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Issue Brief

Setting a National Minimum Standard for Health Benefits: How Do State Benefit Mandates Compare with Benefits in Large-Group Plans?

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ABSTRACT: Many proposed health insurance reforms would establish a federal minimum benefit standard—a baseline set of benefits to ensure that people have adequate coverage and financial protection when they purchase insurance. Currently, benefit mandates are set at the state level; these vary greatly across states and generally target specific areas rather than set an overall standard for what qualifies as health insurance. This issue brief considers what a broad federal minimum standard might look like by comparing existing state benefit mandates with the services and providers covered under the Federal Employees Health Benefits Program (FEHBP) Blue Cross and Blue Shield standard benefit package, an example of minimum creditable coverage that reflects current standard practice among employer-sponsored health plans. With few exceptions, benefits in the FEHBP standard option either meet or exceed those that state mandates require—indicating that a broad-based national benefit standard would include most existing state benefit mandates.

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OVERVIEW

Defining a standard for health insurance is central to comprehensive health reform. Many proposed reforms would establish a federal minimum benefit standard—a baseline set of benefits to ensure that individuals have adequate coverage and financial protection when they purchase health insurance. Such a standard would guard against "surprises" that leave patients and their families without access to essential care or that leave families with substantial medical bills resulting from limits on benefits or lack of catastrophic coverage. Under a reformed health insurance system that includes a requirement for individuals to purchase coverage, the federal minimum benefit standard would be necessary to determine whether insurance policies meet basic requirements for coverage and whether particular policyholders would qualify for premium assistance programs. It would also help consumers compare the cost and quality of insurance policies.

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State mandated benefits come in different forms, including requirements for services, providers, and eligibility for coverage. The mandates generally target specific areas, rather than set an overall standard for what qualifies as health insurance, and apply to private insurance plans in the individual and small group market. Currently, the level of state mandated benefits varies greatly across the country, as insurance market regulation is a function of the states. Someone living in Maryland or Minnesota, for example, has a broader guaranteed range of services than someone living in Idaho or Utah, where only a handful of benefit mandates exist. By contrast, the range of covered benefits in large-group employer health plans is often similar.

Policymakers proposing a federal minimum benefit standard must keep in mind how it would interact with existing state mandates. While the national standard should serve as a floor for benefits, states could be permitted to mandate more generous benefits than the national standard, if they elect to do so. To envision how a federal minimum benefit standard might interact with state regulation, this issue brief compares existing state benefit mandates with the services and providers covered under the Federal Employees Health Benefits Program (FEHBP) Blue Cross and Blue Shield standard benefit package, which reflects current standard practice within employer-sponsored health insurance.[1] Federal guidelines stipulate that the FEHBP standard option must provide a level of coverage similar to what most Americans with health benefits through a large employer currently enjoy.[2] It tends to follow similar coverage patterns as plans in the large-group market, and it expands benefits based on new clinical evidence. Like other plans administered for large-employer groups that self-insure, the FEHBP standard option is not subject to state benefit mandates.[3] Our results indicate that the scope of coverage contemplated in current reform proposals would include most of the benefits targeted by state mandates.[4]

To conduct the analysis, we compared benefit details in the FEHBP standard option to information on current state mandates provided by the National Association of Insurance Commissioners, as well as information found through a Web search on certain

Summary of FEHBP Blue Cross and Blue Shield Standard Option: Services and Providers Targeted by State Mandates

Type of Care	Covered Services
General	Medically necessary physician visits, hospital care, laboratory, X-ray, pharmacy, all covered without limits (dollars or services)
Women's Health	Complete maternity care, broad range of contraceptives, diagnosis and treatment of infertility, mammograms, Pap tests, breast reconstruction
Preventive Care (adult)	History and risk assessment, chest X-ray, EKG, urinalysis, general health panel, metabolic panel test, CBC, fasting lipoprotein profile, screening and behavioral change interventions for tobacco and substance abuse, chlamydial infection test, colorectal cancer tests, prostate cancer tests, cervical cancer tests, breast cancer tests, ultrasound for aortic abdominal aneurysm, routine immunizations
Preventive Care (child)	Routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including routine physical examinations, routine hearing tests, laboratory tests, immunizations, and related office visits; all healthy newborn visits including routine screenings
Mental Health	Inpatient and outpatient care and medications; maximum of 25 visits per year for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment
Other Explicitly Covered Services	Acupuncture, bone marrow transplant, chemotherapy, chiropractic care (limit), circumcision, clinical trials, congenital anomaly, craniofacial abnormality, dental, diabetic supplies and education, eating disorders, foot orthotics, hair prostheses (limit), hearing aids (limit), hemophilia care, home health care (limit), hospice care, metabolic disease formulas, morbid obesity treatment, orthopedic and prosthetic devices, osteoporosis screenings, ostomy supplies, smoking cessation treatment, vision

types of health benefits.[5] The box below summarizes the benefits provided through the FEHBP standard option in the service and provider areas targeted by current state mandates.

FINDINGS

Nearly 100 different benefit mandates are on the books in various states. Most target specific areas rather than define a comprehensive insurance policy. For example, many of the mandates apply to specific preventive care services or parity among different types of care.

Based on our analysis, most of the state-mandated benefits would be included in a national standard for benefits that is broad in scope and includes preventive care, mental health care, care for women and children, and prescription medications. Indeed, very few state mandates go beyond what is included in the FEHBP standard option; the tables at the end of this brief list the areas in which existing state mandates do go beyond those covered by the FEHBP standard option.

Benefits Explicitly Excluded by the FEHBP Standard Option

The vast majority of state benefit mandates that apply to specific services would be covered by a minimum standard equivalent to the FEHBP standard option. Only two benefits mandated by a number of states are explicitly excluded from this plan: in vitro fertilization (IVF) and treatment of temporomandibular joint (TMJ) syndrome.

The FEHBP standard option covers diagnosis and treatment of infertility but excludes assisted reproductive technology (ART) procedures, including IVF. Nine states currently require health insurers to provide coverage for IVF (Table 1). Although tens of thousands of parents benefit from ART procedures each year, the services are expensive: on average, each cycle of IVF costs more than $8,000 plus an additional $4,000 for associated medications. While most mandated benefits have a negligible impact on insurance premiums,[6] mandating coverage for IVF could increase the total cost of a health insurance plan by $0.20 to $2.00 per member per month.[7]

The FEHBP standard option also excludes coverage for orthodontic care for TMJ syndrome. Twenty states require health insurers either to provide or offer coverage of treatment for TMJ syndrome (Table 1).[8]

State-Mandated Benefits Beyond the Standard of Care

A number of states require coverage for medical treatments that are still under development. For example, California and Illinois require health insurers to provide coverage for any AIDS vaccine that might eventually be approved for marketing by the U.S. Food and Drug Administration (FDA), even though such vaccines have not yet been developed. Five states mandate coverage of ovarian cancer screening (Table 2). Although studies are under way of the effectiveness of tests to detect ovarian cancer, including pelvic exams, transvaginal ultrasound exams, and a CA-125 assay, there is currently no standard of care for ovarian cancer screening. The FEHBP standard option does not explicitly cover these particular types of care, owing to a lack of consensus regarding their effectiveness. Because the FEHBP standard option does cover screening tests for other cancers and preventive care where a standard of care exists, it is highly likely that an FDA-approved AIDS vaccine or a proven screening test for ovarian cancer would be covered, once they became available.

Generally, a national standard for preventive care would be likely to cover all preventive care services that have been shown to be effective. Thus, a national minimum standard for benefits that provided for inclusion of new, evidence-based preventive care or screening tests would avoid the need for preemptive state action to mandate coverage of such services.

Providers Explicitly Excluded by the FEHBP Standard Option

States vary in licensure and scope of practice laws for clinicians, especially for nonphysician clinicians. Reflecting these variations, some states include a list of specific providers who are covered for the specific service. These variations apply to mental health care,

as well as some types of counseling and nursing care. To address such variations, rather than listing specific providers a national standard could stipulate that patients would have access to any provider licensed to deliver benefits/services based on each state's scope of practice regulations.

The FEHBP standard option provides access to care from a wide range of in-network and out-of-network providers. However, the standard option explicitly excludes a few types of providers, including naturopaths (alternative medicine providers who focus on natural remedies). Four states mandate coverage of naturopathic providers (Table 3).

Benefits for Which State Mandates Exceed the Number of Visits or Payments in the FEHBP Standard Option

In some states, benefit mandates specify that insurance must cover a greater number of visits than are covered in the FEHBP standard option. Most statutes simply require coverage of a disease or service, but a few specify the dollar amounts or number of visits to be covered.

Mental health is one area of variation. In the FEHBP standard option, mental health coverage is comparable to coverage for other illnesses—except that it is subject to a limitation of 25 visits per year for office visits, outpatient treatment, and partial hospitalizations. (The provisions include a clause that says that limitation may be waived in certain cases, but only if received from preferred providers.) Twenty-one states require coverage of mental health treatment equivalent to coverage of other medical care; the District of Columbia mandates that insurers may not impose treatment visit limitations for mental health care; and three states mandate coverage for a greater number of visits than the 25 covered in the FEHBP standard option (Table 4).

Another example of variation is home health care. Massachusetts' home health care mandate requires insurers to cover all necessary home health services in accordance with a specific treatment plan, whereas the FEHBP standard option covers home nursing care for two hours per day for up to 25 days annually. Home health mandates in Wisconsin and Texas require coverage for at least 40 and 60 visits per year, respectively.

There are few other instances of explicit numeric mandates. The FEHBP standard option limits the total amount it will pay for hearing aids, while five states mandate coverage for hearing aids for adults at higher payment levels. Three states require a more generous benefit for hair prostheses ($350 per year, rather than over a lifetime). Six state mandates require broader coverage for chiropractic care (Table 5).

CONCLUSION

With few exceptions, benefits in the FEHBP standard option either meet or exceed those that state mandates require. This indicates that a broad-based national benefit standard for minimum creditable coverage—one that spans all necessary medical care typical of the benefits provided in large-group plans—would include most existing state benefit mandates.

Table 1. Benefits Explicitly Excluded by FEHBP Standard Option

Mandated Benefit	States	
In Vitro Fertilization (IVF)	Arkansas Connecticut Hawaii Illinois Maryland	Massachusetts New Jersey Rhode Island Texas
Temporomandibular Joint (TMJ) Syndrome	Arkansas California Connecticut Florida Georgia Illinois Kentucky Minnesota Mississippi Nebraska	Nevada New Mexico North Carolina North Dakota Texas Vermont Virginia Washington West Virginia Wisconsin

Source: National Association of Insurance Commissioners.

Table 2. State-Mandated Benefits Beyond Standard of Care

Mandated Benefit	States
Ovarian cancer screening	California Georgia Illinois Minnesota North Carolina

Sources: National Association of Insurance Commissioners; State Cancer Legislative Database.

Table 3. Providers Explicitly Excluded by FEHBP Standard Option

Mandated Provider	States
Naturopath	Alaska Connecticut Hawaii* Montana

* Must offer optional coverage for naturopaths.
Source: National Association of Insurance Commissioners.

Table 4. State Mandates for Mental Health Coverage

Mandated Coverage for Mental Health Illness	States	
Mental health parity	Arkansas Connecticut Delaware Georgia Hawaii Illinois Indiana Iowa Kentucky Missouri Montana	Nebraska New Hampshire New Jersey New Mexico Oklahoma Pennsylvania Rhode Island South Dakota Texas Vermont
No treatment limits for psychologist visits	District of Columbia	
Minimum number of visits exceeds the 25 visits covered in FEHBP Blue Cross and Blue Shield standard option	Mississippi Nevada Pennsylvania	

Source: National Association of Insurance Commissioners.

Table 5. State Mandates Requiring Broader Scope of Benefits Than FEHBP Standard Option

Mandated Benefit	Standard Plan Coverage	State	**State Mandate**
Hearing aids for adults*	$1,000 per ear per 36-month period	Kentucky Louisiana Maine Maryland	$1,400 per aid per 36-month period
		Rhode Island	$1,500 per aid per 36-month period
Hair prostheses	$350 for one wig per lifetime	Connecticut Massachusetts New Hampshire	$350 per year
Chiropractic care	One office visit per calendar year; one set of X-rays per calendar year	Arizona	Minimum of 12 visits per year
		Florida	Minimum of 24 visits per year
		Maryland	Minimum of 20 visits per condition per year
		Connecticut Missouri Nevada	Parity with coverage for physician services

* Data on hearing aids from *Kaiser State Health Facts,* March 2008.
Source: National Association of Insurance Commissioners.

Notes

1 The FEHBP standard option reflects current standard practice within employer-sponsored health insurance with one exception: while a majority of employer-sponsored plans cover abortion, because of federal law prohibiting coverage for federal employees and their dependents in any other circumstances, abortion is covered in the FEHBP standard plan only if the life of the pregnant woman would be endangered if the fetus were carried to term or in the case of rape or incest. See: A. Sonfield, R. Benson Gold, J. J. Frost et al., "U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002," *Perspectives on Sexual and Reproductive Health,* March/April 2004 36(2):72–79; and "Consolidated Appropriations Act, 2008," P.L. No. 110-161, §§ 615-16, 121 Stat. 1844, 2015 (2007).

2 M. Merlis, *Medicare Restructuring: The FEHBP Model* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, Feb. 1999).

3 Large employers that self-insure rather than purchase full insurance do not have to abide by state-mandated health benefit standards because they are exempted by the Employee Retirement Income Security Act (ERISA).

4 In contrast with the narrow focus of state benefits mandates, the policy options released by the Senate Finance Committee in May 2009 describe minimum creditable coverage broadly, including preventive and primary care, emergency services, hospitalization, physician services, outpatient services, prescription drugs, mental health services, and many other types of health services. See Senate Finance Committee, *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans, Description of Policy Options*, May 14, 2009.

5 National Association of Insurance Commissioners (NAIC), *Mandated Benefits,* updated Aug. 2008. In addition to using these tables, we drew on results of a Web search of home health benefits (which are not explicitly included in NAIC) and *Kaiser State Health Facts,* http://www.statehealthfacts.org/.

6 J. Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics*, 1994 55(3):433–64.

7 National Conference of State Legislatures, *State Laws Related to Insurance Coverage for Fertility Treatment,* Feb. 2009, http://www.ncsl.org/programs/health/50infert.htm.

8 NAIC, *Mandated Benefits,* 2008.

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