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A Comparative Analysis of Mandated Benefit Laws, 1949–2002

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Objective. To understand and compare the trends in mandated benefits laws in the United States.

Data Sources/Study Setting. Mandated benefit laws enacted in 50 states and the District of Columbia for the period 1949–2002 were compiled from multiple published compendia.

Study Design. Laws that require private insurers and health plans to cover particular services, types of diseases, or care by specific providers in 50 states and the District of Columbia are compared for the period 1949–2002. Legislation is compared by year, by average and total frequency, by state, by type (provider, health care service, or preventive), and according to whether it requires coverage or an offer of coverage.

Data Collection/Extraction Method. Data from published tables were entered into a spreadsheet and analyzed using statistical software.

Principal Findings. A total of 1,471 laws mandated coverage for 76 types of providers and services. The most common type of mandated coverage is for specific health care services (670 laws for 34 different services), followed by laws for services offered by specific professionals and other providers (507 mandated benefits laws for 25 types of providers), and coverage for specific preventive services (295 laws for 17 benefits). On average, a mandated benefit law has been adopted or significantly revised by 19 states, and each state has approximately 29 mandates. Only two benefits (minimum maternity stay and breast reconstruction) are mandated in all 51 jurisdictions and these were also federally mandated benefits. The mean number of total mandated benefit laws adopted or significantly revised per year was 17 per year in the 1970s, 36 per year in the 1980s, 59 per year in the 1990s, and 76 per year between 2000 and 2002. Since 1990, mandate adoption increased substantially, with around 55 percent of all mandated benefit laws enacted between 1990 and 2002.

Conclusions. There was a large increase in the number of mandated benefits laws during the managed care "backlash" of the 1990s. Many states now use mandated benefits to prescribe not only what services and benefits would be provided but how, where, and when services will be provided.

Key Words. Mandated benefits, insurance, state legislation/policy, managed care

Individuals are likely to have more information about their potential need for care than insurers, so the latter have concerns that potential enrollees seeking coverage may be at greater than average risk. This information asymmetry creates incentives for insurers to offer less broad coverage than the public would want if neither consumer nor insurer knew who was likely to use the coverage. The resulting market failure provides the economic rationale for public mandates that all insurers or health plans provide certain coverage. Mandated benefit laws require health plans and insurers to offer or provide coverage for particular services, and/or types of providers, or laws may provide coverage for the treatment of specific diseases or conditions, such as coverage for pregnancy. Previous research suggests that between 1970 and 1996, there was a 25-fold increase in mandated benefit laws enacted, with a high degree of variation across states, and an expanding scope of mandated services (Jensen and Morrissey 1999).

This paper explores *what* gets mandated, *when*, and *where*, by using a comparative and historical approach to study mandated benefit or service laws. We examine trends in the adoption of mandated benefit laws enacted in the period 1949–2002 in the 50 states and the District of Columbia. The interaction between federal and state mandated benefit laws is also discussed. Data on mandated benefit laws were derived from multiple sources of existing compendia of health insurance mandates (Partnership for Prevention 2002; Blue Cross Blue Shield Association 2003; National Cancer Institute 2005), and therefore is more comprehensive than has been previously analyzed. We find that only two mandates were adopted in all jurisdictions and these were federally mandated: laws requiring a minimum maternal and newborn length of stay following childbirth for mothers and newborns, and breast reconstruction following mastectomy and/or lumpectomy. In the mid-to-late 1990s states and the federal government used mandated benefit laws in new ways as a method to respond to the "managed care backlash."

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BACKGROUND

State-mandated benefit laws reflect the statutory framework for regulating health insurance established by the McCarran–Ferguson Act (United States 1945; King 2003) and developed over the twentieth century. States are primarily responsible for regulating the health plans and insurers selling health insurance to small firms and individuals, however, the role of states differs according to whether insurance is purchased by employers and individuals from insurers, or managed and offered only within a "self-insured" group or employer. In general, the Employee Retirement Income Security Act (ERISA) in 1974 essentially eliminated the state role in regulating employee benefit plans provided by self-insured employers. However, the interpretation of ERISA on other issues such as any willing provider (AWP) has given states power to regulate aspects of self-insured employer plans. Specifically, the U.S. Supreme Court upheld state AWP laws in *Kentucky Association of Health Plans Inc.* vs. *Miller*, 538 U.S. (2003). The Miller case suggests that states may have some latitude in regulating self-insured plans (as long as the law applies to all insurers in the state).[1]

Four federally mandated benefit laws discussed below override ERISA's provisions on exemptions for self-insured firms. The Pregnancy Discrimination Act of 1978 amended Title VII of the Civil Rights Act and requires employer-based health plans and insurers to have the same coverage for pregnancy and other medical conditions (United States Equal Employment Opportunity Commission 2005, 2006). The Newborns' and Mothers' Health Protection Act of 1996 requires hospitalization benefits to cover a minimum number of days in hospital following childbirth. The Mental Health Parity Act of 1996 requires the same annual or lifetime dollar limits for mental and other health benefits, if the insurer or plan offers mental health benefits. The Women's Health and Cancer Rights Act of 1998 requires coverage of breast reconstruction, if mastectomies are also covered, and if reconstructions is performed in connection with a mastectomy. Coverage of prostheses and complications of mastectomy is mandatory, including lymphedema, if insurers also cover mastectomy.[2]

Federally mandated benefit laws do not necessarily override state law, if a state law *also* regulates benefits for these firms and individuals. For example, most states have laws that take precedence over the federal law on lengths of stay following childbirth (Centers for Medicare and Medicaid Services 2005).

Mandates may address market failures that lead to the under-provision of certain benefits, however the additional cost associated with those benefits

may reduce consumer or employer/employee willingness to have coverage at all. Scholarship on mandates has demonstrated certain negative economic impacts of mandated employee benefits (Summers 1989; Gruber 1994), and employer mandated health insurance (Klerman and Goldman 1994). Scholarship has also focused on the politics and impact of federally mandated benefit laws in the 1990s such as maternal and newborn length of stay (Raube and Merrell 1999; Rogowski 1999; Volpp and Bundorf 1999; Malkin, Broder, and Keeler 2000a; Malkin et al. 2000b, 2003; Hyman 2001; Rogowski et al. 2001; Kotagal et al. 2002, 2003; Mosen et al. 2002; Madlon-Kay, DeFor, and Egerter 2003; Madden et al. 2004; Meara et al. 2004). The legislative process provides a venue for mandates that benefit certain interest groups, be they patients, providers, or producers of certain interventions. Researchers have explored the politics behind mental health parity legislation, and they have researched the policy effects (Frank, Koyanagi, and McGuire 1997; Mechanic and McAlpine 1999; Sturm and Pacula 1999, 2000, 2001; Sturm 2000; Zuvekas 2000; Pacula and Sturm 2000a, b; Gitterman et al. 2001; Sing and Hill 2001; Harrington and Miller 2002; Kjorstad 2003; Bao and Sturm 2004). Exploration of the politics and impacts of mandates is well beyond the scope of this paper. Instead, we offer an overview of the trends and patterns in mandates that can serve as a backdrop to future research on the issue and to the role played by the California Health Benefits Review Program discussed elsewhere in this issue.

Whereas there is considerable research on specific state and federal mandates, there are only a handful of comparative studies of state mandated health insurance benefits. Jensen and colleagues (Gabel and Jensen 1989) first documented the rise in the number of mandated benefit laws over time, and their most recent work (Jensen and Morrisey 1999), used public choice theory to explain the proliferation of provider mandates. Federal and state government reports, as well as business groups (Council for Affordable Health Insurance 2004), have examined mandated benefit laws in the context of regulation in health care (United States General Accounting Office 1996; National Center for Policy Analysis 1997; Texas Department of Insurance 1998; Federal Trade Commission 2004). Most of these studies focus mainly on the cost of mandates to businesses, or question the kinds of benefits that are mandated, rather than examine the long-term trends in their adoption. Other studies have explored inconsistencies in the evidence used to develop preventive mandates (Halpin Schauffler 2000; Rathore et al. 2000).

Despite a growing number of mandated benefit laws enacted at the state level, comparative analyses of mandated benefit laws are unusual. One aspect

missing from the research on mandated benefit laws is a basic understanding of not only the quantity of mandated benefit laws, but also how the nature of mandated benefit laws has changed over time. This study adopts a comparative perspective to provide an understanding of the broad trends in mandate adoption.

Data and Methods

Mandated benefit laws from the 50 states and the District of Columbia were identified from secondary sources. Extensive research of legal codes would provide the most comprehensive source of data, however, as a first attempt to understand the broad trends in mandated benefit laws, we sought to develop a comprehensive dataset by combining several published sources of data. We also researched federal laws and conducted an extensive literature search using Medline, using terms such as mandated benefits, mandates, state regulation, state law, jurisprudence, and terms for specific mandated benefits such as maternal and newborn length-of-stay mandates, and mental health parity.

Mandated benefit laws can be defined in various ways. For example, some authors such as Jensen and Morrissey (1999) consider all AWP laws to be mandates. Blue Cross Blue Shield (BCBS) considers the extension of insurance coverage to dependents, such as domestic partners or grandparents, as mandated benefits. The definition of a mandated benefit used in this study is drawn from a California law,[3] which established a formalized review process for mandated benefits legislation in California AB 1996 (see papers in this volume). This legislation defines mandated benefits as requirements that health insurers and health plans offer or provide coverage for treatment by a particular type of health care provider, treatment or service, including for a specific disease or condition. Under this definition, coverage extension mandates such as domestic partner coverage, are not mandated benefits.

Mandated benefit laws were selected based on three criteria. First, benefits had to conform to the definition of a mandated benefit law used above. As a result, laws extending coverage were not included in our analysis. Second, laws enacted or significantly revised after December 31, 2002 were excluded. The rationale for excluding 2003 mandated benefit laws was that we wanted to ensure comparability between multiple data sources. One source, the Partnership for Prevention data, was collected in 2001, and another (BCBS) included laws through December 2003. The 2002 year was chosen to

improve the comparability of the data. In the case of the BCBS data, we also felt that 2002 data may be more reliable than 2003 data, as data would have been corrected or amended by the survey staff. Third, benefits enacted in fewer than three states were excluded. Rather than including the group of small but rarely adopted or significantly revised mandates, we focused on benefits that have gained acceptance beyond two legislatures because these mandates may have greater legislative popularity in other states in the future.

There are three data sources (two of which are described below), however, the principal data source is a list of mandates enacted compiled by the Blue Cross Blue Shield Association (BCBSA) (Blue Cross Blue Shield Association 2003). These data are used in other studies (e.g., Jensen and Morrisey 1999; Pacula and Sturm 2000b). The data are collected by the BCBSA in an annual survey of its members in the 50 states and the District of Columbia at the close of each state's legislative session, and are usually published in December of that year. Health plans are asked to send the national association a list of mandated benefit laws adopted or significantly revised. Repealed laws are not shown in the data. Therefore the survey includes just those mandates in law at the time the data were collected. Laws are classified as provider mandates, benefit mandates, or extension of coverage mandates. In some instances a state may need to pass two laws to implement a single mandate, with one law addressing health insurance plans, and another law affecting HMOs. In the BCBS data, each mandated benefit is only counted once, even if two different laws are passed for managed care and traditional fee for service plans.

The BCBSA data for this paper were collected during 2003 and the list was published in December 2003.

A total of 111 different types of mandated benefit laws were identified from the BCBSA data.[4] A total of 44 laws were excluded, either because they were passed in less than three states and/or enacted after 2002, leaving 67 types of services or providers encompassed in 1,353 laws. Because many of the excluded mandates were mandated just once or twice anywhere in the United States, the actual numbers of laws excluded was 70 laws for 44 services.

Additional mandated benefit laws from other compendia were examined and, where applicable, these were added to create a more comprehensive dataset than has been used in previous studies. Twenty-three mandates included in a Partnership for Prevention compendium (Partnership for Prevention 2002) were evaluated for inclusion. The Partnership compen-

dium data are based on data from the National Conference of State Legislatures' Health Policy Tracking Service on state requirements affecting preventive service coverage in health plans. The Partnership developed a list that included some services recommended by the U.S. Preventive Services Task Force (USPSTF), second edition, and other services commonly covered by health plans. Researchers then compared the extent to which preventive services recommended were mandated in different states. The data were collected in 2001. The year the legislation was enacted is not given. Several of the mandated benefit laws in the Partnership compendium were already included in the BCBSA data, including breast cancer screening, cervical cancer screening, colorectal cancer screening, contraception, osteoporosis screening, prostate cancer screening, and prenatal care (or maternity services). Four benefits were not mandated by any state (folic acid, injury prevention, oral health screening and counseling, and skin cancer), were excluded from our sample along with two laws that had only been enacted in one state each (problem drinking and HIV–STD counseling). After these exclusions, nine mandated benefits from the Partnership compendium were added to the BCBSA data.[5] Finally, a National Cancer Institute database of cancer-related mandates based on searches of legal code was also searched, for additional mandates, and data for one mandate, lymphedema services, were added from this source. The Kaiser Family Foundation state health policy facts collection (Kaiser Family Foundation 2005) were also examined, but no additional data were added from the Kaiser data.

Based on criteria that they must have been enacted before 2003 and in more than two states, a total of 76 mandates were included in the dataset (66 identified from BCBSA, nine from the Partnership data, and one from the NCI data). Sixty-seven mandated benefits (those from BCBSA and NCI) had information about the year in which the legislation was enacted.

We were interested in understanding the time trends in the passage of different types of mandates. Therefore, benefits were classified according to whether they required the insurer or plan to *provide* coverage in all policies or merely *offer* one or more policies with the specific coverage, and the year of legislation (except for the preventive mandates from the Partnership for Prevention, which did not have year of legislation information). Each mandated benefit law was coded as a provider, health care service, or preventive services law. BCBSA coded all of its data, except those mandated benefits on the supplementary list, as provider or benefit coverage mandates. Laws were coded as provider benefits if they covered treatment by a specific type of professional or prescribed coverage of a particular type of

facility. We created a third category of preventive services and recoded data from the BCBSA as preventive if the benefit was also included in the Partnership for Prevention data or the benefit was a screening or wellness benefit. Eight laws in the BCBSA data were coded as preventive services screening benefits (for blood lead, breast cancer, bone density, cervical cancer, Chlamydia, colon cancer, prostate cancer), and well-child care. Maternity services were not coded as preventive as, although they included preventive prenatal care, maternity services are not primarily preventive services. Laws were coded as health care services if they were curative and personal health care services, including durable medical equipment and standard of service mandates such as length-of-stay requirements and did not name the particular type of providers who could offer such services. The sum of mandates enacted was calculated for each state, each mandated benefit law type, and for each year in the study.

Given the nature of the data, which was collected for other purposes and reflects legislation over a long period of time, there are some limitations. Laws that were repealed are not included in the dataset, as the data reflects all laws enacted and current at the time of the survey. To illustrate, if a new mandate was introduced in 1973 in five states, then three states repealed the legislation in 2000, three mandates would not appear in the data for 2003. The staff at BCBSA reported that legislation is "virtually never repealed" (Laudicinia 2005). We also subsequently obtained the next year of data for laws enacted in 2004 (data that were not available during the data collection phase) and compared it with the data used in the study to find out how many laws had been recently repealed. We found just two laws (0.13 percent of the total) that were repealed—autologous bone marrow transplantation in Minnesota, and one for mental health services, in Missouri, which was replaced with a new mandate for mental health parity. This suggests that the rate of repeal is extremely small, however, the fact that repealed legislation is not included does imply that our sample will slightly understate the level of mandated benefits that have been actually in force in this period.

Second, the data do not distinguish between the date of the original legislation and major revisions of legislation subsequent to the legislation. Therefore, it is difficult to estimate whether legislation is new or revised. The BCBSA staff only registers revisions when fundamental changes, rather than technical changes are made to legislation. The BCBSA staff estimated that around 15 percent of all new legislation is revision of old legislation, however, amendments almost always add *greater* coverage rather than remove mandated coverage (in which case we suspect it would be repealed). A lack of

distinction between new and revised legislation does not limit our ability to understand the aggregate *numbers* of laws in the 51 jurisdictions, nor does it limit our ability to explore the timing of legislation. However, with some exceptions, it is difficult to estimate when legislation is new and when it is revised. The exceptions to this is for mandates adopted or significantly revised more recently that are clearly new technologies, such as autologous bone marrow transplantation, or mandates that we can reliably guess were never adopted or significantly revised previously, such as maternity length of stay. However, for such mandates, if the first state to show legislation adopts this mandate in 1995 but revises it in 1997, we may erroneously attribute the first year as 1997. Therefore, this limits our ability to develop a detailed understanding of the diffusion patterns of mandated benefits that are not clearly new technologies or easily recognized as being entirely new benefits. Regardless of whether a law was a revision or an adoption, the law is still mandating a benefit if it is included in the data. To the extent that we do track the trends of adoption by mandate type, we consider legislation in broad bands of time such as 10-year intervals and only consider what we understand as the "earliest" year of legislation for any type of mandate.

The data does not allow us to distinguish which plans are affected by the laws. A related problem is that mandates are not consistently worded across states and some laws may be more or less specific. The scope of a law is difficult to assess without extensive legislative analysis. Offers of coverage (rather than mandated coverage) are one indication that is used as a proxy for how states deal with the issue of generosity, and we find that only 9 percent use offered coverage rather than mandated coverage.

RESULTS

Fourteen-hundred-and-seventy-one mandated benefit laws in 50 states and the District of Columbia were included in the final dataset. The mean number of mandated benefits adopted or significantly revised by states is 29. On average, between 1949 and 2002, each mandated benefit was introduced or revised in 19 of the 51 jurisdictions. Analyzed by type, 25 mandated benefit laws were provider mandates, 17 were for preventive services, and 34 mandates were health care service mandates. The oldest mandated benefit law was enacted in 1949 by Pennsylvania for coverage of services provided by osteopaths and dentists. Maryland has the most mandated benefit laws (52), followed by California (45) and Texas (41).

Trends in Total Mandated Benefit Legislation over Time

Table 1 shows 1,353 current laws introduced or significantly revised between 1949 and 2002, and 118 had no information on when legislation was enacted. Table 1 shows mandate legislation increasing substantially in the 1990s. Nineteen laws were passed or revised in the 20 years between 1949 and 1969, increasing to 169 in the 1970s. Between 1980 and 1989, 365 laws were enacted, 24.8 percent of all laws passed. The following decade 594 laws were enacted, 38.7 percent of the total. From 2000–2002, 229 laws were passed.

The average number of mandated benefit laws enacted per year was one per year between 1949 and 1969, 17 per year in the 1970s, and 37 per year in the 1980s, rising to 57 per year by the 1990s. Between 2000 and 2002, the average number of mandated benefit laws adopted or significantly revised or significantly revised was 76 per year.

Trends in Mandated Benefits Introduced or Revised for the First Time, and Range of Mandates

Jensen and Morrisey (1999) documented an increased range of mandated services in their study. As mentioned earlier, it is difficult to distinguish new versus revised legislation. However, we are able to document the first year that any mandated benefit law is introduced or significantly revised. Table 1 shows that out of a total of 66 mandates, 6 were introduced or significantly revised between 1949 and 1969, 20 between 1970 and 1979, and peaking at 23 between 1980 and 1989. In the 1990s, just 13 benefit laws were passed or revised for the first time, even though 564 laws were enacted (Table 1). Between 2000 and 2002, four benefits were introduced or significantly revised for the first time.

Table 1 shows the range in the kinds of benefits adopted, or how many different kinds of mandated benefits were adopted per year. The row "Range of benefits: number of benefits per year, averaged" shows an average of 10 different mandates per year in the 1970s, 21 in the 1980s, and 22 in the 1990s. The smaller range of benefits enacted in the 1990s relative to the overall number enacted is likely to be a result of two popular federal mandates of the 1990s (maternal and newborn length of stay, and breast reconstruction after mastectomy or lumpectomy). Between 2000 and 2002 states enacted 37 different types of mandates per year. The data for legislation introduced the first time suggests that the increase in the range of benefits cannot be attributed only to new kinds of services, as Table 1 also shows that only four mandated

Table 1: Trends in Mandated Benefit Laws Adopted or Significantly Revised, by Decade, 1949–2002

	1949–1969	*1970–1979*	*1980–1989*	*1990–1999*	*2000–2002*	*Without Year Data*	*Total*
Total mandated benefit laws legislated	19	171	365	569	229	118	1,471
Total number of mandated benefits	6	20	23	13	4	10	76
Number of mandated benefit laws adopted or significantly revised, averaged	1	17	37	57	76		
Range of benefits: number of distinct benefits per year, averaged	1	10	21	22	37		1.7
Percentage of all mandated benefit laws (%)	1.3	11.6	24.8	38.7	15.6	8	100

Note: Mandated benefit laws enacted in three or more states. Includes District of Columbia. Excludes repealed legislation. Data current as of December 2003.

Table 2: Mandated Benefit Laws between 1990–2002

Year	Total Annual Statutes	New Mandated Benefits	Range of Benefits per Year	Benefits That Appeared for the First Time
1990	48	1	25	Off-label prescription drug use
1991	34	1	20	Contraceptives
1992	29	2	15	Bone marrow transplantation and prostate cancer screening
1993	28	1	20	Diabetic supplies and education
1994	30	1	18	Clinical trial participation
1995	34	4	17	Bone density screening, dental anesthesia, maternal and newborn length of stay, emergency services
1996	60	0	18	None
1997	141	1	26	Postmastectomy or lumpectomy length of stay
1998	103	0	29	None
1999	87	2	30	Treatment for morbid obesity, chlamydia screening
2000	89	1	41	Hearing aids
2001	102	3	40	Hormone replacement therapy, telemedicine, first nursing assistant
2002	49	0	29	None
Total	833	17		

Note: Mandated benefit laws in three or more states. Excludes preventive mandated benefit laws without year of enactment information. Includes District of Columbia. Excludes repealed legislation. Data current as of December 2003.

benefits were introduced or revised for the first time after 2000. Therefore, compared with the 1970s and 1980s, and relative to the overall number of mandates, there may be fewer first time laws or revisions, but more states are adopting or revising the same mandated benefit laws already enacted in other states.

Table 2 focuses on trends since 1990 and shows 17 benefits introduced in the period for the first time. Services range from off-label drug use, to bone marrow transplantation, and hearing aids. The highest number of mandates (141) were adopted or significantly revised in 1997.

State Legislation and Federally Mandated Benefit Laws

Just two benefits are mandated in all 51 jurisdictions: newborn and maternal lengths of stay and breast reconstruction after mastectomy or lumpectomy. Table 3 shows 169 states mandated benefit laws addressing benefits that are also federally mandated. During the 1990s, there appears to be strong

Table 3: Federally Mandated Benefits and State Adoption of Federal Mandates

		Federal Mandates Adopted by States and District of Columbia				
*Federal Mandate: Name**	*Federal Year*	*1970–1979*	*1980–1989*	*1990–1999*	*2000–2002*	*Total*
Breast reconstruction	1998	0	5	45	1	51
Maternal and newborn length of stay	1996	0	0	51	0	51
Maternity services	1978	6	4	3	5	18
Mental health parity	1996	0	1	19	11	31
Total		6	28	118	17	169

Note: For mandated benefit laws in three or more states. Excludes repealed legislation. Data current as of December 2003.

*Breast reconstruction after mastectomy or lumpectomy (1998), maternal and newborn length of stay (1996), equal benefit levels under the Pregnancy Discrimination Act (1978) and Mental Health Parity (1996).

interactions between state and federal legislation. Table 3 provides broad time periods within which federal and state legislation was enacted and shows three out of four federal mandates were enacted between 1996 and 1998. A closer look at the years (not shown) suggests that legislation in the states is clustered around the years when federal legislation was introduced. For example, five states enacted breast reconstruction mandates between 1980 and 1985, well before the federal legislation. Eighteen states enacted such legislation in 1996 and 1997, and 27 states enacted or revised the legislation in 1998. Fifty jurisdictions had enacted their own legislation by the time the federal legislation was passed in 1998. The last state mandate for breast reconstruction occurred in 2002. Likewise, maternal and newborn length-of-stay mandates were adopted in 1995 in four states. In 1996 it was federally mandated, and 28 states also enacted this legislation. A remaining 19 states enacted or revised legislation in 1997, which brought the total number of jurisdictions to 51.

Not *all* mandated benefit laws at the federal level are taken up by states. Before the federal mandate, mental health parity was first mandated in three states. Following the federal mandate, state legislation has been steadily increasing, and mental health parity was mandated in 31 states through 2002. Maternity services benefits were introduced at the federal level in 1978 when five states had already passed this legislation, but just 13 states subsequently adopted or revised this legislation. Because of the nature of the data, understanding the sequence of policy is difficult, however, it appears that states were sometimes following and sometimes leading federal legislation. Detailed case

studies of each mandate would be needed to understand fully the dynamics at play.

Mandated Offering

States often choose between two major approaches in the crafting of a mandated benefit law. Health insurers and health plans can be required to cover the benefit in all their policies, which means a benefit must be included in the policy, whether the buyer wishes it or not. On the other hand, a law that requires insurers and plans to offer the coverage simply means it must be offered to the prospective buyer in one or more policies made available by the insurer. As a result, a buyer will usually be offered policies that have higher premiums when they include mandated benefits. Mandated coverage spreads the costs of the additional benefits over the entire insured population, whether they desire it or not, while the mandated offer makes the coverage available, perhaps at a price not affordable by those who may need it, especially if it is subject to adverse selection. From the perspective of the advocates for a mandated benefit law, an "offer law" is a compromise that precludes a full coverage law, and may or may not be better than none at all.

Of the 1,471 mandates, only 138 laws (or around 9.4 percent),[6] are mandated offering as opposed to mandated coverage laws. Eighty three percent of the 51 jurisdictions have at least one mandated offer law. Idaho has the most, with seven offer mandates, and the highest proportion of mandated offer laws, with 64 percent, as well as a lower overall number of mandated benefits. Both Alabama and Idaho's numbers of 14 and 11 total mandated benefit laws, respectively, are low compared with the mean for all states of 29 mandated benefits per state.

DISCUSSION

This study extends the work of existing comparative studies of insurance regulation and benefits by considering the full range of mandated health insurance benefits and their adoption since 1949. Benefit mandates' purposes have changed and broadened substantially over time. Mandates were initially a way for nonmedical providers (nurses, dentists, social workers) to be able to receive insurance reimbursement. Later, alternative providers (acupuncturists and naturopaths) also sought coverage. Today, mandated benefit laws focus more on how services will be provided (such as length-of-stay legislation), where services would be provided (home health services, hospice care), and

even when services will be provided (emergency services). The emphasis on how and where services will be provided reflects a dynamic change between how health plans and insurers have sought to manage health service utilization, and a change in strategy by legislators who introduce laws. Whereas once extending coverage was seen as sufficient, legislators realize coverage for hospital services does not guarantee access to care. Furthermore, mandated benefit laws have taken on multiple purposes beyond medical care as a source of indirect payment of medical research (clinical trials), a means for financing experimental treatments (off-label uses of drugs), and as a means for encouraging greater use of screening services (colorectal, breast, cervical, and prostate cancers, blood lead, cholesterol, and chlamydia).

A substantial increase in the passage of mandate laws occurred in the 1990s, during a period of HMO enrollment growth and public anxiety regarding managed care practices. During the 1990s people perceived that the benefit coverage they had was becoming less generous. In part this was probably a reflection of insurers using "medical necessity" clauses to reject coverage for certain services they felt were not necessary. The public was fearful that care might not be available or paid for if they got very sick (Blendon et al. 1998) and mandates overrode such restrictions. Twenty-five states enacted legislation prohibiting "gag rules" to prevent purported limits on the discussion by clinicians of some treatment options with patients, again reflecting the fear that plans would deny benefits for services clinicians felt were necessary. There is no evidence, however, that plans had clauses that restricted such discussions about treatment (General Accounting Office 1997) (in contrast to the financial relationships they had with the clinicians), or that physicians were restricting their discussions with patients (Mechanic 2001). Similarly, only a small minority of patients had problems with managed care companies denying patients admission to a hospital (Mechanic 2001).

In the years following the failure of President Clinton's Health Security Act, mandates became a powerful symbolic response by Washington and the states to the perceived problems in the health care system. With the failure of a national approach to health insurance, mandates became a de facto reform effort that imposed no public finance costs, and therefore played to demands for lower taxes *and* health care reform. Legislators focused on mandated benefits as a way to show that they were "doing something" about the "problems" of managed care or "gaps" in the health care system. In some cases, mandated benefit laws may be viewed as "political theater" that allows legislators to be on the right side of an issue, rather than passing more fundamental legislation to address a problem.

Legislation on breast reconstruction and maternal and newborn length of stay suggests that in the 1990s there were interaction effects between, or common causes affecting, federal and state mandates. It is not possible to specify the direction of this interaction: whether states adopted mandated benefits because Congress or other states passed these bills, or if in fact Congress followed legislation from the states. However, in the 1990s, the political conditions were somewhat favorable for both states and federal legislatures to benefit from laws passed by the other. A federal proposal that originates from Congress is likely to raise the awareness of the mandated benefit in state capitols. Congressional attention could build legitimacy for the mandated benefit, if there are political similarities between the state and federal majority parties. From the Congressional standpoint, if a wide range of states adopt legislation, it is a signal that the law has broad support and may be popular nationwide. The ease of passing identical legislation increases at the federal level if numerous states have already adopted legislation, and vice versa. The only exception to this is of course, that federal laws affect the self-insured firms (see "Background"). To some extent state passage of comparable legislation is possibly seen as "costless" to most legislators and businesses at the state level, because they must already comply with the federal law. Voters in state elections (who might be less informed than business interest groups) are unlikely to understand that federal laws already mandate those benefits, so they may unwittingly give credit to state legislators for benefits that they already had under federal law.

Political, rather than scientific, consensus over the effectiveness of mandated services is an important ingredient of health insurance mandate laws. Mandates can encourage the adoption of ineffective technology such as ABMT. Well after this controversial technology was mandated in many states the National Cancer Institute reported in 1999 on its randomized controlled clinical trials, that ABMT was not an effective treatment for breast cancer, and studies showed the lack of benefit and occasional harm associated with ABMT (Rettig et al. forthcoming).

The differences between the relative weight of political and scientific factors is illustrated by the examples of maternal length of stay and mental health parity. There was greater political consensus over maternal and newborn length of stay legislation and less political consensus over mental health parity. Maternal and newborn length-of-stay mandates spread rapidly and they were adopted by all 51 jurisdictions, whereas mental health parity legislation was passed in only 31 states.

No scientific consensus, however, supported the maternal and newborn length-of-stay legislation. Data on postpartum length of stay showed reduc-

tions in postpartum stays and was used to suggest that managed care companies were pushing mothers out of hospital too early. No scientific data demonstrated whether earlier discharges were clinically appropriate or inappropriate (Declercq and Simmes 1997). Yet, there was great political consensus that shortened stays were inappropriate. Mother and newborn length-of-stay legislation was symbolically powerful and attracted a coalition of diverse supporters of physicians, patients, and appealed to middle class swing voters (Declercq and Simmes 1997; Kun and Muir 1997; Hyman 2001). Even though there was no evidence that shorter stays were harmful, the rhetoric of "drive-through deliveries" was politically compelling and engendered a broad coalition of supporters. Subsequent research on the health effects of this legislation have not demonstrated improved health outcomes (Madden et al. 2002).

In contrast, there was stronger clinical consensus by professionals and others that expanded coverage for benefits provided by mental health parity was a good idea, but with considerable political disagreement. Professionals generally believed that mental health illness is both under treated and that treatment is beneficial. Stakeholders disagreed, however, on what mental health parity should cover, reflecting political differences over how much of the risk for the costs of mental illness should be borne by individuals versus insurers, how much parity is desirable, and the extent to which government should intervene in the insurance market to regulate insurers (Mechanic and McAlpine 1999). As a result, states vary a great deal on how parity and even how mental illness are defined (Frank et al. 1997; Gitterman et al. 2001).

Of course, cost influences the political consensus over mandated benefit laws: mental health parity is more costly than maternal and newborn length of stay. Costly mandated benefits may be adopted or significantly revised less often, however, political consensus, either built by interest groups or constituent demands, can sometimes overcome the arguments against high-cost services. The cost of mandated benefit laws varies according to the cost per person benefiting and number of people affected. Some services are very costly but not used by many people, or the number of people who do not already have benefit coverage might be small. Other services may raise unit costs marginally, such as maternal and newborn length of stay, but these services may be used frequently, or by many people. There are other examples of mandated benefit laws that are costly in terms of their unit cost, even if they will be used by a very small segment of the population, such as mandated coverage for special formulas for infants with the metabolic disorder phenylketonuria (PKU), found in an average of 1 baby in 14,000.

By observing changes in mandated benefit laws, especially, *what* gets mandated, we may illuminate broader changes to the system of health insurance as well as they ways technological diffusion may affect legislative mandates, and when mandates facilitate (or impede) technological diffusion. Mandated benefit laws have the potential to create precedents for coverage that become the norm for benefits packages beyond the state where they are mandated. Alternatively, "bare bones" insurance policies are one market reaction to what some insurers consider the burdensome cost of mandates. In the case of mental health parity, mandates create the conditions for new market responses to regulation, such as managed behavioral health care, or carve outs, and companies that manage chiropractic care for large insurers.

This article points to a number of areas for further investigation. One is that the role of political interest groups is likely to be different between treatment and provider mandated benefit laws. Some treatment mandates reflect services or interventions closely associated with a specific manufacturer or group of manufacturers. Provider mandates are often designed to allow certain professionals access to covered payments, or to alter the bargaining power of certain groups. Public choice analyses of the incentives for mandated benefits, as reviewed by Jensen and Morrissey (1999), may not be so useful for understanding more populist mandates such as length of stay legislation or mental health parity (which tends to lower provider reimbursement rates, but expand access). This suggests that analyses of mandate adoption that address political power should examine distinctions and the differences across mandates more carefully. Some mandates seem to "spread" rapidly across states, while others are just adopted in a few, possibly because political and clinical consensus varies across mandated benefit laws. It would be worthwhile to examine why some never spread. Perhaps these are mandated benefit laws for benefits that eventually are shown to have little value, and while they may not be removed from the "books" if they are rarely used they are essentially irrelevant. There also seem to be some states that are particularly averse to mandated benefit laws, and it may be worthwhile exploring their legislative structures and politics. Likewise, it may be fruitful for researchers to examine advocates' or legislators' decisions to opt for or against "offer" legislation. Finally, California is not the only state to have formal processes for assessing proposed new mandated benefit laws. Exploring in more depth the use of such assessments and review processes in the success and failure of mandate proposals will help our understanding the potential role of evidence-based policy.

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NOTES

1. *Kentucky Association of Health Plans Inc.* vs. *Miller* was brought to our attention by the anonymous reviewer No. 2. The authors are grateful for reviewer suggestions on the interpretation of ERISA.
2. The mother needs to be covered for childbirth hospitalization for the mandated benefit law to apply. The plan or insurer does not have to cover the full hospital stay if the attending provider determines that patients can be discharged before 48 or 96 hours.
3. The focus of this paper is on the types of services and providers that states require health plans and insurers to provide. In California, AB 1996 defines a "mandated benefit or service" as a requirement that health insurers and health plans offer or provide coverage of treatment by a particular type of health care provider or a treatment or service (including certain procedures, medical equipment, or drugs used in connection with a health care treatment or service), and coverage for the screening, diagnosis, or treatment of a particular disease or condition, such as coverage of asthma or mental disorders.
4. In this discussion, we use the term "mandate" to refer to a provider, benefit, or coverage mandate that could be enacted in multiple jurisdictions.
5. These were (1) adult immunization, (2) annual physical examinations, (3) blood pressure screening, (4) cholesterol screening, (5) counseling for a healthy lifestyle, (6) infant immunization, (7) newborn hearing screening, (8) tobacco cessation, and (9) vision screening.
6. A table showing these data is available in an appendix to the article that is posted online at www.hsr.org

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SUPPLEMENTARY MATERIAL

The following supplementary material for this article is available online:

APPENDIX 1. Mandated Benefit Laws and Mandated Offer Laws, 2002.