Background Brief on …

Health Insurance Mandates

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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 address other areas, such as requiring coverage or continuation of coverage, coverage regardless of pre-existing conditions, and requirements that health insurance carriers undertake certain duties such as utilization review. Mandatory condition/illness and provider reimbursement tend to receive the most attention because these areas comprise the largest segment of mandates and impact the costs of health insurance coverage the most.

The Department of Consumer and Business Services **(DCBS)** Insurance Division is responsible for consumer protection and regulation of the more than 1,500 insurance companies doing business in Oregon. The Division investigates and resolves complaints against insurance companies and producers, 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.

Oregon's mandates (*2013 Transitional Plan Coverage List, separate document*) for diseases/conditions and provider reimbursement, including statutory information and types of insurance subject to the law is included in this chapter.

Types of Mandates

The applicability and operation of the mandates vary and may, in some cases, depend on the health plan. 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. All mandates apply to health benefit plans (major medical) but some have broader application to other health insurance. Some mandates apply to all health insurance, but some apply only to group plans,

For example, in the individual market, coverage for treatment of alcoholism must be offered to an applicant for insurance. However, an insurer may charge an additional premium for providing this coverage and may deny such coverage according to the insurers usual underwriting standards. Treatment of alcoholism in the group market is required under Oregon's Mental Health Parity mandate, and an applicant cannot be denied such coverage or charged an additional premium. The cost for this coverage in the group market is included into the total premium.

The *2013 Transitional Plan Coverage List* also provides detailed information about the applicability of each mandate.

Federal versus State

The federal Employee Retirement Income Security Act **(ERISA**) generally exempts self-insured employers (employers that use their own funds to pay employee medical claims rather than purchase health insurance for their employees) from state regulation. However, self-insured employers are regulated by the U.S. Department of Labor and must provide coverage for federally mandated benefits, including coverage for reconstructive breast surgery for women after covered mastectomies, minimum hospital stays after childbirth, and mental health treatment (if mental health services are covered by the plan). 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 applicable federal health insurance mandates.

Oregon's mandates may be affected by the Patient Protection and Affordability Care Act **(PPACA)**, which could change the applicability or operation of the Oregon mandates. For more information about those potential changes, please see the separate Background Brief on federal health reform.

Costs and Benefits

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 do not have to turn to public-sector health care because they have insufficient private health insurance coverage. However, opponents state that excessive mandates add to the cost of health insurance and result in employers dropping employee health insurance, spending more for coverage, and/or passing costs on to their employees as companies and workers can no longer afford basic insurance.

Under federal law, if a state mandates a health coverage or treatment that is above and beyond those included in federal law as an essential health benefit, or that is not already required by state law before 2010, or included in the state benchmark plan, the costs of the mandated coverage must be borne by the state rather than the insurer. Essentially, if a mandated benefit is established after 2010, the state may be required to pay the increased cost to insurers for providing the mandated benefit. This requirement would only apply to qualified health plans sold inside the exchange.

Proposing New Mandates

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

- The extent to which treatment or service will be used in Oregon;

- The extent of coverage already available in Oregon;
- The proportion of Oregonians who already have such coverage;
- The extent to which lack of coverage results in financial hardship in Oregon;
- Evidence of medical need in Oregon for the proposed treatment or services; and,
- The financial effect of the proposed measure, including the increase/decrease of costs of treatment, the extent to which coverage will increase treatment, the extent to which mandated treatment is expected to be a substitute for more expensive treatment, the impact on administrative expenses of the insurer and premiums/administrative expenses of policyholders, and the overall impact on total cost of health care.

Automatic Repeal

In 1985, legislation was enacted that automatically repealed health insurance mandates effective on or after July 13, 1985, that do not specify a repeal date (ORS 743A.001). 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:

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

In 2002, the 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 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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