Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

SFA BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bills 260 and 261 (as enrolled)
Sponsor: Senator John J.H. Schwarz, M.D. (S.B. 260)
Senator Dianne Byrum (S.B. 261)
Senate Committee: Health Policy
House Committee: Insurance and Financial Services

Date Completed: 1-4-01

RATIONALE

Millions of Americans are afflicted with diabetes, which if left untreated can lead to disabling and/or life-threatening conditions. Diabetes can cause several serious health complications, including amputations, blindness, kidney disease, heart disease, stroke, and nerve damage. According to the Michigan Diabetes Coalition, diabetes is the leading cause of blindness, kidney failure, and lower-limb amputation, and increases a person's risk of heart disease or incidence of stroke by two to four times. The American Diabetes Association (ADA) reports that diabetes causes over 180,000 deaths nationwide each year. In Michigan there are approximately 375,000 cases of diagnosed diabetes. About 10% of these are Type I, that is, individuals who must take insulin daily or face death. The remaining 337,500 are considered Type II diabetics. About 135,000 of these people take insulin daily in an effort to treat their conditions; the remainder of those diagnosed with diabetes handle their conditions with varying combinations of treatments. Reportedly, over 200,000 individuals in the State have diabetes but have not been diagnosed.

Despite the incidence of the disease and the severe conditions that can result from it, the ADA reports that with proper treatment the risk of developing further complications from diabetes can be reduced by 50% to 76%. While some people with diabetes may be able to halt or delay complications from the disease with monitoring, diet, and exercise, Type I and most Type II diabetics need a host of daily medication and treatment, including insulin, syringes, blood glucose monitors, test strips, lancets, insulin pumps, etc. It has been pointed out that daily medication requirements, and the use of testing and monitoring equipment, can be expensive. While some health insurance plans include coverage for the treatment of diabetes, many do not; other plans may include reimbursement for certain medication, but not for testing or monitoring equipment. Some people believe that since unmanaged diabetes can lead to such severe conditions, and that since many of those conditions can be delayed or prevented with proper treatment, health insurers should be required to provide coverage for the treatment of diabetes, and for teaching people to manage their disease.

CONTENT

The bills would amend two Acts to require health insurers, health maintenance organizations (HMOs), and Blue Cross and Blue Shield of Michigan (BCBSM), to include coverage for certain equipment, supplies, and educational training for the treatment of diabetes, and to require BCBSM, HMOs, and health insurers to establish diabetes prevention programs for insured individuals and participating providers. Coverage or benefits provided under the bills would not be subject to dollar limits, deductibles, or copayment provisions that were greater than those for physical illness generally. Under the bills, "diabetes" would include gestational diabetes, insulin-dependent diabetes, and non-insulin-dependent diabetes.

Senate Bill 260 would amend the Nonprofit Health Care Corporation Reform Act, which governs BCBSM; Senate Bill 261 would amend the Insurance Code, which governs private insurers and HMOs.

Coverage for Equipment & Supplies

The bills would require BCBSM in each group and nongroup certificate, a private health insurer that issued an expense-incurred hospital, medical, or surgical policy or certificate, and an HMO contract to include coverage for the following equipment and supplies for diabetes treatment, if determined to be medically necessary and prescribed by a physician: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices; syringes; and insulin pumps and medical supplies required for the use of an insulin pump.

Senate Bill 260 also would require BCBSM to

provide coverage for insulin and nonexperimental medication for controlling blood sugar, if determined to be medically necessary and prescribed by a physician. Under Senate Bill 261, if an insurer or HMO issued a policy or contract providing outpatient pharmaceutical coverage directly or by rider, then the policy or contract would have to include coverage for insulin or nonexperimental medication for controlling blood sugar, if determined to be medically necessary and prescribed by a physician.

In addition, the bills would require BCBSM, an HMO, and a private health insurer to provide coverage for medically necessary medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes, if prescribed by an allopathic, osteopathic, or podiatric physician.

(Except as provided in regard to foot ailments, references in the bills to a "physician" mean an allopathic or osteopathic physician.)

Self-Management Training

A health certificate, policy, or contract also would have to provide for diabetes self-management training, if determined to be medically necessary and prescribed by a physician, to ensure that persons with diabetes were trained as to the proper self-management and treatment of their diabetic condition.

The coverage would be limited to completion of a certified diabetes education program under either of the following conditions:

-- If considered medically necessary upon the diagnosis of diabetes by a physician who was managing the patient's diabetic condition, and if the services were needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.
-- If a physician diagnosed a significant change with long-term implications in the patient's symptoms or conditions that necessitated changes in a patient's self-management or a significant change in medical protocol or treatment modalities.

In addition, the training would have to be provided by a diabetes outpatient training program certified to receive Medicare or Medicaid reimbursement or certified by the Department of Community Health. This training would have to be conducted in group settings whenever practicable.

Prevention Program

The bills would require BCBSM, private insurers, and HMOs to establish and provide to insured individuals and participating providers a program to prevent the onset of clinical diabetes. The program for participating providers would have to emphasize best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. A private insurer, an HMO, and BCBSM would have to measure the effectiveness of a program by regularly surveying insured individuals covered by a policy, contract, or certificate. Within two years after the bills' effective date, BCBSM and each insurer and HMO that provided a program would have to prepare a report that contained the results of the survey and give a copy of the report to the Department of Community Health.

Proposed MCL 550.416b (S.B. 260)
Proposed MCL 500.3406p (S.B. 261)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument
Diabetes is a major health problem nationwide, and this State has not been spared from the troubles it causes. In fact, Michigan has the fifth highest rate of diabetes prevalence in the country, according to the Michigan Diabetes Coalition. Approximately 375,000

Michigan residents have been diagnosed with diabetes; further, it has been estimated that another 200,000 or more have the disease but have not been diagnosed. Diabetes, if left untreated or inadequately treated, can lead to severe health conditions, including heart attacks, strokes, kidney failure, blindness, and amputations. Obviously, short of causing immediate death, these conditions can leave a person disabled, prevent the person from holding a job, and result in enormous medical bills for continuing treatment.

The good news is that proper management of diabetes can prevent or delay the onset of the related health problems. Once established, diabetes is a lifelong condition that requires daily self-management. According to the Michigan Association of Diabetes Educators, diabetes requires the individual to assume 98% of the responsibility for his or her care and daily management. Early education soon after diagnosis is crucial in preventing the condition from worsening and bringing on other complications; therefore, access to diabetes education programs is vital. Individuals with diabetes need to learn how to manage their conditions by monitoring blood sugar levels, which they can achieve only by checking those levels, sometimes several times a day. The equipment and materials needed for continual monitoring of blood sugar levels, and the insulin or other medications that people with diabetes need to help control their condition, can result in significant expenses. These expenses often are more than people can afford if they have health insurance that does not cover diabetes treatment. By requiring insurers to provide coverage for the equipment that is needed to monitor diabetics' conditions, the medication and medication delivery devices needed to control the disease, and education designed to teach people how to monitor and manage diabetes, the bills would offer people with diabetes a powerful tool to use in their daily struggle against debilitation.

Supporting Argument

Reportedly, 31 states now have some form of mandated insurance coverage for diabetes, and Michigan needs to join them. At this time, in view of the severity of the condition and what it can cause, coverage for diabetes is totally inadequate. This is a disease that many people can control, and thus prevent further debilitating conditions; however, if people cannot afford the equipment and medication needed to control diabetes, or cannot afford the education needed to allow them to self-manage their disease, then they will not be able to do what is necessary. In this case, not doing what is necessary can lead to conditions that will demand expensive treatment. Although it can be said that mandated coverage raises insurance rates, which is costly for those who pay the premiums, it is simply not logical for an insurance company to pay for kidney dialysis, or a long hospital stay for a stroke victim, after it has been unwilling to pay for relatively inexpensive care of diabetes, which could have prevented the stroke or the kidney problems in the first place. For example, according to testimony on behalf of the National Kidney Foundation of Michigan, kidney dialysis costs approximately $58,000 per patient per year, and a kidney transplant costs approximately $87,000 plus annual drug maintenance costs of about $10,000. On the other hand, insulin pumps and glucose monitors, which can be used for several years, cost $4,000 and $50, respectively, and a year's supply of lances and test strips costs around $60 and $720. By mandating coverage for diabetes, the bills would prevent some of the terrible complications associated with diabetes, and in the long run save insurers, and their clients, money for expensive treatment of other conditions.

Response: It is not universally accepted that mandated insurance coverage for diabetes would save money in the long run. Traditionally, mandated coverages have resulted in increased insurance costs, both upon their initiation and over time. Many employers, insurance companies, and unions oppose mandatory diabetes coverage because they are interested in reducing costs for health care. If it can be shown that insurance that covers diabetes monitoring equipment and education results in a reduction in overall health costs, then insurers and employers will voluntarily respond by providing those coverages. In fact, in 1998 Medicare coverage for Type II diabetes was expanded, according to the Department of Community Health, to include supplies and medical equipment needed to manage diabetes. Both General Motors and Chrysler increased their coverages by adopting these guidelines for their employees. Ford Motor Company, Detroit Edison, and BCBSM also adopted similar coverages. This is exactly how health care insurance decisions should be made, as it reflects what those companies, rather than governmental officials, perceive to be needed.

Opposing Argument

The bills would micromanage health plans by government mandate, exactly what is not needed for today's employers and employees. These decisions--the contents of health insurance contracts--should be left to the employers and employees because they understand what is needed better than the government does. Over time, the cumulative effect of mandated coverages is a substantial increase in health care costs. Imposing another mandate would add more costs, thus increasing the overall cost per employee for employers that provide health care insurance. Employers should be free to choose their own health care plans, with the flexibility to negotiate with employees what will and will not be covered.

Response: The argument that there needs to be flexibility and choice in coverage for diabetes would, in effect, make this serious disease negotiable. There are ways for diabetes to be treated to prevent other serious conditions, and every attempt should be made to see that they are used.

Opposing Argument

Any effort to increase mandated coverage should be opposed, because it further restricts the ability of purchasers to choose the coverage, as they determine, that best meets their needs and resources. This is especially true for small businesses. According to the Small Business Association of Michigan, mandates increase health insurance costs for small businesses 20% to 30% over the costs paid by large businesses that self-insure under the Federal Employee Retirement Income Security Act (ERISA), which allows them to negotiate directly with providers and thus avoid state-mandated benefits. Small businesses, however, cannot self-insure and thus are unable to avoid mandated coverages. Each mandated coverage places an obstacle in the path of a small business that wishes to obtain a low-cost, basic health care plan. Sometimes small increases in insurance costs can make the difference between being able to afford some insurance and having none. Some firms, regrettably, just like some individuals, may not be able to afford pricey, full-coverage plans, and must choose lower-cost, less comprehensive insurance. If coverage mandates cause the price of basic coverage to rise beyond the reach of small firms, then they may be forced simply not to provide health insurance for their employees. The Small Business Association of Michigan reports that over 50% of small businesses already have no coverage for employees. Also, according to the Michigan Health and Hospital Association, a recent Congressional Budget Office report indicates that with each 1% increase in premium costs, small business sponsorship of health insurance drops by 2.6%.

Further, along these lines, the bills would do nothing for the uninsured. In fact, for those uninsured persons who are almost able to afford health insurance, or obtain a job that provides insurance, a mandated coverage that increased costs would push them further away from being able to get coverage. Thus, the bills could have the inadvertent effect of increasing the numbers of the uninsured.

Opposing Argument

Requiring coverage for diabetes could set off a mandate scramble for other diseases. The argument that State-mandated coverage saves money is potentially limitless. If insurance mandates are a good idea for diabetes, presumably they also would be good for cancer, heart disease, or mental illness.

Response: Diabetes is demonstrably different from other diseases in terms of the specific consequences that can be prevented through intervention and treatment. According to testimony by the president of the American Diabetes Association, much of the opposition to mandated coverage is based on studies that review mandates in general, not diabetes in particular. Reportedly, there is overwhelming evidence that these bills would save millions of dollars annually. "Several independent, case-controlled studies, in addition to a scoring by the Congressional Budget Office, found that improving coverage for diabetes care not only saves money, but saves significantly more money than other screening efforts, including mammography, prostate, and colorectal screenings. Savings can be realized immediately in the reduction of hospitalizations due to poor blood-glucose control, and long-term, through the reduction of complications." Moreover, according to the same testimony, the Upper Peninsula Diabetes Outreach Network ran a seven-year program that demonstrated that diabetes education, direct care, and referrals for specialty care resulted in a 45% lower hospitalization rate. Reportedly, if all of the diabetics living in the Upper Peninsula had the low hospitalization rate of program participants, almost 10,000 diabetes-related hospitalizations would have been prevented during the seven-year life of the program, and would have resulted in a saving of $28 million.

Furthermore, the purpose of spending money on health care today is not simply to decrease future health care costs, but to preserve individuals' health and well-being at a cost that society deems worthwhile.

Legislative Analyst: G. Towne

FISCAL IMPACT

The enactment of these bills could have a material direct and indirect impact on State finances. By definition, mandating insurance coverage for a health service or services will increase costs to the insured

at large, at least in the short run. This is due to the fact that the prima facie impetus behind the mandate is to provide these services (which have a cost), to persons who need the services but cannot currently afford them. In the instant case, a Type I diabetic (requiring insulin to survive) without insurance would spend around $1,100 per year, excluding the cost of insulin, for such things as blood glucose monitors and test strips, lancets, and syringes.

With mandated coverage, these costs would be spread across all insured persons rather than any given diabetic. However, the major fiscal impact of these bills would come not from the coverage of these basic home care items, but rather from the potential for an increased demand of substantially more costly diabetic-related items. These include a variety of insulin pump devices that cost anywhere from $4,000 to $5,000 and new noninvasive or semi-invasive blood glucose monitors that should be coming to market soon with an initial cost of $500 or so. The bottom line is that the cost of diabetic home care devices could jump by a factor of three or four times given broad insurance coverage of these items. Given that there are probably 37,500 Type I diabetics and 337,500 Type II diabetics, with 40% of those requiring insulin, the likelihood of a system-wide insurance cost increase is probable even if a specific price tag cannot be estimated.

While it is recognized that improved home care can delay or eliminate many of the debilitating and costly consequences of poorly managed diabetic treatment, the saving that could occur as a result of these bills would not be apparent for a number of years down the road.

Fiscal Analyst: J. Walker

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