Guttmacher Policy Review
GPR
Spring 2006 | Volume 9 | Number 2

The Movement Against Health Insurance Benefit Mandates: Assessing the Dangers

By Adam Sonfield

America is facing a problem of ever-rising health care costs, consuming an ever-larger portion of families' income and the gross domestic product. These costs have contributed to another problem, the growing number of uninsured Americans. With conservative policymakers setting the agenda in the White House and in Congress, their proposed solutions have taken center stage. At their core is a simple idea: If you give people access to less-expensive insurance, more people will be able to afford coverage.

There is, however, a hitch: Lower-cost insurance almost inevitably means less-comprehensive coverage. Indeed, one key way that conservatives hope to achieve lower-cost insurance is by rolling back policies that require health insurance plans to include coverage of specific services. Women's health advocates worry that without these policies, widely known as benefit mandates, contraceptive and other reproductive health services may be restricted.

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Reactionary Progress

Mandates have long been a focal point in the continuing debates over health insurance in the United States. Overall, the 50 states have adopted more than 1,800 benefit requirements, according to one count by the Council for Affordable Health Insurance, an association largely of small and mid-sized insurance companies that opposes these requirements on principle. Legislators were especially prolific during the 1990s, in response to the debate over and failure of national health care reform and to the rise of managed care. Congress joined the action in 1996, enacting first the Health Insurance Portability and Accountability Act (not a benefit mandate per se, but the largest federal incursion into health insurance to date) and, next, laws to prohibit excessively rapid discharge of mothers and babies (labeled "drive-through deliveries") and to require a degree of parity in coverage between mental and physical health services.

The insurance industry and conservative think tanks pin on these benefit requirements much of the responsibility for rising costs and the uninsured. They make a death-from-a-thousand-cuts argument: Even seemingly inexpensive requirements add up to higher premiums, and even small increases in premiums can lead employers to drop coverage altogether. (Mandates may play some role in these trends, but the conservative argument ignores the potential cost-savings of requiring coverage of preventive services and sidesteps the reasons that health economists typically cite as central to rising costs, such as advancements in health care technology.)

The response of conservative policymakers has been to make new mandates more difficult to enact and to undermine or repeal existing ones. At the state level, they have pushed for laws to require economic studies of any proposed insurance requirements or moratoriums on new

requirements altogether. Moreover, at least 14 states since 2001 have enacted legislation authorizing insurers to offer plans for small employers and individuals that are exempt from some or all benefit mandates, according to AcademyHealth, an association of researchers that works with states to improve health coverage. These "limited-benefit" plans are being promoted explicitly as a money-saving alternative by their proponents.

At the federal level, mandate opponents have made similar efforts designed to supersede state laws. The main vehicle for this federal strategy has been the concept of Association Health Plans (AHPs)—health plans that would be formed across state lines by groups of small businesses, thereby capturing the advantages that large employers have in negotiating rates. Bypassing benefit requirements and other state regulation is a major part of that. AHPs have been a top priority of such powerful interest groups as the National Federation of Independent Businesses, and the House has passed legislation almost annually over the last decade to authorize them. Opponents, however, have successfully blocked the legislation in the Senate, citing a host of concerns, including the elimination of benefit requirements and other patient protections (related article, February 2005, page 8).

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The latest twist on this strategy is the Health Insurance Marketplace Modernization and Affordability Act, sponsored by Sen. Michael Enzi (R-WY), the powerful chair of the Senate committee that writes most health legislation. Supporters have portrayed the measure as a compromise that addresses many key criticisms of AHPs. Most notably, the plans under the new legislation (now called "small business health plans") would have to be offered by insurers, whereas in prior versions, the associations could "self-insure"—paying directly for members' care and thereby becoming entirely exempt from state oversight.

In truth, the Enzi legislation goes well beyond the scope of its AHP predecessors and is particularly damaging in its assault on benefit requirements: It could effectively override mandates in all of the insurance markets that states regulate, rather than merely for the AHPs themselves. Insurers would be allowed to sell policies without any of the benefits that state law requires, as long as they also offered a policy based on the ones available to state employees in the five largest states. (Those policies do typically include a wide range of benefits, but an insurer could, for instance, choose as its benchmark a plan with an extremely high deductible.) At best, the legislation would transform states' benefit mandates into "mandates to offer"—policies that give employers more choices, but leave enrollees without protection.

Enzi's legislation was approved by his committee in March on a party-line vote, but it generated significant controversy. A host of patient advocacy groups, associations of health care providers and state officials voiced their opposition, including the influential AARP and most of the states' attorneys general. Senate Majority Leader Bill Frist (R-TN) attempted to push it through the full Senate in May, but failed to bring it to a vote. Even if the Senate legislation eventually succeeds, it would have to be reconciled with a very different AHP bill that passed the House in 2005.

Coverage of Reproductive Health Services

The Enzi legislation, and indeed all of the assaults on benefit mandates, would impact millions of women who rely on their insurance to pay for reproductive health services and threatens to reverse more than a decade of progress. According to new estimates from the Guttmacher Institute, there are 17 million women of reproductive age in state-regulated employer-sponsored plans. In contrast to those who receive coverage through employers that self-insure, virtually all of these women are protected by at least some reproductive health–related

benefit requirements. That includes more than nine million women of reproductive age protected by contraceptive coverage requirements in 25 states. Other state policies ensure coverage of cervical cancer screening, infertility treatment and access without a referral to obstetrician-gynecologists (see table).

Covering these services provides tangible benefits to women, families, employers, the government and society. For example, coverage of the full range of contraceptive options helps women to choose the method that best fits their needs and lifestyle, thereby facilitating consistent and correct use and greater success in avoiding unintended pregnancies. Employers also benefit from this improved use, according to the Washington Business Group on Health and William M. Mercer, an employee benefits consulting firm. By using Guttmacher data on the cost of contraceptive coverage and factoring in the medical costs of pregnancy and indirect costs such as employee absence and reduced productivity, they estimated that it costs employers 15–17% more to not provide contraceptive coverage in employee health plans than it does to provide such coverage (related article, March 2003, page 12). Indeed, the nation's largest employer, the federal government, found that a 1998 law requiring coverage of contraceptives for federal employees did not increase costs. Evidence from the public sector bolsters the cost-effectiveness argument: States that have greatly expanded eligibility for family planning services under Medicaid have saved tens of millions of dollars annually (related article, page 2). More important than monetary concerns, by preventing unintended pregnancies and helping women to space the children they choose to have, contraception improves health outcomes for mothers and babies, as well as health, social and economic outcomes later in life.

Notes: Includes women who had coverage in insured employer-sponsored health plans at any point in the prior 12 months, and includes coverage received as a dependent. Direct access mandates only apply to managed care plans, and some infertility and cervical cancer mandates apply only to HMOs or to large employers. Most mandates also govern nongroup plans (4.2 million U.S. women 15–44), and direct access and cervical cancer screening may benefit women older than 44; there are 11.3 million women 45–65 in insured employer-sponsored plans and 2.7 million in nongroup plans. *Does not require direct access, but does require OB-GYNs to be allowed as primary care providers. †Will go into effect in July 2006.

GUARANTEED COVERAGE AT RISK

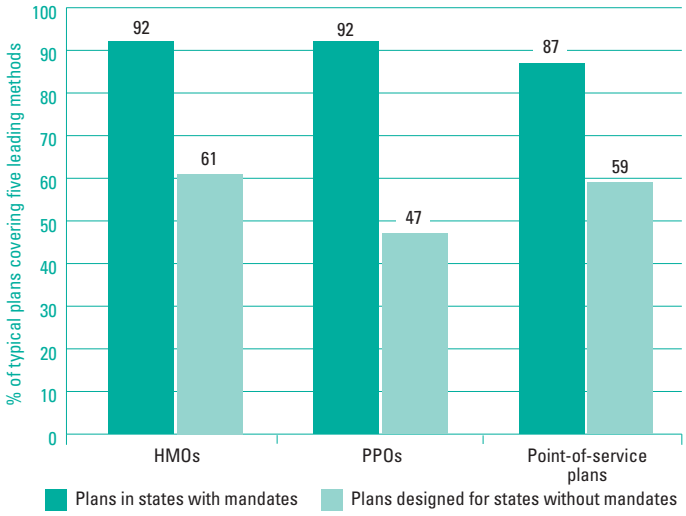
Almost all of the 17 million reproductive-age women with state-regulated, employer-sponsored insurance (ESI) are protected by reproductive health benefit requirements.

	Women 15–44 with state-regulated ESI, 2002–2004	State Reproductive Health Benefit Mandates			
		Contraceptive services/ supplies	Infertility treatment	Direct access to OB-GYNs	Cervical cancer screening
U.S. TOTAL	16,861,100	25	12	42 & DC	26 & DC
Alabama	253,200			X	
Alaska	38,000				X
Arizona	270,200	X			
Arkansas	122,600	X	X	X	
California	2,160,000	X		X	X
Colorado	268,200			X	
Connecticut	213,900	X	X	X	
Delaware	46,200	X		X	X
Dist. of Columbia	37,900			X	X
Florida	769,800			X	
Georgia	492,800	X		X	X
Hawaii	128,700	X	X		
Idaho	68,400			X	
Illinois	750,300	X	X	X	X
Indiana	268,400			X*	
Iowa	147,400	X			
Kansas	161,400			X	X
Kentucky	229,100			X	
Louisiana	227,600			X	X
Maine	76,700	X		X	X
Maryland	357,200	X	X	X	X
Massachusetts	525,300	X	X	X	X
Michigan	586,500			X	
Minnesota	334,400			X	X
Mississippi	134,500			X	
Missouri	291,200	X		X	X
Montana	45,700	X	X	X	
Nebraska	97,900			X*	
Nevada	112,600	X		X	X
New Hampshire	93,000	X		X	
New Jersey	602,300	X†	X	X*	X
New Mexico	99,300	X		X	X
New York	1,376,500	X	X	X	X
North Carolina	345,100	X		X	X
North Dakota	35,300				
Ohio	642,500		X	X	X
Oklahoma	179,000				
Oregon	249,500			X	X
Pennsylvania	941,700			X	X
Rhode Island	93,700	X	X	X	X
South Carolina	177,700			X	X
South Dakota	45,300				
Tennessee	257,100			X	
Texas	924,700			X	X
Utah	164,800			X	
Vermont	37,700	X		X	
Virginia	542,800			X	X
Washington	413,900	X		X	
West Virginia	86,100	X	X	X	X
Wisconsin	316,000	X		X	
Wyoming	21,100				X
Women protected by state mandates		**9,204,400**	**4,944,800**	**15,996,200**	**11,714,600**

Sources: **Women**—Guttmacher Institute tabulations from Current Population Survey, 2003–2005, and Medical Expenditure Panel Survey, 2003. **Contraceptive coverage policies**—Guttmacher Institute, 2006. Infertility coverage and direct access—Health Policy Tracking Service, 2005. **Cervical cancer**—National Cancer Institute, 2005, and National Conference of State Legislatures, 2002.

THE UPSIDE OF MANDATES

By 2002, a greater proportion of health insurance plans in states with contraceptive coverage requirements than of plans designed for other states covered all five leading reversible prescription methods.



Note: The five leading methods in 2002 were the diaphragm, the one- and three-month injectables, the IUD and oral contraceptives. *Source:* Guttmacher Institute, 2004.

In fact, insurance coverage of contraceptives is a true success story for reproductive health advocates, albeit an unfinished one. According to a pair of Guttmacher surveys, contraceptive coverage in employer-sponsored plans improved dramatically between 1993 and 2002: The proportion of typical plans covering a full range of reversible methods tripled from 28% to 86%, and the proportion covering no method at all fell from 28% to 2%. In the years between, advocates had waged a multipronged campaign to raise awareness of the lack of coverage and rectify the situation, a campaign that continues today. The 25 state contraceptive coverage policies are a central achievement and had a clear impact. By 2002, a greater proportion of insurance plans in states with these mandates than of plans in other states covered a full range of contraceptives (see chart). And, in fact, that effect spilled over into states without mandates, because many larger insurance companies standardized their plans across the country (related articles, June 2004, pages 4 and 6).

Similar arguments can be made in favor of covering other reproductive health services, although they have received less public attention or formal study. Screenings for cervical cancer and chlamydia are recommended for large groups of women by the U.S. Preventive Services Task Force because they have been proven to be effective and cost-effective in improving women's health. Both were given high marks in a federally funded assessment of these recommendations, published in 2001 in the *American Journal of Preventive Medicine.* Direct access to women's providers was championed in large part because it reduces the unnecessary time and cost burden of obtaining referrals for what is routine care for women. And several peer-reviewed studies have found that mandated coverage of infertility services leads to fewer multiple births, which are tied to harmful and expensive complications.

Fear and Optimism

Despite the benefits of covering these preventive services, patient advocates worry that, if given the option, insurers might not provide this coverage or employers might not purchase it at an extra premium. Or, perhaps, employers would purchase the coverage, but only with expensive cost-sharing that would lead many women to use fewer preventive services. Part of the problem is that employers frequently change insurance plans and employees frequently find new jobs, creating disincentives for insurers and employers, respectively, to address long-term costs. Similarly, employers may see little reason to provide coverage of many services because the government provides a health care safety net (however frayed) and many women have long found a way to pay out-of-pocket for at least some of the services and supplies they need.

On the other hand, these stripped-down plans may prove less attractive than expected to small business owners who purchase them for themselves and their families, as well as for their employees. In fact, in the states that have authorized them, sales of limited-benefit plans have as yet been minimal and their premiums have only been marginally lower than normal, according to AcademyHealth. Moreover, coverage mandates and the public awareness generated in their pro-

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The Movement Against Mandates

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motion have changed perceptions about private health insurance. What is acceptable coverage? What constitutes discrimination by an employer? What is worth fighting for? The answers are far different in 2006 than in the mid-1990s, when these mandates were first proposed.

Nevertheless, patient advocates are right to be concerned and should remain vigilant to ensure that the benefits they care about are retained. The Georgia legislature, for example, authorized insurers in 2005 to offer many consumers an alternative plan with limited benefits. Yet even then, the legislature retained a selection of benefit mandates, mostly tailored to services for women and children, including contraceptives, cervical cancer and chlamydia screening, and direct access to obstetrician-gynecologists. This experience contrasts sharply with that of Arizona and Texas, where the legislatures have authorized limited-benefit plans without coverage for contraceptives, in both cases just a few years after requiring such coverage in all plans.

At the federal level, advocates are gearing up to ensure that vital protections are retained, even if the Enzi legislation or something similar is enacted. Only one thing seems certain: In one form or another, the debate will continue.

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