to have a suboptimal utilization claim, even though insurance coverage for the treatment at issue is available in the market and some individuals simply choose not to purchase it. Indeed, suboptimal utilization of a medical treatment or service could have many causes. For example, there may be suboptimal utilization of a treatment because externalities exist that distort an individual's cost-benefit analysis. It may also be that individuals have flawed decision making with respect to the treatment or service at issue. As long as their demand for the treatment is price-elastic, insurance coverage can correct such decision-making flaws. To take a simple example, assume that several health insurance policies available on the market cover colonoscopies, but a significant percentage of the population chooses not to purchase such coverage. The failure to purchase coverage for colonoscopies could have many causes. For example, individuals may incorrectly assess their risk for colon cancer, or they may be unaware of clinical guidelines calling for regular colonoscopies in certain age groups. Further assume that without insurance coverage, these individuals decline recommended colonoscopies, unwilling to pay for such screening out-of-pocket. If they had coverage, however, they would follow their doctors' advice, be screened, and health outcomes would improve. In this case, even though coverage for colonoscopies is available in the market, and these individuals have chosen other coverage, a mandate can solve the purchasing "mistake" by requiring every policy to include coverage for a colonoscopy. Under the assumptions given, the mandate would increase the number of individuals obtaining beneficial health treatment and would improve health outcomes as a result.

The final type of market failure claim is one based on a desire to overrule insurers' determinations of "medical necessity" and "experi-

mental" treatments. Nearly all health insurance contracts contain a requirement that treatments or services must be medically necessary, and not experimental, in order to be covered.[137] These definitions, in practice, give insurers leeway to deny coverage for certain treatments and services, and it is nearly impossible for a consumer, in advance, to evaluate an insurer's likelihood of interpreting such terms in a fair and consistent matter. Even an individual who desires to purchase robust coverage (and is willing to pay for it) may be unable to purchase such coverage in the market because of the amorphous character of medical necessity and experimental treatment limitations. And where such insurer denials are widespread for a particular treatment or service, a type of market failure, or at least market inefficiency, results. Mandates are sometimes used to legislatively overrule such determinations.[138] While fairness concerns may also motivate a desire to overrule these determinations, bill files that included arguments about overruling insurers' medical necessity and experimental treatment limitations were coded as having a fairness-based claim only if there was explicit fairness-based language used.[139]

It is important to note that both suboptimal utilization claims, and claims based on overruling insurers' coverage determinations, could just as easily be labeled "population health" claims given that they rely on assumptions that mandating coverage for a particular treatment or service will improve overall health outcomes. Either label is correct, depending on how the issue is framed. On the one hand, these claims are properly considered market failure claims because some deficiency in the health insurance or medical treatment markets is causing suboptimal outcomes. But the claims can also properly be considered population health claims, because passing mandates that improve health outcomes improves population health.

The second subgroup of claims within welfare economics are claims regarding the economic outcomes of a mandate if passed. Whereas market failure arguments were based on the status quo, economic outcome arguments focus on the positive economic consequences of passing the mandate. There are four types of claims based on positive economic outcomes that were coded: positive cost-benefit analysis, positive cost-effectiveness analysis, nonmedical cost savings, and no additional cost claims. The first two types of economic claims have to do with the economics of the mandate within the health insurance system. A positive cost-benefit claim is made where there is an assertion that the cost of mandating the treatment at issue is less than the value that results from coverage.[140] A positive cost-effectiveness claim is made where there is an

137. HAVIGHURST, *supra* note 48, at 125–35.

138. *See, e.g.*, RETTIG ET AL., *supra* note 12, at 152–69 (discussing federal- and state-mandated breast cancer treatment).

139. See discussion of fairness claim coding, *infra*, for additional information.

140. Cost-benefit analysis is notoriously difficult in the medical field, as it involves translating clinical outcomes into monetary terms, often using evidence of what patients are willing to pay for an out-

assertion that paying for the coverage at issue is either less expensive per unit of outcome than an alternative treatment for the same condition that is already covered by health insurance, or where paying for the treatment at issue is less expensive than paying for the medical consequences of failing to cover the treatment.[141] Claims regarding nonmedical cost savings look beyond the particular economics within the health sector, to take into account nonmedical cost savings that might accrue from passing the mandate. For example, if a mandate had evidence in the legislative record that providing the service at issue would lower state welfare costs because the affected individuals would be able to be productive, working members of society if they received the service, it was coded as having a positive economic analysis in the form of "nonmedical cost savings." Finally, claims that passing a mandate would not increase health insurance premiums were coded as "no additional cost" claims. Note that the threshold for determining cost increases was absolute; even if the mandate was expected to increase premium by pennies a month it was not considered a "no additional cost" claim.

The second broad category, fairness-based claims[142] is much simpler, with only a single coding category used. As with the welfare economic categories, only fairness arguments in favor of a mandate were coded, not fairness-based arguments against a bill. No differentiation was made among types of fairness-based claim, but any indication in the record that could reasonably be construed as a fairness-based argument was sufficient to be included in this category. For example, arguing that the current exclusion of coverage for a certain treatment was "unfair" was considered a fairness-based claim, as were claims that a mandate was necessary in order to provide equal treatment to different classes of individuals. Statements that were limited to medical outcomes, however, were not considered fairness claims. For example, a statement that a proposed mandate "would save lives" was not sufficient to be considered a fairness claim but a statement that "if we save people from dying of disease *X*, we should also save people from dying of disease *Y*" was considered a fairness claim. This distinction is based on an assumption that fairness does not necessarily require every health outcome that can be improved to be in fact improved. For this reason, health outcome claims on their own (regardless of the strength of health outcome improvement) were not considered fairness claims without some explicit appeal to fairness or justice concerns.

The coding categories used have significant potential to overlap. For example, a single bill might contain a suboptimal utilization claim, a

come as to its value. *See, e.g.*, Bradley J. Van Voorhis & Craig H. Syrop, *Cost-Effective Treatment for the Couple with Infertility*, 43 CLINICAL OBSTETRICS & GYNECOLOGY 958, 959 (2000).

141. For example, it might be more cost-effective to pay for the *management* of diabetes rather than the adverse health outcomes (treatment which is covered by the health insurance policy) that result from untreated diabetes. *See id.* at 959–60.

142. See *supra* note 1, for the definition of fairness used in this Article.

fairness-based claim, and a cost-benefit claim. If we return to the colonoscopy example, bill proponents might include in their suboptimal claim a statement that it is "immoral" to exclude colonoscopies from coverage because the combination of price elasticity and suboptimal utilization leads individuals to lack access to a life-saving treatment. And proponents might also argue that requiring coverage for colonoscopies will not only increase utilization, but that the cost of covering treatment would be lower than the resulting benefit. Where such overlap is present in the bill files, each distinct argument is separately coded so that it is possible to have a suboptimal utilization claim, a fairness claim, and also a cost-benefit claim within the same argument.

The box below illustrates each of the coding variables and their definitions.

BOX 1:
CODING VARIABLES

Category 1: Welfare Economics

Subgroup 1: Market Failure Claims

- Adverse selection: a claim that the presence of adverse selection has affected the market for insurance for the treatment at issue
- Suboptimal utilization: an argument based on increasing utilization of the treatment or service
- Overrule insurers' determination of "medical necessity" or "experimental" treatment: a desire to overrule insurers' determinations of medical necessity or experimental status of treatment

Subgroup 2: Economic Outcome Claims

- Cost-benefit claim: cost of treatment subject to mandate is lower than its benefit
- Cost-effectiveness analysis: treatment subject to mandate is cost-effective
- Nonmedical cost savings: nonmedical costs decrease as a result of bill passage
- No additional cost: health insurance premiums do not increase as a result of bill passage

Category 2: Fairness

- Fairness: a claim that fairness or justice requires coverage for the treatment at issue

In order to gauge whether legislatures had evidence supporting the claims that were made when they considered proposed mandates, many of the coding variables included indications not only of whether a particular type of claim was present, but also whether such claim was supported by evidence. The definition of evidence used in this study was very broad and included any type of publicly available study documenting the claim made. No attempt was made to distinguish the *quality* of the evidence.

Note that the coding categories included only claims made in *favor* of a mandate. Any refutation of a claim or evidence contrary to a claim was not taken into account because of the difficulty of weighing the extent of the refutation and also the desire to construe potential claims in the most positive light.[143] Because of the many and vocal critics of mandated benefit laws, I desired to study mandates in the most positive light available (i.e., even if we give these laws the benefit of the doubt, do they appear to be well supported, and on what basis?). In addition, the coding did not in any way distinguish between claims that were made just once in a bill file and those that were made multiple times; no attempt was made to distinguish the *strength* of the claims that were made.

I coded all of the bill files myself, but a second coder coded ten percent of the files in order to determine intercoder reliability. Intercoder reliability was calculated using Krippendorf's alpha and achieved an average measure of .85 across all variables.

The initial analysis was done in two parts. First, a simple frequency analysis was performed, showing how often various types of claims in support of proposed mandates were made. Second, the bills were analyzed using a mixed method approach known as QCA, in order to determine which combinations of factors and evidence were most strongly associated with both committee and legislative passage.

Finally, for each state, I examined the mandates that became law. In California, I was able to conduct interviews with staff members at the CHBRP regarding their perceptions of the decision-making process and have included that information in Part G below. The analysis for Connecticut also includes general observations from the public hearing testimony that was reviewed.[144]

D. Methodological Limitations

This study has several methodological limitations. The study was limited to information contained in the official legislative record, and, in some cases, that information may be incomplete. It is possible that legislators were able to obtain outside information to inform their decisions, and this information was not in any part of the official record that was reviewed. Similarly, legislators may have relied on information they received with respect to bills on similar subject matters that were previously introduced.

The study takes arguments in the record at face value, even though such arguments may in fact be a form of rhetorical window dressing. For

143. This may be an additional reason why this study fails to capture the libertarian approach to health insurance regulation, since most libertarian arguments are made *against* mandates, not in their favor.

144. This information was only available for Connecticut, as transcripts are not provided for public hearings in California. Instead, committee staff in California produce summaries of the arguments made for and against proposed bills.

example, a provider group might argue that requiring coverage for treatment *X* is just, even though the group's true motivation is increased financial revenue. The study is obviously unable to distinguish between true motives and stated motives, although it is arguably valuable to study even the rhetoric surrounding these bills.[145]

Also, while the study is helpful in examining the role that information and data play in benefit mandates, and the impact that institutional design may have on the use of such information, there are surely other factors that influence a bill's passage. This study makes no claims to be a definitive examination of the causes of bill passage.

Finally, the study examines only two states and therefore its conclusions are not necessarily valid in other jurisdictions. To the extent that the federal government is trying to determine whether to adopt the positions taken by the states, however, it should be helpful to know what is driving mandates in the most active states. Additionally, to the extent that mandates are viewed as problematic, the high-mandate states should present the "worst-offender" cases. So while the findings here may not apply to states with a much more limited appetite for health insurance content regulation, they do have significant policy relevance for both federal health care reform, as well as broader discussions of the efficacy of such laws.

Despite these limitations, this study represents the first systematic attempt to determine the types of claims that are made in favor of mandated benefits, how successful such claims are, the extent to which evidence is provided to support claims and whether such evidence impacts bill passage, and how institutional design may influence outcomes. The results should help guide the federal government as it steps into the role of mandating health benefits for a significant percentage of the population.[146]

145. *See generally* Glen Staszewski, *Reason-Giving and Accountability*, 93 MINN. L. REV. 1253, 1256 (2009) ("[S]ome legal or policy outcomes would change if there was an obligation to justify them on the merits, rather than by resorting to . . . 'politically accountab[ility]' . . . ."); *see also* Holning Lau, *Identity Scripts & Democratic Deliberation*, 94 MINN. L. REV. 897, 921 (2010) ("[R]eason-giving conversations form the core of deliberative democracy").

146. These findings should also have significant relevance for states that continue to regulate the large-group insurance market following the implementation of federal health care reform.

E. Frequency Analysis

Presented below are tables illustrating the frequency with which various types of economic and fairness claims were made in each state, with California's data broken down into two subparts to take into account the existence of CHBRP beginning in 2004. With respect to the economic claims, the figures illustrate the extent to which claims were supported by evidence.

1. California Pre-CHBRP

TABLE 2:
FREQUENCY OF CLAIMS IN SUPPORT OF PROPOSED MANDATED BENEFIT LAWS, CALIFORNIA, 1999–2002, PRE-CHBRP*

Type of Claim	Total Number of Occurrences	Number of Claims Without Evidence	Number of Claims with Evidence
Adverse Selection	2	2	0
Suboptimal Utilization	13	12	1
Overrule Insurer Decisions	3	3	0
Positive Cost-Benefit	3	2	1
Positive Cost-Effectiveness	5	4	1
Nonmedical Cost Savings	3	3	0
No Additional Cost	1	1	0
Fairness	14	N/A[147]	N/A

*Thirty-one total bills; each type of claim was counted only once per bill file even if the claim occurred multiple times within a single file

147. Fairness claims were not coded for evidence, for somewhat obvious reasons. These claims are often not as concrete as, say, racial disparity claims, for which evidence is available. Rather, they are typically much more general, for example, a claim that like claims should be treated equally.

This frequency analysis presents an interesting picture of benefit mandates prior to the establishment of CHBRP. The most common type of claim made in favor of a proposed mandate was a fairness-based claim, present in fourteen of the thirty-one (forty-five percent) bills during this period. There are many possible explanations for the predominance of fairness-based claims. First, issues of fairness and justice are without a doubt central themes in health policy, and it is not surprising that such themes retain their centrality in debate regarding the content of health insurance coverage. Additionally, and somewhat cynically, they are easy to make. Not only is it easy to make a claim that covering a particular treatment is "the right thing to do" from an ethical perspective, it is also easy to take the position in this context that medical losses should generally be treated equally.

The second most common claim (thirteen bills) was based on suboptimal utilization of a medical treatment or service. Recall that a suboptimal utilization argument involves a claim that utilization of the medical treatment or service at issue is below an optimal level, that demand for the treatment is price-elastic (and therefore once individuals have insurance coverage for the treatment more of them will utilize it) and that health outcomes will improve as a result. While I characterize this type of claim as a market failure claim, the precise type of failure that drives this claim can have many different causes, as discussed previously in Part III.C. Given the wide variety of potential drivers for suboptimal utilization claims, it is not surprising that such claims are so frequently made. It is interesting to note, however, that these claims have very little to do with insurance purchasing decisions or the functioning of insurance markets. Rather, they focus on treatment decisions. And it is also of note that only one of the thirteen bills that contained suboptimal utilization claims had any evidence in the record supporting the claim. In other words, in the majority of bills with suboptimal utilization claims, there was no evidence in the record that (1) demand for the treatment or service was price-elastic or (2) that health outcome would improve if utilization rates increased. The lack of evidence could have many causes. It may be that legislators are not interested in such evidence, it may be that such evidence is not generally available, or it may be that available evidence does not support the claim. Regardless of cause, it is surprising (or at least disheartening) that in only a single instance did a bill containing a suboptimal utilization claim have any type of evidence to support such a claim.

It is surprising that more traditional *insurance* market failures are not more prominent in the bill files. For example, claims based on adverse selection or improper insurance company coverage decisions were present in only two and three bill files, respectively. The reason that the low prevalence of such claims is noteworthy is what it implies with respect to the driver of mandates. Claims related to adverse selection, in

particular, are premised on the notion that even if the individual desired to purchase insurance coverage for the treatment at issue he or she could not (or at least could not at a price lower than the expected cost of treatment plus overhead expenses). Suboptimal utilization claims, on the other hand, can exist even if insurance coverage for the treatment is readily available on the market. Individuals may be freely choosing not to insure against such loss. In this sense, suboptimal utilization claims can be much more paternalistically motivated than adverse selection claims. And while most of the theoretical literature focuses on adverse selection as a prime motivator of mandated benefit laws, such claims clearly play a very small role in the proposed mandates included in this study.

Also somewhat surprising is the apparent low frequency of economic outcome claims. The most frequently made economic outcome claim was a cost-effectiveness claim, but such claims were present in only five (sixteen percent) bill files. And among all categories of economic outcome claims, rates of evidence were quite low. For example, cost-effectiveness claims were supported by evidence in only one of the cases that contained such claims. Yet again, the low incidence of evidence could be caused by either a lack of available supporting evidence or legislative indifference to such evidence.

If we look at the broad categories of claims, those based in welfare economics versus those based in fairness, we see that seventeen bills (fifty-five percent) contained some type of claim grounded in welfare economics and fourteen bills (forty-five percent) contained fairness-based claims, a fairly even split. When we look at welfare economic claims in more detail, it is interesting to note that market failure claims are the most common type of welfare economic claim, occurring in thirteen bills (forty-two percent) and that *a suboptimal utilization claim was present in every bill file that contained a market failure claim*. There were a few bills that contained a suboptimal utilization claim and a different type of market failure claim but none that had only a non-suboptimal utilization market failure claim. This finding further supports the central role such claims played in mandated benefit legislation prior to the establishment of CHBRP. It suggests that bill proponents were often arguing for a mandate based on medical outcomes and fairness, and not traditional insurance market failures such as adverse selection.

Welfare economic claims based on economic outcomes (rather than market failure) were present in only nine (twenty-nine percent) of the bill files. While not insignificant, given the attention paid in the existing literature to the effect that mandates have on premiums and therefore coverage, the percentage is somewhat surprising. It is, however, important to keep in mind that economic outcome claims as understood in this study are positive claims. In other words, they include only claims that the proposed legislation is economically attractive in some way.

Many mandates may not have a positive economic outcome, or there may not be evidence that supports such a claim.

2. California Post-CHBRP

The types of claims, and the extent to which claims are supported by evidence, differs significantly following the establishment of CHBRP, as illustrated in Table 3 below.

TABLE 3:
FREQUENCY OF CLAIMS IN SUPPORT OF PROPOSED MANDATED BENEFIT LAWS, CALIFORNIA, 2003–2008, POST-CHBRP*

Type of Claim	Total Number of Occurrences	Number of Claims Without Evidence	Number of Claims with Evidence
Adverse Selection	3	3	0
Suboptimal Utilization	28	13	15
Overrule Insurer Decisions	2	2	0
Positive Cost-Benefit	4	3	1
Positive Cost-Effectiveness	6	0	6
Nonmedical Cost Savings	2	1	1
No Additional Cost	7	1	6
Fairness	18	N/A	N/A

*Forty total bills; each type of claim was counted only once per bill file even if the claim occurred multiple times within a single file

The use of fairness-based claims remains high, with eighteen bills (forty-five percent) containing such claims, but suboptimal utilization claims now become by far the most common type of claim made in favor of a mandate, being found in twenty-eight (seventy percent) bill files. Where such claims were rarely (one in thirteen) supported by evidence during the pre-CHBRP period of the study, over one-half of such claims (fifteen of twenty-eight) were backed by some type of evidence following the establishment of CHBRP. And while the number of cost-

effectiveness claims remained relatively stable, all such claims were backed by evidence following the establishment of CHBRP. Also of note is the increase of no additional cost claims and evidence. It is perhaps not surprising that certain types of evidence (and therefore claims) increased following the enactment of CHBRP given that CHBRP is required by its statutory charge to provide, among other things, information regarding a bill's likely effect on utilization and premium costs. The increased incidence of such evidence, however, does not appear to diminish or otherwise change the rates at which other types of claims were made.

When we look at the broad categories of claims, there were eighteen bills (forty-five percent) with fairness-based claims and thirty-three bills (eighty-three percent) with welfare economic claims, showing a clear increase in the relative frequency of welfare economic claims following the establishment of CHBRP. Of the bills with welfare economic claims, eleven bills contained both market failure claims and economic outcome claims, nineteen bills contained only market failure claims, and three contained only economic outcome claims. Again, while the incidence of market failure-based claims is very high (thirty of forty bills), nearly all of these (twenty-seven out of thirty) were suboptimal utilization claims.

3. Connecticut

In Connecticut, there were 124 mandates proposed during the study period. As Table 4 illustrates, the frequency with which various types of claims were made in support of such mandates is in many ways similar to California during the pre-CHBRP period.

TABLE 4:
FREQUENCY OF CLAIMS IN SUPPORT OF PROPOSED MANDATED BENEFIT LAWS, CONNECTICUT, 1999–2008*

Type of Claim	Total Number of Occurrences	Number of Claims without Evidence	Number of Claims with Evidence
Adverse Selection	7	7	0
Suboptimal Utilization	40	34	6
Overrule Insurer Decisions	12	9	3
Positive Cost-Benefit	17	8	9
Positive Cost-Effectiveness	34	29	5
Nonmedical Cost Savings	12	7	5
No Additional Cost	0	0	0
Fairness	48	N/A	N/A

*124 total bills; each type of claim was counted only once per bill file even if the claim occurred multiple times within a single file

Fairness claims were the most frequently made (thirty-nine percent of bills), followed by suboptimal utilization claims (thirty-two percent of bills). Connecticut, however, had a significantly higher rate of cost-effectiveness claims (twenty-seven percent of bills) than seen in California, as well as higher levels of evidence provided for several different types of claims.[148] Nevertheless, the overall level of evidence-backed claims remained low.

When we look at the broad categories of claims, there were fifty-two bills that contained some form of welfare economic claim, and forty-eight that contained a fairness claim. As in California, a large majority of the bills with market failure claims contain suboptimal utilization claims. In Connecticut, forty-eight bills contained some type of market failure claim and, of these, forty included a suboptimal utilization claim. Economic outcome claims were less prevalent than either market failure or

148. For example, fifteen percent of the suboptimal claims made in Connecticut are supported by evidence, while only 7.7 percent suboptimal claims made in pre-CHBRP have evidentiary support.

fairness-based claims, mirroring California both before and after the establishment of CHBRP.

4. Overall Findings

Taken together, these data lead to several interesting observations. First, fairness-based claims are very frequently used to support mandates. Indeed, in pre-CHBRP California and in Connecticut, they were the most common form of claim made in favor of mandates. In other words, under the systems without an outside data-gathering source, bill proponents most frequently argued for a mandate based on fairness. Even when California began using CHBRP, fairness claims were the second most frequent claim (remaining at a high forty-five percent of all bills). The implication is that regulating the substance of health insurance likely has a lot to do with perceptions of fairness, as will be examined in more detail in Section G, below. It should be remembered, however, that both states studied had Democratic legislative majorities. One unknown is whether states with a lesser taste for government would show the same role for fairness-based claims in substantive health insurance regulation.

By far the most common type of market failure claim made was one based on suboptimal utilization of a medical treatment or service. As mentioned above, this claim is essentially based on the idea that insurance coverage for a treatment or service will lower the effective price of treatment to the patient, which will lead to a greater number of patients receiving the service, which in turn will lead to improved health outcomes. It is interesting to note that in California before CHBRP, none of the suboptimal utilization claims were supported by evidence and in Connecticut only a small percentage of such claims were backed by evidence. Following implementation of CHBRP, the proportion of claims supported by evidence improved, but still only one-third of such claims were supported by evidence. This is somewhat troubling if one believes that the starting point for any regulatory action should be some evidence that the market is not providing the desired coverage or the optimal level of a given treatment or service (or even that utilization or health outcomes will improve if the mandate passes). CHBRP certainly increased the use of evidence to support such claims, but it clearly did not eliminate the use of unsubstantiated claims by bill advocates.[149]

Another significant observation to be made from the frequency data is how economic outcome claims are made relatively infrequently given

149. And this lack of evidence is particularly troubling given the likely role of lobbying by service providers for such mandates. The bill files included in this study show that service providers frequently advocate for mandates for the services they provide. Without any type of evidence, it is impossible for legislators to evaluate whether the service providers' arguments are based on a genuine likelihood that a mandate will improve patient health outcomes, or whether they are based on economic self-interest.

the importance of cost in health care regulation (such claims were present in thirty-four percent of proposed bills in pre-CHBRP California, thirty-five percent of proposed bills in post-CHBRP California, and forty-nine percent of proposed bills in Connecticut). Even more striking is how infrequently the economic claims that are made are supported by evidence (In pre-CHBRP California, seven percent of proposed bills had economic claims supported by evidence, thirty percent of proposed bills in post-CHBRP California, and thirteen percent of proposed bills in Connecticut.). CHBRP significantly increased the number of economic claims that were supported by evidence, but even so the absolute number remains relatively small.[150] With that said, the striking exception is with respect to cost-effectiveness claims, which went *down* compared to the pre-CHBRP period, but every single cost-effectiveness claim made while CHBRP was in place was supported by evidence. Clearly CHBRP is producing evidence that supports such claims,[151] but one possible explanation for why the number of such claims declines in the post-CHBRP period is that bill proponents know that they cannot "get away" with an unsupported (or, in fact, incorrect) claim regarding cost-effectiveness because the CHBRP report will effectively rebut such claims.

150. The difference in the number of economic claims supported by evidence in the pre-CHBRP period versus the post-CHBRP period is statistically significant under the Pearson chi-square test (chi=9.57, df=1, p=.001987).

151. For an overview of CHBRP's cost analysis, see *Summary: Cost Impact Analysis*, CAL. HEALTH BENEFITS REV. PROGRAM, http://www.chbrp.org/costimpactsum.html (last visited Nov. 9, 2011).

F. QCA

1. Background

QCA[152] is an empirical method that is particularly well-suited to small and intermediate-n studies,[153] and involves both qualitative and quantitative elements.[154] The first step is to use the raw data to create a truth table that illustrates the possible combinations of causal conditions along with the cases containing each combination.[155] For each row in the truth table, the researcher evaluates whether the particular combination of factors leads to roughly comparable outcomes.[156] The truth table data is then "minimized" using principles of Boolean logic.[157] The goal is to specify, in a logically minimal way, the different combinations of factors that produce the outcome being studied.[158] For example, if two combinations of factors produce the same outcome and differ on the presence of only one factor, then the one differing factor is not a "cause" of the outcome.[159] Rather than trying to isolate the effects of single variables, it analyzes the effects of combinations of variables.[160] It is useful in examining causal complexity, because through the use of QCA the researcher can identify different combinations of causal conditions capable of producing the same outcome. Because QCA is not based on probabilities and often involves a small or moderate number of cases, statistical infer-

152. *See* CHARLES C. RAGIN, THE COMPARATIVE METHOD: MOVING BEYOND QUALITATIVE AND QUANTITATIVE STRATEGIES 124 (1987). QCA has been used primarily in the fields of political science and economics, but its use is increasing in other disciplines, including law. *See* Benoît Rihoux, *Bridging the Gap Between the Qualitative and Quantitative Worlds? A Retrospective and Prospective View on Qualitative Comparative Analysis*, 15 FIELD METHODS 351, 357 (2003); *see also* M.V. Lee Badgett, *Predicting Partnership Rights: Applying the European Experience to the United States*, 17 YALE J.L. & FEMINISM 71 (2005) (noting that QCA is used to analyze the factors associated with countries having same-sex partner rights); David Baldus et al., *Improving Judicial Oversight of Jury Damages Assessments: A Proposal for the Comparative Additur/Remittitur Review of Awards for Nonpecuniary Harms and Punitive Damages*, 80 IOWA L. REV. 1109 (1995) (noting that QCA is used to analyze additur/remittitur reviews); Charles H. Blake & Jessica R. Adolino, *The Enactment of National Health Insurance: A Boolean Analysis of Twenty Advanced Industrial Countries*, 26 J. HEALTH POL. POL'Y & L. 679 (2001) (using QCA to analyze conditions associated with countries adopting national health insurance); William Bradford, *In the Minds of Men: A Theory of Compliance with the Laws of War*, 36 ARIZ. ST. L.J. 1243 (2004) (noting that QCA is used to analyze factors associated with the use of anticipatory self defense); Michael J. Friedman, *Dazed and Confused: Explaining Judicial Determinations of Traditional Public Forum Status*, 82 TUL. L. REV. 929 (2008) (noting that QCA is used to analyze factors associated with judicial determinations of public forum status in free speech cases).

153. *See* Rihoux, *supra* note 152, at 353.

154. *Id.* at 356.

155. *Id.* at 354; *see also* Charles C. Ragin, *Using Qualitative Comparative Analysis to Study Causal Complexity*, 34 HEALTH SERVS. RES. 1225, 1230 (1999).

156. Ragin, *supra* note 155, at 1232.

157. *Id.* at 1233.

158. *Id.*

159. Dirk Berg-Schlosser et al., *Qualitative Comparative Analysis (QCA) As an Approach*, *in* CONFIGURATIONAL COMPARATIVE METHODS 1, 2 (Benoît Rihoux & Charles C. Ragin eds., 2009).

160. Ragin, *supra* note 155, at 1225.

ence is not used to test whether conclusions may have occurred by chance.[161]

2. California Pre-CHBRP

Prior to performing the qualitative comparative analysis, the coding variables previously identified were simplified somewhat to reflect slightly broader categories. The variables used for the QCA were suboptimal utilization claims,[162] fairness claims, economic outcome claims, and evidence of positive economic outcome. In California, prior to the establishment of CHBRP, there were thirty-one bills proposed during the study period. Of these, sixteen passed committee (fifty-two percent). Because economic outcome claims and economic outcome evidence are mutually exclusive coding categories, there were a total of twelve different possible combinations of factors that could exist.[163] There were, however, cases in only nine combinations. Table 5 illustrates the distributions of these cases and the number in each combination that passed the committee.

TABLE 5:
COMMITTEE PASSAGE RATES BY FACTORS PRESENT,
CALIFORNIA, 1999–2002, PRE-CHBRP

Factors	Number of Bills	Number Passing Committee	
		N	%
Suboptimal claim AND fairness	4	4	100%
Suboptimal claim AND fairness AND economic outcome claim	4	4	100%
Suboptimal claim AND fairness AND economic outcome evidence	1	1	100%
Suboptimal claim AND economic outcome evidence	1	1	100%
Fairness	4	2	50%
Economic outcome claim	3	1	33%
None	10	3	30%
Suboptimal claim	3	0	0%
Fairness AND economic outcome claim	1	0	0%

161. Steve Harkreader & Allen W. Imershein, *The Conditions for State Action in Florida's Health-Care Market*, 40 J. HEALTH & SOC. BEHAV. 159, 170 (1999).

162. Because only one bill had evidence of suboptimal utilization, it is not included as a separate variable for purposes of this analysis.

163. Normally, with four variables that are not mutually exclusive, there would be sixteen possible combinations.

When the final step of QCA is undertaken in order to logically simplify the above information, the result is that a suboptimal utilization claim combined with a fairness claim is the combination of factors that is most strongly associated with committee passage pre-CHBRP. All nine bills that contained both factors passed committee, explaining over one-half of the bills that passed committee during this period. In two cases, the committee passed bills that had only a fairness-based argument in the record, and in three cases, the committee passed bills that had neither a market failure claim, fairness claim, or economic claim in the record. So while the combination of a suboptimal claim with fairness was particularly powerful, bills also passed with very little to support them in the record. Overall the data suggests, from the committee's perspective, that health outcomes and fairness concerns trump economic concerns.

At the legislative level, the impact of the various factors on passage is less clear. The legislature had sixteen proposed mandates before it during the pre-CHBRP period of the study, and it passed eight of these (fifty percent). Again, because there were four variables measured, two of which were mutually exclusive, there were twelve possible combinations of variables. The sixteen bills before the legislature contained seven different combinations of factors, illustrated in Table 6 below.

TABLE 6:
LEGISLATIVE PASSAGE RATES BY FACTORS PRESENT, CALIFORNIA, 1999–2002, PRE-CHBRP

Factors	Number of Bills	Number Passing Committee	
		N	%
Suboptimal claim AND economic outcome evidence	1	1	100%
Suboptimal claim AND fairness AND economic outcome claim	4	3	75%
Suboptimal claim AND fairness	4	2	50%
Fairness	2	1	50%
None	3	1	33%
Economic outcome claim	1	0	0%
Suboptimal claim AND fairness AND economic outcome evidence	1	0	0%

In the final step of the QCA, the only combination of factors that appears to have had a significant impact on legislative passage is a suboptimal utilization claim in combination with a fairness and economic outcome claim. This particular combination of factors, however, had both a lower occurrence (37.5 percent of bills) and a lower rate of consistency (seventy-five percent) than the relevant combination identified at the committee level. One implication of this finding is that the legislature may have had more fluid preferences than the relevant committees. It is also possible that the legislature based its decisions on something other than the factors included in the study. It does seem to indicate, however, that the legislature may have had a greater interest in economic effects of mandates than did the committee.

During the pre-CHBRP period, the governor vetoed only one of the eight bills that were sent to him by the legislature. Given these small numbers, a QCA was not performed on gubernatorial signing rates pre-CHBRP. The one bill that was vetoed was a bill requiring coverage for routine patient care costs for individuals enrolled in prostate cancer clinical trials. In his veto statement, Governor Davis stated that he could not sign a bill that provided coverage only for those in prostate cancer trials and ignored other types of cancer trials, specifically mentioning the omission of breast cancer trials.[164]

3. California Post-CHBRP

During the portion of the study period that CHBRP was in place and providing expert reports on proposed mandates, forty proposed mandates were introduced. Of these, twenty-five were approved by the relevant committee (sixty-three percent). In performing the QCA analysis, the same factors were used as above, with a few minor changes. First, because suboptimal utilization was not the only type of market failure claim made, and because some types of market failure claims were supported by evidence, the suboptimal utilization variable was replaced by two market failure variables: market failure claim and market failure evidence. Market failure claims and evidence encompass suboptimal utilization claims, adverse selection claims, and overruling insurer decision claims. As a result, with a total of five variables, two sets of which are mutually exclusive, eighteen possible combinations of factors exist. Data was present for fourteen of these combinations. Table 7 illustrates the combinations and the committee passage rates for each.

164. Letter from Gray Davis, Governor of Cal., to Cal. State Senate (Sept. 30, 2000) (announcing executive veto of Senate Bill 1839).

TABLE 7:
COMMITTEE PASSAGE RATES BASED ON COMBINATION OF FACTORS, CALIFORNIA, 2003–2008, POST-CHBRP

Factors	Number of Bills	Committee Passage	
		N	%
Market failure claim AND economic outcome evidence	3	3	100%
Market failure claim AND fairness AND economic outcome evidence	2	2	100%
Market failure evidence AND fairness	2	2	100%
Fairness AND economic outcome evidence	1	1	100%
Market failure evidence AND fairness AND economic outcome evidence	1	1	100%
Market failure claim AND fairness	9	8	89%
Market failure evidence	3	2	67%
Market failure evidence AND economic outcome evidence	3	2	67%
Market failure claim	7	4	57%
None	4	0	0%
Fairness	2	0	0%
Economic outcome evidence	1	0	0%
Economic outcome claim	1	0	0%
Market failure evidence AND economic outcome claim	1	0	0%

The final stage of the QCA reveals certain combinations that are very strongly associated with committee passage, as illustrated in Table 8 below.

TABLE 8:
PATHS TO COMMITTEE PASSAGE,
CALIFORNIA, 2003–2008, POST-CHBRP

Combination	Percentage of Bills with Combination That Pass Committee
Fairness AND economic outcome evidence	100%
Market failure claim AND economic outcome evidence	100%
Market failure claim AND fairness	91%
Market failure evidence BUT NOT economic outcome claim	78%

These four combinations cover eighty-four percent of the bills that passed committee, with a weighted average consistency rate of 87.5 percent. In examining the four combinations listed above, it is interesting to note that mere claims continue to have an impact on committee passage, even in the face of better evidence. Additionally, fairness is featured in two out of the four combinations most strongly associated with committee passage, indicating that although evidence is more frequently used post-CHBRP, it has not necessarily lessened the important role that fairness claims play in mandate passage.

At the legislative level, twenty-one of the twenty-five mandates approved by committee were passed (eighty-four percent).[165] Nine different combinations of factors were present among the bills. Table 9 illustrates the combinations present and their legislative passage rates.

165. The legislative passage rate for bills during the post-CHBRP period is significantly higher than the rate prior to the establishment of CHBRP (eighty-five percent versus fifty percent). There are many possible explanations. It might be that the evidence provided by CHBRP gave legislators more confidence in proposed mandates, it could be that legislators were more constrained in what types of mandates they offered, knowing that CHBRP would review each, or it could be that the legislature was more willing to vote in favor of a mandate given the high likelihood that it would be vetoed by the Governor (who signed only twenty-seven percent of all mandates during this period).

TABLE 9:
LEGISLATIVE PASSAGE RATES BY FACTORS PRESENT, CALIFORNIA, 2003–2008, POST-CHBRP

Factors	Number of Bills	Legislative Passage	
		N	%
Market failure claim AND economic outcome evidence	3	3	100%
Market failure claim AND fairness AND economic outcome evidence	2	2	100%
Market failure evidence AND economic outcome evidence	2	2	100%
Market failure evidence AND fairness	2	2	100%
Market failure evidence AND fairness AND economic outcome evidence	1	1	100%
Market failure claim AND fairness	8	7	88%
Market failure claim	4	3	75%
Market failure evidence	2	1	50%
Fairness AND economic outcome evidence	1	0	0%

At this stage, it is noteworthy that the majority of the combinations that resulted in one hundred percent legislative passage rates contained evidence of economic outcomes. Seven of eight bills that had only a market failure claim and a fairness claim passed, however.

In the final stage of the QCA, we find that the following combinations of factors, presented in Table 10, were most strongly associated with legislative passage.

TABLE 10:
PATHS TO LEGISLATIVE PASSAGE,
CALIFORNIA, 2003–2008, POST-CHBRP

Combination	Percentage of Bills with Combination That Pass Legislature
Economic outcome evidence AND (market failure claim OR evidence)	100%
Market failure evidence AND fairness	100%
Market failure claim AND fairness	91%

Another way of expressing these findings is that legislative passage post-CHBRP is associated with: (1) economic outcome evidence combined with either a market failure claim or evidence and (2) fairness, combined with either a market failure claim or evidence. Together, these factors "explain" approximately eighty-one percent of the bills that passed the legislature, with a weighted consistency rate of ninety-five percent.

Of the twenty-one bills that were passed by the legislature, only five were signed into law (twenty-four percent). Among the bills that went to the governor for signature, there were eight different combinations of factors, as illustrated in Table 11.

TABLE 11:
GUBERNATORIAL SIGNING BY COMBINATION OF FACTORS, CALIFORNIA, 2003–2008, POST-CHBRP

Factors	Number of Bills	Gubernatorial Signing	
		N	%
Market failure evidence	1	1	100%
Market failure claim AND economic outcome evidence	3	2	67%
Market failure claim AND fairness AND economic outcome evidence	3	1	33%
Market failure claim	3	1	33%
Market failure claim AND fairness	7	0	0%
Market failure evidence AND economic outcome evidence	2	0	0%
Market failure evidence AND fairness	2	0	0%
Market failure evidence AND fairness AND economic outcome evidence	1	0	0%

In the final stage of QCA, the above results are reduced, and the two combinations most strongly associated with gubernatorial signing are (1) a market failure claim combined with evidence of positive economic outcome and (2) evidence of market failure without either a fairness claim or positive economic evidence. These results explain four out of the six bills signed by the governor, but with a weighted average consistency rate of only sixty-seven percent. As a result, these results are not nearly as strong as those at the legislative or committee levels. A more detailed discussion of those bills that became law during the post-CHBRP period is provided in Part II.F.1.

4. Connecticut

In Connecticut, there were 124 mandates proposed during the study period. Of these, forty-one passed committee (thirty-three percent), and of the forty-one that passed through committee, eighteen were approved by the legislature and signed into law (forty-four percent of bills eligible for a legislative vote).

In analyzing the data from Connecticut, the data categories were condensed, as they were in post-CHBRP California, into three broad categories of market failure, fairness, and economic outcomes, with distinctions made for market failure and economic outcome claims that had evidence in the record to support such claims. Recall that the types of market failure claims made in Connecticut during the study period were more diversified than in California, with a greater percentage being non-suboptimal utilization claims.[166] Of the eighteen possible combinations of factors, there were thirteen combinations present in the data. Those combinations are listed in Table 12, along with committee passage rates.

166. In California during the pre-CHBRP period, of the thirteen bills with market failure claims, all (one hundred percent) contained a suboptimal utilization claim. In post-CHBRP California, twenty-nine of thirty-two (ninety-one percent) of bills with market failure claims contained suboptimal utilization claims, while the incidence was forty of forty-eight bills (eighty-three percent) in Connecticut. *See supra* Part III.E.

TABLE 12:
COMMITTEE PASSAGE RATES BY COMBINATIONS OF FACTORS, CONNECTICUT, 1999–2008

Factors	Number of Bills	Committee Passage	
		N	%
Market failure claim AND fairness	8	8	100%
Fairness AND economic outcome claim	3	3	100%
Market failure evidence AND fairness AND economic outcome claim	3	3	100%
Market failure claim AND economic outcome evidence	1	1	100%
Market failure claim	6	5	83%
Market failure evidence AND fairness AND economic outcome evidence	3	2	67%
Fairness	10	5	50%
Market failure claim AND economic outcome claim	4	2	50%
Market failure evidence AND economic outcome claim	2	1	50%
Market failure claim AND fairness AND economic outcome claim	12	5	42%
Market failure claim AND fairness AND economic evidence	9	3	33%
None	62	3	5%
Economic outcome claim	1	0	0%

These data lead to many observations. First, the combination of a market failure claim combined with a fairness claim had the strongest association with committee passage, just as it did in California during the pre-CHBRP period. Also, similarly to pre-CHBRP California, evidence did not appear to play a large role in committee passage. Fairness-based claims appear to have been quite influential, with one-half of all bills with only a fairness-based claim passing committee.

In the final stage of the QCA, the above results are minimized into the following four combinations.

TABLE 13:
PATHS TO COMMITTEE PASSAGE,
CONNECTICUT, 1999–2008

Combination	Percentage of Bills Containing Factors That Pass Committee
Fairness AND economic outcome claim BUT NOT a market failure claim	100%
Economic outcome evidence BUT NOT a fairness claim	100%
Market failure claim BUT NOT evidence or claim of economic outcome	93%
Market failure evidence AND fairness	83%

These results are puzzling. They explain approximately fifty-four percent of the bills that passed committee, with a weighted consistency rate of ninety-two percent. It is difficult, however, to come up with a cohesive explanation about why these combinations of factors drive committee passage, other than to observe that there is a tremendous amount of causal complexity at the committee level in Connecticut.[167] It may be that factors beyond those being studied drove committee passage, or it may be that the committee applied factors inconsistently or weighed their value in a way not contemplated by this study.

167. In contrast, in pre-CHBRP California, a single combination of factors (suboptimal utilization claim combined with fairness) explained fifty-four percent of the bills that passed committee with one hundred percent consistency. *See supra* Part III.F.2.

At the legislative level in Connecticut, there were forty-one proposed mandates eligible for a legislative vote, of which eighteen were passed and signed into law (forty-four percent). Because the governor did not veto any mandates during the study period, it was not necessary to separately analyze the bills that were subsequently signed by the governor. Of the forty-one bills that were eligible for a legislative vote, there were twelve combinations of factors present, illustrated in Table 14.

TABLE 14:
LEGISLATIVE PASSAGE BY FACTORS PRESENT,
CONNECTICUT, 1999–2008

Factors	Number of Bills	Legislative Passage	
		N	%
None	3	3	100%
Market failure evidence AND fairness AND economic evidence	2	2	100%
Market failure evidence AND economic claim	1	1	100%
Market failure evidence AND fairness AND economic claim	3	2	67%
Market failure claim	5	3	60%
Market failure claim AND economic outcome claim	2	1	50%
Fairness	5	2	40%
Market failure claim AND fairness	8	3	38%
Market failure claim AND fairness AND economic outcome claim	5	1	20%
Fairness AND economic outcome claim	3	0	0%
Market failure claim AND fairness AND economic outcome claim	3	0	0%
Market failure claim AND economic outcome evidence	1	0	0%

TABLE 15:
PATHS TO LEGISLATIVE PASSAGE,
CONNECTICUT, 1999–2008

Factors	Percentage of Bills with Factors That Passed Legislature and Became Law
None	100%
Market failure evidence AND fairness AND economic outcome evidence	100%
Market failure evidence AND economic outcome claim	75%

The final reduction of the QCA is presented in Table 15. While these combinations have high rates of consistency with a bill becoming law (a weighted average consistency rate of eighty-nine percent), the three combinations listed above explain only forty-four percent of the bills that became law. This suggests significant inconsistency with respect to the effect that different combinations of factors have on legislative passage.

One apparent puzzle in the data is the fact that three bills passed without any type of claim or evidence in the record to support them. There is, however, a relatively simple explanation. Those three bills (requiring coverage for hearing aids for children, mammograms, and psychotropic prescription drugs) were each added as floor amendments to a bill that passed out of committee requiring coverage for routine patient care costs in cancer clinical trials. Given the timing of when they were added, it would be impossible to build a record for those mandates. It is likely that the cancer clinical trials mandate was popular, and these floor amendments were an easy way to gain passage of mandates that, for various unknown reasons, would have had difficulty passing on their own. While this illustrates a profound weakness in the legislative process, at least from the perspective of having an evidence-based process, it is notable that this is the only instance of mandates being added as floor amendments in all of the bills included in this study. In the end, the study shows that there was significant causal complexity in mandated benefit passage in Connecticut during the study period.

5. A Comparison of California and Connecticut

The tables below present a comparison between California and Connecticut with respect to the strongest paths to committee and legislative passage.

TABLE 16:
PATHS TO COMMITTEE PASSAGE, CALIFORNIA AND CONNECTICUT

California, Pre-CHBRP	California, Post-CHBRP	Connecticut
Suboptimal utilization claim AND fairness	Economic outcome evidence AND (fairness OR market failure claim) Fairness AND (market failure evidence OR claim)	Fairness AND economic outcome claim BUT NOT a market failure claim Economic outcome evidence BUT NOT a fairness claim Market failure claim BUT NOT evidence OR claim of economic outcome Market failure evidence AND fairness

TABLE 17:
PATHS TO LEGISLATIVE PASSAGE, CALIFORNIA AND CONNECTICUT

California, Pre-CHBRP	California, Post-CHBRP	Connecticut
Suboptimal utilization claim AND economic outcome claim[168]	Fairness AND (market failure claim OR evidence) Economic outcome evidence AND (market failure claim OR evidence)	Market failure evidence AND economic outcome claim None Market failure evidence AND fairness AND economic outcome evidence

168. These findings were particularly weak, explaining relatively few bills, and with only seventy-five percent consistency.

In California pre-CHBRP we see a focus on suboptimal utilization and fairness claims at the committee level, with more focus on suboptimal utilization and economic outcomes at the legislative level. After CHBRP was established, we see more reliance on evidence, but still a significant number of unsubstantiated claims associated with bill passage. In Connecticut, there was much less consistency in the paths to committee and legislative passage. A variety of combinations, involving both claims and evidence, were associated with bill passage.

G. A Closer Examination of the Bills

While the above analysis provides an overall view of the evidence in the legislative record to support proposed mandates and how such evidence may or may not have influenced the legislative outcome, this Section takes a closer look at those bills that did became law during the study period. Additionally, findings from an interview with CHBRP staff are included below, as are general observations from the public hearing testimony in Connecticut. The analysis below illustrates, among other things, that many bills that became law in post-CHBRP California duplicated coverage that was already available in the market and were expected to have very little impact on cost or utilization rates as a result. In pre-CHBRP California, there was a profound lack of evidence in the record for those bills that became law, and several were aimed at policy goals outside of the private health insurance market. In Connecticut the analysis shows many mandates passed that made only minor changes to existing coverage, and little reliance on evidence. We also see in Connecticut evidence of the influence of both single individuals in giving rise to a proposed mandate, and the prevalence of anecdote-driven testimony.

1. California

a. Which Bills Became Law?

During the study period, twelve proposed mandates became law in California.

TABLE 18:
NEW MANDATED BENEFIT LAWS, CALIFORNIA, 1999–2008

Bill	Subject Matter	CHBRP Review?	Factors Present
2007 A.B. 1461	Prohibits insurers from denying coverage for otherwise allowable claims on the basis that an individual was intoxicated or under the influence of a controlled substance when the loss was incurred	Yes	Suboptimal utilization claim
2007 A.B. 1894	Requires coverage of HIV testing, regardless of whether it is related to a primary diagnosis	Yes	Suboptimal utilization claim Evidence of cost-effectiveness
2005 A.B. 228	Prohibits insurers from denying coverage for organ transplants on the basis that the recipient is HIV positive	Yes	Overrule insurance company coverage determination Fairness Evidence of no additional cost
2005 S.B. 1245	Broadens existing cervical cancer screening mandate to include the HPV screening test	Yes	Overrule insurance company coverage determination Evidence of no additional cost
2003 A.B. 2185	Requires coverage for inhaler spacers, nebulizers, and peak flow meters for the treatment of pediatric asthma if a plan covers outpatient prescription drug benefits	Yes	Evidence of suboptimal utilization

Continued on next page

TABLE 18—Continued

2001 S.B. 1219	Requires coverage for annual screening for cervical cancer using any method approved by the FDA if a plan covers treatment of cervical cancer	No	Suboptimal utilization claim Fairness Evidence of no additional cost
2001 S.B. 37	Requires coverage of routine patient costs for individuals enrolled in cancer clinical trials	No	Suboptimal utilization claim Cost-benefit claim Evidence of cost-effectiveness
2001 S.B. 446	Requires coverage for an AIDS vaccine if approved by the FDA	No	None
1999 A.B. 12	Requires coverage for a second opinion under specified conditions	No	Suboptimal utilization claim Fairness
1999 A.B. 88	Requires coverage for the diagnosis and medically necessary treatment of severe mental illnesses	No	Adverse selection Suboptimal utilization claim Fairness Cost-effectiveness claim Nonmedical cost saving claim

Continued on next page

TABLE 18—Continued

1999 S.B. 5	Requires coverage for screening, diagnosis, and treatment of breast cancer	No	Fairness
1999 S.B. 64	Requires coverage for equipment and supplies for the management and treatment of diabetes, prescription drugs necessary for the treatment of diabetes, and diabetes self-management training	No	Suboptimal utilization claim Fairness Cost-effectiveness claim

Examining the twelve bills that became law during the ten-year study period yields interesting results. The seven bills that passed during the pre-CHBRP period present an interesting mix of rationales, along with a striking lack of evidence supporting most claims. Each bill that became law, with the single exception of Senate Bill 446, contained either a health outcome focused market failure claim[169] or a fairness claim, and often both. This suggests that improving both health outcomes and the fairness of the health insurance system were significant motivations during this period.

Senate Bill 446, introduced in 2001, is perhaps one of the most unusual mandates.[170] It requires health insurers to cover the AIDS vaccine, if the FDA ever approves one.[171] Clearly, there can be no evidence of market failure or any economic-based claims regarding a service that does not yet exist. From the record, it appears that the intent behind the law was to induce pharmaceutical companies to invest in the research and development costs necessary to develop an AIDS vaccine by creating a large, waiting market through the mandate.[172] While technically an insurance mandate, this does not really fit within theories of either fairness or welfare, except to the extent it ends up being successful in encouraging research and development of an AIDS vaccine. In evaluating this bill in terms of rent seeking, it is an interesting example of the securing of future economic rents by an as yet undetermined pharmaceutical company. After all, if insurance companies are required, in advance, to cover an AIDS vaccine, this creates an enviable negotiating position for the vaccine's manufacturer. Essentially, Senate Bill 446 is putting future economic rents on the table for the first taker. The bill also fits into the apparent preference in California to focus on mandates that improve

169. The term "health outcome focused market failure claim" refers to claims that, while market failure claims, rely on an implicit or explicit assertion that health outcomes will be improved if the market failure is fixed.

170. *See* S. 446, 2001 Leg., 2001–2002 Sess. (Cal. 2001).

171. *Id.* (proposing changes to section 22793.2 of the California Code).

172. CAL. ASSEMB., COMM. ON APPROPRIATIONS, S. 446, 2001–2002 Sess., at 2 (2001).

health. After all, if the mandate results in an AIDS vaccine being brought to market, it would have the effect (presumably) of improving population health.

Senate Bill 37, introduced in 2001, is also an attempt to advance a goal that is not necessarily related to current insurance market failures or the health outcomes of current patients.[173] By requiring insurers to cover routine patient care costs for participants in cancer clinical trials, it sought to make cancer clinical trials more attractive to potential enrollees.[174] Based on the record, there were health insurers who were denying coverage for routine patient care costs (e.g., periodic blood draws or imaging studies) for individuals enrolled in clinical trials, making participation in such trials financially unattractive for potential enrollees.[175] After all, if a patient declined to participate in such a trial and instead underwent a standard treatment regime, such routine costs would be covered. The premise of the mandate was therefore the suboptimal utilization of cancer clinical trials, but of course increasing the utilization of such trials would not necessarily improve health outcomes for the covered individual. Rather, increasing utilization of such trials is thought to lead to improved health outcomes for the broader public, which benefits from the data gained from widespread participation in such trials. Like the AIDS vaccine mandate, the clinical trials mandate is really grounded in a desire to achieve a policy goal not directly related to insurance coverage or even direct health improvements for the individuals covered by the mandates.

The other bills passed during the pre-CHBRP period, requiring coverage for all FDA-approved cervical cancer screening, second opinions, mental illness, breast cancer screening, diagnosis and treatment, and diabetes drugs, equipment, and self-management training all were supported by various claims, none of which were backed by evidence. As a result, it would have been very difficult for legislators to have any sense whether the mandate they were voting for would have any practical effect. For example, Senate Bill 1219 from 2001 mandated coverage for any FDA-approved cervical cancer screening.[176] Based on the bill file, it is clear that the intent of the bill was to require health plans to cover the new "liquid base prep" Pap smear, and by doing so give more women access to such test.[177] It is also clear, however, that the extent of the "problem" was unknown, for there was no data regarding how many insurers

173. S. 37, 2001 Leg., 2001–2002 Sess. (Cal. 2001).

174. The only coverage mandate contained in the federal health care legislation, other than the requirement to cover preventive services, is a requirement that all insurers and group health plans cover routine patient care costs for enrollees in cancer clinical trials. *See* ACA, Pub. L. No. 111-148, 124 Stat. 119, 892–96 (2010) (to be codified at 42 U.S.C. § 300gg-8) (adding section 2709 to the PHSA).

175. CAL. ASSEMB., COMM. ON HEALTH, S. 37 (SPEIER) – AS AMENDED: JUNE 11, 2001 (hearing date June 19, 2001).

176. S. 1219, 2001 Leg., 2001–2002 Sess. (Cal. 2001).

177. CAL. ASSEMB., COMM. ON HEALTH, S. 1219 (ROMERO) – AS AMENDED: JUNE 21, 2001 (hearing date July 10, 2001), at 2.

denied coverage for the new type of Pap smear, or even how many women were declining the new test to the extent they had to pay any cost differential out-of-pocket.[178] And while there were statements regarding the improved effectiveness of the new test, no studies were cited to back up such assertions.[179] It was also uncertain whether the new Pap test was already required under existing law.[180] In other words, this law was passed in order to increase utilization and improve health outcomes, even though there was no evidence in the record that the test improved health outcomes, that anyone currently lacked coverage for the test, or that insurers were denying coverage for the test. This same uncertainty was present with each of the bills that proposed mandates in order to increase utilization of a particular treatment or service, as none were supported by evidence pre-CHBRP.

The five bills that passed while the CHBRP was in effect are striking in that they were expected to have very little impact on coverage, utilization, or costs, as illustrated in Table 19.

178. *Id.*

179. *Id.*

180. CAL. ASSEMB., COMM. ON APPROPRIATIONS, S. 1219 (noting that under existing law, generally medically accepted cervical cancer screenings are required to be covered on an annual basis, but that it is not clear whether liquid-based preps are generally medically accepted).

TABLE 19:
BILLS THAT PASSED WHILE CHBRP WAS IN EFFECT, 2003–2008

Bill	Percentage of Affected Population Without Coverage for the Service/Treatment Pre-Mandate	Expected Increase in Utilization	Expected Increase in Cost in the Individual Market
2007 A.B. 1461 (no denial of claims based on intoxication)	3.7%	None[181]	.005%
2007 A.B. 1894 (HIV testing)	0%	None	.0011%[182]
2005 A.B. 228 (organ trans-plants for HIV+ individuals)	0%	None	None
2005 S.B. 1245 (HPV screening)	0%	None	None
2003 A.B. 2185 (pediatric asthma devices and training)	0–9% lacked coverage for disease management 6–25% lacked coverage for certain types of medical devices	10% increase in self-management training and education	.009%

The bills mandating coverage for HIV testing, organ transplants for HIV positive patients, and HPV screening were, according to CHBRP studies, requiring coverage that was already provided to all affected individuals prior to the mandate being passed.[183] None of these bills were

181. The only expected effect of the bill is that claims that had previously been denied on the basis of an individual's intoxication would be paid. CHBRP found that in 2006, 281 claims had been denied on the basis of intoxication in California. *See* CAL. HEALTH BENEFITS REV. PROGRAM, CHBRP 07-05 ANALYSIS OF ASSEMBLY BILL 1461: ALCOHOL & DRUG ABUSE EXCLUSION 8 (2007) [hereinafter INTOXICATION EXCLUSION REPORT], *available at* http://www.chbrp.org/docs/index.php?action=read&bill_id=58&doc_type=3. CHBRP found no compelling evidence that physician practices would change as a result of the bill.

182. According to CHBRP, this increase translates to less than one cent per member per month. CAL. HEALTH BENEFITS REV. PROGRAM, CHBRP 08-04, ANALYSIS OF ASSEMBLY BILL 1894: HIV TESTING 29 (2008) [hereinafter HIV TESTING REPORT], *available at* http://www.chbrp.org/docs/index.php?action=read&bill_id=45&doc_type=3.

183. *See id.* at 25; CAL. HEALTH BENEFITS REV. PROGRAM, CHBRP 05-02, ANALYSIS OF ASSEMBLY BILL 228 TRANSPLANTATION SERVICES: HUMAN IMMUNODEFICIENCY VIRUS 19 (2005) [hereinafter HIV TRANSPLANT REPORT], http://chbrp.org/documents/ab_228final.pdf; CAL. HEALTH BENEFITS REV. PROGRAM, CHBRP 06-04, ANALYSIS OF SENATE BILL 1245 HEALTH CARE COVERAGE: CERVICAL CANCER SCREENING TEST 21 (2006) [hereinafter CERVICAL CANCER

expected to affect utilization of the given treatment.[184] The bill requiring coverage for HIV testing was expected to have a very modest impact on costs, solely because of some modest shifts in where individuals might receive their HIV testing (and therefore who pays for it).[185] In slight contrast, the bill preventing insurers from denying coverage on the basis of an individual's intoxication was expected to provide new coverage for the 3.7 percent of the population whose current contracts excluded such coverage prior to the mandate.[186] It was not expected, however, to have any impact on how many individuals received substance abuse counseling and treatment—the main argument in favor of the bill.[187] It passed anyway. The bill requiring coverage for pediatric asthma devices and training was expected to have the largest impact on utilization of any of the bills passed during the post-CHBRP study period. The increase, however, was expected to result from "better awareness" of the benefit following the passage of the mandate, not from the actual broadening of coverage.[188] After all, nearly all individuals already had coverage for disease management and education prior to the passage of the mandate. This group of bills is certainly underwhelming in terms of their collective impact on health care practices or even the scope of health insurance. This finding lends significant weight to the theory proposed by both Professors Hyman and Korobkin that many mandates are likely to be superfluous, to simply require what is already provided in the market. And while it may be beneficial to inform individuals of effective, available health care that is covered by insurance, there are surely more effective ways of communicating that care's availability than passing a mandate. Other information campaigns would seem likely to be much more effective in conveying this information.

b. CHBRP Observations

I conducted a group interview via telephone with several key staff members[189] at CHBRP in order to learn more about how the CHBRP review process works, and also to get their impressions of whether the information that is provided is considered useful, impartial, and relied on in the legislative process. They were also asked about the advantages

SCREENING REPORT], *available at* http://www.chbrp.org/docs/index.php?action=read&bill_id=67&doc_type=3.

184. CERVICAL CANCER SCREENING REPORT, *supra* note 183, at 25; HIV TESTING REPORT, *supra* note 182, at 28; HIV TRANSPLANT REPORT, *supra* note 183, at 19.

185. HIV TESTING REPORT, *supra* note 182, at 26–29.

186. INTOXICATION EXCLUSION REPORT, *supra* note 181, at 18.

187. *Id.* at 26.

188. CAL. HEALTH BENEFITS REV. PROGRAM, CHBRP 04-09, ANALYSIS OF ASSEMBLY BILL 2185 CHILDHOOD ASTHMA MANAGEMENT 19 (2004), *available at* http://www.chbrp.org/docs/index.php?action=read&bill_id=97&doc_type=3.

189. In accordance with the University of Minnesota's Institutional Review Board policies, these interviews were conducted on a confidential basis. *See* U. OF MINN. INSTITUTIONAL REV. BD., PROTECTING HUMAN SUBJECTS GUIDE (2004).

and disadvantages of the process, and whether they had any suggestions for improving it.

CHBRP staffers reported high overall satisfaction with the process. In interviews conducted with all of their stakeholders as part of a comprehensive review process, CHBRP staffers received uniform feedback that the reports produced by CHBRP had "raised the level of debate" regarding proposed mandates. Stakeholders also reported viewing the reports as "trusted" and "nonpartisan." CHBRP staffers reported that "transparency is really emphasized" and it helps that they provide data only, not recommendations on what should pass or what should not. The legislature is apparently so pleased with this process that it is considering implementing similar systems for other subject areas.

The interview also revealed that the process is an intense one. The sixty-day timeframe to complete a report is challenging, and ideally they would like not only to have more time to complete their reports, but also some mechanism for staggering reports (often they can get multiple requests at the same time, which strains their resources). The reports themselves are consensus-based, and often subject to internal debate prior to publication. CHBRP staffers reported, however, that because the legislature's charge to CHBRP (contained in the authorizing legislation) is so specific, it really helps to structure the report.

With respect to the findings themselves, CHBRP staff reported that their overall medical effectiveness findings are typically "not questioned" but that they are more likely to receive quibbles about their public health findings and utilization projections. These concerns are typically based on the assumptions that were used to make the projections. Because the data sources used are transparent, however, there is not a lot of conflict. CHBRP staffers reported that cost-effectiveness had proved to be the most difficult concept to explain in their reports, and that legislators often misunderstood such findings.

Given how closely the CHBRP staff works with legislators on proposed mandates, I also asked them about their perceptions of these laws. They indicated that, from their perspective, the proposed mandates typically "do not have a huge public health impact" but rather address rare conditions or gaps in coverage. In their experience, these bills almost always have some effect on premiums. They might be cost-effective, but overall cost savings "almost never happen." Their impression was that budget outlook often has a lot to do with mandate passage and noted that many of the mandates that have passed since the CHBRP came into existence have been "essentially no cost." They characterized mandates as "a very specific, targeted policy tool."

2. Connecticut

a. Which Bills Became Law?

During the study period, eighteen proposed mandates became law in Connecticut.

TABLE 20:
NEW HEALTH INSURANCE MANDATES IN CONNECTICUT, 1999–2008

Bill	Subject Matter	Factors Present
2008 H.B. 5696	Requires coverage for physical therapy, speech therapy, and occupational therapy services for the treatment of autism spectrum disorders	Suboptimal utilization claim Fairness Cost-benefit evidence Cost-effectiveness claim
2006 S.B. 422	Requires coverage in specified circumstances for breast cancer screening via ultrasound	Suboptimal utilization claim
2005 S.B. 508	Requires coverage of the diagnosis and treatment of infertility	Adverse selection Suboptimal utilization evidence Fairness Cost-benefit evidence Cost-effectiveness claim
2004 H.B. 5464	Requires coverage of wigs for patients who suffer hair loss as a result of chemotherapy	Suboptimal utilization claim Fairness
2004 H.B. 5201	Requires coverage of nutritional formulas for children who have cystic fibrosis	Suboptimal utilization claim Fairness

Continued on next page

Table 20—Continued

2003 S.B. 918	Requires coverage of general anesthesia for complex dental procedures	Suboptimal utilization claim Overrule insurers' coverage decisions Cost-effectiveness evidence
2003 S.B. 1	Requires coverage of orthodontic processes and appliances for the treatment of craniofacial disorders	Fairness
2002 H.B. 5566	Requires coverage for medically necessary ambulance services	Suboptimal utilization claim
2001 S.B. 524	Requires coverage of metabolic nutritional formulas for children age three and under	Suboptimal utilization claim Overrule insurers' coverage decisions with evidence of improved health outcomes Fairness Cost-effectiveness evidence
2001 S.B. 325	Requires coverage of routine patient care costs for individuals enrolled in cancer clinical trials	Suboptimal utilization claim Fairness
2001 S.B. 325	Requires coverage of hearing aids for children	None
2001 S.B. 325	Clarifies that required obstetric and gynecologic services include coverage for Pap smears	Suboptimal utilization claim

Continued on next page

TABLE 20—Continued

2001 S.B. 325	Requires coverage for colorectal cancer screening	Suboptimal utilization evidence Cost-effectiveness evidence
2001 S.B. 325	Requires coverage for mammograms	None
2001 S.B. 325	Prohibits insurers who provide required mental health benefits from limiting the availability of psychotropic drugs in various ways	None
2000 H.B. 5120	Requires plans that provide coverage for ostomy surgery to include coverage for medically necessary appliances and supplies relating to an ostomy	Overrule insurers' coverage determinations Fairness Cost-effectiveness evidence
1999 H.B. 5950	Prohibits insurers who cover outpatients prescription drugs from excluding coverage for prescription contraceptives	Suboptimal utilization claim Fairness Cost benefit evidence Cost-effectiveness evidence
1999 H.B. 7032/1331	Prohibits insurers from denying coverage for a procedure, treatment, or the use of any drug based on an "experimental" coverage exclusion if such procedure, treatment, or drug has successfully completed a phase III clinical trial	Fairness

Interestingly, like California, all of the bills that became law in Connecticut during the study period that had any type of claim or evidence in their record had either a health outcome focused market failure claim or a fairness claim. While some bills that passed have no claims in the record, those that did appear to be focused on improving health outcomes and the fairness of health insurance coverage.

Several of the bills that passed essentially have no relevant information in the record. In some cases, that was because they were the result of floor amendments[190] and therefore did not go through the committee process where such information is typically gathered. And in other cases, the mandates were part of much broader bills and the hearings that took place focused on other aspects of the bill.[191]

There were, however, several bills that passed that did appear to be well supported by evidence in the record. For example, Senate Bill 508, requiring coverage for infertility treatment had not only many claims made, but also evidence of both suboptimal utilization and of a positive cost-benefit analysis (in addition to adverse selection, fairness, and cost-effectiveness claims).[192] Senate Bill 524 from 2001, requiring coverage for metabolic nutritional formulas, similarly had several claims in the record supported by evidence.[193] And five of the eighteen bills had evidence that the treatment required to be covered was cost-effective.[194] Overall, however, there was a significant lack of evidence supporting these mandates. Less than one-half of the bills that became law had any type of evidence in the record.

Three of the mandates passed during the study period were essentially minor changes to existing coverage requirements. House Bill 5566 from 2002 mandates coverage for "medically necessary" ambulance service.[195] Previously, coverage was required only for "emergency" ambulance service. Clearly this has the potential to broaden coverage for ambulance services, but a large degree of "medically necessary" ambulance services will be in emergency situations. The provision in Senate Bill 325 regarding coverage for Pap smears is an even less significant change.[196] The record indicates that all insurers had been interpreting an existing requirement to offer obstetric and gynecologic services to include coverage for Pap smears, but a third party organization had apparently raised questions about whether Pap smear coverage was required in Connecti-

190. The mandates covering hearing aids for children, Pap smears, colorectal cancer screening, and mammograms were added as floor amendments to Senate Bill 325, which included only coverage for routine patient care costs associated with cancer clinical trials when first introduced. S. 325, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001) (amended); S. 325, 2001 Gen. Assemb., Jan. Sess. (Conn. 2001) (original bill).

191. The mandates regarding experimental treatment exclusions and medically necessary ambulance services were each part of broader bills, and there was little to no testimony or committee discussion of such mandates. *See, e.g.*, H.R. 5566, 2002 Gen. Assemb., Reg. Sess. (Conn. 2002).

192. S. 508, 2005 Gen. Assemb., Reg. Sess. (Conn. 2005).

193. S. 524, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001).

194. The five bills that contained such evidence are S. 918, 2003 Gen. Assemb., Reg. Sess. (Conn. 2003) (mandating coverage for anesthesia for complex dental procedures); S. 325, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001) (amended) (colorectal cancer screening); S. 524, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001) (nutritional formulas); H.R. 5120, 2000 Gen. Assemb., Reg. Sess. (Conn. 2000) (ostomy supplies); and H.R. 5950, 1999 Gen. Assemb., Reg. Sess. (Conn. 1999) (prescription contraceptives).

195. H.R. 5566, 2002 Gen. Assemb., Reg. Sess. (Conn. 2002).

196. S. 325, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001) (amended).

cut.[197] The law was intended to clarify coverage, not to change it.[198] The third bill with a seemingly minor change in coverage was Senate Bill 422 from 2006, which requires insurers to cover ultrasound screening of a breast if a mammogram demonstrates heterogeneous or dense breast tissue, or if a women is at increased risk for breast cancer due to a variety of factors such as family or personal history.[199] This represents a "clarification" of prior law, which provided such coverage if "recommended by a physician" under certain circumstances.

Another interesting thing to note is that two of the passed mandates were essentially overruling the traditional boundaries of medical insurance contracts. Senate Bill 1 from 2003 requires insurers to cover "medically necessary orthodontic processes and appliance for the treatment of craniofacial disorders," specifically for the treatment of cleft palates and cleft lips.[200] Historically, nearly all treatment of the teeth was specifically excluded from medical insurance[201] and would have to be covered by dental insurance if at all. In this situation, the treatment of cleft palates and cleft lips, while accomplished primarily through surgery which is covered by health insurance, involves the use of orthodontia to support the area that is being surgically treated. Even though the orthodontia related to a covered medical condition, insurers would still deny coverage because of the specific exclusion for dental treatment, including orthodontia. Similarly, Senate Bill 918 from 2003 requires coverage for general anesthesia for certain patients undergoing complex dental procedures.[202] The covered patients include very young children and those with various disabilities that make cooperating with dental treatment very difficult if not impossible. While typically denied because the anesthesia relates to dental treatment, which is not covered by traditional medical insurance policies, Senate Bill 918 overrode that distinction.[203] Overruling such traditional coverage boundaries provides an interesting and unexplored rationale for a mandate.

As in California, we see in Connecticut at least one mandate that became law in order to effectuate a public health goal. Senate Bill 325, introduced in 2001, requires insurers to cover routine patient care costs for individuals enrolled in cancer clinical trials.[204] As in the bill with near-

197. *An Act Concerning Health Insurance Coverage for Pap Smear Tests: Hearing on S. 116 Before the Ins. & Real Estate Comm.*, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001) (statement of Natasha Pierre, Legis. Analyst, Permanent Comm'n on the Status of Women).

198. *Id.*

199. S. 422, 2006 Gen. Assemb., Reg. Sess. (Conn. 2006).

200. S. 1, 2003 Gen. Assemb., Reg. Sess. (Conn. 2003).

201. HAVIGHURST, *supra* note 48, at 141 n.4.

202. S. 918, 2003 Gen. Assemb., Reg. Sess. (Conn. 2003).

203. *Id.*

204. S. 325, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001) (amended). There were several individuals who argued that the bill should be broadened to include clinical trials for *any* disease, not just cancer. *An Act Concerning Health Insurance Coverage During Clinical Trials: Hearing on S.B. 325 Before the Pub. Health, Ins. & Real Estate Comm.*, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001) (statement of Dr. Timothy Vollmer, Dir., Yale Multiple Sclerosis Research Ctr.).

ly identical coverage provisions in California, the goal of this mandate was to increase participation in cancer clinical trials in order to benefit the public at large through better outcome data.

Several of the bills that passed were strongly centered on fairness concerns. In particular, the autism, infertility, and oral contraceptive mandates had a great deal of testimony devoted to fairness-based claims. In general, these claims were based on the perceived unfairness of covering one type of medical treatment but not another. The arguments in favor of oral contraceptive coverage also focused on the perceived gender inequality of health care coverage, citing evidence of how much more women pay for health care than men.[205]

While fairness was a frequent topic in the discussions leading up to votes on mandates, one bill appeared to be focused on relieving the emotional burden of disease. House Bill 5464, introduced in 2004, mandates coverage for wigs where an individual suffers hair loss as a result of chemotherapy.[206] The premise here is interesting, as there was no evidence in the record that having access to a wig following chemotherapy helps to improve patient outcomes. The primary argument for the coverage contained in the record was that it would help cancer sufferers feel better and lead more normal lives.[207] While there were claims that some individuals forgo wigs because of their cost, there was no evidence of this phenomenon.[208] So it was not clear from the record that demand for wigs is price-elastic, or that health outcomes improve where wigs are utilized. So what explains a health insurance mandate for something that is not actually a medical treatment or service?

There are many possible explanations. It may be politically wise for state legislators to support those who battle cancer. Or perhaps it is an example of cancer sufferers using the state legislature to secure economic rents. Or maybe it acknowledges a role for insurance that is broader than that contemplated by many theorists. For example, insurance coverage may be a form of consolation for the loss caused by cancer.[209] In other words, the financial payment from insurance in these circumstances helps to lessen the blow of bad health, even though it is not directly re-

205. *An Act Requiring Health Insurers to Cover Prescription Birth Control: Hearing on H.R. 5950 Before the Ins. & Real Estate Comm.*, 1999 Gen. Assemb. Jan. Sess. (Conn. 1999) (statement of Leslie Brett, Exec. Dir., Permanent Comm'n on the Status of Women).

206. We have, yet again, an interesting example of boundary drawing here. The coverage was limited to those who suffer hair loss as a result of chemotherapy. It does not cover hair loss caused by radiation to the head region or hair loss that is the result of a different medical condition such as alopecia. It is not at all clear from the record why such a distinction was made. *See* H.R. 5464, 2004 Gen. Assemb., Reg. Sess. (Conn. 2004).

207. *An Act Concerning Health Insurance Coverage for Wigs for Chemotherapy Patients: Hearings on H.R. 5464 Before the Ins. & Real Estate Comm.*, 2004 Gen. Assemb., Reg. Sess. (Conn. 2001) (statement of Ruth Pulda); *see also id.* (statement of Bev Brakeman, Dir., Nat'l Org. for Women).

208. *See id.* (statement of Andrea Toree).

209. *See* Daniel Schwarcz, *Regulating Consumer Demand in Insurance Markets*, 3 ERASMUS L. REV. 23, 38 (2010) (noting that insurance payouts may provide "a form of emotional support through 'symbolic value'").

imbursing medical expenses. It may also be a way to effectively smooth welfare between high-utility and low-utility states of the world.[210] These latter hypotheses regarding consolation for loss and welfare smoothing have not been fully explored in the health insurance context and are worth further research.

b. Additional Observations from Connecticut's Public Hearing Testimony

As previously mentioned, Connecticut's bill files contained transcripts of the public hearings held to discuss the proposed mandates. These transcripts were a rich source of information regarding the arguments, claims, and evidence that legislators received in support of the mandates. Below are some general observations made from these public hearing transcripts.

i. Mandates Were Proposed in Response to a Single Individual's Experience

From the transcripts, it is clear that mandates often came about as a result of a single individual's experience. For example, House Bill 5687, introduced in 1999, would have allowed women to schedule annual mammograms up to four weeks prior to the date on which they had received a mammogram in the prior year.[211] The state representative who introduced the bill explained that she submitted the bill because of her own experience in receiving her annual mammogram two days prior to the day she had received one in the previous year, and the hassle in getting such a mammogram approved solely because it was being received more frequently than once per year.[212] She stated in her testimony that she did not actually think the bill should pass, but that insurance companies should voluntarily work with the legislature and voluntarily agree to change their practices.[213]

ii. Supporters Often Provide Deeply Personal Information and Anecdotes

Reading through thousands of pages of public hearing testimony was often heart wrenching, and underscored the difficult decisions that legislators must make. The testimony provided to the committees re-

210. *See generally* Steven P. Croley & Jon D. Hanson, *The Nonpecuniary Costs of Accidents: Pain-and-Suffering Damages in Tort Law*, 108 HARV. L. REV. 1785 (1995) (exploring why consumers might demand insurance against pain and suffering in the tort context).

211. H.R. 5687, 1999 Gen. Assemb., Jan. Sess. (Conn. 1999).

212. *An Act Concerning Insurance Coverage for Mammography: Hearings on H.R. 5687 Before the Ins. & Real Estate Comm.*, 1999 Gen. Assemb., Reg. Sess. (Conn. 1999) (statement of Rep. Ruth Fahrbach).

213. *Id.*

garding proposed mandates was often deeply personal and full of desperation. For example, one father testifying in support of a bill to mandate coverage for medically necessary specialized formula stated, "You never know the helpless feeling when your child is deathly ill and you can't do anything about it."[214] Other parents included with their written testimony a picture of their young child who required such formula.[215]

Often the pleas made to legislators were very direct. One parent who testified in favor of a mandate to cover specialized nutritional formulas told legislators, "You are holding Ryan's life and others stricken with this horrible disease in your hands."[216] She went on to plea, "Please listen and answer the pleas of those who are asking for assistance in helping their children live to be adults . . . ."[217] And finally admonishing, "This should not even be debated. I mean this is my child's life and you can't measure a child's life with dollars. You just—you can't."[218] On the whole, the public hearing testimony in Connecticut lends support to Professor Hyman's claim that mandates are frequently anecdote driven. There were, however, plenty of bills with very moving personal anecdotes that did not pass the legislature, and so it is difficult to gauge the actual impact such stories have on decision making. It may be that the effect of personal anecdotes is greatest at the committee level, where the members hear the testimony themselves, than at the legislative level.

iii. The Role of Interest Groups Is Complicated

Interest groups were active in providing testimony as the committees considered mandates. In nearly all cases, trade groups representing several large insurers and business interests in the state would testify against mandates, as would Blue Cross/Blue Shield. For the most part, that testimony was against the concept of mandates, not against the particular mandate at issue. These opponents of the proposed mandates spoke against interfering with choice in the health insurance market, the cost impact of mandates, and their effect on health insurance coverage rates.[219] In general, even under direct questioning, insurance representa-

214. *An Act Requiring Health Insurance Policies to Cover Medically Necessary Infant Nutritional Formulas: Hearings on S. 46 Before the Pub. Health, Ins. & Real Estate Comm.*, 2001 Gen. Assemb., Reg. Sess. (Conn. 2001) (statement of Jeff Leuczyk).

215. *Id.* (statement of Anne Hosack).

216. *An Act Concerning Newborn Screening and Medically Necessary Nutritional Formula for Cystic Fibrosis: Hearing on H.R. 5201 Before the Ins. & Real Estate Comm.*, 2004 Gen. Assemb., Reg. Sess. (Conn. 2004) (statement of Tammy Trochsler).

217. *Id.* (statement of Harold Soloff).

218. *Id.* (statement of Tammy Trochsler).

219. *See, e.g.*, *An Act Requiring Health Insurance Coverage for Craniofacial Disorders: Hearing on S.B. 1*, 2003 Gen. Assemb., Reg. Sess. (Conn. 2003) (statement of Conn. Ass'n of Health Plans opposing S.B. 1) ("Some national statistics suggest that for every 1% increase in premiums, 200,000 people become uninsured demonstrating that passage of mandates may actually decrease access rather than increase it as the bill intends."); *An Act Requiring Health Insurance Policies to Cover Hearing Aids: Hearing on S. 136 Before Comm. on Aging*, 2002 Gen. Assemb., Reg. Sess. (Conn. 2002) (statement of

tives declined to speak on the merits of coverage for the treatments or services at issue. One such representative, in response to a legislator's direct question on the desirability of a proposed mandate about which he submitted testimony, said, "I'm coming to you not to speak on the merits. I think that there are benefits—there are needs and there are benefits from the proposals that are before you."[220] Despite the insurers' general reluctance to engage on the merits of particular proposed mandates, there were several instances where the insurers' representatives deviated from the standard antimandate arguments and instead in their written and oral testimony disputed the clinical effectiveness of the treatment or service at issue.[221]

On the other side of the debate were patient-centered interest groups arguing in favor of mandates. Often this testimony would take the form of an individual patient or an individual medical provider presenting arguments in favor of the mandate. Occasionally, however, organizations who presumably would benefit from the mandate actually testified against it. For example, the American Cancer Society testified *against* a proposed mandate requiring coverage for ovarian cancer screening.[222] In that case, the American Cancer Society presented evidence that the test at issue was not helpful in detecting ovarian cancer in asymptomatic women and suggested amending the bill language to have a narrower application.[223] This perhaps shows that "rent seeking" when it comes to benefit mandates is not just a straightforward economic issue. More coverage is not necessarily better if the treatment at issue leads to less-than-desired health outcomes. Perhaps rent seeking in this context should be broadened to encompass not just economic rents (securing insurance coverage for treatment you would otherwise bear the full cost of) but also health rents (providing access to treatments or services that improve health outcomes). This model of advocacy is consistent with the apparent focus we see at the legislative level of mandates focused on improving health outcomes.

Jan Spegele, Vice-President & Gen. Counsel, Conn. Bus. & Indus. Assoc.) ("New mandates like SB 136 may benefit some individuals. But they will further drive up the costs of health care benefits for everyone and jeopardize access to coverage for growing numbers of Connecticut citizens. I urge [you] to reject the proposed new coverage mandate . . . .").

220. *An Act Concerning Health Insurance Coverage for Craniofacial Disorders: Hearing on S.B. 1 Before the Pub. Health Comm.*, 2003 Gen. Assemb., Reg. Sess. (Conn. 2003) (statement of Jan Spegele, Vice-President & General Counsel, Conn. Bus. & Indus. Assoc.).

221. *An Act Requiring Health Insurance Coverage for Ovarian Cancer Screening: Hearing on S.B. 18 Before the Ins. & Real Estate Comm.*, 2003 Gen. Assemb., Reg. Sess. (Conn. 2003) (statement of Melissa Petro, Am. Cancer Soc'y).

222. *Id.*

223. *Id.*

iv. Legislators Were Frustrated by a Lack of Data

It was abundantly clear after reading ten years worth of public hearing testimony on mandates that not only was there a serious lack of data in Connecticut regarding the costs of proposed mandates, but that legislators were very frustrated by the inability to understand how much a proposed mandate was likely to cost. For example, one legislator expressed his frustration with the lack of data on cost of the mandates:

> [I]f I . . . look at the [mandate to cover treatment of craniofacial defects], . . . which I think that children with those defects certainly need . . . [t]here's not a doubt in my mind. So, how much money does that actually cost the insurance company? How much of a payout is it going to be? There's only a limited number of cases each year . . . That's data that we could have before this Committee, and I think it would be helpful in making that decision as to whether it is worthwhile.[224]

In one case, an advocate for a bill requiring coverage for the treatment of lymphedema cited studies conducted by Virginia, Massachusetts, and CHBRP looking at the expected cost of similar mandates introduced in those states. After commenting that similar bills had been introduced in Connecticut for four out of the last five years, the committee member stated, "So I thank you for finally bringing the numbers. Very few people come here with numbers. So again I appreciate that and I hope all of our Committee Members will take that into consideration as to the cost benefit of this."[225]

v. Legislators Were Frustrated by Their Inability to Regulate Self-Insured Plans

The other frustration that was clear from the testimony was the inability of the state legislature to reach the sizeable population covered by self-insured plans. After hearing testimony in favor of a bill, it was not uncommon for a legislator to ask witnesses whether they knew whether their employer's plan was insured or self-insured, and whether they understood that even if they passed a mandate, it would not affect self-insured plans. Legislators often brought up the fact that mandates would only affect about fifty percent of the insured population because of the exemption for self-insured plans.[226] The inability of state legislatures to

224. *An Act Concerning Health Insurance Coverage for Craniofacial Disorders: Hearing on S. 1 Before the Pub. Health Comm.*, 2003 Gen. Assemb., Reg. Sess. (Conn. 2003) (statement of Rep. Vickie Orsini Nardello, Member, Pub. Health Comm.).

225. *An Act Concerning Health Insurance Coverage for Supplies for The Treatment of Lymphedema: Hearings on S. 5691 Before the Ins. & Real Estate Comm.*, Gen. Assemb., Reg. Sess. (Conn. 2008) (statement of Rep. Vickie Orsini Nardello, Member, Ins. & Real Estate Comm.).

226. *An Act Requiring Health Insurance Coverage for Medically Necessary Weight Reduction Surgery: Hearings on S.B. 1300 Before the Ins. & Real Estate Comm.*, 2005 Gen. Assemb., Reg. Sess. (Conn. 2005) (statement of Sen. Louis DeLuca, Member, Ins. & Real Estate Comm.).

regulate self-insured plans, and therefore a significant percentage of the insured population, is certainly not a new critique,[227] but it is interesting that state legislatures are well aware of this and are frustrated by their lack of power.

IV. IMPLICATIONS FOR HEALTH CARE REFORM

Regulating the content of health insurance contracts will remain a critical policy issue when federal health care reform is fully implemented in 2014. This Part examines the broad implications of the study presented in this Article for such regulation in a post-health care reform world, first examining whether and to what extent the federal government should borrow from state-mandated benefit laws in defining essential health benefits and concluding by examining the lessons that the federal government can learn from the state experience. It is important to note at the outset that the definition of essential health benefits is a critical policy issue; it will affect the market for insurance in complex and broad ways. The analysis contained in this Part is not meant to offer definitive guidance on essential health benefits but to look at the critical, but limited, issue of whether and to what extent HHS should borrow from existing state regulation in defining essential health benefits.

A. Should State Regulation Influence the Federal Process?

As discussed in the Introduction, regulating the content of health insurance pursuant to federal health care reform is a high-stakes affair. A broad definition of essential health benefits has the potential to significantly increase the cost of health care reform to the federal government and also exempt a significant number of individuals from the reach of the individual mandate. At the same time, the scope of coverage is critical to ensuring adequate protection for those who purchase health insurance.

The statute, which delegates authority to HHS to define essential health benefits, specifies many broad categories of treatment that must be covered, but leaves to HHS the task of determining, within each category, the precise treatments and services that must be covered. The strongest directive given to HHS in defining essential health benefits is that it ensure that the scope of essential health benefits is equal in scope to the typical employer plans.[228] Because over forty percent of all employee coverage is regulated at the state level,[229] this suggests that the federal government may borrow heavily from state regulation of the content of health insurance. At a theoretical level, such an approach is rela-

227. *See, e.g.*, Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89 (2005); Monahan, *supra* note 34.

228. ACA, Pub. L. No. 111-148 § 1302(b)(2), 124 Stat. 119, 163–68 (2010) (to be codified at 42 U.S.C. § 18022).

229. *See* EMPLOYER HEALTH BENEFITS 2010, *supra* note 9, at 155.

tively appealing. After all, the state laws came about as a result of a democratic legislative process, and adopting the majority view of the states with respect to a particular benefit may be seen as democratically legitimate and affirmatively desirable.

As an initial matter, it is important to consider whether the state regulatory process is sufficiently similar to the federal government's task as to be considered relevant. States, in mandating the inclusion of specific benefits in health insurance contracts, were mandating against the backdrop of existing policies. Insurers drafted policies, and the states were stepping in to fill perceived shortcomings in the coverage offered. The federal government, on the other hand, is starting from scratch. It will not be working from a preexisting contract. This certainly changes the nature of the task, but not in a way that renders state regulation irrelevant. Because HHS has been given broad categories of treatment and services that must be covered, it, like the states, will be regulating against a backdrop of existing coverage, mirroring to some degree the state setup of existing contracts. Additionally, state regulation often concerns decisions along the margins; these are not, for the most part, decisions about whether broad categories of treatment, such as hospitalization, should be covered. They are decisions about whether very specific treatments and services should be covered. And it is in the fine details that HHS will likely have the most difficult task. For example, HHS already knows that preventive services and prescription drugs must be covered, but must oral contraceptives be included in every policy?[230] This is very similar to the task that has faced state governments. Therefore, given both the theoretic appeal of adopting state positions and the reasonable proximity of the regulatory tasks, the federal government might well be tempted to borrow heavily from existing state regulation in defining essential health benefits.

The study presented in this Article gives the federal government reason to be cautious about borrowing from or adopting state-level regulation. The study has two main findings that are of particular concern. First, in relatively few circumstances did the legislatures studied have data in the record to support the reasons cited for enacting a mandate. Second, the bills that became law during the study period were justified almost without exception based on health outcome focused market failures or fairness concerns.

Is the lack of evidence at the state level a problem from the federal government's perspective? The harms that might result from a mandate that passed based on inaccurate claims are varied. For example, what if a mandate was passed based on the assertion that it would increase suboptimal utilization of a beneficial medical treatment, but it turned out that the treatment was not beneficial, or worse, was harmful? In that case,

230. *See, e.g.*, Sarah Kliff, *Free Birth Control Under Health Care?*, POLITICO (June 1, 2010, 4:36 AM), http://www.politico.com/news/stories/0510/37980.html.

health outcomes could actually be harmed rather than improved. In perhaps a less troublesome case, what if legislatures were merely mistaken that the demand for the treatment at issue was price-elastic? In that case, a windfall is essentially provided to those who would have utilized the treatment without insurance coverage, health outcomes are not improved, but insurance prices are raised for those who would not otherwise purchase the coverage at issue. One would think HHS would be hesitant to incorporate existing state mandates without having independent data about the treatments and services at issue.

The second question is whether there is any concern about adopting mandates that reflect a state's particular approach to health insurance regulation. In the states studied, the approaches appeared to be based in large part on fairness and improving health outcomes by correcting certain types of market failure. Other states may have similar or wildly different approaches to this area of law. Leaving aside evidentiary issues, is there any downside of simply aggregating state preferences? Doing so raises a number of issues. First is that it would lead to a definition of essential health benefits with a fair amount of internal inconsistency. Even if we assume that every state takes a similar approach to California and Connecticut in regulating the content of health insurance coverage, each state would likely be internally inconsistent (as California and Connecticut appear to be). Even within a single state, mandates do not appear to reflect a consistent vision of when and under what circumstances it is appropriate to regulate the content of a health insurance contract. It is perhaps inevitable that the state political process leads to a somewhat incoherent approach to regulation. After all, most state legislators are term limited, and both the ad hoc nature of the process and the temporal inconsistency is likely to lead to an uneven approach to this area of legislation.

This state-level inconsistency directly impacts HHS's broader task in defining essential health benefits. HHS is likely to adopt a framework and guidelines for defining essential health benefits, and incorporating existing state mandates into that framework is likely to create inconsistencies within that framework. For example, assume HHS decides that a particular conception of fairness should be a guiding principle in defining essential health benefits. Some existing state mandates might fit within HHS's conception of fairness, and others might not. Similarly, what if a state had passed a mandate that was designed to improve health outcomes, but at a cost that was unacceptable under the broader HHS framework? Assuming that not all existing mandates will fit within the framework for essential health benefits adopted by HHS, incorporating existing state mandates would mean that some treatments and services would be covered even though they did not meet the standards for inclusion in essential health benefits that every other treatment or service would have to satisfy. This seems problematic and would need to be jus-

tified on some ground that trumps the desire for a consistent approach to essential health benefits. Without such a compelling justification, the harm of simply incorporating existing mandates into the definition of essential health benefits appears to outweigh its benefits.

B. What Can the Federal Government Learn from the State Experience?

While the federal government may not want to simply adopt the majority approach of the states in regulating health insurance, the study does provide some valuable lessons for HHS as it begins this very difficult, and very important, decision-making process.

1. HHS Should Not Rely on Interested Parties to Provide the Relevant Information

It is hard to imagine that defining essential health benefits can be done well without data. Given that the primary task involves balancing the comprehensiveness of coverage with the affordability of coverage, there is an abundance of data needed. These needs have been outlined in detail elsewhere,[231] but at a minimum, the decision maker should know the medical effectiveness of the coverage at issue, the costs involved in requiring such coverage, the cost per relevant outcome measure (e.g., quality adjusted life year, cancer cases detected, lives saved, etc.), and how the cost per outcome compares to other available treatments. The study presented in this Article strongly suggests that the standard state legislative process does not do a good job in gathering such data. It is unlikely that a federal administrative procedure that similarly relied on interested parties to provide information would yield different results.

It is not terribly surprising that in a system that relies on proponents and opponents to supply information to decision makers, not much hard data are supplied. It may be that this is not the language of persuasion, or it may be that the relevant interest groups lack access to the data. For example, a group of parents arguing in favor of a mandate to cover autism therapies would be unlikely to know what percentage of the insured population lacks coverage, the cost of such therapies, or the increased premiums that might result from adding such services. Health insurers, who based on the study presented here are almost always opponents of mandate,[232] are much more likely to have the requisite data. They also might have a strong motivation not to share such data. For example, if a health insurer opposes a mandate, it would not want to present data that estimate a given mandate would increase the cost of insurance by a mere four cents per individual per month.

231. *See* Monahan, *supra* note 44.

232. There is good reason to believe that the interests of insurers will dramatically change under health care reform, but I leave that issue for future work.

The evidence from California suggests that the provision of information can be effectively supplied by an independent body, but it also makes clear that merely having access to the relevant data does not ensure that decisions will always be made on the basis of such evidence. The first step for HHS should be to ensure independent, accurate data collection. The Subsection below considers the need for a decision-making framework.

2. HHS Needs a Robust Decision-Making Framework

One clear finding of the study presented in this Article is that state legislatures do not use a coherent and cohesive decision-making framework when legislating health insurance content requirements.[233] This is not surprising. State legislatures have high and frequent turnover, and they appear to lack interest in committing themselves to a decision-making framework by, for example, delegating the regulatory authority in this area to an administrative agency.[234] Without such a framework, the political reality is likely to lead to very mixed motivations for such laws.

But a mixed approach, one that does not reflect a cohesive view of health insurance coverage decisions, is undesirable. We have limited health care resources, and potentially unlimited health care demands. Difficult choices must be made, and they should not be made haphazardly.

The federal government's experience with Medicare coverage decisions only underscores the need for a comprehensive framework. Medicare's statutory language is quite different than the language in ACA concerning essential health benefits. The Medicare statute requires coverage for all "reasonable and necessary" medical services.[235] The Centers for Medicare and Medicaid Services, which are responsible for Medicare coverage decisions, refuses to publish its decision-making guidelines, and in practice they rarely refuse to cover a treatment.[236] Medicare's significant cost should convince us that this is not the route to take with respect to health insurance coverage for the nonelderly population.

Despite the strong conclusion, this Article does not mean to suggest that creating a framework is an easy task. One interesting and significant

233. Such frameworks are rare in state legislatures, with the exception perhaps of state-balanced budget requirements. Even in the balanced budget context, state legislatures have significant discretion in meeting balanced budget requirements. *See State Balanced Budget Requirements*, NAT'L CONF. STATE LEGISLATURES, http://www.ncsl.org/default.aspx?tabid=12660 (last updated Dec. 2003).

234. Other options exist for such precommitment. Legislatures could, for example, pass a law specifying the basis on which health insurance contracts would be regulated (i.e., no law regulating the substance of health insurance contracts shall be passed unless *X*, *Y*, and *Z* have been established). A future legislature could of course undo such actions, but having the law in place might be sufficient to prevent mandates that do not meet the requirements from passing.

235. 42 U.S.C. § 1395y(a)(1)(A) (2006).

236. *See* Kolber, *supra* note 5, at 515.

change from the current state-based process is that HHS does not need to respond to market failures—at least in the initial defining of essential health benefits. Rather, HHS will be *making* the new individual and small group markets. There is no existing "market" to which to respond. HHS needs to start from scratch in defining a health insurance contract. This gives it the great advantage of being able to consider the bigger picture into which content regulation fits, rather than considering specific coverage requests on a piecemeal basis. This advantage, however, will not last long. Because the market will change in response to HHS regulation and because new treatments and services will be developed over time, HHS needs a framework that will help it evaluate new coverage requirements in the future. HHS's task is not an easy one, but if it is to avoid repeating the mistakes made at the state level, it must act quickly and decisively to create an evidence-based regulatory process that has clear rules and guidelines.

A fundamental issue that HHS must tackle is how to weigh the competing concerns of fairness and welfare. Both are clearly relevant to the inquiry, but the outcomes they dictate often clash. For example, it may be unjust to exclude infertility treatment from coverage, but how is that weighed against the increased premium cost that results, particularly when the increased cost will mean both a greater expenditure by the federal government and potentially fewer individuals with any health insurance? Health reform does not, after all, make the cost issue go away. While the law will require most Americans to purchase health insurance or face a monetary penalty, there is an exception if coverage is considered "unaffordable." If essential health benefits are broadly defined, and the cost of coverage therefore increases, fewer individuals may be subject to the individual mandate, and coverage levels may be subsequently reduced. Additionally, the cost of health care reform to the federal government rises as premiums rise, since the tax credits provided by ACA increase along with average premiums. And, of course, it is easy for fairness and welfare concerns to become intertwined. After all, some would consider a regulatory approach just only if it maximized welfare; others may think so only if it maximizes liberty.[237] The difficult issues surrounding fairness concerns are addressed in more detail in the Subsection below.

3. Operationalizing Fairness

Fairness clearly has a place in health policy discussion, and it is not surprising that the study found that fairness arguments are very frequently used to support benefit mandates. Often these fairness claims were equality-based claims, arguing that it is unfair for health insurance to

237. *See, e.g.*, Louis Kaplow & Steven Shavell, *Fairness Versus Welfare*, 114 HARV. L. REV. 961, 969–70 (2001) (noting that some individuals' notion of fairness is one that maximizes welfare).

cover some types of medical losses but not others. Mandates essentially come down to a decision regarding which medical risks must be shared within the insured community, and in many circumstances, people are likely to find it unfair that certain medical losses are not covered solely because of historical insurance practices.[238] For example, excluding coverage for orthodontic devices that are used as part of a cleft palate repair, simply because nearly all forms of dental treatment have historically been excluded from health insurance contracts, is likely to be considered unfair by many individuals.

While the prominence of fairness-based claims in supporting mandates is not particularly surprising, it is problematic from a policy perspective. The issue boils down to what fairness requires with respect to the sharing of medical risks. One option is that fairness requires that all medical risks, or at least those not directly caused by personal action, should be shared. The other option is that we can make distinctions between those risks that must be shared and those that must not, provided that those distinctions are meaningful. Neither of these options is easy to implement, as is discussed more fully below.

The first option, requiring health insurers to cover all medically necessary treatments and services, is attractive to the extent it can eliminate the current coverage distinctions made between different types of medical losses. The problem is that it is not easy to implement. While there would no longer be clear coverage exclusions, the coverage fight would shift to a fight over what is medically necessary.[239] It would be even worse if we attempt to exclude coverage for medical losses that were directly attributable to personal action, because then we would also fight about the meaning of "directly attributable to personal action." One could imagine the medical costs for a Type II diabetic being denied on the grounds that the patient had failed to control his or her dietary intake. While it might seem simple to cover all medical losses, it just shifts the coverage disputes from relatively clear terms to more ambiguous ones.[240]

Additionally, even if the definition of coverage were unproblematic, the approach would require some other type of cost control mechanism. If we are not going to control costs through limited coverage, we would have to use some other type of cost containment mechanism, such as physician gatekeeping or significant cost-sharing requirements. And

238. There are, of course, many assumptions that must be made in order to find the situation sympathetic. The medical loss suffered must be one that the individual does not have reason to believe he or she would suffer at the time he or she purchased the insurance contract, and one must accept that the scope of health insurance contracts is quite difficult to evaluate ex ante.

239. Determining what is, and what is not, medically necessary is neither a clear nor an easy task. *See, e.g.*, Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992). *See also* HAVIGHURST, *supra* note 48, at 125–32.

240. The ambiguity could perhaps be lessened by procedural rights and safeguards, such as a uniform definition of medical necessity and the ability to appeal medical necessity determinations to an independent body.

there may be significant practical problems with these other types of cost containment. We know from experience that patients do not respond well to having their utilization of medical care rationed by physician (or insurance company) gatekeepers, and we also know that significant cost-sharing requirements may be untenable for many Americans.[241]

The second possibility, and the one that is implicitly embraced by our current regulation of health insurance, is to make distinctions among medical losses. The problem with this approach is that fairness requires that those distinctions be made on some reasoned basis, not historical accident or random luck. It is undesirable as a matter of policy that certain types of medical treatments and services are not covered by insurance simply because that is the way the contract has historically been written. We must, then, embrace some other framework for making these distinctions.

Such a framework could take many forms. One possibility is to adopt a utilitarian approach and simply choose to cover those treatments that maximize utility. The downside of such an approach is that those with rare diseases would likely find themselves without available insurance coverage for their medical costs. Another possibility is to employ a system like that used in Britain, which evaluates coverage for treatments based on the cost of each Quality-Adjusted Life Year (QALY) obtained by the treatment.[242] It could start with the assumption that all medical losses not directly caused by personal action should be covered, but then, in an effort to control costs, limit coverage based on the cost-effectiveness of the service involved. In that way, you can make coverage decisions based on which treatments offer the best "bang for your buck." While using QALYs is appealing in its scientific approach and the ease with which it facilitates comparative coverage decisions, it involves some morally controversial assumptions, one being that a QALY is of equal "worth regardless of who gets it."[243] And those whose health needs are more expensive to treat may be without health coverage, as may be those whose treatment carries with it a modest chance of success. The lesson is that even the methods that attempt to bring clarity and scientific rigor to the coverage debates have significant moral assumptions and implications that must be closely examined.

The importance of this issue cannot be overstated, and the preliminary discussion contained above only touches on the complex and difficult issues involved. HHS needs to have some method of determining

241. Even relatively modest, unreimbursed medical expenses can result in financial distress and bankruptcy. *See* Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y L. & ETHICS 239 (2010).

242. *See* David J. Kerr & Mairi Scott, *British Lessons on Health Care Reform*, 361 NEW ENG. J. MED. e21(1), e21(3) (2009).

243. DANIELS, *supra* note 46, at 114. It should also be noted that it is unclear from the statutory language whether HHS would even have the ability to use QALY-based distinctions.

what gets covered and what does not. It is a difficult choice, but it must be made.

V. CONCLUSION

The study presented in this Article suggests that state-based health insurance content regulation is not an evidence-based process. Laws are generally passed under circumstances where lawmakers have no reliable data on the scope of the problem they are addressing nor the likelihood that the law they are passing will solve the alleged problem, let alone the cost of doing so. While having an independent data source clearly improves the quality of the information that legislators have to base their decisions upon, it does not prevent unsupported bills from becoming law. The study also found, in the states studied, that mandates are passed not to correct traditional insurance market failures such as adverse selection, but rather to achieve fairness or health outcome-related goals, with a fairly even split between fairness and welfare claims.

Taken as a whole, the study found that the mandates were based on unsupported claims reflecting varying welfare and fairness rationales. While not necessarily generalizable, the findings suggest that if HHS were to merely incorporate existing state mandates into the definition of essential health benefits, it might end up mandating coverage for services that harm health outcomes or have unacceptably high costs. Even where specific mandates are well supported by evidence, including them in the definition of essential health benefits without subjecting them to the same criteria used in determining essential health benefits generally would likely result in an essential health benefit package that fails to reflect a uniform vision of what is truly essential.

APPENDIX A:
FACTORS TO BE INCLUDED IN CHBRP REPORTS

Public health impacts	The impact on the health of the community, including the reduction of communicable disease and the benefits of prevention The impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed scientific and medical literature The extent to which the proposed service reduces premature death and the economic loss associated with disease
Medical impacts	The extent to which the benefit or service is generally recognized by the medical community as being effective in the screening, diagnosis, or treatment of a condition or disease, as demonstrated by a review of scientific and peer-reviewed medical literature The extent to which the benefit or service is generally available and utilized by treating physicians The contribution of the benefit or service to the health status of the population, including the results of any research demonstrating the efficacy of the benefit or service compared to alternatives, including not providing the benefit or service The extent to which the proposed services do not diminish or eliminate access to currently available health care services

Continued on next page

APPENDIX A—Continued

Financial impacts	The extent to which the coverage will increase or decrease the benefit or cost of the service The extent to which the coverage will increase the utilization of the benefit or service, or will be a substitute for, or affect the cost of, alternative services The extent to which the coverage will increase or decrease the administrative expenses of health care service plans and health insurers and the premium and expenses of subscribers, enrollees, and policyholders The impact of this coverage on the total cost of health care The potential cost or savings to the private sector, including the impact on small employers, the Public Employees' Retirement System, other retirement systems funded by the state or by a local government, individuals purchasing individual health insurance, and publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program The extent to which costs resulting from lack of coverage are shifted to other payers, including both public and private entities The extent to which the proposed benefit or service does not diminish or eliminate access to currently available health care services The extent to which the benefit or service is generally utilized by a significant portion of the population The extent to which health care coverage for the benefit or service is already generally available The level of public demand for health care coverage for the benefit or service, including the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts, and the extent to which the mandated benefit or service is covered by self-funded employer groups

APPENDIX B:
BILLS INCLUDED IN STUDY

TABLE 1:
CALIFORNIA

Legislative Session	Bill Number	Subject
1999–2000	AB 12	Second opinions
1999–2000	AB 2265	Hospice
1999–2000	AB 525	Reproductive health services
1999–2000	AB 591	Clinical trials
1999–2000	AB 610	Childhood cancer
1999–2000	AB 88	Mental health
1999–2000	SB 1839	Prostate cancer
1999–2000	SB 2022	Maternity/Preexisting conditions
1999–2000	SB 362	Ovarian cancer screen
1999–2000	SB 5	Breast cancer
1999–2000	SB 64	Diabetes
2001–2002	AB 1826	Infertility
2001–2002	AB 1996	Prescription drugs
2001–2002	AB 1354	Genetic diseases
2001–2002	AB 1237	Cervical cancer screen
2001-2002	AB 1896	Ovarian cancer screen
2001–2002	AB 2464	Scalp prosthesis
2001–2002	AB 2692	Osteoporosis
2001–2002	AB 2763	Hyperbaric oxygen
2001–2002	SB 1219	Cervical cancer screen
2001–2002	SB 1638	Hearing aids
2001–2002	SB 2884	Hearing aids
2001–2002	SB 37	Clinical trials
2001–2002	SB 446	AIDS vaccine
2001–2002	SB 573	Acupuncture
2001–2002	AB 1786	Bone marrow testing
2001–2002	SB 599	Substance abuse
2003–2004	AB 2999	Aortic aneurism
2003–2004	AB 37	Mental health

Continued on next page

TABLE 1—Continued

2003–2004	AB 438	Osteoporosis
2003–2004	AB 547	Ovarian cancer screen
2003–2004	SB 1157	Intoxication
2003–2004	SB 1158	Hearing aids
2003–2004	SB 101 & 1192	Substance abuse
2003–2004	SB 1555	Maternity
2003–2004	SB 174	Hearing aids
2003–2004	SB 797	Osteoporosis
2003–2004	SB 897	Maternity
2003–2004	AB 1084	Vision care
2003–2004	AB 1549	Pediatric asthma
2003–2004	AB 1927	Vision care
2003–2004	AB 2185	Asthma
2005–2006	AB 1185	Chiropractic
2005–2006	AB 213	Lymphedema
2005–2006	AB 228	HIV+ Organ transplants
2005–2006	AB 8	Post-mastectomy hospital stays
2005–2006	SB 415	Alzheimer's drugs
2005–2006	SB 572	Mental illness
2005–2006	SB 573	Repeal intoxication exclusion
2005–2006	SB 576	Tobacco cessation
2005–2006	SB 749	Pervasive developmental disorders
2005–2006	SB 913	Rheumatic disease drugs
2005–2006	AB 2012	Orthotics/Prosthetics
2005–2006	AB 264	Pediatric asthma
2005–2006	SB 1223	Hearing aids
2005–2006	SB 1245	Cervical cancer screening
2005–2006	SB 1508	Colonoscopies
2007–2008	AB 1429	HPV vaccine
2007–2008	AB 1461	Repeal intoxication exclusion
2007–2008	AB 30	Inborn errors of metabolism
2007–2008	AB 423	Mental illness
2007–2008	AB 54	Acupuncture

Continued on next page

TABLE 1—Continued

2007–2008	SB 24	Tobacco cessation
2007–2008	AB 16	HPV vaccine
2007–2008	AB 1774	Uterine & ovarian cancer screening
2007–2008	AB 1887	Mental health services
2007–2008	AB 1962	Maternity
2007–2008	AB 1894	HIV testing
2007–2008	AB 2174	Elemental formulas
2007–2008	AB 2234	Breast cancer screening
2007–2008	SB 1634	Cleft palate

TABLE 2:
CONNECTICUT

Legislative Session	Bill Number	Subject
2008	HB 5696	Autism
2008	HB 5514	Epidermolysis/Ostomy
2008	SB 280	Bone marrow testing
2008	HB 5691	Lymphedema
2008	HB 5521	Wound care
2007	SB 1014	Bone marrow testing
2007	HB 6723	Lead screening
2007	HB 6662	Ectodermal dysplasias
2007	HB 6663	Wound care
2007	HB 6282	Hearing aids
2007	SB 815	Lymphedema
2007	SB 816	Hearing aids
2007	SB 818	Fertility
2007	SB 586	Dentures
2007	HB 5672	Mental health
2007	SB 164	Emergency medical care
2007	HB 5303	Lymphedema
2007	HB 5053	TMJ
2007	SB 55	Lymphedema
2006	SB 579	Obesity

Continued on next page

TABLE 2—Continued

2006	SB 446	ED/Prostate cancer
2006	HB 5592	Prosthetics
2006	SB 422	Breast cancer screenings
2005	SB 1300	Weight reduction
2005	SB 1246	Artificial discs
2005	HB 6588	Infertility
2005	HB 6128	Mammograms
2005	HB 6130	Developmental disorders
2005	HB 6140	Infertility
2005	SB 688	Behavioral health
2005	HB 5721	Gastric bypass
2005	HB 5722	Hearing aids
2005	SB 508	Infertility
2005	SB 437	Experimental cancer treatment
2005	HB 5255	Hearing aids
2005	SB 162	Prosthetics
2005	HB 5029	Hypodontia
2004	SB 416	Interpreter services
2004	HB 5464	Wigs
2004	SB 113	Developmental disorders
2004	HB 5206	Infertility
2004	HB 5201	Nutritional formulas
2004	SB 107	Specialized formulas
2003	HB 6607	Developmental disorders
2003	SB 918	Complex dental procedures
2003	HB 5881	Talking Rx bottles
2003	SB 694	Craniofacial
2003	HB 5482	Fertility
2003	SB 346	Ovarian cancer screening
2003	SB 350	Experimental cancer treatment
2003	SB 216	Hearing aids
2003	SB 217	TMJ
2003	SB 221	Infertility

Continued on next page

TABLE 2—Continued

2003	HB 5121	Psychotropic drugs
2003	HB 5069	Ovarian cancer screening
2003	SB 18	Ovarian cancer screening
2003	SB 1	Craniofacial defects
2002	HB 5563	Physical therapy
2002	SB 449	Infertility
2002	HB 5566	Ambulance services
2002	SB 136	Hearing aids
2001	SB 1352	Preventative tests/services
2001	SB 1310	Hearing aids
2001	HB 6450	Mammoplasty
2001	SB 942	Mental illness
2001	SB 680	IVF
2001	HB 5622	Infertility
2001	SB 407	Psychiatric visits
2001	SB 412	Hearing aids
2001	SB 474	TMJ
2001	HB 5639	Rx reform
2001	SB 524	Metabolic formula
2001	SB 325	Clinical trials
2001	SB 325	Hearing aids for children
2001	SB 325	Pap smears
2001	SB 325	Colorectal cancer screening
2001	SB 325	Mammograms
2001	SB 325	Psychiatric prescription drugs
2001	HB 5298	Hearing aids
2001	SB 205	Specialists
2001	SB 162	Allergies/Asthma
2001	SB 46	Nutritional formulas
2000	HB 5824	TMJ
2000	SB 547	Infertility
2000	HB 5738	Hearing aids
2000	HB 5696	Nutritional formulas

Continued on next page

TABLE 2—Continued

2000	HB 5120	Ostomy supplies
1999	HB 7024	Tobacco cessation
1999	HB 6704	Dental anesthesia
1999	SB 1050	Mental health
1999	HB 5950	Oral contraceptives
1999	SB 646	Infertility
1999	HB 5502	Birth control
1999	HB 5664	Diabetes
1999	HB 5665	Multiple personality disorder
1999	HB 5668	Colostomy bags
1999	HB 5669	TMJ
1999	HB 5675	Mental health/Substance abuse
1999	HB 5679	Post-mastectomy care
1999	HB 5681	Advance practice RNs
1999	HB 5682	Prescription drugs
1999	HB 5686	Prescription drugs
1999	HB 5687	Mammography scheduling
1999	HB 5692	Any provider
1999	HB 5695	Weight-loss treatment
1999	SB 409	Mental health
1999	SB 436	Mental health
1999	HB 5351	Mental health
1999	HB 5354	Prostate cancer
1999	SB 201	Mental health
1999	SB 237	Provider credentialing
1999	SB 238	Prosthetics
1999	HB 5164	Diabetes
1999	SB 111	TMJ
1999	SB 67	Pain treatment
1999	SB 27	Diabetes
1999	SB 42	AWP
1999	SB 43	Experimental treatment
1999	SB 45	Pediatric physicals

Continued on next page

TABLE 2—Continued

1999	SB 55	Clinical trials
1999	HB 7032/1331	Experimental treatments
1999	SB 5694	Lyme disease
1999	HB 6468	Hearing aids
1999	HB 5036	Ostomy supplies