TAHP
The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

Understanding Health Benefit Mandates

Health Insurance Mandates Increase the Cost of Health Care Coverage

State legislators have regularly debated and enacted "mandates," or required health coverage for specific treatments, benefits, providers and eligible enrollees. States continue to debate whether such mandates actually ensure adequate protection for their constituents or if they simply further increase health care costs.

Most states have state-mandated benefit laws that require insurers to provide benefits that health plans may not have traditionally covered otherwise. According to a study by the Council for Affordable Health Care, Texas ranks very high among the states with the most mandates, with over 60 separate mandated benefits[1]. Additionally, the Affordable Care Act (ACA) mandates health benefits through a defined essential health benefits package[2].

Few question that increasing health benefit mandates **drives up the cost of insurance coverage** for employers and consumers. Industry analysts suggest that mandates often prevent consumers from being able to purchase policies that meet their specific needs. They also point to the fact that many never use the coverage provided by the mandates, and yet they are forced to absorb the cost for the benefits through increased premiums.

Impact of Mandates on State of Texas, Employers & Consumers

The Texas Association of Health Plans (TAHP) generally does not oppose or support health benefit mandates. However, we feel that it is important for the Legislature to understand the cost impact of these mandates and the impact of federal law on implementation. TAHP is a resource to the Legislature on helping to understand the increased cost impact of mandates, including the impact on employers and consumers through increased premiums and the potential impact on the state. States must now pay for new benefit mandates that exceed the ACA essential health benefits package. Additionally, any mandates applicable to state employee plans or Medicaid or CHIP plans add extra costs to the state.

Legislators Must Consider Cost vs. Benefits of New Mandates

Though the cost and coverage impact of each individual mandate varies, legislators considering new mandates must carefully consider if the benefit of each mandate to the public's health outweighs the cost of implementation. The legislature must also carefully consider the number of new mandates added, because each new mandate adds a separate cumulative cost. While each new mandate may not, individually, significantly impact premium costs, the cumulative cost of mandated benefits is substantial. At least 30 states now require that a mandate's cost must be assessed before it is implemented.

Mandates Increase Cost

- *New mandates can each increase the cost of a monthly premium from less than 0.1 percent to more than 5 percent[3].*
- *Texas: Every 1 percent increase in premiums costs employers and consumers an estimated $228 million a year in the fully insured market.*
- *New health benefit mandates were responsible for as much as 23 percent of all premium increases from 1996-2011[4].*

[1] http://www.cahi.org/article.asp?id=1115

[2] http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx

[3] http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx

[4] http://sites.temple.edu/jamesbailey/files/2013/08/The-Effect-of-State-Health-Insurance-Benefit-Mandates-on-Premiums.pdf

For the 84th Legislative Session, it is important to note that any proposed new mandates:

- *Will increase costs to consumers and employers*
- *Will have a fiscal impact on the state, if the mandate exceeds the ACA essential health benefits package*
- *Can likely not go into effect until January 1, 2017, due to federal regulations*

What is a Health Benefit Mandate?

A health benefit mandate requires carriers to offer (and, consequently, requires individuals, families, employers and other groups to purchase) additional coverage for specific health care services, treatments or practices; types of providers; and types of enrollees and dependents. A number of health care benefits are mandated by either state law or federal law, and in some cases, both. Between the federal government and states, America's Health Insurance Plans (AHIP) estimates that there are more than 2,000 state mandates requiring insurance companies to cover, for example, the cost of acupuncture, fertility treatments, or substance abuse programs. It is also important to note that state-mandated benefits do not have a large impact on the community, even though they do increase costs. This is due to the fact that states can mandate benefits only for fully insured health plans, which make up only 30% of the market.

Mandated health insurance laws passed at either the federal or state level usually fall into one of three categories:

1. *The health care services or treatments that must be covered, such as substance abuse treatment, contraception, in vitro fertilization, maternity services, prescription drugs, and smoking cessation. A state may also mandate that certain benefits be offered to the policyholder rather than included in all policies ("mandated offers"). However, mandated offers are usually cost prohibitive due to adverse selection.*
2. *The types of health care providers other than physicians, such as acupuncturists, chiropractors, nurse midwives, occupational therapists, and social workers who must be included for payment.*
3. *The categories of dependents, such as children placed for adoption, dependent grandchildren and domestic partners who must be covered.*

ACA Increased Benefit Mandates

The ACA requires health plans to cover the "essential health benefits" (EHB) package for ("non-grandfathered") health insurance coverage that started on or after January 1, 2014. This requirement applies to qualified health plans in the exchanges, as well as health insurance plans offered in the small group and individual markets outside of the exchanges. Qualifying health plans are required to offer the EHB package defined by 10 general categories.

The ACA already mandates that health plans cover preventive benefits (with no cost-sharing) as listed in the US Preventive Task Force as A & B recommendations. Their recommendation can be found here: **http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations**

Essential Health Benefits

- *Ambulatory patient services*
- *Emergency services*
- *Hospitalization*
- *Maternity and newborn care*
- *Mental health and substance use disorder services, including behavioral health treatment*
- *Prescription drugs*
- *Rehabilitative services and devices*
- *Laboratory services*
- *Preventive and wellness services and chronic disease management*
- *Pediatric services, including oral and vision care*

The ACA Requires States to Pay for Benefit Mandates That Exceed Essential Health Benefits

As noted above, as of 2014, a state must pay for the cost of any new benefits that it mandates in its exchange products that exceed the EHB package. The ACA requires a state to fully reimburse an individual or insurance provider for the cost of any mandate that drives up the price of a policy offered through the exchange for enrollees receiving subsidies[5]. This provision means that states must consider their cost in mandating any new health coverage benefits.

Deadlines for Benefit Mandates

The Center for Consumer Information and Insurance Oversight (CCIIO) and Centers for Medicare & Medicaid Services (CMS) require that rates and policy forms for coverage effective on or after January 1, 2016 (with open enrollment beginning November 1, 2015), both on and off the exchanges, be filed with CMS and TDI no later than May 15, 2015[6]. See TDI's Federal Health Reform Resources for Health Carriers for additional information: **http://www.tdi.texas.gov/health/fhrcarriers.html**

Because health plans must file 2016 rates and policy forms in the coming weeks, prior to the end of session, any new mandates adopted this session should not be required to take effect until 2017.

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[5] http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_91.pdf

[6] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf

14 Proposed Mandate Bills for the 84th Legislative Session

HB 449 – expansion of current low-dose mammography mandate

HB 838/SB 1774 – new PTSD mandate

HB 2133/SB 1558 – expansion of current diabetes services and supplies mandate

HB 2219 – new self-inflicted injury mandate

HB 2505/SB 1094 – new abuse-deterrent opioid analgesic drugs mandate; must apply same pre-authorization as for an opioid analgesic drug that does not have abuse-deterrent properties; prohibits the use of step therapy for the drugs

HB 2541 – new treatment for individuals with terminal illness mandate; applies to ERS, TRS, UT/A&M and Medicaid/CHIP

HB 2749/SB1478 – new certain eating disorders mandate

HB 2813/SB 2003 – new ovarian cancer screening mandate

HB 2979 – new hearing aids mandate; prohibits applying charges to deductible; Applies to ERS, TRS, UT/A&M

HB 3115/SB 1698 – new Medicaid and the CHIP mandate for postpartum depression

HB 3194 – new Diagnostic Mammography mandate

HB 3986 – expansion of current autism mandate to include "recreational therapy"

SB 194 – new HIV screening mandate

SB 1884 – new Medicaid mandate for cognitive rehabilitation therapy for a recipient who suffers an acquired or traumatic brain injury

About TAHP

The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas. As the voice for health plans in Texas, TAHP strives to increase public awareness about our members' services, health care delivery benefits and contributions to communities throughout the state.

For more information, follow us on twitter @txhealthplans or visit www.tahp.org

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