UNIVERSITY OF CALIFORNIA SAN DIEGO

Analysis of Health Insurance Benefit Mandates Prior and Post Affordable Care Act in the United States

A thesis submitted in partial satisfaction of the requirements

for the Master Degree

of

Public Health

by

Christina Esparza Schaefer

Committee in charge:

Professor Sara B. McMenamin, Chair
Professor Richard Kronick
Professor Todd Gilmer

2023

The thesis of Christina Esparza Schaefer is approved, and it is acceptable in quality and form for publication on microfilm and electronically.

University of California San Diego

2023

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to Dr. Sara McMenamin for her exceptional guidance and support throughout the completion of this thesis. Her expertise and insightful feedback have been invaluable in shaping my research. Dr. McMenamin's dedication, mentorship, and attention to detail have greatly enhanced the quality of my work. I am deeply grateful for her time, expertise, and unwavering encouragement. Thank you, Dr. McMenamin, for your invaluable contributions to my academic journey.

I would also like to acknowledge Dr. Richard Kronick for his valuable feedback and guidance on my thesis. His expertise and insights made this thesis possible and greatly contributed to the development and improvement of my research.

ABSTRACT OF THE THESIS

Analysis of Health Insurance Benefit Mandates Prior and Post Affordable Care Act in the United States

by

Christina Esparza Schaefer

Master of Public Health

University of California San Diego, 2023

Professor Sara B. McMenamin, Chair

The objective of this paper is to understand and compare trends in state mandated benefit laws to examine if the ACA influenced implementation of new state mandated benefit laws. A comparative analysis of state mandated benefit laws from years 1949-2022 was conducted. Data

was collected through 1. BlueCross BlueShield (BCBS) 2. CMS database of state mandates, 3. Searches of legiscan and google, and 4. California Health Benefit Review Program (CHBRP). Dates were collected and compared for each individual mandated law. Additionally, categories of state mandated laws specific to fertility preservation were examined. Data from 2011-2019 showed a total of 48 state mandated benefit laws from CMS and 81 from BCBS, indicating that there was a decrease in enacted/revised mandated benefit laws after the ACA. State legislative bill text for mandates specific to fertility preservation was analyzed to determine what type of language is being used to ensure states are not responsible for defraying the cost of mandated benefit laws. The objective of this paper was to analyze trends in state mandated benefit laws after the ACA intended to reduce the growing rate. The main findings from this study highlights that there are still benefit mandate laws that are being enacted post the ACA that could fall outside of EHBs. This study highlights that there are gaps with what constitutes benefit mandate laws falling under EHBs or needing state defrayal. Additionally, more clarification is needed on what the current process is of determining which benefit mandate laws requires state defrayal.

Chapter 1: Background

1.1 Health Insurance Benefit Mandates

Health Insurance Benefit Mandates, commonly known as state mandated benefits are laws that require health insurers to provide coverage for specific types of medical services or treatments under specified health insurance plans. The way an individual obtains their insurance impacts if their plan must abide by state mandated benefits. State mandated benefit laws most often apply to health insurance coverage offered by employers and private health insurance purchased by individuals (Bihari, 2022). Some employers are not required to abide by the mandated benefit laws in their state such as those that are self-insured and regulated under federal law known as ERISA or if they are headquartered in another state.

State mandated benefit laws are intended to address failures and inefficiencies in the health insurance market, increase access to care, and prevent serious health conditions from worsening by having access to early detection (Cubanski & Helen H. Schauffler, 2017). Mandated benefit laws vary by state and may include coverage for a wide range of services such as autism spectrum disorder, mental health care, diabetes, fertility treatments, and maternity care. (Webber & Bailey, 2014).

1.2 History of State Benefit Mandate Laws

The first mandated benefit law was implemented in 1956 when Massachusetts required that coverage under private plans included mentally and/or physically disabled children (Jensen et al., 1999). During the mid-1960s other states began to follow suit and required private plans to extend coverage to specific groups of people who would otherwise have difficulty getting health insurance (Jensen et al., 1999). During the early 1970s many states began to require that insurance policies cover specific services such as dental, psychiatric, and podiatrists and by the

late 1990s there were an estimated over 1,000 state benefit mandate laws (Jensen et al., 1999). Jensen described that the appeal of state legislators implementing state mandated benefits was because they don't raise taxes, don't affect government revenue, appease advocacy groups, and are shown to be successful (Jensen et al., 1999). Opponents to mandated benefit laws argue that they increase costs of premiums and could lead to a reduction in employer willingness to provide coverage (Jensen et al., 1999).

Findings from Laugesen's et al., A Comparative Analysis of Mandated Benefit Laws, 1949–2002 showed that there was a large increase of state mandates since the 1990's. This analysis concluded that there was a total of 1,471 laws that mandated coverage for 76 types of providers and services with 55% of all mandate benefit laws enacted between 1990-2002 (Laugesen's et al, 2006). This analysis demonstrated that each year, the average amount of enacted or revised mandates had been steadily increasing with an average of 17 per year in the 1970s, 36 per year in the 1980s, 59 per year in the 1990s, and 76 per year between 2000 and 2002 (Laugesen's et al, 2006).

Trends regarding the adoption of state mandates in the mid to late nineties have been studied, yet the impact of the ACA on benefit mandate laws have not been explored. Recent literature has focused on analyzing benefit mandate laws that pertain to specific conditions such as autism spectrum disorder, diabetes treatment, breast cancer or fertility preservation. However, there is still a gap in understanding the broader impact of the ACA on state benefit mandate laws. This suggests the need for further research in this area.

1.3 The ACA and Potential Impact on State Mandated Benefit Laws

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010 by President Obama. The ACA focused on creating health insurance reforms that expanded

healthcare coverage to create a better health care system in the United States (Schoen et al., 2011). The ACA is a wide-ranging piece of legislation. The most notable effect of the legislation was to reduce the number of uninsured by approximately 20 million, but the ACA also had provisions affecting many areas of health care, including disparate areas such as the operations and financing of the Medicare and Medicaid programs, workforce policy, and community health center funding. One relatively little noticed provision of the ACA was intended to discourage states from enacting new mandated benefit laws. This was done by establishing a list of Essential Health Benefits (EHBs) which are a set of medical services and treatments that health insurance plans are required to cover at the federal level. If states wanted to include additional mandate laws that expand coverage beyond the federal EHB requirements, states would have to then defray the cost.

1.4 Defrayal of State Additional Required Benefits

Section 1302(b)(4) of the ACA states:

> (3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.— (A) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b). (B) STATES MAY REQUIRE ADDITIONAL BENEFITS.— (i) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b). (ii) STATE MUST ASSUME COST.—øReplaced by section 10104(e)(1)¿ A State shall make payments— (I) to an individual enrolled in a qualified health plan offered in such State; or (II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled; to defray the cost of any additional benefits described in clause (i).

The intent of this provision was to reduce the number of new mandated benefit laws enacted by states.

Although legislative history providing the rationale for this provision is not available, it seems likely that there were two main rationales. First, groups representing employers have expressed concern for many years about the effects of state mandated benefit laws on premiums and have consistently lobbied against mandated benefit laws. The inclusion of the 'defrayal' provision in the ACA may have been, in part, an attempt to increase employer support for the ACA.

Second, and perhaps more importantly, the ACA provides that individuals with incomes under 400% of the Federal Poverty Level are required to pay no more than a specified percentage of their income for health insurance. For example, 2% for individuals between 200%-250% of FPL, increasing to 8.5% for individuals above 400% of FPL (KFF, 2022). As a result of these subsidies, if a state mandates new benefits that lead to increases in premiums for people purchasing non-group insurance, for most people with incomes below 400% of FPL, the cost of the increased premiums will be paid for by the federal government through increased subsidies, and not by the individuals purchasing insurance.

Prior to the ACA, one factor that may have limited the willingness of state legislatures to enact new mandates was the knowledge that premiums would increase, and health insurance would become less affordable for individuals purchasing coverage. The ACA subsidy structure changes that calculus for state legislators, assuring that most of the cost of new mandates would be borne by the Federal treasury, not by people purchasing individual insurance. It seems likely that the 'defrayal' provision was included in the ACA to provide a check on the willingness of state legislators to enact new mandates and shift the cost to the federal government.

An issue brief published by the California Health Benefit Review Program discusses the relationship between California's benefit mandate laws post ACA. It was described that there is

uncertainty among who is responsible for deciding if a state benefit mandate falls under EHBs in California. CHBRP highlighted there are no specific federal guidelines and California has not designated a responsible party to oversee state benefit mandate laws. However, there are no known cases of a state benefit mandate in California exceeding EHBs so far (CHBRP, 2022).

The aim of this thesis is to determine whether the provision of the ACA cited above had the intended effect of reducing the passage of state benefit mandate laws.

1.5 Essential Health Benefits and State Mandated Benefits

One of the intended purposes of the ACA and state mandated benefit laws is to ensure that individuals, families, and small businesses have access to comprehensive health insurance options that meet their healthcare needs and provide necessary coverage for a range of medical services and treatments (French et al., 2016). In doing so, the ACA established regulations and requirements for both the individual/family and small group markets to ensure that individuals, families, and small businesses have access to affordable and comprehensive health insurance options.

The statutory provision cited above requires that states must defray the cost of mandated benefits that are in excess of the benefits included in Essential Health Benefits (EHBs). However, the ACA is not very specific about exactly what benefits are included as EHBs, and the statutory language alone is not sufficient to determine whether any specific state mandated benefit is in excess of EHBs and would require defrayal. The ACA requires all non-grandfathered plans in the individual and small group markets to cover EHBs.

The ACA states:

Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

The ten categories listed above delineate the broad categories that all plans in the individual and small group markets must cover, but this listing doesn't provide guidance about whether any individual service mandated by a state. For example, Applied Behavioral Analysis (ABA) for children with autism is certainly included in category (E). However, the statute does not require **all** items and services in each category to be an EHB, and thus it is not clear from the statute whether ABA is an EHB.

1.51 The Department of Health and Human Services Regulation of EHBs

The Secretary of HHS was given substantial discretion in defining EHBs, with the statute providing guidance only that EHBs should be equal to the scope of benefits provided under a 'typical' employer plan. Employer plans vary in the benefits they offer, and it is far from clear which benefits are included in a 'typical' employer plan. The Secretary had at least three options for defining EHBs:

1) HHS could have adopted the approach used by Medicare, and created a process to determine, for each individual service – such as ABA for children with autism, or in-vitro fertilization – whether the service was an EHB.
2) HHS could have promulgated regulations by simply repeating the language in the statute and defining EHBs as any item or service included in one of the 10 categories.
3) HHS could have defined EHBs as the services included in a specified 'benchmark' plan, providing each state with a menu of plans to choose as a benchmark.

If HHS had adopted the first option, almost inevitably some of the benefits that were currently mandated by states would not have been included in EHBs. In that scenario, state legislatures would have been forced to consider whether to repeal mandates that were in excess of EHBs, or to appropriate funds to defray the costs. That was not an attractive scenario for HHS because state legislatures had much work to do to prepare for the implementation of coverage expansions in 2014, and focusing the work of the legislatures on contentious fights about repealing mandated benefit laws would not have been productive.

If HHS had adopted the second option, then any service mandated by a state that arguably was included in one of the ten categories would be an EHB. In this scenario, states would be

free to enact additional mandates, and be assured that federal subsidies would pay for most of the added cost. That was not an attractive scenario for HHS.

HHS chose the third option, which appears to avoid the pitfalls of the first two options. HHS promulgated regulations providing that a EHBs would be defined as the benefits included in a 'benchmark' plan. As provided by HHS regulation, a benchmark plan must be chosen from a menu of plans, where the menu included:

1. The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market
2. Any of the largest three state employee health benefit plans options by enrollment
3. Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment
4. The largest insured commercial non-Medicaid HMO, by enrollment, operating in that state.

(CMS, 2013)

If a state failed to choose a benchmark plan by December 26, 2012, then it would automatically be assigned the small group health plan with the largest enrollment (CMS, 2012).

This structure assured that if a state chose the largest small group market plan as the benchmark plan, that all benefits mandated for inclusion in that plan would, by definition, be an EHB. (There could be a theoretical problem that if a state mandated a benefit in the individual market but not in the small group market, then that mandate would not be included in EHBs. However, in practice, it did not appear that any states did mandate benefits in the individual market that were not also mandated in the small group market.) Almost all states did choose the

largest small group plan as their benchmark (or defaulted to that choice if the state did not make an active choice.)

This structure for defining EHBs also should have restrained states from enacting new mandated benefit laws. EHBs were defined by the benefits offered by the benchmark plan on December 26, 2012. If a state enacted a new mandate – for example, adding ABA for children with autism or in-vitro fertilization – in 2012 or subsequent years, then unless that benefit were included in the benchmark plan on 12/26/2012, it would be a benefit in excess of EHBs, and, in theory, the state would be required to defray the cost of that benefit for all enrollees in the individual and small group markets.

However, in practice, as described below, it is not clear how or whether HHS enforced the defrayal requirement, and, as I describe, states have adopted creative approaches to enacting new mandates in ways that arguably do not trigger the defrayal requirement.

The ACA does not prevent states from enacting mandated benefit laws, yet it has created a barrier by requiring states to fund any mandated benefit law that does not fall under the federally defined EHB package under 42 U.S.C. § 18031(d)(3)(B)(ii) (Section 1311(d)(3)(B)(ii) of the Act) (Ryan, 2018). This requirement places a financial burden on states that wish to enact state-mandated benefit laws beyond the federally defined EHBs.

1.52 Benefit Mandate Review Laws

To better understand the impact that state benefit mandate laws were having on the cost and quality of health insurance coverage, many states began implementing laws to require a review of proposed legislation known as mandate benefit review laws (Bellows et al., 2006). These laws vary from state to state, but typically require at a minimum a projection as to how much the proposed benefit mandate will cost. California has one of the oldest and most robust

mandate benefit review laws which established the California Health Benefits Review Program (CHBRP). CHBRP was established in California in 2002 to provide an independent analysis of proposed health insurance benefit mandates. The program was created to provide unbiased and evidence-based information to policymakers to inform their decision-making regarding health insurance benefit mandates and repeal bills. CHBRP analyzes the potential costs and benefits of proposed health insurance benefit mandates in California. CHBRP provides a catalog of all of the current mandates in place in California as well as makes their reviews on proposed benefit mandates available to the public.

1.6 Research Objectives

This research project has three primary objectives related to the impact of the ACA on enactment of benefit mandates across the United States. Specifically, this research seeks to determine what effect the ACA had on the enactment of state benefit mandates in terms of a) the number of mandates passed each year, b) the types of mandates passed each year, and c) the inclusion of language that addresses EHBs in the mandates passed post ACA implementation.

This chapter is based on a collaborative project with Sara McMenamin and Richard Kronick, who provided critical feedback and helped shape the ideas presented in this chapter.

Chapter 2: Methods

As of March 2023, no comprehensive data set of benefit mandate laws from all 50 states and the District of Columbia exists. Triangulation between multiple sources was conducted to create a comprehensive list of state benefit mandate laws.

2.1 Data Sources

Data related to the number of mandates passed each year was taken from two sources: 1.) Blue Cross Blue Shield (BCBS) Association State Legislative Healthcare and Insurance Annual Reports and 2.) Centers for Medicare & Medicaid Services (CMS).

Data from BCBS is annually collected through a survey of its members across all 50 states and the District of Columbia at the close of each state's legislative session. Health plans are asked to submit to the national association a comprehensive list of mandated benefit laws that have been adopted or significantly revised. Mandates are categorized into provider mandates, benefit mandates, or extension of coverage mandates. BCBS only counts mandates once, even if multiple laws are passed for managed care and traditional fee-for-service plans (Laugesen et al, 2006). The results from BCBS annual survey are annually published every December until 2017.

CMS has data sets published on their website as of October 2022 on state required benefits for all 50 states and the District of Columbia from 1971-2019. Data from CMS included the name of the required benefit, market applicability, citation number of benefit mandate laws, and if the benefit mandate law was enacted prior or post 2012. CMS did not include the exact date of benefit mandate law enactment as well as no information was available about how CMS collected and assembled the data.

Data on the types of mandates passed over time was not available for every state but was available for mandates passed in California. The data used in this analysis was taken from an

Issue Brief published by CHBRP categorizing the type of state mandates passed in California through January, 2023 (n=85). Using California as a case study CHBRP categorized state benefit mandates in 4 different groups:

(a) Health insurance plans that provide coverage for screening, diagnosing, and treating specific medical conditions

(b) Health insurance plans that offer coverage for different types of health care treatments or services such as surgery, therapy, or rehabilitation. It also includes the coverage of medical equipment, supplies, or drugs that are used in a treatment or service.

(c) Health insurance plans that allow policyholders to receive treatment or services from specific types of health care providers, such as hospitals, clinics, or specific doctors. Specify terms for categories A-C, for example limits, timeframes, copayments, deductibles, coinsurance, etc.

(d) Health insurance plans that specify terms for categories A-C. For example, limits, timeframes, copayments deductibles, coinsurance, etc. (CHBRP, 2023).

Benefit mandates were then classified into two categories to determine if there was a shift in mandate type over time. Category A+B represented traditional types of mandates that required coverage for specific treatments or services. Category C+D represented non-traditional mandates that added requirements related to the types of providers that insurers must reimburse or the specifications of the benefit design such as the cost-sharing or duration of coverage.

To describe the type of language used in mandates passed post-ACA, fertility preservation benefit mandates were used as a case study. Fertility preservation for iatrogenic infertility (i.e. infertility due to medical intervention) benefit mandates have been introduced in more than two-thirds of the states in the US, but it was not until 2017 that the first benefit

mandate was passed. We used the data collected by the Alliance for Fertility Preservation and presented on their website to identify the states with current FP benefit mandate laws and the dates they were passed.

2.2 Extracting Data

Dates that were collected from BCBS and CMS were compared to determine if dates corresponded correctly. If mandated benefit dates matched between both sources, no further search was conducted. If there was a discrepancy between BCBS and CMS dates, then additional searches were conducted through individual state legislature databases, legiscan database which is a free online database of enacted legislation in the US, and google.

Individual searches of state legislation databases were examined using the name of the required benefit as well as citation numbers provided by CMS. If the date found on state legislature websites corresponded with a date provided by BCBS or CMS then that date was used as the final enactment date. If date was unidentifiable through state legislature or if the date collected did not match data from either BCBS or CMS, then a third search was conducted using other sources (i.e. legiscan database, google, NCSL, and published journal articles).

During the third search phase, multiple searches were conducted to confirm date of legislation enactment. Search terms included: mandated benefits, mandates, state regulation, insurance coverage state laws, and mandated coverage. Specific terms for benefit mandate laws were also used such as colorectal screening coverage, diabetes preventive care, mental health benefits, autism spectrum disorder, fertility preservation, and insurance coverage state laws.

2.3 Data Analysis

Final benefit mandate law dates were entered into a spreadsheet and analyzed using statistical software to compare trends in benefit mandate laws in the United States pre- and post-implementation of the ACA.

To categorize the type of benefit mandate laws being enacted over time, California was selected as a case study, as it was beyond the scope of this project to categorize all laws across the US. To examine the shared patterns among state benefit mandate laws collected by BCBS and CMS, an approach was taken to narrow down and analyze the California mandates through CHBRP's published data. CHBRP mandates were organized by mandate subject (behavioral health, cancer, chronic conditions, etc). Dates were found by entering in the statute numbers into https://casetext.com/ and the statutes were retrieved and examined for the enactment date. A total of 85 mandates were identified, with 13 of those mandates being enacted post the ACA.

To obtain a narrative of present trends and statuses of benefit mandate laws in the United States a separate analysis was conducted categorizing mandates related to fertility preservation (FP). This was done to specifically analyze bill language, process of enactment, and language related to state defrayal for exceeding EHBs. Mandates were collected from Resolve: The National Fertility Association and American Society for Reproductive Medicine. The goal was to identify any benefit mandate laws specific to fertility preservation (FP) that have been enacted post 2012 that have not yet been documented by BCBS or CMS. This analysis yielded a list of new benefit mandates that potentially do not fall under EHBs and were enacted after the ACA, adding to the broader discussion of state benefit mandate laws and their impact on healthcare coverage.

This chapter is based on a collaborative project with Sara McMenamin and Richard Kronick, who provided critical feedback and helped shape the ideas presented in this chapter.

Chapter 3: Results

3.1 Trends in the Number of State Benefit Mandates Over Time

Examining the trends in Figure 1, data collected from BCBS and CMS show that there was a spike in benefit mandate laws from 1997-2001. Data from BCBS and CMS show similar trend lines indicating that there was a spike in benefit mandate laws in the late nineties, with a decline after 2012. Although these two databases had varying dates of benefit mandate laws collected, the overall trend follows a similar pattern.

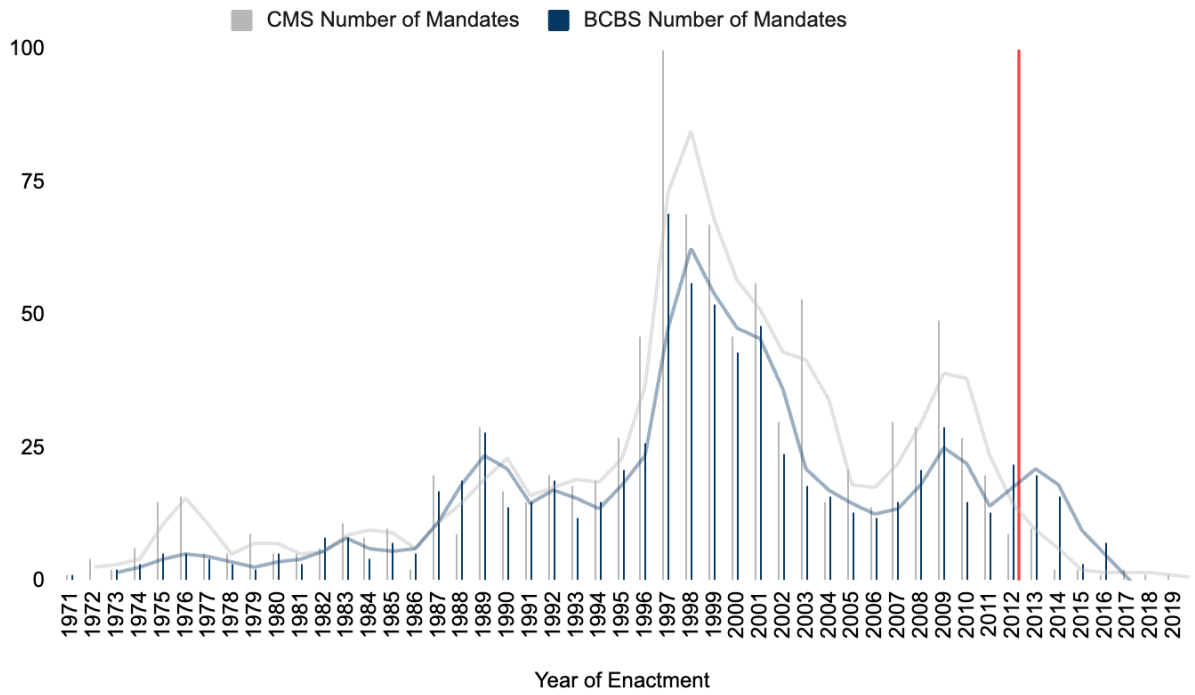

Figure 1: CMS & BCBS Trends of State Mandated Benefit Laws By Year: 1971-2019

Source: CMS & Blue Cross Blue Shield 3.2 CMS and BCBS Average Number of Mandates Per Decade

Table 1 provides data on the total and average number of mandates enacted and reported by the CMS, BCBS and CHBRP during each decade from 1971-2023.

This analysis demonstrated that each year, the average amount of enacted or revised mandates had been steadily increasing with trends from both CMS and BCBS showing a large

increase of state mandates from 1991-2000 with a total of 427 documented by CMS and 328 documented by BCBS. Trends from 2001-2010 showed a decrease with CMS reporting 324 mandated benefit laws and BCBS reporting 211 mandated benefit laws enacted during this time frame. Lastly, new data from 2011-2019 showed a total of 48 state mandated benefit laws from CMS and 81 from BCBS, indicating that there was a decrease in enacted/revised mandated benefit laws after the ACA. CMS and BCBS do not have data indicating the amount of mandates passed from 2020-2023.

Table 1 shows that from data collected from CHBRP indicated that from 1971 to 1980, there were 2 mandates enacted/revised in California. The number of mandates showed a gradual rise in the following years, starting with a total of 6 state benefit mandates enacted/revised from 1981-199. However, there was a substantial surge in mandates from 1991 to 2000, with a total of 23 enacted/revised mandates. Following a decline from 2001-2010, with a total of 12 mandates enacted/revised. The trend then shifted, and from 2011 to 2019, there was a total of 15 mandates enacted/revised indicating a slight increase. Most recent data from 2020-2023 show a total of 11 mandates that have been enacted/revised within the last three years.

Table 1: CMS, BCBS, & CHBRP: Trends of Enacted State Mandated Benefit Laws: 1971-2016

Decade of Enactment	CMS Number of Total Mandates	BCBS Number of Total Mandates	CA Number of Total Mandates
1971-1980	68	30	2
1981-1990	117	113	6
1991-2000	427	328	23
2001-2010	324	211	12
2011-2019	48	81	15
2020-2023	-	-	11
Decade of Enactment	CMS Number of Average Mandates	BCBS Number of Average Mandates	CA Number of Average Mandates
1971-1980	6.8	3.3	0.2
1981-1990	11.7	11.3	0.6
1991-2000	42.7	32.8	2.3
2001-2010	32.4	21.1	1.2
2011-2019	5.3	9	1.67

Source: BCBS, CMS, and CHBRP

3.2 The Trend in the Types of Mandates Over Time

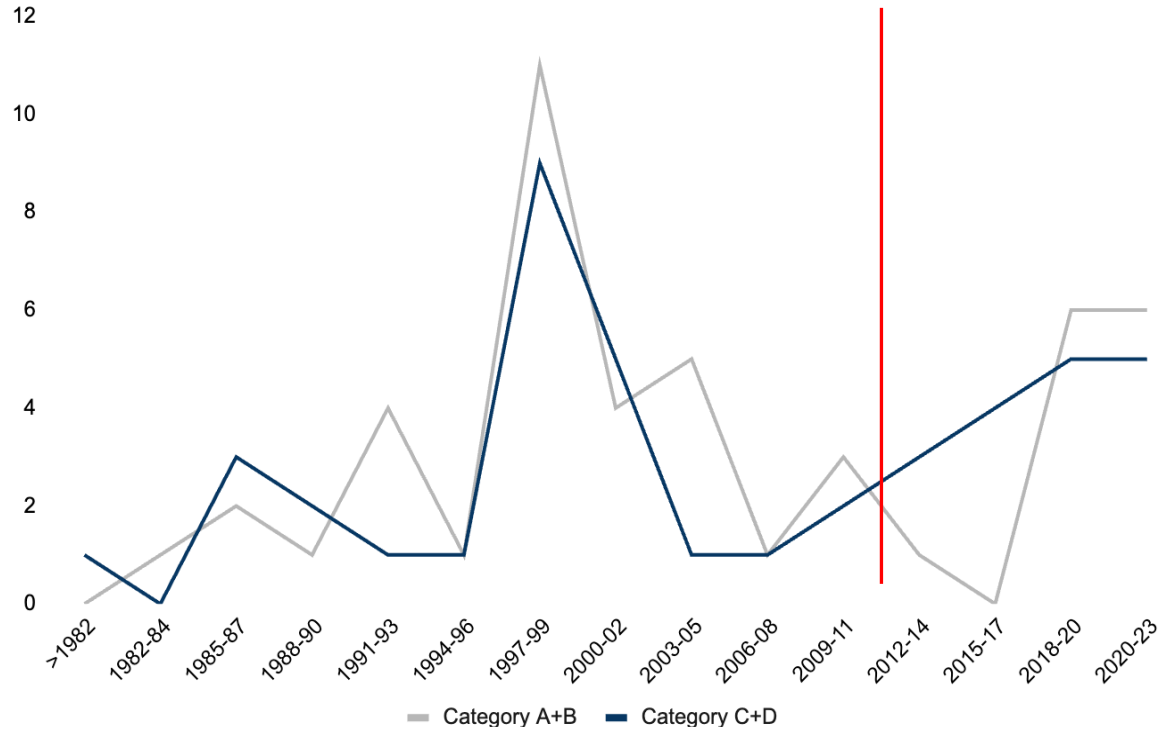

Figure 2: CHBRP Trends of State Mandated Benefit Laws: 1982-2023

Source: CHBRP Trends of State Mandated Benefit Laws: 1982-2023

Using California as a case study CHBRP categorized state benefit mandates in 4 different groups. Data from Figure 2 shows that the number of traditional and non-traditional mandates followed a fairly similar pattern pre-ACA implementation. Post-ACA there was a period from 2012-2017 were the non-traditional mandates significantly outnumbered the traditional mandates. But eventually by 2018, they were back on the same pattern.

A total of 9 mandates have been enacted in California post the ACA that fell under category A+B. These mandates specifically covered treatment for behavioral health, outpatient prescription drugs, colorectal cancer, COVID-19 diagnostic, and screening testing. It appears that California has been able to pass these mandates by using specific language stating that benefits do not exceed EHBs (CHBRP, 2022).

3.3: Language Related to Exceeding EHBs

State legislative bill text for mandates specific to fertility preservation was analyzed to determine what type of language is being used related to the possibility of the mandate exceeding EHBs and thus requiring the state to defray the cost of mandated benefit laws. A total of 12 states FP mandate laws text were analyzed, with 7 states (California, Colorado, Maryland, New Hampshire, New Jersey, Rhode Island, and Utah) using language that provided guidance related to state defrayal of the cost of exceeding EHBs, by mentioning the ACA, EHBs, or defrayal. In addition, although California did not include any of these terms, it is included below as an example of a state that instead added coverage for FP services as a "basic healthcare service" under state law, thus adding FP services to the state list of EHBs. Five states (Connecticut, Delaware, New Jersey, Rhode Island, Utah) did not include any language in their bill text that mentioned any of the provisions under the ACA.

Table 2: State Mandates with Legislative Text addressing EHBs

State	**EHB Provision**
California	*This bill would clarify that, when a covered treatment may cause iatrogenic infertility to an enrollee, standard fertility preservation services are a basic health care service and are not within the scope of coverage for infertility treatment, as described above. The bill would state that these provisions are declaratory of existing law. The bill would state that these provisions do not apply to Medi-Cal managed care health care service plan contracts or any entity that contracts with the State Department of Health Care Services to deliver health care services pursuant to the Medi-Cal program* (California's Senate Bill 600).
Colorado	*More than three hundred sixty-five days have passed since the division submitted its determination and request for confirmation that the coverage specified in this subsection (23) is not an additional benefit that requires state defrayal pursuant to 42 u.s.c. sec. 18031 (d)(3)(b), and the federal department of health and human services has failed to respond to the request within that period, in which case the division shall consider the federal department's unreasonable delay a preclusion from requiring defrayal by the state (Colorado's House Bill 1158).*

Table 2: State Mandates with Legislative Text addressing EHBs, continued

State	EHB Provision
Illinois	*If, at any time before or after the effective date of this amendatory Act of the 100th General Assembly, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register, publishes a comment in the Federal Register, or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Pub. L. 111–148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of coverage for fertility preservation services, then this Section is inoperative with respect to all such coverage other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for fertility preservation services* (Illinois House bill 2617).
Maine	*Upon consultation with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), the Superintendent of Insurance shall evaluate whether the coverage can be incorporated as part of the essential health benefit package or whether CMS would determine that the transfer of costs defrayed by the State to CMS would be required. The superintendent shall report by December 31, 2022 to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters concerning its consultation with CMS and the outcome of that consultation* (Maine's House Bill 1539).
Maryland	*The essential health benefits required under § 1302(a) of the Affordable Care Act: (1) shall be the benefits in the State benchmark plan, selected in accordance with this section; and (2) notwithstanding any other benefits mandated by State law, shall be the benefits required in: (i) subject to subsection (f) of this section, all individual health benefit plans and health benefit plans offered to small employers, except for grandfathered health plans, as defined in the Affordable Care Act, offered outside the Exchange; and (ii) subject to § 31–115(c) of this title, all qualified health plans offered in the Exchange* (Maryland's Senate Bill 271).

Table 2: State Mandates with Legislative Text addressing EHBs, continued

State	EHB Provision
New Hampshire	*The federal ACA law specifies that the cost of newly enacted mandates associated with coverage through the exchange must be borne by the State (so as not to impact premiums for exchange products). According to the State's benchmark, covered services include diagnostic tests to find the cause of infertility, as well as services to treat the underlying medical conditions that cause infertility including endometriosis and hormone deficiency, but do not include artificial insemination services or assisted reproductive technologies or the diagnostic tests and drugs to support the same. The Department assumes that the costs associated with artificial insemination services and assisted reproductive technologies, as well as the cost of the diagnostics tests and drugs to support the same, for exchange products, would be borne by the State's general fund. The Department assumes the proposed language in RSA 417-G:2, IV is intended to exempt exchange based coverage from the new mandates in order to avoid the costs described above. Since the bill would not require such coverage across all platforms within a market, there may be antiselection, which may lead to changes in premiums and market enrollments* (New Hampshire Senate Bill 279).
New York	*Should this act be determined to be a mandate pursuant to section 1311 (d)(3)(B) of the Patient Protection and Affordable Care Act, then this act shall not apply to coverage offered in the individual and small group market unless the state appropriates funds sufficient to cover the full cost of such coverage, as determined by the department of financial services and independently verified by an independent actuarial firm certified by the American academy of actuaries* (New York Senate Bill 8441).

States with no EHB-related language: Connecticut, Delaware, New Jersey, Rhode Island, Utah

This chapter is based on a collaborative project with Sara McMenamin and Richard Kronick, who provided critical feedback and helped shape the ideas presented in this chapter.

Chapter 4: Discussion

The objective of this paper was to analyze trends in state benefit mandate laws after the ACA intended to reduce the growing rate by trying to answer a) the number of mandates passed each year, b) the types of mandates passed each year, and c) the language in the mandates related to exceeding EHBs passed post ACA implementation. The main findings from this study highlights that there are multiple shifts that have happened post-ACA related to enactment of new benefit mandate laws.

4.1 Trends in the Number of State Benefit Mandates Over Time

Findings from data collected from CMS indicated a total of 1,100 mandated benefit laws enacted from 1971-2019. BCBS data shows that a total of 763 mandated benefit laws were enacted from 1971-2016. The data collected from BCBS and CMS show that there was a spike in benefit mandate laws from 1997-2001 with a decline after 2012. Although substantial variation over time in the number of mandates enacted makes it difficult to draw a definitive conclusion about the effects of the ACA on the number of mandates, it seems very likely that the ACA did result in a substantial reduction in the number of mandates. In the CMS data, the number of mandates was declining from 2008 through 2011, and the post-2012 results look as a continuation of the 2008-2011 trend. However, the number of new mandates in 2015-2019 were at an unprecedently low level, and almost certainly are a result of the ACA. The argument for cause and effect is limited, however, by the observation that the CMS data and BCBS data, may be incomplete. Whether they are differentially incomplete pre- and post-ACA is unclear. The BCBS results, particularly for 2015-2017 also provide strong suggestive evidence that the ACA resulted in a reduction in the number of new mandated benefit laws.

4.2 Types of Mandates Over Time

The data indicate that there may have been a shift in the types of mandates that were introduced post-ACA, but that this difference has now largely disappeared. It is possible that states were uncertain how the ACA provision related to defraying the cost of exceeding EHBs would be implemented, so at first were hesitant to introduce "traditional" benefit mandates (i.e. Type A + B) and instead shifted focus to mandates that described benefit design limitations (ie. Type C+D). Over time as it was clear that states were not being asked to pay to defray the cost of state mandates, more states started introducing "traditional" mandates along side the "benefit design" mandates.

4.3 Legislative Language related to EHBs

Specifically looking at fertility preservation (FP) services, there have been 12 states (California, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, New Hampshire, New Jersey, New York, Rhode Island, and Utah) that have passed mandated benefit laws. Due to the lack of clarity on what constitutes "exceeding" EHBs, states have gotten creative with bill language to safeguard against being asked to defray the cost of enacting benefit mandates with the potential to exceed EHBs.

Table 2 indicates that 7 out of those 12 states have included text that removes the responsibility from the state having to pay for new mandates. Colorado, Illinois, and Maine have specific bill text imposing the responsibility upon HHS to assess whether particular coverage exceed or can be included as part of EHBs. Additionally, text language states that is HHS determines that the mandate exceeds EHBs, the state is then not obligated to bear the costs of covering services in such cases.

4.3.1 California's Legislative Text

California Senate Bill (SB) 600 was passed in October 2019 and requires health insurance companies in California to cover specific fertility preservation treatments as a basic healthcare service. It clarifies that these provisions are already part of an existing law defining basic healthcare services. Therefore, the SB 600 language prevents California from having the responsibility of paying for new benefit mandate laws while still ensuring that insured individuals have coverage for fertility preservation services.

4.3.2 Colorado's Legislative Text

Colorado's House Bill (HB) 1158: Insurance Cover Infertility Diagnosis Treatment Preserve, was passed on April 1st, 2020. The national infertility association stated that those in the individual and small group insurance markets will not receive coverage until HHS decides whether the state should cover the cost of fertility services. However, there is no indication of when this decision will be made or if it will be favorable.

Colorado's legislative text indicated that more than a year has passed without receiving a response from the HHS. Therefore, the division will consider their delay as a reason not to require the state to pay for the coverage. It is unclear how this provision will be implemented. Questions to consider are: who has responsibility to submitting the potential benefit mandate laws to HHS, was follow up conducted, and who at HHS is appointed to review submissions of requests for confirmation that the coverage may or may not require defrayal.

4.3.3 Maine's Legislative Text

Maine's HB 1539: An Act To Provide Access to Fertility Care was enacted on May 2, 2022. This law requires private health insurance policies provide coverage for fertility diagnostic

care, fertility treatment, and medically necessary fertility preservation. This bill language differs from others because the effective date will be on January 1, 2024 to allow for review of coverage. HB 1539 had specific language that indicates that consultation with HHS and CMS will occur to evaluate whether coverage can be included as a part of EHBs. If CMS determines that the costs of coverage under HB 1539 should be defrayed to the state of Maine, the outcome must be reported to the legislature by December 31, 2022. The status of this bill was passed on April 25, 2022.

4.3.4 Illinois Legislative Text

Illinois HB 2617 coverage iatrogenic infertility was passed on August 27, 2018. This bill language states that if the HHS creates rules or regulations that require Illinois to cover fertility preservation services under the ACA, then his section of the law will not apply to the coverage of those services and the state will not have to cover the cost of those services.

4.3.5. New Hampshire's Legislative Text

New Hampshire passed SB 279 an act relative to access fertility care on August 5, 2019. SB 279 had distinct bill language that differed significantly from the others. Legislative text specifically stated that the current benchmark plan in the state offers coverage for diagnostic tests, endometriosis, and hormone deficiency treatments, but does not offer coverage for insemination services or assisted reproductive technologies or the diagnostic tests and drugs. This bill discussed that SB 279 will be funded by the State's general fund. This means that the government would cover these expenses rather than placing the financial burden on individuals or insurance providers. The bill then goes on to state that the proposed language aims to create an exemption to prevent the costs that will fall on the state above by discussing antiselection. This

bill text should be analyzed further to gain deeper insight on how states are avoiding defraying costs of new state mandate laws.

4.4 Limitations

This study had multiple limitations. First being that a comprehensive list of state benefit mandate laws in the United States failed to exist. Multiple sources were used in an attempt to create a unified data set, although inconsistencies were identified between the existing data sources and the newly collected data. This resulted in some discrepancy in the collected information.

Secondly, there hasn't been a recently published list of current benefit mandate laws since 2016. A lack of recent published laws from CMS or BCBS resulted in inadequate amount of data and made it difficult to determine if there has been a reduction in benefit mandate laws. Due to a lack of national data on state mandates, California and FP mandates was looked at as case studies, yet these may not be generalizable to state mandate trends nationwide. Additionally, inconsistences between what states consider a benefit mandate law that does not fall under EHBs makes it difficult to know if there has been a clear reduction or not.

4.5 Conclusion

Looking at new FP mandates in recent years, it is evident that there are still benefit mandate laws that are being enacted post the ACA that could fall outside of EHBs. This study highlights that there are gaps with what constitutes benefit mandate laws falling under EHBs or needing state defrayal. Additionally, more clarification is needed on what the current process is of determining which benefit mandate laws requires state defrayal.

Despite various limitations in this study, this research acknowledges an important step in beginning to understand the effect the ACA had on state benefit mandate laws. The intent of the

ACA was to discourage states from adopting new mandated benefit laws post 2012. This study highlights that there have been new mandates passed, yet a lack of regulation exists surrounding who is responsible for determining what is considered an exceeding EHB mandate as well as how to enforce states to pay for costs of exceeding EHB mandates. The findings in this study can be used to promote future research on the connections of the ACA and mandated benefit laws.

This chapter is based on a collaborative project with Sara McMenamin and Richard Kronick, who provided critical feedback and helped shape the ideas presented in this chapter.

References

Bagley, N., & Levy, H. (2014). Essential Health Benefits and the Affordable Care Act: Law and process. Journal of Health Politics, Policy and Law, 39(2), 441–465. https://doi.org/10.1215/03616878-2416325

Bellows, N. M., Halpin, H. A., & McMenamin, S. B. (2006). State-Mandated Benefit Review Laws. Health Services Research, 41(3p2), 1104–1123. https://doi.org/10.1111/j.1475-6773.2006.00522.x

Cassidy, A. (2012, April 25). Essential Health Benefits (updated) . Health Affairs. https://www.healthaffairs.org/do/10.1377/hpb20130502.454771/

California Health Benefits Review Program (CHBRP). (2022, January). Issue brief: California State Benefit mandates and the Affordable Care Act Essential Health Benefits. California Health Benefits Review Program . https://chbrp.org/sites/default/files/202301/EHB%20Brief%202022%20final%20011322.pdf

California Health Benefits Review Program (CHBRP). (2022). Issue Brief: California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits. Berkeley, CA

Cubanski, J., & Helen H. Schauffler, H. H. (2002, June 5). Issue Brief - Mandated Health Insurance benefits: Tradeoffs among benefits, coverage, and costs? . Kaiser Family Foundation . Retrieved December 9, 2022.

Centers for Medicare & Medicaid Services (CMS). (2012). Retrieved from https://www.cms.gov/cciio/resources/data-resources/ehb Retrieved December 9, 2022.

Centers for Medicare & Medicaid Services (CMS). (2013, February 20). Essential Health Benefits Standards: Ensuring quality, affordable coverage. CMS.gov. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013

Devine, K., Stillman, R. J., & DeCherney, A. H. (2014). The Affordable Care Act: Early implications for fertility medicine. Fertility and Sterility, 101(5), 1224–1227. https://doi.org/10.1016/j.fertnstert.2014.01.024

Eibner, C., & Nowak, S. (2018, July 11). The effect of eliminating the individual mandate penalty and the role of behavioral factors. Commonwealth Fund. Retrieved December 9, 2022, from https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors

Explaining health care reform: Questions about health insurance subsidies. KFF. (2022, October 27). https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/

Fernandez , B. (2010, June 25). Self-Insured Health Insurance Coverage. Congressional Research Service. Retrieved December 9, 2022, from https://www.ncsl.org/documents/health/SelfInsuredPlans.pdf

Flores Ortega, R., Yoeun, S., Mesina, O., Kaiser, B., McMenamin, S., & Su, H. (2021). Assessment of Health Insurance Benefit mandates for fertility preservation among 11 US states. JAMA Health Forum, 2(12). https://doi.org/10.1001/jamahealthforum.2021.4309

French, M. T., Homer, J., Gumus, G., & Hickling, L. (2016). Key provisions of the Patient Protection and Affordable Care Act (ACA): A systematic review and presentation of early research findings. Health Services Research, 51(5), 1735–1771. https://doi.org/10.1111/1475-6773.12511

Frequently Asked Questions on Essential Health Benefits Bulletin. Centers for Medicare & Medicaid Services (CMS) . (2018, October 23). https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs

Garrow, S. (2022, October 21). How does cost sharing and health insurance work? . eHealthInsurance. Retrieved December 9, 2022, from https://www.ehealthinsurance.com/resources/individual-and-family/cost-sharing-health-insurance-work

Health insurance coverage of the total population. KFF. (2022, October 28). Retrieved December 9, 2022, from https://www.kff.org/other/state-indicator/total-population/

Information on essential health benefits (EHB) benchmark plans. Centers for Medicare & Medicaid Services (CMS). (2020). Retrieved December 9, 2022, from https://www.cms.gov/cciio/resources/data-resources/ehb

Laugesen, M. J., Paul, R. R., Luft, H. S., Aubry, W., & Ganiats, T. G. (2006). A comparative analysis of mandated benefit laws, 1949-2002. Health Services Research, 41(3p2), 1081–1103. https://doi.org/10.1111/j.1475-6773.2006.00521.x

Mantel, J. (2020). Access to affordable health care coverage. The Patient and Health Care System: Perspectives on High-Quality Care, 55–69. https://doi.org/10.1007/978-3-030-46567-4_5

Michael Bihari, M. D. (2022, October 30). Understanding Mandated Health Insurance Benefits. Verywell Health. Retrieved December 9, 2022, from https://www.verywellhealth.com/mandated-health-insurance-benefits-1738931

Norris, L. (2022, November 20). There are two different definitions of benchmark plan under the ACA. Verywell Health. Retrieved December 9, 2022, from https://www.verywellhealth.com/under-the-aca-what-is-a-benchmark-plan-4160065

Insurance coverage by state: Resolve: The National Infertility Association. RESOLVE. (2022, June 6). https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/

Ryan, M. (2018, February 17). Too clever by half: Commanding the nonuse of State authority to regulate health benefits in the ACA. University of Massachusetts Law Review. Retrieved December 9, 2022.

Shaw, F. E., Asomugha, C. N., Conway, P. H., & Rein, A. S. (2014). The Patient Protection and Affordable Care Act: Opportunities for Prevention and Public Health. The Lancet, 384(9937), 75–82. doi:10.1016/s0140-6736(14)60259-2

Schoen, C., Doty, M. M., Robertson, R. H., & Collins, S. R. (2011). Affordable care act reforms could reduce the number of underinsured us adults by 70 percent. Health Affairs, 30(9), 1762–1771. https://doi.org/10.1377/hlthaff.2011.0335

Skopec, L., Henderson, A., Todd, S., & Young, P. L. (2011, December). Essential health benefits: Comparing benefits in small group products and state and federal employee plans. ASPE. Retrieved December 9, 2022.

Sreeramoju, Pranavi V., et al. " Access to Affordable Health Care Coverage." The Patient and Health Care System: Perspectives on High-Quality Care, Springer International Publishing, Cham, 2020, pp. 55–69.

Tikkanen, R., Osborn, R., Mossialos, E., Djordjevic, A., & Wharton, G. A. (2020, June 5). International Health Care System Profiles United States. The Common Wealth Fund. Retrieved December 9, 2022, from https://www.commonwealthfund.org/international-health-policy-center/countries/united-states

Tolbert, J. Published: Mar 02, J. (2015). The coverage provisions in the affordable care act: An update. Retrieved from https://www.kff.org/health-reform/issue-brief/the-coverage-provisions-in-the-affordable-care-act-an-update/

Webber, D., & Bailey, J. (2014). Retrieved from https://www.mercatus.org/research/working-papers/political-roots-health-insurance-benefit-mandates

Weiner, J., & Colameco, C. (2015, June 22). Essential health benefits: 50-state variations on a Theme. Essential Health Benefits: 50-State Variations on a Theme. https://collections.nlm.nih.gov/master/borndig/101645913/essential%20health%20benefits%2050%20state%20variations.pdf

White, C., & Lechner, A. (2012, February). State benefit mandates and National Health Reform. National Institute For Health Care Reform. Retrieved December 9, 2022, from https://www.nihcr.org/news-releases/news-state-benefit-mandates/