



## Trends in State Mandated Benefits, 2008

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, 2008," has identified 1961 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 has been 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 on the cost of a health insurance policy, is available in CAHI's "Health Insurance Mandates in the States, 2008." ([www.cahi.org](http://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 health insurance.

*Autism.* Autism and treatment for its various complications is becoming one of the most discussed mandates.

Autism is a brain disorder that affects three areas of development: communication, social interaction, and creative or imaginative play. In the past, autism has fallen under the broader category of mental health, but one of the latest state legislative trends is to pass an autism mandate separately from mental-health benefit mandates. The legislation can provide for evaluation and treatment of autism, as well as specific services such as school mainstreaming. However, states often differ on what they include in evaluation and treatment. There are now 11 states with an autism-specific mandate.

One important question is whether autism falls under the broader category of mental health. CAHI has tracked 39 states that have mental-health benefit mandates, and 47 that have state mental-health parity laws on the books. Most states define mental health as a state of emotional and psychological well-being. A mental-health benefit mandate provides for the payment of mental-health evaluation and treatment, but sometimes at a higher out-of-pocket cost for the patient or limitations are imposed on the coverage.

Historically, mental health and substance abuse services have higher patient cost-sharing and shorter day and visit limits than other services for physical illness or injury. A mental-health parity law tries to eliminate this difference by requiring the same limitations and cost-sharing for mental health — including substance abuse, medical, surgical and hospital providers — as for traditional medical care.

In the 2007 legislative session we saw some additional activity. For example, New Mexico enacted an autism mandated benefit study, and both Illinois and the District of Columbia enacted a "habilitative services" mandate for congenital and genetic birth defects to enhance the ability of children to function in society, which includes autism as one of the disorders covered by the mandate.

The autism support groups and their families looking for financial relief or more alternative treatments want to include coverage of Applied Behavior Analysis and other therapies which, according to proponents, contain some of the most effective forms of treatment and have the best outcomes and long term economic benefits for families. They believe that health insurance companies should assume the financial burden — typically in the range of \$50,000 per year per child — for autistic children that families and school districts have borne.

Insurance carriers argue that most medically related treatments are already covered for autism. In addition, they note that autism is an individually based disorder, and so there is often no clear standard of care to determine the appropriate therapy. In many instances, the most effective therapies are typically provided by parents or unlicensed medical providers such as play

therapies, which can require up to 10 separate interactions per day. Some of the other therapies address developmental delays, which are not typically covered under health insurance.

In other words, autism generally falls into a disability category needing long term care, not health insurance. If the autistic child breaks an arm, health insurance should cover the treatment. But health insurance isn't disability or long term care insurance.

*HPV Vaccine.* Over the past several years we have seen a steady increase in the cervical cancer/Human Papillomavirus (HPV) screening mandate. At least 29 states have enacted this screening mandate.

Now we can add an HPV vaccine mandate to the list. This mandate covers the vaccine against Human Papillomavirus, which causes cervical cancer and genital warts. In the 2007 legislative session, at least 41 states introduced legislation to mandate coverage for this vaccine and 24 states introduced legislation to mandate the HPV vaccine as part of the school entrance vaccine list. At least 16 states actually enacted the HPV vaccine this past legislative session.

With legislators looking at enacting such mandates, we expect more specific disease-screening mandates to emerge. Since these mandates currently cost less than one percent of premium, legislators may deem them "affordable" and require insurers to cover it. However, our actuaries have cautioned us that creating a separate screening mandate could have a significant increase in premium, because it will make it easier to add other new disease screening mandates as they become available.

*Eligibility Mandates.* In the 2007 legislative session, we reported that 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. But the age trend is changing. In an attempt to address the uninsured, states recognize that young adults are now the fastest growing segment of the uninsured population. Why? Young adults often consider themselves to be invincible, and therefore don't need health insurance — at least those comprehensive policies that can be very expensive for someone just starting out. This population is typically:

- Between the ages of 18 and 30;
- More active and healthy than their older, uninsured counterparts;
- More willing to take the risk of being uninsured; and has lower incomes.

At least 30 states have this dependent-student mandate, and a few of them have either introduced or enacted legislation to increase the dependent-eligibility age — to as much as age 30, regardless of student status. As a result, some commonly refer to this mandate as the "slacker mandate."

There is a valid underwriting reason for opposing the extension of health insurance policies to adults up to 30 years of age: the cost of coverage. Insurers price children at much lower rates than adults, because children between the ages of

2 and 18 are, as a group, very healthy. Once people hit age 21, they are adults, not children, and the likelihood of them incurring significant health care costs goes up dramatically. If those young adults have been covered under a parent's policy, they are likely qualified to get an individual policy on their own. By legislatively forcing them to be covered as children under their parents' policy, states are simply forcing health insurers to raise the price of children's coverage to compensate for the increased losses of adults being underwritten as children.

While the dependent-student mandate is popular, we are seeing new eligibility categories emerge. For example, "domestic partner," "legal alien," "grandchild" and "U.S. armed services personnel." Domestic partner is increasingly popular, with 13 states including a domestic partner as an eligible dependent on a health insurance policy. Maine has extended eligibility for health insurance coverage to include a person who is not yet a United States citizen but who is residing legally in this nation. Oregon added elderly parents who meet certain Medicaid criteria. And at least four states — Maryland, Minnesota, New York and Texas — have extended eligibility for health insurance coverage to include a grandchild who is financially dependent on the grandparent. Finally, Illinois and Pennsylvania have added the military — the armed services personnel can remain dependents for the amount of time they spent serving this country.

**Trends in State "Mandate-Lite" 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 individuals to purchase a policy with fewer mandates and so more tailored to their needs and financial situation.

**Trends in Mandated Benefit Studies.** There are now at least 30 states that require a mandate's cost to be assessed before it is implemented.

**Conclusion.** The introduction of state-mandated benefit legislation is slowing down — rather than seeing some 100 mandates enacted each year, we are seeing about 50 or 60 enacted. That reduction implies that state legislators are finally getting the message. While one mandate by itself may not generate a large increase in premium, it is the culmination of many mandates that increase the cost of coverage. 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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*Trends & Ends* can be found exclusively online at [www.cahi.org](http://www.cahi.org).

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