New York HPA Health Plan Association

Issue Brief

TIME FOR AFFORDABILITY

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The Impact of Mandated Benefits on Health Care Costs

New York has more than 45 mandated benefit laws in statute, requiring coverage for more than three dozen types of treatments or services. In the current legislative session, 91 mandated benefit bills have been proposed to require coverage for nearly 30 new services or provider types, including coverage for dental night guards, infant formula, acupuncture, and electrolysis, as well as limits on cost-sharing, and restrictions on prior authorization and provider contracting. The collective impact of mandated benefits adds significantly to the cost of health insurance coverage for everyone – consumers, employers, union benefit funds and the state – and runs counter to efforts to make New York more affordable.

This issue brief provides an overview of mandated benefits — in both federal and state law — who pays for these benefits and recommendations for policymakers including:

- Establishing an independent review process before adopting new mandated benefits.
- Recognizing the cost of mandated benefits in premium rates.

What Are Mandated Benefits?

Mandated benefits are statutory or regulatory provisions that require coverage of specific types of services, treatments or providers. Typically, mandated benefits fall into one of two categories:

- A requirement that health plans cover specific types of health care services or treatments.
- A requirement that health plans reimburse particular providers other than physicians.

What Services are Mandated in New York?

Federal Requirements: ACA Essential Health Benefits (EHBs)

The Affordable Care Act (ACA) established and defined a comprehensive set of benefits and services, known as the Essential Health Benefits (EHBs) package – 10 categories of services that health insurance plans must cover. The requirement to cover EHBs applies to all individual and small group policies with effective dates on or after January 1, 2014, and includes the following services:

• Ambulatory services (outpatient care)	• Mental health and substance use disorder services
• Emergency services	• Rehabilitative and habilitative services and devices
• Hospitalization (inpatient care)	• Laboratory services
• Maternity and newborn care	• Preventive care and chronic disease management
• Prescription drugs	• Pediatric services, including oral and vision care

New York State Requirements

Under the ACA, states must establish a benchmark plan, outlining the specific benefits and services that would serve as the EHB package and constitute the minimum required benefits for coverage offered in the individual and small group markets in the state. New York state law mandates coverage for 47 specific services, treatments, supplies and practitioners that go beyond the federal requirements. This includes home health care, enteral formula, eye drop refills, infertility treatment, chiropractic care, various cancer screenings, biomarker testing, diabetic equipment and supplies, testing for dyslexia, and services for autism spectrum disorders.[1]

[1] NY State Department of Financial Services, State Mandated and Make Available Benefits for Comprehensive Commercial, HMO & Article 43 Health Insurance Contracts – note the current list only reflects mandates passed through 2018. https://www.dfs.ny.gov/apps_and_licensing/health_insurers/mandated_make_available_benefit_listing

Who Pays for Mandated Benefits?

Implications for Consumers, Employers & Labor Unions

Mandated benefit bills pertain only to fully-insured policies, which usually are purchased either by individuals buying coverage on their own or small, medium-sized businesses for their employees, or union benefit funds. Mandating coverage of specific services limits the ability of employers and labor unions to manage their health care costs and requires inclusion of benefits their workforce may not want or need.

Large companies typically "self-insure," providing employee health benefits by directly paying health care claims to providers. These companies are governed by the Federal Employee Retirement Income Security Act (ERISA), which preempts states from regulating these plans. This enables them to avoid covering certain mandated benefits and provides them with greater control over their health care costs. Today, more than half of New York's commercial marketplace is covered under a self-insured plan and as more employers self-insure, state mandated benefits affect an increasingly smaller portion of residents.

Implications for the State

States may mandate benefits beyond the EHB, but the ACA requires that States defray the cost of additional mandated benefits in the individual and small group markets. Originally, the ACA required that states absorb the costs of any mandated benefits passed after December 31, 2011 that fell outside the EHB package established as part of a state's benchmark plan. In 2024, CMS updated its rule to clarify that states would not be required to absorb the cost of a new mandate if the benefit is already included in the state's benchmark plan, but would require defrayal for new benefit mandates that go beyond the benefits in the benchmark plan. As a result, if the state passes a law mandating coverage for a benefit that is not included within the state's benchmark plan, federal rules require New York to defray those costs by either reimbursing the health plan or the member. This would require that the state appropriate the funds as part of the budget.

No New Mandated Benefits

New Yorkers are struggling with high health care costs. Given the challenge employers and consumers face and the uncertainty the impact federal health care cuts will have on the state and the cost of coverage, legislators should avoid passing new mandates. Rather than piling on more costs and making coverage more expensive, policymakers should adopt the following proposals:

- **Establishing an Independent Review of Mandate Benefits:** More than 30 states have a process to review the cost of mandates. Before any new mandated benefits are passed, an independent analysis should be undertaken to provide policymakers with the estimated fiscal impact of existing mandated benefits. The Department of Financial Services should conduct a review of mandated benefits required by state law in effect as of December 31, 2024, to understand the current costs mandates have on premiums.
- **Recognizing the Cost of Mandated Benefits in Premium Rates:** The enactment of new mandated benefits has an implication on premium rates. If requiring coverage of particular services or treatments is a policy priority for lawmakers, there should be a process to ensure that those costs are recognized, with the Department providing an analysis of their impact on premiums before any new mandated benefits take effect.