OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature
ResearchReport

Health Insurance Benefit Mandate Reimbursement Process

By: Alex Reger, Associate Analyst
October 3, 2019 | 2019-R-0189

Issue

Explain the health insurance benefit mandate reimbursement process required under federal law.

Summary

The federal Affordable Care Act requires states to defray the cost of any health insurance benefit mandate enacted after December 31, 2011, that is part of an insurance plan sold on a state exchange and:

1. in addition to the state's essential health benefits (EHBs) and
2. related to specific care, treatment, or services (P.L. 111-148 § 1311(d)(3) & 45 CFR 155.170).

Federal law requires (1) the state to identify benefit mandates that are in addition to the state's EHB and (2) insurers to report the cost of those benefits back to the state (i.e., excess cost reports). The state must then defray the cost of the additional mandates by making the appropriate payment directly to an enrollee or to the insurer on the enrollee's behalf (45 CFR 155.170).

A 2017 federal final rule (§ 19) changed the entity responsible for identifying mandates and receiving excess cost reports from the state's exchange to the state. According to Access Health CT, the state's health insurance exchange, carriers did not (and currently do not) report excess costs to the exchange.

The Connecticut Insurance Department (CID) has identified at least two benefit mandates that are in addition to the state's EHBs: tomosynthesis (CGS §§ 38a-503 & 530) and prosthetic devices (PA 18-69, CGS § 38a-492t & 518t). However, CID states it is not the assigned entity to collect excess cost reports from insurers.

It is not clear whether insurers are reporting excess costs to the state, and if so, to which state agency. In coordination with the Office of Fiscal Analysis, we were unable to find evidence that the state has collected such information or made any benefit defrayal payments to insurers or enrollees.

Additional Information - EHBs

The ACA requires most health insurers to cover 10 benefits categories, known as EHBs. All plans offered on a state exchange must cover at least the following EHBs:

1. outpatient care;
2. emergency services;
3. hospitalization;
4. pregnancy, maternity, and newborn care;
5. mental health and substance use disorder services;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care.

Additionally, the ACA requires each state to select a health insurance plan, known as a "benchmark plan" that meets certain criteria for care, treatment, and services. The benchmark plan must cover at least the 10 EHBs and any state mandates enacted before January 1, 2012. Information on Connecticut's benchmark plan is available here, and the full list of pre-2012 state required benefits is listed here.

Generally, states do not have to defray the cost of benefits that are in addition to the EHBs if they are unrelated to specific care, treatment, or services. These include mandates related to provider types, cost-sharing, reimbursement and deliver methods, and dependent coverage requirements. (For more information on these mandates, see OLR Report 2015-R-0188.)

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