Background Brief on …

Health Insurance

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Inside this Brief

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Oregon Health Insurance Mandates

In Oregon, as in other states, the law requires that most group and individual health insurance plans include coverage for certain illnesses or conditions, that care by certain providers be reimbursed by insurance, and that certain populations—such as newborns—be covered. These requirements are called "health insurance mandates." Mandates also may deal with other areas, such as requiring coverage for continuation and insurance portability, coverage regardless of pre-existing conditions, and requirements that health insurance carriers undertake certain duties like utilization review. Mandates in the first two areas above—condition/illness covered and providers eligible for reimbursement—tend to be the type that receive the most attention from lawmakers, the public, insurance carriers, employers, and health care providers because these areas comprise the largest segment of mandates and impact the costs of health insurance coverage.

The Insurance Division, as part of the Department of Consumer and Business Services, is the state agency responsible for consumer protection and regulation of the 1,500 insurance companies doing business in Oregon. The Division investigates and resolves complaints against insurance companies and agents, investigates violations of Oregon insurance law and takes appropriate enforcement actions when necessary, monitors companies selling insurance to ensure they are financially sound, reviews policies to ensure they comply with state law, and monitors policy issues such as health insurance mandates.

The Insurance Division has identified 26 condition/illness and provider mandates currently in Oregon law. Attached is a chart of Oregon's mandates for diseases/conditions and provider reimbursement, last updated January 2005, including statutory information and types of insurance subject to the law.

Types of Mandates

Most of Oregon's mandates require either that the specified condition, illness or service be covered to the same extent as other benefits, or that the services by the specified provider be covered to the same extent as services provided by a physician. However, there are two exceptions to this policy that apply to Oregon's health-related benefits. *Minimum mandated benefits* means that while coverage for certain services may be mandated, they may be less equal in coverage for other benefits. This may include different limits, co-payments,

and deductibles. In Oregon, mental health and chemical dependency treatment benefits have lower amounts of required coverage than for physical illnesses. *Mandatory offering* requires that insurers offer the option of a policy with certain coverage, and that the optional coverage can be accepted by the insured, usually with an additional or higher premium. Oregon requires a mandatory offering of alcoholism treatment in individual policies, but allows the insurance company to charge a different premium for this benefit if chosen.

Federal Versus State Mandates

The federal Employee Retirement Income Security Act **(ERISA)** allows self-insured employers (employers who provide funds to make claim payments for company employees and dependents instead of paying premiums to an insurance company for coverage) to be exempt from state regulation. However, self-insured employers are regulated by the U.S. Department of Labor and must adhere to federally-mandated benefits, which currently include reconstructive breast surgery for women after covered mastectomies, rules on minimal hospital stays after birth, and portability and pre-existing condition issues. A group health insurance policy that is governed by Oregon law and issued to an employer will include the statutorily mandated benefits as well as any federal health insurance mandates.

Costs and Benefits of Mandates

There is debate around the issues of health insurance mandates. Proponents contend that mandates are necessary to ensure that insured individuals have adequate access to a broad spectrum of health care, and that people do not have to turn to public-sector health care because they cannot receive treatment through private insurance. Opponents note that excessive mandates add to the costs of health insurance and result in employers dropping employee health insurance, spending more for coverage and/or passing costs on to their employees, leading to more uninsured individuals in the state as companies and workers can no longer afford basic insurance.

Proposing New Mandates

ORS 171.875 requires that every proposed legislative measure containing health insurance coverage mandates be accompanied by a report that assesses both the social and financial effects of the coverage. Areas that must be addressed in this report include:

- Extent that treatment or service will be used in Oregon
- Extent of coverage already available in Oregon
- Proportion of Oregonians already having such coverage
- Extent to which lack of coverage results in financial hardship in Oregon
- Evidence of medical need in Oregon for the proposed treatment or services
- Financial effect of the proposed measure (including increase/decrease of costs of treatment, extent that coverage will increase treatment, extent that mandated treatment is expected to be a substitute for more expensive treatment, impact on administrative expenses of insurer and premiums/administrative expenses of policyholders, and overall impact on total cost of health care)

Automatic Repeal of Mandates

In 1985, legislation was enacted that automatically repeals health insurance mandates effective on or after July 13, 1985, which do not specify a repeal date (see ORS 743.700). This "automatic repealer" abolishes such statutes on the sixth anniversary of each law's effective date.

The law applies to individual or group health insurance mandates that do any of the following:

- Requires coverage of specific physical or mental health conditions or specific hospital, medical, surgical or dental services
- Requires coverage for specific people
- Requires carriers to reimburse specific providers
- Requires insurers to provide coverage on a nondiscriminatory basis
- Forbids insurers from excluding covered services from payment or reimbursement
- Forbids excluding people due to their medical history

In 2002, the Insurance Division received an Attorney General's **(AG)** opinion regarding two mandates that were revised in 1999. The AG opined that, as a general rule, subsequent amendments to a health insurance mandate do not modify the automatic repeal date of a mandate; however, the AG stated that the exception to the rule is when "substantial or material changes" are amended into current law on health insurance mandates, and that the six-year automatic repealer (unless noted otherwise in the amended bill) starts from the effective date of the newly amended law.

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