Mandated Benefits

Introduction

Among the study topics of the Interim Health Insurance Committee was the study of the impact of insurance mandates, including whether mandates have impacted the affordability and availability of health insurance. As a part of this study, information was compiled for the committee on mandated benefits and the committee requested that the information be distributed to all members of the Legislature. This issue memorandum is the vehicle to accomplish this dissemination of information.

Background

During the last legislative session, bills[1] were introduced to require that certain insurance policies reimburse the services of licensed professional counselors—mental health and marriage and family therapists. These two groups sought to be added to the statute that requires insurance policies to reimburse for services legally performed by the providers listed in the statute.[2] These bills did not pass.

Mandated benefits require health plans to provide coverage for particular services or providers. Often, mandates are viewed in terms of services rather than providers. However, it is important to bear in mind those mandates referred to as provider mandates.

Another distinction to keep in mind in the discussion of mandates is that of mandated benefits and mandated offers. In this discussion, providers and services are lumped together with the distinction being made between those coverages that must be provided and those that must be offered. Mandated benefits require that if an insurance policy is sold in the state, it must include coverage for the mandated provider type or mandated service. The coverage of anesthesia and hospitalization for dental care for children under five and for certain disabled adults is a recent example of this in South Dakota.[3] Mandated offers require that the insurer offer coverage for particular providers and services. An example in South Dakota is coverage for inpatient alcoholism treatment.[4]

Yet another way to look at the issue is in terms of mandated benefits, mandated offers, and mandated providers. In this scheme, mandated benefits require coverage of specific diseases, conditions, or services. Mandated offers require insurers to offer specific coverage, but the additional coverage is for additional premium. Provider mandates require coverage for specific providers or settings.

Before 1970, there were few mandates, as the term applies to mandated benefits, mandated offers, and mandated providers. There was a tremendous increase in mandates from 1970 to 1996; in the late 1960s there

were fewer than ten mandates across the country and today there are over 1,000. In 1997, 134 mandates were enacted in 42 states.[5] In 1998, the number of mandates dropped to 94 mandates enacted in 33 states, and, in 1999, the decrease continued with 65 mandates enacted in 26 states.[6]

Historically, the most common mandates were those for preventative treatments, like mammography, and treatment for mental health and alcohol and substance abuse. In South Dakota, the treatment of alcoholism was the first mandate enacted. States then shifted to minimum lengths of stays for certain procedures, e.g., maternity stays. South Dakota passed legislation for a minimum maternity stay in 1996.[7] More recently, bills have sought to mandate coverage for specific procedures or conditions, e.g., diabetes supplies and education. Just last session, a bill mandating diabetes supplies and education was passed in South Dakota.[8]

Debate

At its core, the debate around mandates centers on consumer protection versus cost. Proponents contend that mandates are necessary to ensure adequate benefits for consumers. They point out that some diseases and conditions do not have enough representation or a large enough impact on people for market forces to work. Also, smaller businesses are at a disadvantage in negotiating with health plans because their size makes them less attractive, and larger firms may use comprehensive health benefits to compete for employees.

Opponents argue that mandates lead to an increase in the cost of premiums and ultimately to fewer people being insured. The General Accounting Office conducted a study on claims cost for mandated benefits in six states in August of 1996. The study found that between 5.4 percent (Iowa) and 22 percent (Maryland) of the claims were for mandated benefits and concluded that the rise is subsequently passed to consumers through higher premiums.[9] A study commissioned by Health Insurance Association of America (HIAA) and released January 1999 reported that a “fifth to a quarter of the uninsured have no coverage because of mandates.”[10] In addition, state mandates may affect only a portion of the state’s population due to ERISA. Therefore, the mandates more heavily affect small employers because these are the ones less likely to be able to self-insure. The report also found more employers seeking to self-insure to avoid the mandates.

However, a survey of data by the National Conference of State Legislatures found different results in the correlation between uninsured rates and state mandated benefits. Data from 1997[11] revealed that the ten states with the highest percentages of uninsured persons were not the ten states with the highest number of state mandated benefits. Those states with the highest percentages of uninsured persons were Texas, Arizona, Arkansas, New Mexico, California, Mississippi, Florida, Montana, Louisiana, and Alaska. The states with the most mandated benefits were Maryland, Florida, Minnesota, California, New York, Connecticut, Arkansas, Virginia, Texas, North Carolina, Nevada, and Pennsylvania. In addition, the ten states with the lowest percentages of uninsured persons were not the ten states with the fewest state-mandated benefits. The states with the lowest uninsured rates are Hawaii, Wisconsin,

Minnesota, Vermont, Pennsylvania, Rhode Island, Nebraska, Indiana, Washington, and Ohio. Those states with the fewest mandated benefits are Idaho, District of Columbia, Delaware, Wyoming, Alabama, Vermont, Kentucky, Hawaii, Iowa, New Hampshire, South Carolina, and West Virginia. Minnesota and Pennsylvania are both in the top ten for the most mandated benefits, yet they are also in the top ten for the lowest uninsured population.

There are a number of things to bear in mind with mandated benefits studies. First, most studies calculate the cost of claims for each mandated benefit instead of the incremental cost of adding a benefit. Many plans may already offer the same or a similar benefit; therefore, there would be no additional cost. However, the total cost of mandates is not limited to a particular procedure. For example, if coverage for infertility treatments is mandated and the treatment is successful, the ensuing maternity costs may be higher then normal due to high-risk pregnancies or multiple births. Moreover, mandated coverage as it pertains to providers has the potential to raise or lower costs. There may be increased costs if covered persons use providers that were previously not covered. On the other hand, costs may go down by using less expensive providers for a necessary service. Finally, if a particular service is covered, a covered person may seek treatment at an earlier stage of an illness rather than at a later, more expensive stage.

Comparison

The chart at the end of this memorandum includes mandated benefits and mandated offers of surrounding states, but not mandated providers.

Minnesota has the highest number of mandates and Wyoming the fewest. South Dakota has a similar number of mandates when compared to the other surrounding states.

Summary

While this memorandum cannot judge the merits of future mandates to come before the Legislature, it can provide some additional information in the form of a synopsis of where the discussion has been and a table of where the state is situated as compared with other states to aid the policymakers faced with bills regarding mandated benefits. Currently, health care mandates constitute one of the most topical and frequent issues before state legislatures nationwide. For those legislators who wish to know more about mandates there is a wealth of information to be accessed through the National Conference of State Legislatures, lobby groups, and legislative service agencies.

MANDATED BENEFITS AND MANDATED OFFERS
SOUTH DAKOTA AND SURROUNDING STATES

Benefits	IA	MN	MT	NE	ND	SD	WY
Alcoholism Treatment		M	M	M	M	O	
Ambulatory Surgery		M					
Anesthesia and Hosp. Chgs. for Dental(1)					M	M	
Bone Marrow Transplants		M					
Breast Reconstruction	M	M	M	M	M	M	M
Cervical Cancer Screening		M					
Cleft Palate		M					
Diabetic Education and/or Supplies	M	M		M		M	
Drug Abuse Treatment		M	M		M		
Emergency Services	M	M		M	M	M	
Formula for PKU		M	M		M	O	
Hair Prostheses		M					
Home Health Care			O				
Infertility Services(2)			M				
Mammography Screening	M	M	M	M	M	M	
Maternity		M					
Mental Health (General)		M	M		M		
Mental Health (Parity)		M		M		M	
Metabolic Disease			M		M		
Minimum Mastectomy Stays			M				
Minimum Maternity Stays	M	M	M	M	M	M	M
Off-Label Drug Use		M		M			
Prostrate Cancer Screening					M		
TMJ Disorders		M		O	O		
Well-Child Care	M	M	M	M			
TOTAL Mandated Benefits	**6**	**19**	**11**	**9**	**11**	**7**	**2**
TOTAL Mandated Offers			**1**	**1**	**1**	**2**	

Mandated Benefits = M
Mandated Offers = O

(1) Procedures for Children and the Disabled
(2) Other than Invitro Fertilization

Sources: Blue Cross and Blue Shield Association, December 1998
Health Policy Tracking Service, June 30, 1999

This issue memorandum was written by Jacque Storm, Principal Legislative Attorney for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.

Endnotes

[1] House Bill 1171 added licensed professional counselors—mental health. House Bill 1157 added marriage and family therapists. House Bill 1156 added both providers. All these were unsuccessful.

[2] SDCL 58-17-54. Notwithstanding any provision of any policy of insurance subject to the general provisions of this title, if a policy or contract provides for reimbursement for any service which may be legally performed by a person licensed in this state for the practice of medicine, surgery, anesthesia by a certified registered nurse anesthetist licensed under chapter 36-9, psychology, dentistry, osteopathy, social work by an independent social worker licensed under § 36-26-17, optometry, chiropractic or podiatry, the reimbursement under that policy or contract may not be denied if the service is rendered by a person so licensed. The provisions of this section apply to all practitioners licensed pursuant to chapters 36-4A and 36-9A after July 1, 1980, and to any plan of self-insurance for public employees. Reimbursement may be denied to a policyholder treating himself or any member of his family residing in his household. However, reimbursement for durable medical equipment, pharmaceuticals and prosthetic devices may not be denied if within policy coverages.

No policy, certificate or contract may exclude or limit reimbursement for any lawful diagnostic or treatment service by a licensee under chapter 36-5 if the exclusion or limitation is based wholly or in part on any requirement that the service be performed in a place of service not normally used by the licensee.

A policy, certificate or contract may only limit or make optional the reimbursement for any lawful diagnostic or treatment service by a licensee under chapters 36-4 and 36-5 if the limitation is based on a rational basis which is not solely related to the license under, or practices authorized by, chapter 36-5 or is not dependent upon a method of classification, categorization or description based directly or indirectly upon differences in terminology used by different licensees in describing human ailments or in the diagnosis or treatment of human ailments.

This section does not require reimbursement for any method or service not necessary, not reasonable or not generally accepted by the peers of the particular licensed health care provider.

[3] SDCL 58-17-84.1. Any health benefit plan as defined by § 58-17-63 shall cover anesthesia and hospital charges for dental care provided to a covered person who:

(1) Is a child under age five; or

(2) Is severely disabled or otherwise suffers from a developmental disability as determined by a licensed physician which places such person at serious risk.

Such coverage applies regardless of whether the services are provided in a hospital or a dental office. A health carrier may require prior authorization of hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

[4] SDCL 58-17-30.5. Any insurer which delivers or issues for delivery in this state any insurance policy under this chapter which provides coverage on an expense incurred basis shall offer, in writing, to include in such policy or contract issued or renewed on or after July 1, 1979, coverage for the inpatient treatment of alcoholism in licensed hospitals and residential primary treatment facilities approved by the State of South Dakota which are carrying out an approved program pursuant to the diagnosis and recommendation of a doctor of medicine. When coverage for inpatient treatment is included in any policy, such coverage shall include inpatient treatment at any South Dakota approved inpatient alcoholism treatment facility.

[5] Health Policy Tracking Service. *Issue Brief: Mandated Benefits.* Washington, D.C.: National Conference of State Legislatures, June 30, 1999.

[6] Ibid.

[7] SDCL 58-17-88. If a health insurance policy that is issued or renewed on or after July 1, 1996, provides maternity coverage, the policy shall provide coverage for a minimum of forty-eight hours of inpatient care following a vaginal delivery and a minimum of ninety-six hours of inpatient care following delivery by cesarean section for a mother and her newborn child in a health care facility licensed pursuant to chapter

34-12, except as otherwise provided in § 58-17-89. Any policy that provides coverage for complications of pregnancy, and does not provide other maternity benefits, is not required to comply with this section.

[8] SDCL 58-17-1.2. Every policy of health insurance delivered, issued for delivery, or renewed in this state, except for policies that provide coverage for specified disease or other limited benefit coverage, shall provide, in writing, coverage for equipment, supplies, and self-management training and education, including medical nutrition therapy, for treatment of persons diagnosed with diabetes if prescribed by a physician or other licensed health care provider legally authorized to prescribe such treatment. Medical nutrition therapy does not include any food items or nonprescription drugs.

Coverage for medically necessary equipment and supplies shall include blood glucose monitors, blood glucose monitors for the legally blind, test strips for glucose monitors, urine testing strips, insulin, injection aids, lancets, lancet devices, syringes, insulin pumps and all supplies for the pump, insulin infusion devices, prescribed oral agents for controlling blood sugars, glucose agents, glucagon kits, insulin measurement and administration aids for the visually impaired, and other medical devices for treatment of diabetes.

Diabetes self-management training and education shall be covered if: (a) the service is provided by a physician, nurse, dietitian, pharmacist, or other licensed health care provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified as a diabetes educator; and (b) the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the South Dakota Department of Health.

Coverage of diabetes self-management training is limited to (a) persons who are newly diagnosed with diabetes or have received no prior diabetes education; (b) persons who require a change in current therapy; (c) persons who have a co-morbid condition such as heart disease or renal failure; or (d) persons whose diabetes condition is unstable. Under these circumstances, no more than two comprehensive education programs per lifetime and up to eight follow-up visits per year need be covered. Coverage is limited to the closest available qualified education program that provides the necessary management training to accomplish the prescribed treatment.

The benefits provided in this section are subject to the same dollar limits, deductibles, coinsurance, and other restrictions established for all other benefits covered in the policy.

[9] U.S. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS-96-161 (Washington, D.C.: August 1996).

[10] Gail A. Jensen and Dr. Michael A. Morrisey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance*, (Health Insurance Association of America: January 1999).

[11] The source of this data was State Mandated Benefits and Providers from Blue Cross, Blue Shield Association, December 1997. NCSL has included mandated benefits, mandated offers, and mandated providers.