

MANDATED HEALTH INSURANCE BENEFITS: TRADEOFFS AMONG BENEFITS, COVERAGE, AND COSTS?

Juliette Cubanski, MPP, MPH, and Helen H. Schauffler, PhD
Center for Health and Public Policy Studies, University of California, Berkeley
Phone: 510.643.1675 - Website: <http://chpps.berkeley.edu>

The Debate Over Health Insurance Benefit Mandates

Regulating the health insurance market has long been a priority for policymakers who are concerned about consumer rights and protections, as well as the availability and affordability of health insurance. Mandating health insurance benefits is one form of insurance regulation that has been very popular among legislators in all 50 states and in Congress. Benefit mandates require health plans to cover specific benefits and services, allow access to certain types of providers, or extend benefits to certain populations. Such mandates are meant to improve the value of insurance to consumers but may also add to its cost.

In recent years, the number of mandated benefit laws has increased significantly, with most enacted at the state level, but a few applicable nationwide. According to the American Association of Health Plans (AAHP), more than 1,400 coverage mandates exist at the state and federal level. A survey of states conducted by the Health Insurance Association of America (HIAA) documented that during 2001, every state had introduced bills mandating new benefits. Overall, more than 550 new benefit mandates were introduced in all states, and 65 became law.

At the federal level, the debate over benefit mandates revolves primarily around legislation to require parity between coverage for physical and mental health disorders (“mental health parity”). Another recent issue that has raised questions about mandated benefits is a congressional proposal to expand association health plans (AHPs). In its current form, the legislation would exempt AHPs from many state insurance regulations, including state-imposed mandated benefits laws.

Parity legislation is a very popular benefit mandate at the state level—according to the Health Policy Tracking Service (HPTS) of the National Conference of State Legislatures (NCSL), 22 states currently have laws that require parity in health insurance benefits for the treatment of mental illnesses (including California), and 24 other states require plans to offer or provide some minimum level of coverage. As of March 31, 2002, at least 88 bills related to coverage for the treatment of mental illness and/or substance abuse were introduced in 28 states, and many states are revising their current parity laws to narrow or expand them.

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 insurance market.

ance market. Thus, benefit mandates appeal to consumers who are concerned about access to care and the potential for under-provision of important services, and policymakers at both the state and federal levels have been responsive to these concerns.

Opponents of mandated benefits argue that the losses from mandate laws detract from their gains. To the extent that additional coverage requirements result in higher costs to health plans, mandated benefits may increase costs to purchasers through higher premiums. Opponents claim that as a result of higher costs, some employers may drop coverage or consumers may decline coverage, which contributes to a higher uninsurance rate. Opponents suggest that state-imposed mandates might also cause some purchasers to drop coverage because they do not want to pay for benefits they view as unwanted or unnecessary. Furthermore, opponents argue that mandates limit the flexibility that plans have in designing policies that match the preferences and the budgets of a diverse set of purchasers. Considered individually, a mandate to add a benefit to a health insurance policy may add only one or two percent to the total cost, but the accumulation of coverage mandates over time could add considerably to the total annual cost of a health insurance premium. Thus, opponents argue that laws requiring health plans to cover certain services and benefits may contribute to higher premiums and lower coverage rates in the aggregate.

What Does The Evidence Suggest About The Impact Of Mandated Benefits?

Evidence to support the claim that federal and state mandates have contributed to both increasing health insurance costs and uninsurance rates comes from both public and private sources. The Congressional Budget Office (CBO) has estimated the private-sector costs of proposed federal mandates on health plans, including mental health parity, insurance portability and access requirements, and patients' rights. In its cost analyses, CBO takes into account how employers who offer health coverage might react to the additional costs imposed by the mandate. Analysis by the CBO in 2001 of the Domenici-Wellstone mental health parity bill (S. 543) estimated an 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 percent of claims costs in Maryland, 12 percent in Virginia, and 5 percent 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 mandate more costly benefits, such as mental health services and substance abuse treatment.

The effect of mandates on rates of uninsurance across states was analyzed by researchers at the Urban Institute in 1998. They investigated the impact of four of the most expensive mandates: treatment 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 premiums concluded that government mandates and regulation contributed 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 government mandates and regulation. This increase represents \$10 billion of the \$67 billion overall increase in health premiums during this period. According to a 1998 study by Frank Sloan and Christopher 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 Morrissey, 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 insurance policies is that they do not apply to, and therefore do not affect coverage or costs, for all insured people. People with public coverage such as Medicaid and Medicare are unaffected by state-imposed benefit mandates because their coverage is not subject to state regulation. 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-imposed benefit mandates (but are not exempt from federal mandates). 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. According 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 required 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 benefit; 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 mandate law, the incremental cost of mandating its coverage in all plans could be minimal. Another factor that could mitigate the cost im-

fact 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 mandating coverage 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 Mary-

land 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.

For Further Reference

- American Association of Health Plans (AAHP)
<http://www.aahp.org>
- AAHP Report "The Factors Fueling Rising Healthcare Costs" by PricewaterhouseCoopers (April 2002)
http://www.aahp.org/Template.cfm?Section=Access_Cost&Template=/TaggedPageTaggedPageDisplay.cfm&TPLID=4&ContentID=2680
- California Association of Health Plans
<http://www.calhealthplans.com>
- California Chamber of Commerce
<http://www.calchamber.com/>
- Congressional Budget Office (CBO)
<http://www.cbo.gov/>
- Council for Affordable Health Insurance (CAHI)
<http://www.cahi.org/>
- Families USA
<http://www.familiesusa.org>
- Health Access
<http://www.health-access.org/>
- Health Benefits Coalition
<http://www.hbcweb.com/>
- Health Insurance Association of America (HIAA)
<http://www.hiaa.org>
- HIAA Report "Mandated Benefit Laws and Employer-Sponsored Health Insurance" by Gail A. Jensen and Michael A. Morrissey (January 1999)
<http://membership.hiaa.org/pdfs/jensenrpt.pdf>
- Health Policy Tracking Service 2002 State Health Priorities Survey
<http://www.hpts.org/HPTS97/home.nsf>
- Kaiser Family Foundation
<http://www.kff.org>
- National Conference of State Legislatures (NCSL)
<http://www.ncsl.org/>
- Official California Legislative Information
<http://www.leginfo.ca.gov/>
- Pennsylvania Health Care Cost Containment Council
<http://www.phc4.org>
- Urban Institute
<http://www.urban.org>
- Urban Institute Report "Variations in the Uninsured: State- and County-Level Analyses" by Jill Marsteller et al (June 1998)
<http://www.urban.org>
- Washington State Sunrise Process for Mandated Health Insurance Benefits
<http://www.doh.wa.gov/hsqa/sunrise/1999/mandated.htm>