Prepared by the North Dakota Legislative Council staff for the Budget Committee on Health Care
October 2001

HEALTH INSURANCE COVERAGE MANDATES IN OTHER STATES

A health insurance coverage mandate is a law requiring an insurance company to include a specified benefit in certain health insurance policies or to make a specified benefit available at the option of policyholders. Coverage mandates can require that insurance policies cover a particular benefit, that coverage be provided for the services of a category of health care providers, or that coverage be extended to a population group not otherwise covered. In addition to coverage mandates, there are other types of mandates which may affect health insurance providers, such as administrative mandates which may impose new requirements relating to the processing or payment of claims.

In 1965 there were only seven state-mandated benefits. By 1997 there were approximately 1,000 state-mandated benefits. By 1999 based on a survey conducted by Blue Cross Blue Shield, the number of state health insurance mandate laws had increased nearly 40 percent to 1,391, of which 677 mandated certain benefits, 444 mandated the coverage of specific provider services, 241 mandated specific persons be covered, and 29 mandated coverage for specific procedures.

The Blue Cross Blue Shield publication entitled *State Legislative Health Care and Insurance Issues: 2000 Survey of Plans* indicates that during the year 2000, state legislatures enacted numerous benefits and other mandates, as summarized below:

State	Description of Mandate	
	Benefit Mandate	**Administrative/Other Mandate**
Alabama	**Mental health care** - Health plans covering 50 or more employees must cover the treatment of mental illness.	
Alaska	**Diabetic care** - Health plans must cover diabetic medication, supplies, and self-management training.	
	Prostate cancer - An existing prostate cancer screening mandate was expanded by lowering the mandatory age.	
Arizona	**Chiropractic care** - Health plans are required to cover chiropractic services.	**Payment of claims** - Clean claims (those submitted initially with all required information) must be paid within 30 days.
	Clinical trials - Plans must cover patient costs for treatment provided in cancer clinical trials.	
	Metabolic disorders - Plans must cover medical foods to treat metabolic disorders, up to $5,000 per year.	
Colorado	**Eye care** - Health plans are prohibited from imposing deductibles or coinsurance for eye care services that are greater than those for other medical services.	
	Prosthetic devices - Health plans must cover prosthetic devices.	
Connecticut	**Pain management** - Plans must cover medically necessary medications and procedures ordered by a physician pain management specialist.	
	Ostomy-related supplies - Plans must cover ostomy-related appliances and supplies up to $1,000 annually.	
Delaware	**Contraceptives** - Plans must cover contraceptive drugs and devices.	

State	Description of Mandate	
	Benefit Mandate	**Administrative/Other Mandate**
	Diabetic equipment - Plans must cover diabetic equipment and supplies.	
	Colorectal cancer - Plans must cover colorectal cancer screening.	
	Cervical cancer - Plans must cover cervical cancer screening.	
District of Columbia	**Diabetic equipment** - Plans must cover diabetic equipment, supplies, and self-management training.	
Florida	**Newborn hearing** - Plans must cover newborn hearing screening and any followup evaluations.	
Hawaii	**Diabetic equipment** - Plans must cover diabetic equipment, supplies, and self-management training.	
Indiana	**Obesity** - Plans must cover the surgical treatment of morbid obesity if it has persisted for at least five years.	
	Colorectal cancer - Plans must cover colorectal cancer examinations and laboratory tests.	
Iowa	**Dental care** - Plans must cover necessary hospital and anesthesia charges for certain individuals needing dental care.	
	Contraceptives - Group plans must cover prescribed contraceptives.	
Kansas		**Payment of claims -** Plans must pay clean claims within 30 days or be faced with a civil money penalty.
Kentucky	**Mental health care** - Large group plans must provide coverage for treatment of a mental health condition under the same terms as treatment of a physical health condition.	**Payment of claims** - Plans must reimburse provider clean claims within 30 days.
	Mammograms - The existing mammography benefit was expanded to require health plans to cover mammograms for any covered person, regardless of age, who has been diagnosed with breast disease.	
	Metabolic diseases - Plans must pay for foods needed to treat metabolic diseases, up to $4,000 per year.	
Maine	**Clinical trials** - Plans must cover routine patient costs in clinical trials if an insured has a life-threatening illness for which no standard treatment is effective.	
Maryland	**Hair prosthesis** - Plans must cover one hair prosthesis for hair loss resulting from chemotherapy or radiation treatment for cancer, up to a cost of $350.	
	Child habilitative services - Plans must cover habilitative services for a child under age 19 who was born with a mental or physical disability.	

State	Description of Mandate	
	Benefit Mandate	Administrative/Other Mandate
	In vitro fertilization - Plans must provide coverage for in vitro fertilization procedures up to three attempts per live birth, not to exceed a lifetime maximum of $100,000.	
Massachusetts	**Emergency services** - Plans must cover emergency room screening and stabilization services.	
	Mental health care - Plans must cover treatment of biologically based mental health illnesses as well as services for rape-related mental or emotional disorders.	
Michigan		**Claim review period** - The time period allowed for a plan to review a denied claim was reduced from 90 to 45 days.
Minnesota		**Payment of claims** - Plans must pay clean claims within 30 days to avoid an interest penalty.
New Hampshire	**Clinical trials** - Plans must cover patient care costs for clinical trials for cancer and other life-threatening diseases.	**Payment of claims** - Plans must pay electronically submitted clean claims within 15 calendar days; nonelectronic clean claims within 45 days.
	Chiropractic visits - Managed care plans must provide coverage for up to 12 chiropractic visits annually without referral from a primary care provider.	
New Jersey	**Wellness examinations** - Coverage for wellness examinations was changed from a mandated offering to a required benefit.	
	Mammograms - The eligibility age for annual mammography screening was lowered from 50 to 40 years of age.	
New Mexico	**Mental health care** - Group health plans are prohibited from imposing treatment limits or financial requirements on the provision of mental health benefits if identical limits or requirements are not imposed on benefits for other conditions.	**Payment of claims** - Plans must pay electronic claims within 30 days and nonelectronic claims within 45 days.
New York	**Occupational therapy** - Plans must cover services provided by a licensed occupational therapist.	
North Carolina		**Payment of claims** - Plans are subject to an interest penalty of 18 percent if they fail to process a claim within 30 days.
Oklahoma	**Hair prosthesis** - Plans sold to groups of 50 or more must cover hair prosthesis or wigs for employees who have lost hair due to cancer treatment.	
	Eye care - Plans must provide the same fee schedule for reimbursement of optometrists as for ophthalmologists.	
Rhode Island	**Hearing aids** - Plans must offer employer groups the option of purchasing a hearing aid coverage rider.	
	Prostate and colorectal cancer - Plans	

State	Description of Mandate	
	Benefit Mandate	**Administrative/Other Mandate**
	must provide coverage for prostate and colorectal examinations and laboratory tests.	
	Contraceptives - Plans must provide coverage for FDA-approved prescription contraceptive drugs and devices.	
South Carolina	**Mental health care** - Mental health parity coverage was mandated on a pilot basis for the state employee insurance plan.	
South Dakota	**Prescription drugs** - Plans must provide coverage for the "off-label" use of prescription drugs used for the treatment of cancer or life-threatening conditions.	
Tennessee		**Prescription drug cards** - Plans that provide coverage for prescription drugs must issue a card to each insured with the insured's name and other information.
		Payment of claims - Plans must pay electronically submitted clean claims within 21 days and non-electronically submitted clean claims within 30 days.
Utah	**Emergency services** - Plans must cover emergency room screening and stabilization services.	
	Mental health care - Small group plans must cover catastrophic mental health services on a limited parity basis.	
	Diabetic equipment - Plans must cover diabetic equipment, supplies, and education.	
Virginia	**Colorectal cancer** - Plans must cover colorectal cancer screening.	
	Dental anesthesia - Plans must cover dental anesthesia when performed on an inpatient basis.	
	Obesity - Plans must cover treatment for morbid obesity.	
	Immunizations - Health maintenance organizations must cover all routine and necessary immunizations for children from birth to age 3.	
Washington	**Prescription drugs** - Individual plans must cover prescription drugs up to $2,000.	
	Maternity care - Plans must cover maternity care up to $2,000.	
West Virginia	**Colorectal cancer** - Plans must cover colorectal cancer examinations and laboratory tests.	
Wisconsin	**Immunizations** - Plans must cover appropriate and necessary immunizations from birth to age 6 for dependent children.	

The Blue Cross Blue Shield report, *State Legislative Health Care and Insurance Issues: 2000 Survey of Plans,* from which the preceding information was taken, includes an appendix listing various categories of mandates and the year enacted in each state. That information is attached as an Appendices A and B to this memorandum.

Appendix A shows mandates grouped in “provider” and “persons covered” categories. Appendix B shows benefit mandates.

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