The Council for Affordable Health Insurance
TRENDS & Ends
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Trends in State Mandated Benefits, 2006

Since the early 1990s, the Council for Affordable Health Insurance (CAHI) has tracked state mandate legislation in all 50 states and Washington, DC. Although there was only a handful of state mandates in the 1960s, CAHI's most recent report, "Health Insurance Mandates in the States, 2006," has identified 1,843 nationwide.

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

What Is a Mandate? A mandated benefit is a law that requires a health insurance policy or health plan to cover (or offer to cover) specific providers, procedures, benefits or people. The vast majority of mandates come from state legislatures, though the federal government is increasingly willing to impose mandates.

While mandated benefits make health insurance more comprehensive, they also make it more expensive. Mandates require insurers to pay for care that consumers previously funded out of their own pockets, if they purchased it at all, so insurers have to pay more claims — and eventually they must raise premiums to cover those costs. 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 drive up the cost of health insurance, and that some employers or individuals will not be able to afford it.

CAHI's team of actuaries has estimated that, depending on the state, mandates can boost the cost of a policy between 20 and 45 percent. A full state-by-state tabulation of those mandates, plus an actuarial estimate of each mandate's impact of the cost of a health insurance policy, is available in CAHI's "Health Insurance Mandates in the States, 2006." (www.cahi.org)

Increasingly Popular Mandates. 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. Such mandates gain a momentum that can be hard to stop, regardless of what they might do to the cost of insurance.

*Diabetic Self-management***.** This mandate means the self-management and treatment of diabetes. The mandate typically provides for evaluation, supplies, education and treatment. We saw an increase this year from 22 states to 27. States that added diabetic self-management include: Arkansas, Washington DC, North Carolina, Nevada and New York.

The "Slacker" Mandate. Most health insurance plans allow dependent eligibility up to age 19 but make an allowance for full-time students until they graduate — typically to the age of 22 or 23 years old. About 20 states have introduced legislation to increase the dependent eligibility age beyond this age limit — regardless of their student status. Most recently, two states, New Mexico and New Jersey, passed health insurance eligibility laws commonly referred to as the "slacker mandates" which increase the age of unmarried resident dependents or those who are fulltime students. New Mexico now allows health insurance coverage of unmarried dependents until the age of 25 and New Jersey until the age of 30. A few other states, including Colorado, Massachusetts and Utah, already have laws on the books.

Autism. About 40 states have state mental health benefit mandates and 42 states have state mental health parity laws on the books. Although most states define mental health as a state of emotional and psychological well-being, they often differ on what they include in evaluation and treatment. Hence, we are starting to see a trend in some mental health benefits, such as Autism, being separated from the general mental health benefit legislation. Autism is a brain disorder that affects three areas of development: communication, social interaction, and creative or imaginative play. The latest state legislative trend is to pass an Autism mandate separately from mental health benefit mandates so that the law provides for evaluation and treatment of Autism as well as specific services such as school integration. The number of states with an Autism specific mandate is now seven.

Wal-Mart bills. We should also include what has become known as the "Wal-Mart bill," which requires large employers to provide employees with health insurance or pay a tax to the state. While not a mandate in the traditional sense of the term (and so does not appear in CAHI's mandate publication), it is still a mandate on employers — and an expensive one at that. The legislation — which used to be called "pay or play," because an employer either had to provide health insurance (i.e., play) or pay the state a tax (i.e., pay) — started out in Maryland, and was passed by the Legislature, and then enacted over the governor's veto. Almost immediately, 30 states introduced some version of the legislation. It has become one of the fastest growing mandates facing state legislatures.

A Slowing Rate of Increase in Mandates? On a more positive note, there is reason to believe that state legislators are getting more cautious about blindly supporting each and every

proposed mandate. CAHI's analysis has found that as most states come to the conclusion of the 2006 legislative session, the total number of mandates either stayed the same or increased by only one. And some states are beginning to cut back on their mandates.

Changes in the Number of State Mandates — Refers to the total number of mandates in each state:

- 26 states had no change in the number of mandates;
- And 20 states increased by at least one.

Changes in the Number of Benefit Mandates — A benefit mandate requires insurers to cover a specific benefit, such as drug and alcohol abuse counseling or well-baby care. This list refers to the increase in states that have passed a given mandate.

- 18 different benefit mandates increased (i.e., more states adopted those mandates);
- 5 benefit mandates decreased in number;
- And 59 of the benefit mandates remained the same.

Changes in the Number of Provider Mandates — A provider mandate requires an insurer to cover specified providers such as chiropractors and podiatrists. (Note: In some cases there is little distinction between a "provider mandate" and a "benefit mandate." If the state requires insurance to cover a chiropractor, it is paying for the service, i.e., benefit, that professional provides.)

- 13 different provider mandates went down in number;
- 17 provider mandates stayed the same;
- And only 3 provider mandates increased.

In all, five states, plus Washington DC, reduced the number of mandates — four states dropped one mandate and Utah dropped 15).

These totals may indicate a trend that state legislators are more cautious about imposing even more mandates on states — mandates that consumers ultimately must pay for.

With respect to specific states:

Provider Mandates. The state of Utah has dropped many of its provider mandates. CAHI surveyed Utah's Department of Insurance in 2003 (one of the ways we track mandates), which included 36 provider mandates. By 2005 the survey showed it only had 21.

Emergency Services. The mandate provides for appropriate medical care in emergency situations based upon the "prudent layperson" standard. We saw a decrease in the reporting of the mandate this year — from 46 states to 43 states. Based upon State Department of Insurance Surveys of the individual market, we saw that in Colorado, Maryland and Nebraska the mandate applies to only HMOs and managed care. In previous years it was reported as a mandate in the individual and small group markets as well.

Unusual Mandates. State legislators occasionally introduce some unusual mandates, which don't usually pass. We did not see many of them this year, but the last legislative session we saw:

- 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, 28 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.

Trends in State "Mandate-Free" Policies. A few states are getting the message: mandates make health insurance more expensive. There are at least 10 states that provide for mandate-lite policies, which allow an individual to purchase a policy with fewer mandates more tailored to his or her needs and financial situation.

Conclusion. States are moving in the right direction as the explosion of state mandated benefit laws is slowing down. When the number of people without health coverage is increasing, it is important to recognize that mandates can make health insurance more expensive and that some employers or individuals may not be able to afford health insurance coverage.

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