The Council for Affordable Health Insurance
TRENDS & Ends
December 2005
A CAHI Web Memo

Trends in State Mandated Benefits

A state mandated benefit is a state law that requires a health insurance policy or health plan to cover (or offer to cover) specific providers, procedures, benefits or people. The number of mandates has swollen over the past 40 years from just a few to more than 1,800 nationwide.

Since the early 1990s, the Council for Affordable Health Insurance (CAHI) has tracked state mandate legislation in all 50 states. That information is made available in CAHI's "Health Insurance Mandates in the States, 2005."

While some mandated benefits make health insurance more comprehensive, they also make it more expensive. Because insurers are required to pay for care that consumers previously funded out of their own pockets or that wasn't purchased at all — insurers often must raise premiums to cover those costs. CAHI's team of actuaries has estimated that, depending on where one lives, mandates can boost the cost of a policy between 20 and 45 percent. And experience demonstrates that when health insurance costs increase, more people drop or decline coverage.

At a time when the number of people without health coverage is growing, it is important to recognize that mandates make health insurance more expensive and that some employers or individuals will not be able to afford it.

Trends in State Mandated Benefits. As CAHI's state mandate report shows, some mandates have passed in virtually every state; others appear in only a few states. That's because some mandate legislation "catches on." That is, one or two states pass it, legislators in other states hear about it — often through a special interest group pushing the legislation in numerous states — and they introduce a version of the legislation in their own state.

Since CAHI closely monitors state mandate legislation nationwide, we see mandate "trends" developing long before many others. The purpose of this short report is to identify some of those trends: which state mandates are growing in popularity among state legislators and in which states.

- **Dental Anesthesia.** This mandate requires coverage for general anesthesia and associated facility charges for medically necessary dental procedures in a hospital. In many states, the enrollees are limited to children and the infirm who would need hospitalization for certain dental procedures. In just the past few years, 27 states have adopted this mandate. Arkansas has recently added it for children and the infirm, bringing the total to 28 states.

- **Diabetes Self-Management.** Most states have diabetes mandates on the books, despite the fact that most health insurance policies already cover diabetes. But the new trend is to pass a diabetes self-management coverage mandate, or mandate that such coverage be offered. This mandate requires that insurance companies cover efforts by patients to educate themselves about their disease — a process not typically required of any other disease — and can include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider.

  Nineteen states have added diabetes self-management to their list of mandates in just the past couple of years. However, while several states introduced the mandate in this legislative session, nothing was signed into law.

  Note: The concern here is that this mandate is paving the way for other diseases that require nutrition and education. Support groups for other diseases refer to the diabetes self-management mandate as the "golden mandate" to pave the way for food and other metabolic diseases such as PKU, etc.

Unusual and Costly State Mandated Providers and Benefits

PROVIDERS	Number of States	Estimated Cost
Acupuncturists	11	1% to 3%
Chiropodist	3	<1%
Chiropractors	47	1% to 3%
Marriage Therapists	11	<1%
Massage Therapists	4	<1%
Pastoral Counselors	2	<1%
BENEFITS	**Number of States**	**Estimated Cost**
In Vitro Fertilization	15	3% to 5%

Source: "Health Insurance Mandates in the States, 2005," Council for Affordable Health Insurance.

- **Cervical Cancer Screening.** Since the late 1980s, Massachusetts required a cervical cancer screening mandate. Now more states have joined the list. The laws vary slightly, with some requiring coverage for annual cytological screening for cervical cancer for women ages 18 and older to requiring that the coverage be dependent upon a physician referral. Yet others specifically refer to the Pap Smear test, or testing for the Human Papilloma Virus (HPV) or Chlamydia. Twenty-four states have added a cervical cancer screening mandate, and this legislative year, four more joined them: Maryland, New Mexico, Rhode Island and Texas.

- **Contraceptives.** States began in the late 1990s to require health plans that cover prescription drugs to include coverage of contraceptives or outpatient contraceptive services. The trend accelerated with news reports that Viagra was covered by many insurance plans on a gender-equity basis. (Most state laws allow religious employers to be exempt, however.) Prior to this year, 21 states required policies to include (or at least offer) contraceptive coverage when other prescription drugs were covered. This year, two states have added this mandate: Arkansas and West Virginia.

  There are numerous contraceptive services that are now mandated that were not about seven years ago. This expansion is interesting in that most employer plans covered some forms of contraception, just not all. In addition, the cost of birth control, about $20 per month, is well within the financial range of many of the professional working people who have been calling for it.

Unusual Mandates Emerging During the 2005 Legislative Session. This year, we have seen some relatively new mandates make it through state legislatures. For example:

- An athletic trainers mandated provider benefit (Arkansas);

- A mandated offer for medically necessary breast reduction and/or systematic varicose vein surgery (Maine); and;

- An "early intervention services" mandate, which means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, management, nutrition, service plan development and review, nursing services, and assisted technology services from birth to three years of age (Rhode Island).

Trends in States Requiring Mandate Studies. Before a state legislature passes a new mandate, it should require a comprehensive cost analysis to assess the mandate's likely impact on health insurance premiums. And before imposing it on the whole population, the state should include the mandated coverage in state workers' policies. To date, 27 states conduct state mandated benefit studies. In some cases a specific mandate may be reviewed by a study commission, as has been done in a number of states with mental health mandates. Another option: requiring passage of the mandate in two consecutive legislative sessions, thus allowing a better study of the cost effects. (**Note:** In theory, in many of these cases the mandates are considered in short legislative sessions [i.e. Virginia] without real committee time on the issue, so two years would allow more evaluation by larger groups). This year, three states — Arkansas, Colorado and Indiana — enacted legislation to either establish or continue their mandate study commissions.

Trends in State "Mandate-Free" Policies. A few states are getting the message: mandates make health insurance more expensive. Prior to 2005, Arkansas, Colorado, Florida, Montana, North Dakota and Utah allowed mandate-free policies. This year, two new states — Georgia and Kentucky — added mandate-free or mandate-light (i.e., limited benefits) options. In addition, Montana passed a law this session opening up its limited-benefit policy demonstration project to more state residents. While such policies are often criticized because they have coverage gaps — which also may be why they haven't proved that popular — they are much more affordable and provide a level of protection against an unforeseen medical event. Even so, several other states introduced legislation authorizing plans that limit mandated benefits, but none were enacted.

Prepared by: Victoria Craig Bunce, Director of Research and Policy, Council for Affordable Health Insurance

Trends & Ends can be found exclusively online at www.cahi.org.

Copyright © 2005 The Council for Affordable Health Insurance

All rights reserved. Reproduction or distribution without the express consent of CAHI is prohibited.

Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org