

Cancer Insurance Mandates and Exceptions

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States face difficult decisions in regulating insurance. On the one hand, states seek to require coverage for various insurance benefits to promote public health and protect people from financial risk. On the other hand, insurance mandates raise the cost of policies. Since state mandates do not apply to self-insured Employee Retirement Income Security Act (ERISA) plans that typically are provided by large employers, the cost of state mandates fall more heavily on already more expensive small group and individual markets. Thus, states often find that they must perform a delicate balancing act based on the reality that some coverage may be better than none, but that limited coverage is not always desirable. "Mandate-lite" or "mandate-free" plans target specific populations and markets that are most likely to be uninsured, such as young adults and individual and small group markets.

The decision to require insurance coverage for cancer is particularly challenging. A cancer diagnosis often is unexpected. Early diagnosis often determines the difference between life and death, making effective screening more vital. This report summarizes state insurance requirements for cancer-related services and exemptions provided by states.

State Cancer Mandates

States have required certain health benefits and treatments since the 1960s. Early mandates guaranteed that the insured would receive a certain level of care and benefits under a given policy. More recently, advocates for specific diseases and conditions have lobbied legislatures to improve access and treatment for people with particular diseases.

Cancer-related mandates began as requirements for treatments but now include screening and prevention efforts to expand access to life-saving services. Over the years, organizations such as the American Cancer Society have promoted screening recommendations based on current research and evidence.¹ Early detection, treatment and follow-up reduces the chance that cancer will spread, making it generally easier—and less costly—to treat.²

There are 25 cancer-related mandates enacted in at least one state. Federal law requires insurance coverage for breast reconstruction after a mastectomy, which applies to every state and ERISA plans. Mammography is the most common state mandates, found in 49 states and the District of Columbia. Requirements for minimum stays after a hysterectomy or testicular cancer procedure are found in only two and one state, respectively. Some mandates—such as hospice care, long-term care, second opinions and infertility treatment—apply to broader segments of the population and are not considered cancer-specific costs or benefits. A wide variation exists in the number of cancer-related mandates in a given state, from 18 in Rhode Island to two in Idaho and Utah.

Although state statutory mandates typically require coverage, "mandated offerings" require insurers to offer at least one additional type of insurance policy including coverage for that benefit. Because they do not require employers or individuals to choose that policy, however, they do not ensure coverage for an enrollee. Appendix A lists the cancer-related mandated benefits and offerings by state.

¹American Cancer Society, "Chronological History of ACS Recommendations on Early Detection of Cancer" (Atlanta: ACS, 2009); www.cancer.org/docroot/PED/content/PED_2_3X_Chronological_History_of_ACS_Recommendations_on_Early_Detection_of_Cancer.asp?sitearea=PED.

²D. M. Eddy, "Screening for Cervical Cancer," *Annals of Internal Medicine* 113 (1990): 214-226; www.michigancancer.org/PDFs/CancerAdvocacyToolKit/CostSavingsAssocWCaScreening.pdf.

Many people recognize the value of preventive care, even without mandates. The *Wall Street Journal* reports³ that 72 percent of large employers cover 100 percent of the cost of preventive care, including cancer screening, although confusion among providers, patients and insurers can lead to preventive service billing errors. Mandates can minimize billing errors by standardizing coverage for a treatment or procedure within a state.

Limited Benefit Options

According to the U.S. Census Bureau,⁴ 45.7 million people—17.1 percent of the population under age 65—were uninsured in 2007. That number has since increased due to higher unemployment rates and state budget shortages that have limited public coverage programs. According to the Kaiser Family Foundation,⁵ 58.9 percent of the uninsured in 2007 were under age 35, 65.3 percent had incomes below 200 percent of the federal poverty guidelines, and 69.1 percent had a full-time worker in the family. The uninsured face greater medical and economic risks and also cost states and the insured through safety-net programs, uncompensated care and cost-shifting.

Several states have adopted limited benefit plans to lower the cost of insurance and reduce the number of uninsured, often targeting these plans at small businesses and young adults. Limited benefit plans usually are considered a compromise between the ideal of comprehensive insurance and the reality of not having insurance coverage. Appendix B lists statutes and legislation to establish limited benefit plans and summarizes how the plans address cancer-related requirements.

Some are concerned that limited benefit plans will draw in people who currently have comprehensive insurance, which could spur adverse selection, driving up premiums in comprehensive plans and increasing uncompensated care that would have been covered in a comprehensive plan. In response, many limited benefit plans include crowd-out provisions similar to many public insurance plans that require small businesses or individuals to have been uninsured for some period of time before they can enroll.

In practice, these benefit options have met with limited commercial use⁶. According to a report from the State Coverage Initiative,⁷ many insurers chose not to offer limited benefit options because premiums were not substantially cheaper (typically less than 10 percent reduced), concerns about adverse selection and a lack of enrollee interest in the reduced benefit package. Most limited benefit plans that are offered are small, with enrollment below 1,000. Among the uninsured, the availability of safety-net options can reduce demand for limited benefit coverage.

An exception to the limited use of these plans has been state-subsidized limited benefit plans. Maryland's Primary Adult Care program, Pennsylvania's adultBasic and Utah's Primary Care Network provide limited benefit coverage to low-income, uninsured adults, a group not generally eligible for state insurance programs. All have reached their enrollment caps, ranging from 8,000 to 40,000, with demand exceeding the availability of funding. This led Maryland and Pennsylvania to expand their programs. The Maryland and Utah programs are funded through a section 1115 Medicaid waiver, while Pennsylvania supports the program with tobacco settlement funds.

³ Anna Wilde Mathews, "Why Patients May Be Billed for Free Exams," *The Wall Street Journal*, May 21, 2009; online.wsj.com/article/SB124287021368941879.html.

⁴ U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007; www.census.gov/hhes/www/hlthins/historic/index.html.

⁵ Kaiser Family Foundation, *Health Insurance Coverage in America, 2007*, 2009; facts.kff.org/chartbook.aspx?cb=55.

⁶ Lynn Quincy, "State Policies to Encourage High-Deductible and Limited-Benefit Health Plans: Costs, Constituents, and Concerns," *Policy Brief* (Princeton: Mathematica Policy Research, Inc., March 2009); www.mathematica-mpr.com/pdfs/health/statepolicyencourage09.pdf.

⁷ Isabel Friedenzohn, "Limited-Benefit Policies: Public and Private-Sector Experience," *Issue Brief* 5, no. 1 (Washington, D.C.: State Coverage Initiatives, 2004); www.statecoverage.org/files/Limited-Benefit%20Policies%20-%20Public%20and%20Private-Sector%20Experiences.pdf.

The Arkansas ARHealthNet is a limited benefit plan for small businesses, with premium assistance provided for low-income employees. This program is funded through a Medicaid waiver. CoverTN is Tennessee's subsidized limited benefit program for small employers and low-income self-employed or uninsured workers and recently unemployed individuals. Although many state limited benefit plans focus on primary and preventive care and provide little catastrophic coverage, the Healthy Indiana Plan is a high-deductible, health savings account-based plan, coupling catastrophic coverage with specific incentives promote preventive care.

Unlike limited benefit or "mandate-lite" plans, high-deductible plans have been more successful in the private market since they were authorized nationwide in 2004. According to a study by America's Health Insurance Plans,⁸ 8 million people were enrolled high-deductible health plans, often coupled with health savings accounts, in January 2009. These plans typically achieve lower premiums by increasing enrollee cost sharing rather than reducing covered services. The annual deductibles—the amount not covered by any insurance—are a minimum of \$1,150 for an individual and \$2,500 for a couple in 2009, but may range upward to \$10,000 or \$20,000 per year. Recent studies found that cost sharing as part of an insurance plan significantly reduced the use of effective clinical prevention services.^{9,10,11} A study by the American Academy of Actuaries,¹² however, finds that high-deductible plans have similar or higher use of preventive care and recommended chronic disease treatment compared to traditional plans and provide substantial cost savings.

Conclusion

Appropriate cancer screening and treatment saves lives and money, which has led many states to enact coverage mandates. However, such mandates do not reach the growing population who are uninsured. One strategy to reduce the cost of insurance for the uninsured has been to provide limited benefits and exempt the plans from state mandates. The plans typically have not provided significant cost reduction nor have they proven popular. State-subsidized limited benefit plans and private high-deductible plans have been popular in several states and may help reduce the number of uninsured. They may not do enough, however, from the perspective of those who seek to promote preventive care or protect the economic security of people diagnosed with cancer.

The desire to increase access and affordability for cancer screening and treatment is likely to remain a challenge. Expanding programs that use state subsidies may not be an appealing option in today's economy but many large employers who cover preventive services and the incentives built into programs such as the Healthy Indiana Plan, can provide direction for private market efforts to combine lower cost products for the uninsured with increased access to cancer services.

⁸ Center for Policy Research, *January 2009 Census Shows 8 Million People Covered By HSA/High-Deductible Health Plans* (Washington, D.C.: America's Health Insurance Plans, May 2009); www.ahipresearch.org/pdfs/2009hsacensus.pdf.

⁹ N. Lurie et al, "Preventive care: do we practice what we preach?" *American Journal of Public Health* 77 (1987): 801-804.

¹⁰ G. Solanki, H. H. Schauffler and L.S. Miller, "The direct and indirect effects of cost-sharing on the use of preventive services," *Health Services Research* 34, no. 6 (February 2000): 1331-1350.

¹¹ J.F. Wharam et al, "Cancer screening before and after switching to a high-deductible health plan," *Annals of Internal Medicine* 148, no. 9 (May 6, 2008): 647-55.

¹² American Academy of Actuaries Consumer-Driven Plans Work Group, *Emerging Data on Consumer-Driven Health Plans* (Washington, D.C.: American Academy of Actuaries, May 2009); www.actuary.org/pdf/health/cdhp_may09.pdf.

Appendix A. State Cancer Mandates (continued)

Benefit	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Ambulatory Cancer Treatment					Y												
Bone Marrow Transplant									Y								
Breast Reconstruction (Federal)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cancer Medications						Y							Y				
Cervical Cancer Screening		Y	Y	Y	Y	Y	Y		Y*	Y			Y		Y		Y
Chemotherapy				Y	Y	Y			Y								
Clinical Trials		Y				Y			Y			Y	Y		Y	Y	
Colorectal Screening	Y		Y	Y	Y	Y			Y*	Y			Y	Y	Y		Y
Hair Protheses			Y			Y											
HPV Vaccine	Y									Y	Y			Y			
Hospice Care													Y	Y*			
Infertility Treatment						Y									Y		
In Vitro Fertilization						Y				Y					Y		
Long-Term Care				Y											Y		
Mammography Screening	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Mastectomy			Y	Y	Y	Y	Y						Y				
Minimum Mastectomy Stay			Y		Y	Y	Y		Y	Y			Y		Y		
Minimum Hysterectomy Stay						Y							Y				
Minimum Testicular Cancer Stay																	
Off-Label Drug Use	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y			
Ovarian Cancer Screening					Y	Y											
Prostate Cancer Screening	Y		Y	Y		Y	Y	Y	Y	Y		Y	Y	Y*	Y		Y
Second Opinion						Y								Y	Y		
Smoking Cessation						Y											
Testicular Cancer																	

Source: Blue Cross and Blue Shield Association, December 2008; Council for Affordable Health Insurance, 2009.

*Mandated offering; affects only policies purchased voluntarily.

Appendix B: State Limited Benefit Laws

At least 20 states have statutes or signed legislation allowing some commercial market insurance products to exempt or exclude certain mandates or covered benefits. The laws vary widely in application; not all recent laws may be in effect in 2009.

State	Legislation/Statute Citation	Summary
Arizona	2009 HB 2324, (Ch. 9 of the Acts of 2009) Ariz Rev. Stat. §20-846; §20-1079	Allows insurers to offer individual market plans exempted from some state mandates to uninsured individuals. No cancer-specific mandates are exempted.
Arkansas	Ark. Stat. Ann. §23-98-107	Insurer can offer plan without mandated coverage but must inform enrollee which mandated elements are not covered. Specifically exempted are mandates covering mammograms and in-vitro fertilization.
Colorado	Colo. Rev. Stat. §10-16-105	Insurer can offer any of three designated basic health plans (for small businesses/groups) but must inform enrollee which mandated elements are not covered. Mandates for prostate cancer screening and colorectal screening of high-risk individuals are specifically exempted.
Florida	Fla. Stat. §627.6699	Health Care Access Act allows for mandate-lite plans for small businesses, provided the insurer provides notification of mandated benefits that will not be covered. Retains mandate of mammograms and mastectomy.
Georgia	Ga. Code §33-60	Small Business Employee Choice of Benefits Health Insurance Plan Act allows group and individual insurers to offer plans exempt from some state mandates, although it retains mandate of cancer screenings and cancer treatment for dependent children. Insurer must provide notification that not all mandated benefits will be covered.
Kansas	Kan. Stat. Ann. §40-4704	Provides statutory basis for a low-cost, subsidized small business plan that exempts some mandates, but it has never been subsidized and has not been renewed. It retains mandates for preventive and screening services.
Kentucky	Ky. Rev. Stat. §304.17A-096, 097	Requires disclosure for basic health plan that coverage is limited. Retains federally mandated coverage but excludes state mandated benefits. Basic health plans are offered to individuals, small groups and employer-organized associations.
Louisiana	La. Rev. Stat §40:2212	Outlines basic benefit plan notification standards. Limited benefit plan is exempt from all state mandates.
Maryland	2004 MD SB 570, (Ch. 287 of 2004) Md. Insurance Code §15-1207	Insurers with greater than 10 percent of the small group market are required, and others are allowed, to offer a limited-benefit package provided it is less than 70 percent of comprehensive coverage cost. Only small businesses with average wage below 75 percent of the state average that have not offered coverage in the past year can enroll. Requires that standard, mandate-free plan rate is equal to or less than 10 percent of the average annual wage in the state.
Minnesota	Minn. Stat. §62L.056	Allows insurers to offer plans exempt from state mandates to small businesses. Employer must be

		provided a list of mandated services that are not being covered.
Montana	Mont. Code Ann §33-22-262 Mont. Code Ann §33-22-1821	Demonstration project offering limited benefits for uninsured individuals. Must notify specifically areas where coverage is reduced or absent relative to state mandates. Expired June 2009. Basic health plan for small businesses allows some exceptions to state mandates, but retains some mandated benefits, including mammography.
New Hampshire	N.H. Rev. Stat. Ann. 37 §420-G:4-b	Creates the New Hampshire HealthFirst standard wellness plan for small employers. Based on an ongoing set of meetings, a standard limited-benefit plan will be established for implementation by October 2009 if possible.
New Jersey	N.J. Rev. Stat. §17B:27A	Requires offering limited benefit (basic and essential) plans in the individual market, including the option for a mandate-free offering.
North Dakota	N.D. Cent. Code §26.1-36-12.5	Allows individual and small business (<50 employees) insurers to offer coverage mandates as optional. Specifically exempted is coverage of off-label drug use, mammography and prostate cancer screening.
Rhode Island	R.I. Gen. Laws §27-50-10.1	Allows offering of mandate-free options to small businesses that have not offered insurance to employees in prior year. Option expires at end of calendar year 2010 without further legislative action. Retains mandate on second opinion on elective surgery.
Texas	Tex. Insurance Code Ann. §8G.1507	Allows insurers to offer plans that exclude state-mandated benefits and requires notification to the insured of uncovered mandated benefits. Cancer treatment can be excluded, but cancer screenings cannot.
Utah	Utah Code Ann. §31A-22-633 2009 HB 188 Utah Code Ann. §31A-22-618.5	Allows private insurers to offer plans limited to state Medicaid waiver (Primary Care Network) coverage level. A major health reform package, HB 188, includes a provision allowing some state mandates to be exempted in a plan offered to individual, small employer group, and conversion markets. Does not exempt cancer-related mandates, but does provide exemption from any future state mandates.
Virginia	2009 HB 2024, (Ch. 796 of the Acts of 2009) Va. Code §38.2-3406.1	Allows insurers to offer small employers (50 or fewer employees) a plan exempt from any or all state mandates. Requires clear statement of covered mandates.
Washington	Wash. Rev. Code §48.21.045	Allows small group insurers to offer a policy exempt from most state-mandated benefits. Specifically exempted are mammography and hospice care (a mandated offering).
West Virginia	2009 SB 552, Ch. 135	Revises prior options allowing for limited benefit plans for individuals who have been uninsured for six months (or experienced a qualifying event) and do not have access to other health insurance or for a small employer that has not offered insurance in the prior six months. Retains most cancer mandates but does exempt coverage of clinical trials.

Source: NCSL, 2009; State Coverage Initiatives, 2009.