

Health Benefit Mandate Review

PJ Mitchell, Director of Regulatory and Health Policy

Federal Requirements

- The Affordable Care Act (ACA) created the concept of essential health benefit (EHB) packages and the ACA requires qualified health plans (QHPs) offered in the individual market and small group health plans to provide coverage of 10 categories of EHBs.
- The EHB categories are broadly defined, but states designate a state-specific EHB Benchmark Plan that sets forth the specific items and services included within the 10 EHB categories that must be covered.
- The ACA allows states to require coverage above and beyond the benefits included in the state's EHB Benchmark Plan, but for new benefits required after 2012, states are required to defray the cost of benefits added for QHPs, consistent with the process described under federal regulations at 45 CFR 155.170.
    - 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.

COMMERCE DEPARTMENT

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.

Mandated Health Benefit Proposals

- Under the statute, 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

Process for 62J Review

- 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.
- Commerce has 180 days to develop and submit the reports to the legislature.
- This process includes:
  - Issuing a request for information (RFI) to gather and summarize feedback and data from various stakeholders, including advocates, providers, and health plans on the relevant proposals.
  - Receiving analysis from MMB on coverage and fiscal impacts of each mandate on SEGIP.
  - Conducting a literature review and completing claims analysis to determing a per-member, per-month impact, if applicable.
  - Conducting a defrayal analysis for each proposal to determine whether a mandate would be defrayed under federal regulations.

Limiting Factors

- Limitations in available data or claims for a specific mandate
- Specificity of coverage of diagnoses, treatments, and procedures
- 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

Thank You!

PJ Mitchell

Appendix A

2026 Mandate Evaluations

Mandate	Requires defrayal?	Year 1 defrayal estimate	AIR PMPM estimate	Issuer PMPM estimates
Coverage for Augmentative and Alternative Communication Systems	Unclear	N/A	N/A	Range from $0.09 PMPM to $14.24 PMPM
Prohibition of Step Therapy Protocols for Diabetes Treatment	No	N/A	N/A	Unable to estimate. Additional clarity needed.
Coverage for Opioid Alternatives for Pain Treatment and Management	Unclear	N/A	N/A	Range from $0.40 PMPM up to $5.05 PMPM
Prohibition of Prior Authorization for Antineoplastic Cancer Treatment	No	N/A	N/A	Range from $0.30 PMPM up to $2.10 PMPM
Cost-Sharing Limitations for Epilepsy Medications and Supplies	No	N/A	$0.04	Up to $0.35 PMPM
Coverage for Coordinated Specialty Care and Assertive Community Treatment	No	N/A	N/A	Range from $5.45 and $7.70 PMPM, but additional clarity needed

2025 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