Health Benefit Mandates

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Federal Requirements & History

- Prior to the Affordable Care Act (ACA), states regularly passed state mandated benefit laws to define the benefit package required by state-regulated health issuers.
- The ACA created the concept of essential health benefit (EHB) packages and requires qualified health plans offered on the individual market and small group market plans to provide coverage of 10 EHBs.
- The ACA allowed states to states to require coverage above and beyond the 10 EHBs but requires that states defray the cost of benefits added after 2012 following the process in 45 CFR 155.170.
- Between 2012 and 2021, Minnesota passed one benefit mandate that exceeded the state's EHB coverage and requires defrayal.
- As part of the health benefit evaluation process, Commerce determines if a mandate exceeds the coverage required under the state's EHB plan and requires defrayal.

Health Benefit Mandates

Minn Stat. § 62J.26

A "mandated health benefit proposal" is a proposal that would require a health plan to:

- Provide or increase coverage for the treatment of a certain disease, condition, or other health care need;
- Provide or increase coverage of a particular type of treatment or service or of equipment, supplies, or drugs used in connection with a treatment or service;
- Provide coverage for care delivered by a specific type of provider;
- Require a particular benefit design or cost-sharing for:
  - The treatment of a certain disease, condition, or other health care need
  - A particular type of treatment or service
  - The provision of a particular type of treatment or service or of equipment, supplies, or drugs used in connection with a treatment or service
- Impose limits or conditions on a contract between the plan and a provider

What is not a mandate and applicability

- "Mandated health benefit proposals" do not include:
  - Proposals that amend the scope of practice of licensed health care professionals
  - Proposals that make state law consistent with federal law
- State mandates can only apply to state regulated insurance products
  - Typically applies to about 18% of Minnesotans, including those enrolled in individual (187k), small group (210k), and fully insured group (670k)
  - Depending on the bill, may also apply to Medicare supplement plans, SEGIP and Minnesota Health Care Programs

Important terms

- Defrayal cost:
  - Amount the state must pay to issuers annually to defray the cost of coverage for state mandated benefits that are in addition to the state's EHB benchmark plan.
  - Full defrayal vs partial defrayal
- PMPM cost:
  - The estimated impact of covering an additional benefit on health insurance premiums. Can be the result of increased utilization, reductions in cost sharing or prohibitions on utilization management, medical trend increase, etc.

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Health Benefit Mandate Evaluations

Statutory Authority

- State law (Minn. Stat. § 62J.26) requires the Department to evaluate and report the potential impacts of legislative proposals that would require health insurers to add or increase coverage for certain conditions, diseases or other health care needs.
  - Evaluations focus on potential fiscal, economic and public health impacts of proposed legislation.
- Commerce contracts with a vendor – American Institutes for Research (AIR) – to assist in the evaluation process.

Timeline

- Legislators submit proposed mandates by August 1 of each year.
- House and Senate Commerce chairs prioritize lists based on number of mandates submitted, capacity available for evaluation, and the relative difficulty of the evaluations.
- Once the list is determined, Commerce has 180 days to submit the evaluations to the legislature.

What goes into a mandate evaluation?

- AIR assesses the mandate, including available literature and data from MDH, to determine the scope of evaluation:
  - Full
  - Full without actuarial analysis
  - Limited
  - Modified

What goes into a mandate evaluation?

- For each evaluation, Commerce posts a request for information (RFI) to gather data from advocates, providers, and health plans.
  - Commerce also receives information from MMB about coverage and fiscal impacts of each mandate on SEGIP.
- AIR conducts key informant interviews with the member who submits the mandate proposal.
- AIR conducts a literature review and works with MDH to analyze claims data to assist in defrayal determinations and determine a per-member, per-month impact, if applicable.
- Commerce completes a defrayal analysis and health actuaries use the information from MDH and AIR to calculate an estimated cost of defrayal, if applicable.

Process Limitations

- Limitations in available data
  - Evaluations of the cost related to newer treatments (e.g., gene therapies) have limited claims experience.
  - Commerce and AIR can only utilize data available from claims in the APCD or provided by the health plans via the RFI.
    - PMPM estimates calculated by Commerce and AIR may differ from those calculated by carriers due to use of different methodologies, data sources, and/or assumptions.
- Mandate evaluations that include broad coverage of diagnoses, treatments, and procedures can limit the accuracy of evaluation results.
- Reviews and estimates are based on original language submitted; changes to bill language may impact estimated costs and limit accuracy of findings.
- Potential downstream cost savings associated with coverage of proposed mandates exceed the scope of the project

Evaluations by the Numbers

- Commerce has completed 34 benefit mandate evaluations over 4 years.
  - 26 of those create requirements for issuers to cover specific care, treatment, or services.
  - 11 were determined to require defrayal under the ACA.
    - Of these 11:
      - 5 were determined to require full defrayal.
      - 6 were determined to require partial.
  - 2 were unclear whether partial defrayal is required.
  - 4 bills requiring defrayal have passed since establishment of the mandate review process.
  - 9 additional bills that did not require defrayal have passed.

Retrospective Evaluations

- The 2023 legislature directed Commerce to conduct a retrospective evaluation of one existing benefit mandate annually until 2028.
- 2023
  - Evaluated coverage of breast cancer screening using 3D mammograms for enrollees at high risk of breast cancer (62A.30, subd.4)
- 2024 (underway)
  - Evaluating coverage of chiropractic care

2024 Mandate Evaluations

Mandate	Requires defrayal?	Year 1 defrayal estimate	AIR PMPM estimate	Issuer PMPM estimates
Coverage for vasectomies	No	N/A	$0.23	$0 to up to $0.20
Coverage for genetic testing and imaging for cancer	No	N/A	$1.53	Up to $1.35
Coverage for gene therapy treatment for sickle cell anemia	No	N/A	N/A	$0
Coverage for OTC contraceptives	No	N/A	N/A	Up to $2.20
Coverage for powered standing systems	Yes	$400k - $1.5 million	N/A	Up to $0.10
Coverage for bowel & bladder management for spinal cord injuries	Unclear	N/A	$0.01	Up to $0.10
Coverage for inherited metabolic diseases	Unclear	N/A	N/A	Up to $0.65
Eliminate copays for mental health services for children	N/A	N/A	N/A	Up to $2.40
Requirement for maternal mental health programs	N/A	N/A	N/A	Up to $0.70 but hard to estimate

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Existing Health Benefit Mandates

Evaluated Health Benefit Mandates in Law

Year Evaluated	Mandate	Requires defrayal?	Defrayal estimate	AIR PMPM estimate
2021	Requires flat drug copay plans (62Q.81, subd. 6)	N/A	N/A	N/A
2021	Changes copays for coverage for breast cancer follow-up services (62A.30, subd 5).	No	N/A	$0.25 to $0.63
2022	Requires inclusion of PRTFs in their networks (62K.10)	N/A	N/A	N/A
2022	Limits cost-sharing for chronic disease drugs and supplies (62Q.481)	No	N/A	$1 in year 1; $1.34 in year 10
2022	Provides out of network coverage for rare diseases (62Q.451)	N/A	N/A	$7.28 in year 1; $11.13 in year 10
2022	Coverage of biomarker testing (62Q.473)	Yes	$432,000 to $2,594,000 in year 1	$0.09 to $0.22 in year 1; $0.14 to $0.32 in year 10

Evaluated Health Benefit Mandates in Law

Year Evaluated	Mandate	Requires defrayal?	Defrayal estimate	AIR PMPM estimate
2023	Coverage for gender-affirming care (62Q.585)	No	N/A	$0.05 in year 1; $0.91 in year 10
2023	Coverage for scalp hair prostheses (62A.28)	No	N/A	$0.13 in year 1; $0.17 in year 10
2023	Coverage for prenatal, maternity, and postnatal care (62A.0411, 62A.047, 62Q.521)	No	N/A	N/A
2023	Coverage for intermittent catheters (62Q.666)	No	N/A	$0.46 to $2.06 in year 1; $2.92 to $15.40 in year 10
2023	Coverage for orthotic and prosthetic devices (62Q.665)	Yes, partial	$350,000 to $520,000 in year 1	$0.39 in year 1; $3.65 in year 10
2023	Coverage for abortion and abortion-related services (62Q.524)	Yes, partial	$90,000 to $300,000	N/A
2023	Coverage for rapid whole genome sequencing (62A.3098)	Yes	$20,000 to $800,000	$0.02

Defrayal Payment Process

- Each spring, carriers submit their actual claims experience for the prior plan year to Commerce for defrayal.
- Commerce reimburses based on claims paid for that mandated benefit.

PANS/PANDAS Defrayal Experience

- Effective January 1, 2020
- Total amount defrayed since 2020: $139,323.89

Plan Year	Number of Plan Requests	Total Amount Defrayed
2020	0	$0
2021	1	$40,962.30
2022	1	$31,784.24
2023	2	$66,577.35

Newly Enacted Mandates Requiring Defrayal

The following benefit mandates became effective for plan year 2025 and will result in future defrayal payments:

- Coverage of rapid whole genome sequencing (estimated cost of $20,000 to $800,000 in the first year)
- Coverage of biomarker testing (estimated cost of $432,000 to $2,594,000 in the first year)
- Coverage of abortion and abortion-related services (estimated cost of $90,000 to $300,000 in the first year)
- Coverage of orthotics and prosthetics (estimated cost of $350,000 to $520,000 in the first year)

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Thank You!

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