



HEALTH INSURANCE BENEFIT MANDATES

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HEALTH INSURANCE MANDATES

For health insurance plans sold on a state or federal exchange, federal law requires states to defray the cost of any benefit mandate enacted after December 31, 2011 that is (1) in excess of the state's essential health benefits (EHBs) and (2) related to specific care, treatment, or services (ACA § 1311(d)(3)).

However, states do not have to defray the cost of benefits above the EHBs that are unrelated to specific care, treatment, or services.

ISSUE

When are states required to defray the cost of health insurance benefit mandates (i.e., benefits required by state law) under the federal Patient Protection and Affordable Care Act (ACA)?

SUMMARY

The ACA requires all health insurance plans sold on a state or federal exchange to meet minimum standards, called essential health benefits (EHBs). States that require insurance plans to offer benefits above and beyond the EHBs, must, in most cases, pay for them. However, states are not required to pay for benefit mandates that do not apply to specific care, treatment, or services.

The U.S. Department of Health and Human Services (HHS) has identified at least six benefit mandates unrelated to specific care, treatment, or services. These include mandates related to (1) provider types, (2) cost-sharing, (3) reimbursement methods, (4) delivery methods, (5) dependent-coverage, and (6) ACA conforming changes.

BENCHMARK PLANS AND EHB

The ACA required each state to select a 2012 health insurance plan that met certain criteria for care, treatment, and services as a "benchmark plan," effective for plan years beginning January 1, 2014. The benchmark plan had to cover at least 10 benefit categories, known as EHBs. If a state chose a benchmark plan already subject to state mandates, those mandates are included in the state's EHBs.

States must reimburse the individual insured or the health insurance plan for any state-required benefit above and beyond the EHBs. According to HHS, a state-

required benefit is one which mandates the coverage of "[specific care, treatment, or services](#)."

MANDATES UNRELATED TO SPECIFIC CARE, TREATMENT, OR SERVICES

A state may enact requirements unrelated to specific care, treatment, or services and not be responsible for defraying the cost. Such mandates still require health carriers (e.g., insurers) to provide the required coverage but do not require the state to cover its cost.

HHS has provided at least six examples of benefit-mandates unrelated to specific care, treatment, or services:

1. **Provider Types.** Mandates that require a covered service to be covered by additional health care provider types (e.g., allowing advanced practice registered nurses to be reimbursed for a covered service within their scope of practice for which the insurer already reimburses doctors).
2. **Cost-Sharing.** Mandates that require or change cost-sharing amounts for covered services, including deductibles, copayments, and coinsurance (e.g., limiting the deductible for a covered service to a specified amount).
3. **Delivery Methods.** Mandates that require health carriers to cover new methods of delivering covered services, such as through telemedicine.
4. **Reimbursement Methods.** Mandates that require health carriers to reimburse health care providers for covered services provided in new ways (e.g., requiring health insurers to provide reimbursement to providers for telemedicine).
5. **Dependent-Coverage.** Mandates that require health carriers to define dependents in a certain way or to cover dependents under specific circumstances (e.g., newborn or adopted children coverage).
6. **ACA Conforming Coverage.** Mandates required to comply with ACA requirements (e.g., removing lifetime benefit maximums or certain age restrictions).

For example, requiring health carriers to cover consultations through telemedicine is not considered a state-required mandate above the EHBs. HHS [provides this explanation](#):

"The physician consultation is the service; the requirement to pay for telemedicine relates to payment for the service delivery method. Since the requirement addresses a specific delivery method, not the underlying care, treatment, or service being delivered, there is no requirement to defray the cost."

However, requiring health carriers to cover treatment for an illness not previously covered relates to specific care, treatment, and services above the EHBs. The state would be required to defray the cost of such mandates.

EHB CHANGE

HHS allowed states, in 2014, to choose new benchmark plans for plan years beginning in 2017. However, according to the Connecticut Insurance Department, the new benchmark plan will not change the EHBs. As a result, the state is still responsible for the cost of any new benefit mandate related to specific care, treatment, or service above and beyond the EHBs, regardless of any change to the benchmark plan.

The Centers for Medicare and Medicaid Services publishes a [guide](#) to understanding benchmark plans, as well as each state's [benchmark plan and required benefits](#) (Connecticut's is available [here](#)).

RESOURCES

The following resources are listed in the order in which they appear in the report.

Federal Register, *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*, <https://www.federalregister.gov/articles/2012/11/26/2012-28362/patient-protection-and-affordable-care-act-standards-related-to-essential-health-benefits-actuarial#footnote-8>, last visited August 18, 2015.

Centers for Medicare and Medicaid Services, *Guide to Reviewing Essential Health Benefits Benchmark Plans*, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ehb-benchmark-review-guide.pdf>, last visited August 18, 2015.

Center for Consumer Information & Insurance Oversight, *Additional Information on State Essential Health Benefits Benchmark Plans*, <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>, last visited August 18, 2015.

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