Finding a balance between adequate and affordable coverage has been a challenge for federal and state policymakers. Some mandates may be desirable to some consumers but unimportant to others. The debate over the value of and need for legally mandated health insurance benefits is taking on new urgency, since health care spending and insurance premiums have been increasing at a faster rate in recent years than in the 1990s. The U.S. Department of Health and Human Services (DHHS) reported that health care spending in 2000 increased by 6.9 percent, the largest one-year percentage increase since 1993. According to an employer survey conducted in 2001 by the Kaiser Family Foundation and the Health Research and Educational Trust, health insurance premiums increased an average of 11 percent nationwide in 2001. The benefits consulting firm William M. Mercer predicted an increase of another 13 percent in 2002 for firms overall, and 20 percent or more for small businesses. With the California Public Employees Retirement System (CalPERS) anticipating a 25 percent premium hike for 2003, the situation in California—often a bellwether for the nation—is more sobering than in other states.

What Are The Arguments For And Against Mandated Benefits?

Health insurance coverage mandates are both beneficial and costly to consumers. Benefit mandates are popular because they are intended to provide health care consumers with greater access to particular services, many of which are important preventive services or critical to the treatment of particular disorders. Absent a mandate, supporters argue that these services might otherwise be under-provided. Moreover, mandating certain preventive services could reduce a health plan’s overall costs and improve worker productivity through early intervention in potentially serious health conditions. Another argument in favor of mandates is that the additional services might improve the quality of patient care and reduce medical errors. Supporters of specific mandated benefit requirements argue that these actions would not be necessary if insurers provided adequate benefits that cover all “medically necessary” treatments, although there is dispute over what services are medically necessary. This argument suggests that a reason for states to impose mandated benefits is to correct failures in the health insur-
concluded that while people may not drop coverage because such a
alcohol or drug abuse treatment was correlated with reduced private
and chiropractic care. They found that the presence of mandates for
tigated the impact of four of the most expensive mandates: treat-
analyzed by researchers at the Urban Institute in 1998. They inves-
the effect of mandates on rates of uninsurance across states was
varied across states, with mandated benefits accounting for 22 per-
costs imposed by the mandate. Analysis by the CBO in 2001 of the
additional increase in employer health care costs of $23 billion over
five years. In 1996, the U.S. General Accounting Office (GAO)
conducted a study of the cost effect of state benefit mandates. Costs
varied across states, with mandated benefits accounting for 22 per-
cent of claims costs in Maryland, 12 percent in Virginia, and 5 per-
cent in Iowa. The GAO found that the cost effect varies due to
differences in state laws and employer practices, and that costs are
higher in states with more mandated benefits and in states that man-
date more costly benefits, such as mental health services and sub-
stance abuse treatment.

The effect of mandates on rates of uninsurance across states was
analyzed by researchers at the Urban Institute in 1998. They investi-
gitated the impact of four of the most expensive mandates: treat-
ment for alcoholism, treatment for drug abuse, mental health parity,
and chiropractic care. They found that the presence of mandates for
alcohol or drug abuse treatment was correlated with reduced private
coverage and increased overall uninsurance rates. The researchers
concluded that while people may not drop coverage because such a
mandate is enacted, the mandate may contribute to generally higher
premiums over time, which may make insurance unaffordable for
some individuals and employers.

An April 2002 study conducted by PricewaterhouseCoopers for
AAHP on the factors affecting rising costs in health insurance pre-
miums concluded that government mandates and regulation con-
tributed 15 percent to the total increase in premiums between 2001
and 2002. The study reported that the average increase in health
insurance premiums for large employers between 2001 and 2002 was
13.7 percent, of which two percentage points was due to govern-
ment mandates and regulation. This increase represents $10 bil-
lion of the $67 billion overall increase in health premiums during
this period. According to a 1998 study by Frank Sloan and Chris-
topher Conover, using data from 1989-1994, approximately 20 to 25
percent of the uninsured lacked coverage because of the cost of state
benefit mandates. Research also suggests that mandates discourage
small firms from offering coverage altogether; according to a 1999
study by Gail Jensen and Michael Morrisey, about one-fifth of small
firms that did not offer coverage would offer it in a mandate-free
environment.

A concern about the inclusion of benefit mandates in health insur-
ance policies is that they do not apply to, and therefore do not affect
coverage or costs, for all insured people. People with public cover-
age such as Medicaid and Medicare are unaffected by state-imposed
benefit mandates because their coverage is not subject to state regu-
lation. In addition, purchasers who self-fund (self-insure) their health
benefits—typically large employers who can afford to bear the risk—
are exempt from state health insurance regulations, including state-
mandated benefit mandates (but are not exempt from federal man-
dates). The Council for Affordable Health Insurance estimated that
in 1997 about 60 million insured people were affected by benefit
mandates, many of whom work for small firms that do not self-
insure. The ability to self-fund presents a potential for employers to
avoid costs that may be associated with mandated benefits. Accord-
ing to an employer survey conducted in 2001 by the Kaiser Family
Foundation and the Health Research and Educational Trust, costs
for fully insured health plans rose 37.1 percent from 1998 to 2001,
while self-insured health plan costs rose 24.8 percent over the same
period.

Ultimately, assessing the impact of mandated benefits on costs and
coverage requires an understanding of how many people might have
access to and use the new benefit, and how many plans will be re-
quired to offer the benefit that did not offer it before the mandate.
CBO has concluded that the cost impact and the loss of insurance
coverage likely to result from federal benefit mandates depend on a
number of factors, including: how highly consumers value the ben-
efit; how common the benefit is in current insurance policies; whether
states already mandate the benefit; and the types of firms primarily
affected, whether large or small. If few people are projected to use
the benefit, the mandate may not contribute significantly to the cost
of an insurance policy. Moreover, if the majority of plans already
provided coverage for the new benefit prior to the passage of a man-
date law, the incremental cost of mandating its coverage in all plans
could be minimal. Another factor that could mitigate the cost im-
pact of mandated benefits is if the benefit is for a preventive service, coverage for which may reduce health care costs in the long term. Additional costs of mandated coverage associated with preventive services may reduce costs if disease is prevented or caught early when treatment is less expensive.

What Is The Status Of Mandated Benefits In Other States?

According to NCSL, several states have placed a high priority on mandates for certain health care services during their 2002 sessions, including mental health parity (23 states), cancer screenings (20 states), diabetes (17 states), and osteoporosis (10 states). Weighing against the concern about the potentially negative impact of mandated benefits legislation on premium costs and coverage rates is the concern that health care consumers may not have access to critical benefits and services. With increasing health care costs on the one hand and the importance of regulating employer-sponsored health insurance coverage on the other, policymakers in many states are looking for ways to balance the potential tradeoffs associated with mandated benefits legislation.

One approach to benefit mandate proposals that is becoming increasingly popular is to require cost-benefit analyses prior to the adoption of state-imposed coverage requirements. Such studies are designed to determine the financial and social impact of mandating specific benefits. Research by NCSL found that six states enacted such legislation during the 2001 session, and 10 states indicated that this issue would be a high priority during the 2002 session. Furthermore, several states introduced legislation that would allow insurers to sell policies that do not cover all mandated benefits, with two states enacting such legislation during the 2001 session. One state enacted a bill prohibiting additional coverage requirements until 2005. It has also been suggested that health and medical experts should work to increase the awareness of state legislators about evidence-based guidelines to inform their decisions about proposals to mandate coverage of preventive services. In 1999, 18 states mandated prostate-screening coverage, despite the fact that in 1996, the U.S. Preventive Services Task Force (USPSTF) recommended against routine screening for prostate cancer.

More than a dozen states—including Arizona, Arkansas, Florida, Georgia, Hawaii, Kentucky, Louisiana, Maine, Maryland, North Dakota, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin—have enacted laws requiring a review of proposed health benefit mandates. These laws attempt to provide policymakers with systematic analyses of mandate proposals and to increase their awareness of the costs and benefits associated with mandates. In evaluating mandated benefits, states generally focus on the fiscal impact, medical efficacy, impact on access to services, and the costs and utilization of the proposed benefit. States that have established review commissions generally require them to file reports on their findings and make recommendations to the state legislature. Examples of this legislation include:

- In Maryland, the mandated benefit review law requires the commission to make an annual determination of the full cost of all existing mandates as a percent of average annual wages in the state and as a percent of health insurance premiums. The Maryland Health Care Commission’s 2000 report indicated that on a full-cost basis, the total cost for all mandates as of 1999 was about 13 percent of the premium.
- In Pennsylvania, an independent state commission, the Pennsylvania Health Care Cost Containment Council (PHC4), is required to review mandated health benefit proposals. PHC4 reviews proposed benefits legislation when requested by the State Secretary of Health or appropriate committee chairs in either chamber of the Pennsylvania State Legislature. PHC4 has produced reports on proposals to mandate services such as contraception drugs and devices, dental anesthesia, colorectal cancer screening, acupuncture reimbursement, osteoporosis, and Hepatitis B immunization, among others.
- In Washington, proponents of mandates are required to provide specific information to the state legislature about the potential impact of the mandate. At the request of the legislature, the Department of Health makes recommendations to the legislature on the proposed mandate, guided by an evaluation of its financial and social impact and evidence of health care service efficacy. The intent is that the benefits of all proposed coverage mandates exceed their costs and will not “unreasonably” affect the cost and availability of health insurance.

Some states have attempted to make insurance coverage more affordable by allowing health plans to offer policies that do not include state-imposed coverage mandates, or exempting small firms from having to purchase policies that include such mandates. Arkansas and North Dakota enacted legislation in 2001 that gives consumers the option of purchasing individual or group health plans that comply with all, some, or none of the state-imposed health benefits. A bill in Florida would establish a new small group health insurance product that would not require that the state’s mandated benefits be included. Another bill in Florida would allow for mandate-free plans to be sold to low-income individuals through a pilot program in three areas of the state. A bill in Georgia would make mandated coverage optional for individuals and small firms if the insurer and purchaser agree.

The Status Of Mandated Benefits Legislation In California

In response to the 2002 State Health Priorities Survey conducted by HPTS, governmental contacts in California indicated that expanding preventive service benefits in health plans is a priority, and that certain mandated benefits—including cancer screening, clinical trials, morbid obesity treatments, and mental health/substance abuse parity—had a high priority on the legislative agenda. In the past few years, policymakers in California have passed laws to add more than 20 new programs and services to health plan policies, including pain management, dental anesthesia, hospice care, contraceptives, longer hospital stays after childbirth and mastectomies, and mental health treatment. Almost as many mandate proposals have been introduced in the 2001-2002 session, including coverage for acupuncture (SB 573), infertility (AB 1826), bone marrow testing (AB 1786), substance abuse (SB 599), and hearing aids (AB 2884). The California Association of Health Plans (CAHP) has estimated that the costs associated with 12 of these proposals could equal nearly $3 billion, equivalent to a premium increase of $174 per insured person per year.
None of California’s current benefit mandates have been subject to the scrutiny of an official cost-benefit evaluation such as that which occurs in some other states. However, the Senate Insurance Committee has used a task force led by the California HealthCare Foundation to evaluate mandate proposals. In 1999, this group studied the cost of bills that would require coverage for mental health, diabetes education, hospice care, and contraception, all of which were signed into law. Fueled by concern over rising health care costs and the uncertain influence of mandated benefits on increases in premiums and uninsurance rates, some state legislators have recommended putting current mandate bills on hold.

Assemblywoman Helen Thomson, chair of the Assembly Health Committee, has introduced a bill (AB 1996) that would establish a process for an independent review of the costs and benefits of proposed coverage mandates, similar to the work of the Pennsylvania Health Care Cost Containment Council. In its amended version, the bill establishes a commission to assess the public health, medical, and financial impact of proposed new mandates, hold public hearings, and report findings to the Legislature. The California Chamber of Commerce supports establishing such a review process. CAHP has supported the legislation but not the proposed funding mechanism, which requires health plans to pay fees that cover costs to conduct the reviews.

**Conclusion**

The volume of state-imposed mandated benefits legislation suggests that state policymakers have determined that such benefits are desirable and necessary and should be covered by health plans. However, unintended consequences often result from well-intended policymaking. Legislators seeking to provide consumers with more health insurance benefits do so without intending to increase premiums and reduce coverage rates. Yet the possibility that mandates add cost and reduce access to coverage is a particular concern now that employers are experiencing double-digit percentage increases in health insurance premiums.

Research from the states suggests that striking the proper balance between increasing access to benefits and maintaining a stable health insurance market can be difficult. Policymakers who wish to strike this balance have a number of options at their disposal, including implementing a review process for all newly proposed mandated benefits, expanding the availability of “bare-bones” and catastrophic health insurance plans, imposing sunset dates on newly adopted mandated benefit provisions, and subjecting mandated benefits to review. With information about the costs and benefits of proposed mandates, policymakers might be better able to address their constituents’ health care service needs.