Texas Mandated Benefit Cost and Utilization Summary Report

October 2014 - September 2015 Reporting Period

Texas Department of Insurance

EXECUTIVE SUMMARY

Texas Insurance Code Chapter 38, Subchapter F, instructs the Texas Department of Insurance to collect data to determine the costs associated with mandated health benefits. This report summarizes the data covering 20 mandated benefits and two mandated offers collected for the 12-month reporting period of October 1, 2014, through September 30, 2015.

2015 Overview

The 2015 mandated benefits data call report reflects information submitted by 25 health plan issuers. Of these, nine submitted data for group coverage only and five for individual coverage only. Eleven issuers reported data for both types of coverage to bring the report totals to 20 for group coverage and 16 for individual coverage.

Group health plans had a slight decrease in the dollar amount of premiums written and a small increase in total claims paid. In 2014, individual health plans saw significant increases in the dollar amount of premiums written and total claims paid due to the federal Affordable Care Act going into effect. This trend continued in 2015 with increases of over 58 percent in premiums written and approximately 77 percent in total claims paid.

The total claims costs for the identified mandated benefits for group plans accounted for over 6 percent of the total amount of claims paid, and over 2 percent for individual plans. Tables 5 and 12 compare the cost of each mandated benefit as a percentage of the total claims paid for group and individual plans from 2006 to 2015.

The report includes a comparison of the average annual claims cost per certificate issued and the average annual premium cost estimates for single and family coverage. For group plans, both the total single and family coverage premium estimates for the identified mandates were more than the average annual claims cost per certificate. For individual plans, the total single coverage premium estimate was less than the average annual claims cost per certificate, and the total family coverage premium estimate was more than the average annual claims cost per certificate.

Issuers provided estimates of the annual administrative costs associated with the mandated benefits requirements. Many of the issuers calculate administrative costs as a percentage of claims costs. Tables 8 and 14 present the administrative cost data and the claims costs percentages for each mandated benefit, and the data shows a correlation between higher claims costs and higher administrative costs.

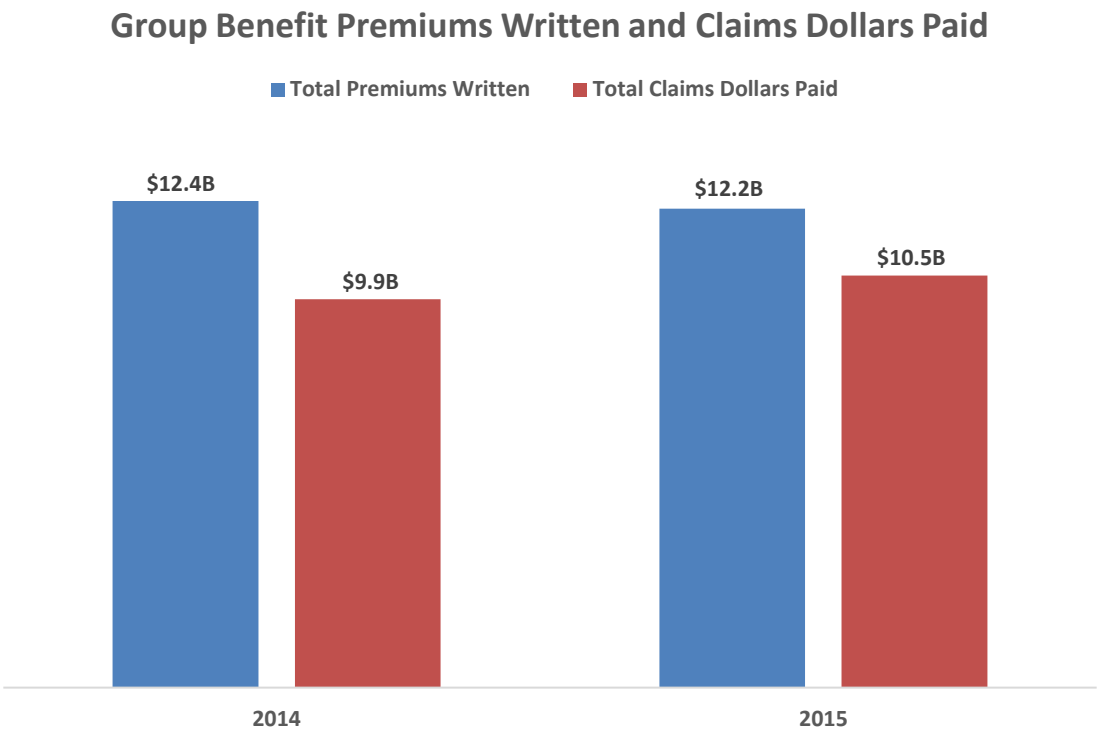
This study does not take into account the cost savings that accompany some mandated benefits. Mandated benefits that improve and maintain the health of covered Texans may reduce the need for future medical treatment in some cases, thus lowering the long-term cost of care. As such, any consideration of mandated benefits should include both the short-term and long-term economic impacts, as well as the impact on health status.

The appendices at the end of this report have additional information about mandated benefits, reporting limitations, and data collection methodology.

GROUP COVERAGE

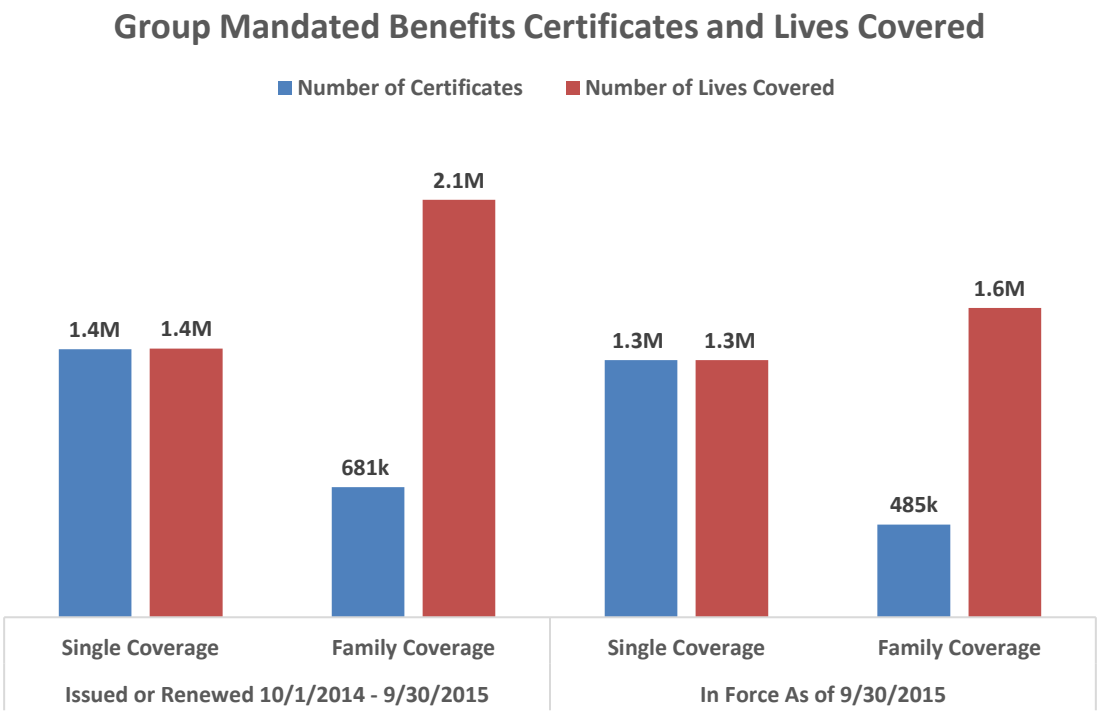
Group Benefit Plans - Mandated Benefit Premiums Written and Claims Dollars Paid

Issuers reported the total amount of premiums written and total amount of all claims paid in Texas on applicable group policies that are subject to mandated benefits and offers for the reporting period. The total claims amount includes claims paid for all covered services, including both mandated benefits and claims for all other covered services. In 2015, there was a decrease of 1.55 percent in the premiums written and an increase of 6.06 percent in the claims dollars paid for group plans.



Group Benefit Plans - Mandated Benefit Certificates and Lives Covered

Issuers provided the number of group certificates issued or renewed during the reporting period, as well as the total number of group certificates that were in force on the last day of the reporting period. The issuers also reported the total number of lives covered under group certificates issued or renewed during the reporting period and the total number of lives covered under group certificates in force on the last day of the reporting period. Issuers reported the number of certificates and lives separately for single coverage and family coverage. TDI instructed issuers to include all covered family members (primary insured, spouse, and all dependents) in the lives covered calculations for family coverage.



Group Benefit Plans - Mandated Benefit Claims Costs

Issuers reported the total amount of claims paid for each mandated benefit and offer during the reporting period. Claims data reported to TDI for 2015 shows that the claims paid for each mandated benefit accounted for less than 1 percent of the total claims cost, and the total of all of the mandated benefits was slightly more than 6 percent. The two mandated benefits with the highest amounts of claims paid were diabetes education and testing supplies with over $94 million in paid claims and serious mental illness (full parity for universities and local governments) with over $83 million in paid claims. The benefit with the lowest amount of claims paid was telemedicine services with approximately $191,000 in paid claims. Table 1 shows the data for all of the mandated benefits.

Table 1 - Group Mandated Benefit Claims Costs

Mandated Benefit	Dollar Amount of Mandated Benefit Claims Paid	Mandated Benefit Claims Amount as a Percentage of Total Claims Paid
Acquired Brain Injury	$42,429,011	0.40%
AIDS, HIV, and Related Illnesses	$41,376,759	0.39%
Chemical Dependency	$57,156,340	0.54%
Childhood Immunizations	$44,015,241	0.42%
Colorectal Cancer Testing	$45,584,281	0.43%
Craniofacial Surgery for Children	$1,997,197	0.02%
Diabetes Education and Testing Supplies	$94,858,999	0.90%
Hearing Screening for Children	$57,986,427	0.55%
Mammography Screening	$44,895,893	0.43%
Nutritional Supplements for PKU and Other Heritable Diseases	$2,049,742	0.02%
Osteoporosis Detection	$2,330,893	0.02%
Prescription Contraceptive Drugs, Devices, and Related Services	$46,496,229	0.44%
PSA Testing for Prostate Cancer	$7,169,834	0.07%
Psychiatric Day Treatment	$7,393,276	0.07%
Reconstructive Breast Surgery Following Mastectomy	$29,438,030	0.28%
Serious Mental Illness - 45 Inpatient Days and 60 Outpatient Visits	$41,036,841	0.39%
Serious Mental Illness - Full Parity for Universities and Local Governments	$83,095,845	0.79%
Telemedicine Services	$191,068	0.00%
TMJ Treatment	$3,260,470	0.03%
TOTAL	**$652,762,376**	**6.18%**

The sum of the percentages may not exactly match the total shown due to rounding.

Table 2 shows that the dollar amounts paid for each of the mandated offer claims were also less than 1 percent of the total claims cost.

Table 2 - Group Mandated Offer Claims Costs

Mandated Offer	Dollar Amount of Mandated Offer Claims Paid	Mandated Offer Claims Amount as a Percentage of Total Claims Paid
In Vitro Fertilization	$1,647,171	0.02%
Treatment of Speech or Hearing Loss	$8,544,275	0.08%
TOTAL	**$10,191,446**	**0.10%**

Group Benefit Plans - Mandated Benefit Utilization

Issuers reported the total number of separate claims paid for each mandated benefit and offer during the reporting period. As shown in Table 3, claims figures vary significantly among mandated benefits. Utilization reflects how common the medical condition is and whether the benefit applies to a limited population based on age or gender. The mandated benefit with the highest number of claims paid was prescription contraceptive drugs, devices, and related services, which accounted for almost a quarter of the claims paid. The second highest was diabetes education and testing supplies at just over 11 percent. The contraception category is significantly higher than the other benefits due to frequent refills, since each refill initiates a new claim. The benefits with the lowest number of claims paid were craniofacial surgery for children (0.02 percent) and telemedicine services (0.06 percent).

Table 3 - Group Mandated Benefit Utilization

Mandated Benefit	Number of Mandated Benefit Claims Paid	Percentage of Mandated Benefit Claims Paid
Acquired Brain Injury	267,365	7.67%
AIDS, HIV, and Related Illnesses	57,227	1.64%
Chemical Dependency	220,261	6.32%
Childhood Immunizations	248,523	7.13%
Colorectal Cancer Testing	55,832	1.60%
Craniofacial Surgery for Children	687	0.02%
Diabetes Education and Testing Supplies	390,542	11.21%
Hearing Screening for Children	328,833	9.44%
Mammography Screening	287,228	8.24%
Nutritional Supplements for PKU and Other Heritable Diseases	5,948	0.17%
Osteoporosis Detection	19,341	0.56%
Prescription Contraceptive Drugs, Devices, and Related Services	864,287	24.80%
PSA Testing for Prostate Cancer	181,630	5.21%
Psychiatric Day Treatment	32,823	0.94%
Reconstructive Breast Surgery Following Mastectomy	28,870	0.83%
Serious Mental Illness - 45 Inpatient Days and 60 Outpatient Visits	95,421	2.74%
Serious Mental Illness - Full Parity for Universities and Local Governments	317,982	9.13%
Telemedicine Services	1,959	0.06%
TMJ Treatment	79,630	2.29%
TOTAL	**3,484,389**	**100.00%**

Table 4 shows that the majority of the mandated offer claims paid were for the treatment of speech or hearing loss.

Table 4 - Group Mandated Offer Utilization

Mandated Offer	Number of Mandated Offer Claims Paid	Percentage of Mandated Offer Claims Paid
In Vitro Fertilization	2,635	6.22%
Treatment of Speech or Hearing Loss	39,746	93.78%
TOTAL	**42,381**	**100.00%**

Group Benefit Plans - Mandated Benefit Claims Cost Comparison 2006 - 2015

TDI has collected mandated benefit cost and experience data from the largest insurers and HMOs since 1992. The initial data set was limited to only 10 mandated benefits, and in 1998, TDI expanded the data set to include additional benefits. Table 5 displays the mandated benefit claims costs percentages for the past 10 years and shows that the totals have remained generally consistent over time, with steady increases for each of the past three years.

Table 5 - Group Mandated Benefit Claims Cost Comparison 2006 - 2015

Mandated Benefit	Mandated Benefit Claims Costs as a Percentage of Total Claims Paid									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Acquired Brain Injury	0.18%	0.18%	0.33%	0.33%	0.33%	0.31%	0.37%	0.40%	0.40%	0.40%
AIDS, HIV, and Related Illnesses	0.22%	0.35%	0.61%	0.35%	0.31%	0.27%	0.28%	0.29%	0.28%	0.39%
Chemical Dependency	0.18%	0.19%	0.20%	0.26%	0.29%	0.27%	0.34%	0.38%	0.41%	0.54%
Childhood Immunizations	0.37%	0.41%	0.41%	0.37%	0.40%	0.44%	0.41%	0.42%	0.40%	0.42%
Colorectal Cancer Testing	0.42%	0.45%	0.21%	0.36%	0.31%	0.38%	0.38%	0.13%	0.15%	0.43%
Craniofacial Surgery for Children	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.02%
Diabetes Education and Testing Supplies	0.60%	0.71%	0.75%	0.56%	0.58%	0.62%	0.62%	0.65%	0.65%	0.90%
Hearing Screening for Children	0.41%	0.39%	0.46%	0.45%	0.45%	0.51%	0.52%	0.58%	0.59%	0.55%
Mammography Screening	0.33%	0.34%	0.38%	0.40%	0.43%	0.47%	0.47%	0.44%	0.43%	0.43%
Nutritional Supplements for PKU and Other Heritable Diseases	0.00%	0.00%	0.01%	0.00%	0.00%	0.01%	0.01%	0.00%	0.01%	0.02%
Oral Contraceptives	0.18%	0.16%	0.21%	0.21%	0.22%					
Osteoporosis Detection	0.04%	0.04%	0.03%	0.03%	0.03%	0.03%	0.02%	0.02%	0.02%	0.02%
Prescription Contraceptive Drugs, Devices, and Related Services	0.07%	0.06%	0.08%	0.10%	0.08%					
Prescription Contraceptive Drugs, Devices, and Related Services						0.37%	0.37%	0.42%	0.70%	0.44%
PSA Testing for Prostate Cancer	0.06%	0.06%	0.07%	0.07%	0.07%	0.07%	0.06%	0.05%	0.04%	0.07%
Psychiatric Day Treatment	0.07%	0.07%	0.06%	0.68%	0.60%	0.57%	0.05%	0.03%	0.04%	0.07%
Reconstructive Breast Surgery Following Mastectomy	0.62%	0.60%	0.58%	0.26%	0.30%	0.22%	0.22%	0.22%	0.23%	0.28%
Serious Mental Illness - 45 Inpatient Days and 60 Outpatient Visits	0.56%	0.49%	0.45%	0.43%	0.33%	0.34%	0.25%	0.33%	0.25%	0.39%
Serious Mental Illness - Full Parity for Universities and Local Governments	0.04%	0.03%	0.06%	0.06%	0.20%	0.26%	0.48%	0.63%	0.67%	0.79%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%
TMJ Treatment	0.04%	0.02%	0.03%	0.03%	0.02%	0.02%	0.01%	0.01%	0.01%	0.03%
TOTAL	**4.40%**	**4.58%**	**4.94%**	**4.96%**	**4.96%**	**5.17%**	**4.88%**	**5.02%**	**5.31%**	**6.18%**

Notes: TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011. The sum of the each year's figures may not exactly match the totals shown due to rounding.

Group Benefit Plans - Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Benefit

Table 6 compares each benefit's average annual claim cost per certificate to the average annual premium cost of the benefit. A certificate is a proof of insurance document that verifies coverage. Issuers may issue one certificate to an individual or to a family. TDI calculated the average annual claim cost per certificate using aggregate claims data submitted by the issuers. Issuers reported the average annual premium cost estimates for single and family coverage. Family coverage premiums reflect multiple enrollees covered under a single certificate. Six of the single coverage estimates were lower than the average annual claim cost per certificate for the mandated benefits, while none of the family coverage estimates were lower.

Table 6 - Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Group Mandated Benefit

Mandated Benefit	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates	
		Single Coverage	Family Coverage
Acquired Brain Injury	$20.54	$41.13	$84.55
AIDS, HIV, and Related Illnesses	$20.05	$13.46	$23.61
Chemical Dependency	$13.85	$27.06	$65.27
Childhood Immunizations	$25.27	$18.86	$50.21
Colorectal Cancer Testing	$26.27	$31.95	$54.88
Craniofacial Surgery for Children	$1.15	$2.09	$5.34
Diabetes Education and Testing Supplies	$45.28	$49.18	$103.29
Hearing Screening for Children	$27.82	$24.70	$49.40
Mammography Screening	$21.39	$43.78	$63.83
Nutritional Supplements for PKU and Other Heritable Diseases	$0.98	$1.96	$4.34
Osteoporosis Detection	$1.13	$2.55	$4.25
Prescription Contraceptive Drugs, Devices, and Related Services	$22.96	$20.27	$47.28
PSA Testing for Prostate Cancer	$3.42	$9.86	$19.23
Psychiatric Day Treatment	$3.57	$23.91	$75.64
Reconstructive Breast Surgery Following Mastectomy	$14.06	$24.86	$44.16
Serious Mental Illness - 45 Inpatient Days and 60 Outpatient Visits	$35.75	$29.48	$69.60
Serious Mental Illness - Full Parity for Universities and Local Governments	$109.52	$44.51	$109.63
Telemedicine Services	$0.11	$2.12	$4.44
TMJ Treatment	$1.58	$2.44	$5.24
TOTAL	**$394.70**	**$414.17**	**$884.19**

*Figures represent all claims, including those occurring under both single and family coverage.

As shown in Table 7, one single coverage estimate was lower than the average annual claim cost per certificate for the two mandated offers, and neither of the family coverage estimates were lower.

Table 7 - Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Group Mandated Offer

Mandated Offer	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates	
		Single Coverage	Family Coverage
In Vitro Fertilization	$2.32	$44.61	$11.43
Treatment of Speech or Hearing Loss	$7.46	$4.38	$29.57
TOTAL	**$9.78**	**$48.99**	**$41.00**

*Figures represent all claims, including those occurring under both single and family coverage.

Group Benefit Plans - Mandated Benefit Administrative Costs and Claims Costs Comparison

Issuers provided estimates of the annual administrative costs incurred due to the mandated benefit and offer requirements. Common administrative costs include expenses for processing claims payments, treatment authorizations, and specialist referrals. In addition, administrative costs include the cost of revising policy forms and marketing materials when legislation adds new mandated benefits. Administrative costs depend on such factors as the number of claims processed and whether certain benefits require additional administrative services like authorizations and referrals. As with premium cost estimates, TDI gave issuers discretion in determining the value of the administrative costs associated with each mandated benefit and offer.

Table 8 shows the total administrative costs reported for each mandated benefit, as well as the administrative costs as a percentage of total claims dollars paid. The table also includes the claims costs as a percentage of total claims dollars paid. The comparison shows a correlation between higher claims costs and higher administrative costs that is consistent with many of the issuers calculating the administrative costs as a percentage of claims costs.

Table 8 - Group Mandated Benefit Administrative Costs and Claims Costs Comparison

Mandated Benefit	Total Administrative Costs	Administrative Costs as a Percentage of Total Claims Paid	Claims Costs as a Percentage of Total Claims Paid
Acquired Brain Injury	$8,495,480	0.08%	0.40%
AIDS, HIV, and Related Illnesses	$3,870,456	0.04%	0.39%
Chemical Dependency	$9,206,860	0.09%	0.54%
Childhood Immunizations	$6,059,555	0.06%	0.42%
Colorectal Cancer Testing	$5,361,070	0.05%	0.43%
Craniofacial Surgery for Children	$204,489	0.00%	0.02%
Diabetes Education and Testing Supplies	$7,574,250	0.07%	0.90%
Hearing Screening for Children	$10,315,044	0.10%	0.55%
Mammography Screening	$7,018,410	0.07%	0.43%
Nutritional Supplements for PKU and Other Inheritable Diseases	$367,410	0.00%	0.02%
Osteoporosis Detection	$429,085	0.00%	0.02%
Prescription Contraceptive Drugs, Devices, and Related Services	$6,422,459	0.06%	0.44%
PSA Testing for Prostate Cancer	$731,187	0.01%	0.07%
Psychiatric Day Treatment	$1,333,666	0.01%	0.07%
Reconstructive Breast Surgery Following Mastectomy	$4,842,510	0.05%	0.28%
Serious Mental Illness - 45 Inpatient Days and 60 Outpatient Visits	$3,505,254	0.03%	0.39%
Serious Mental Illness - Full Parity for Universities and Local Governments	$15,036,980	0.14%	0.79%
Telemedicine Services	$52,635	0.00%	0.00%
TMJ Treatment	$253,772	0.00%	0.03%
TOTAL	**$91,080,572**	**0.86%**	**6.18%**

The sum of the percentages may not exactly match the totals shown due to rounding.

Table 9 shows the total administrative costs reported for each mandated offer, as well as the administrative costs as a percentage of total claims dollars paid. The table also includes the claims costs per mandated offer as a percentage of total claims dollars paid.

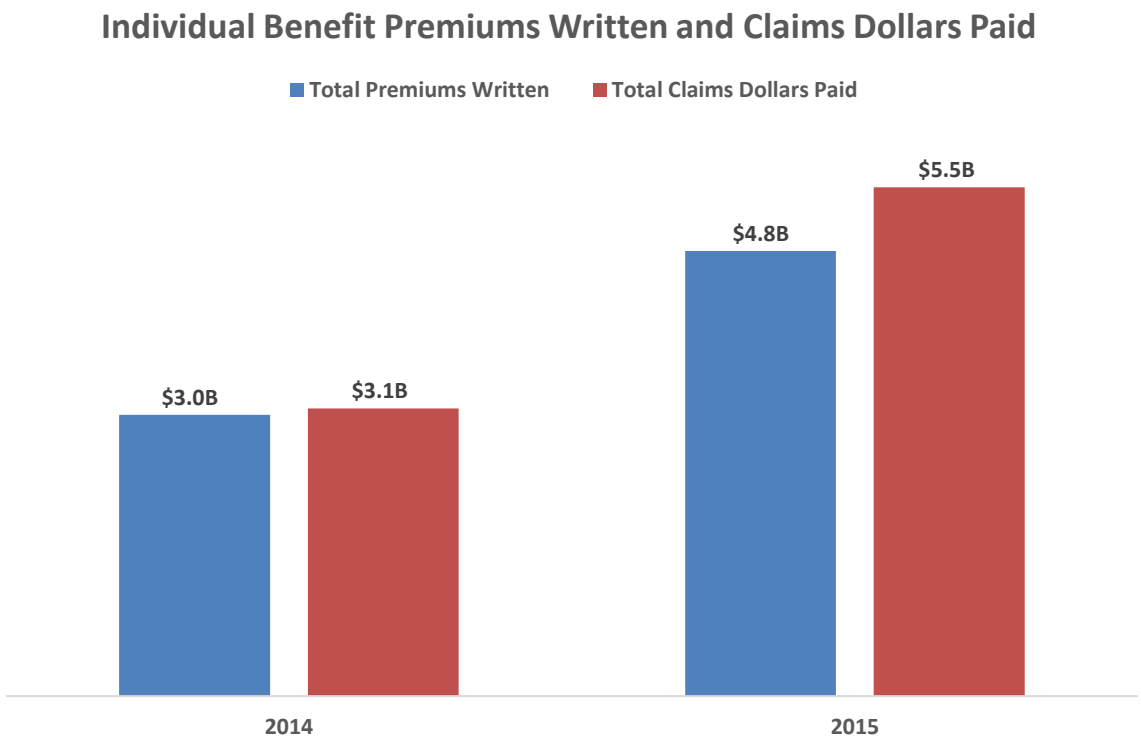
Table 9 - Group Mandated Offer Administrative Costs and Claims Costs Comparison

Mandated Offer	Total Administrative Costs	Administrative Costs as a Percentage of Total Claims Paid	Claims Costs as a Percentage of Total Claims Paid
In Vitro Fertilization	$398,946	0.00%	0.02%
Treatment of Speech or Hearing Loss	$741,095	0.01%	0.08%
TOTAL	**$1,140,041**	**0.01%**	**0.10%**

INDIVIDUAL COVERAGE

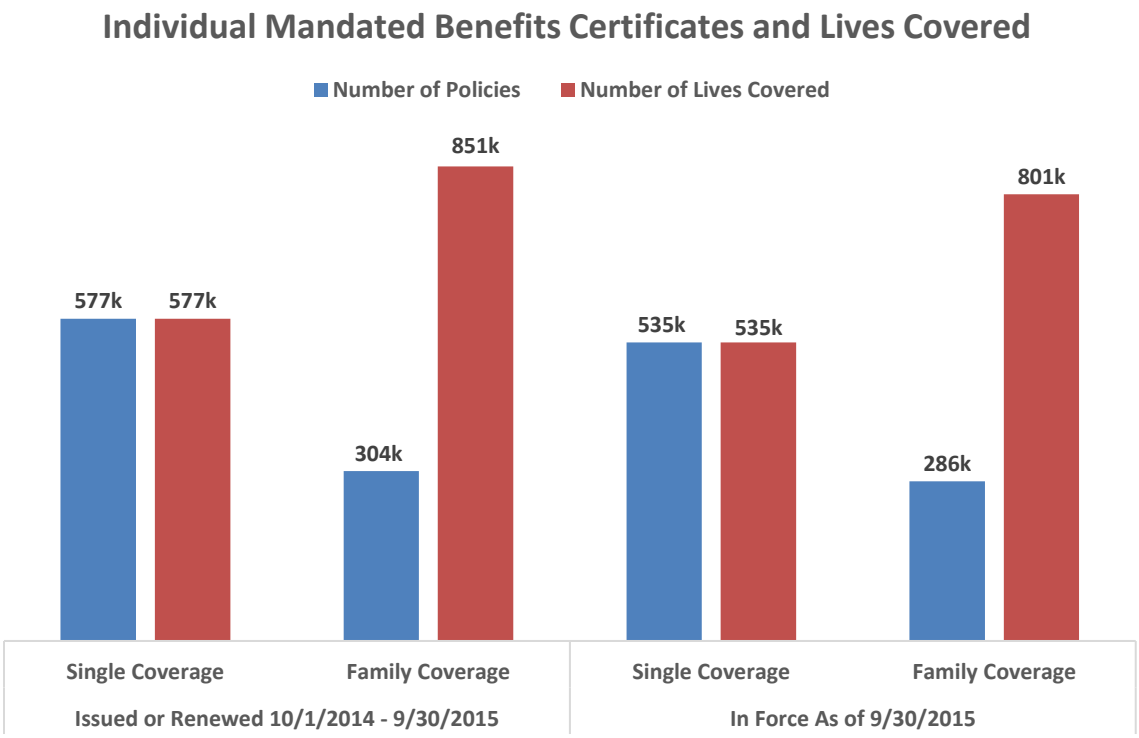
Individual Benefit Plans - Mandated Benefit Premiums Written and Claims Dollars Paid

Issuers reported the total amount of premiums written and total amount of all claims paid in Texas on applicable individual policies that are subject to mandated benefits for the reporting period. The total claims amount includes claims paid for all covered services, including both mandated benefits and claims for all other covered services. Due to the Affordable Care Act going into effect, there were large increases in both the premiums written and the claims dollars paid for individual plan mandated benefits in 2014. In 2015, this trend continued with a 58.36 percent increase in the premiums written and a 76.87 percent increase in the claims dollars paid.



Individual Benefit Plans - Mandated Benefit Policies and Lives Covered

Issuers provided the number of individual policies issued or renewed during the reporting period, as well as the total number of individual policies that were in force on the last day of the reporting period. The issuers also reported the total number of lives covered under individual policies issued or renewed during the reporting period and the total number of lives covered under individual policies in force on the last day of the reporting period. Issuers reported the number of policies and lives covered separately for single coverage and family coverage. TDI instructed issuers to include all covered family members (primary insured, spouse, and all dependents) in the lives covered calculations for family coverage.



Individual Benefit Plans - Mandated Benefit Claims Costs

Issuers reported the total amount of claims paid for each mandated benefit during the reporting period. Claims data reported to TDI for 2015 shows the total of all of the mandated benefits to be slightly more than 2 percent of the total claims cost. The two mandated benefits with the highest amount of claims paid were mammography screening with over $25 million in paid claims, and hearing screening for children with over $23 million in paid claims. The benefit with the lowest amount of paid claims was telemedicine services with just over $105,000 in paid claims. Table 10 shows claims costs data for all of the mandated benefits.

Table 10 - Individual Mandated Benefit Claims Costs

Mandated Benefit	Dollar Amount of Mandated Benefit Claims Paid	Mandated Benefit Claims Amount as a Percentage of Total Claims Paid
Acquired Brain Injury	$5,611,068	0.10%
AIDS, HIV, and Related Illnesses	$10,450,554	0.19%
Childhood Immunizations	$17,378,786	0.31%
Colorectal Cancer Testing	$6,976,714	0.12%
Craniofacial Surgery for Children	$436,979	0.01%
Diabetes Education and Testing Supplies	$8,437,297	0.15%
Hearing Screening for Children	$23,937,129	0.43%
Mammography Screening	$25,289,013	0.45%
Prescription Contraceptive Drugs, Devices, and Related Services	$16,150,526	0.29%
PSA Testing for Prostate Cancer	$1,525,616	0.03%
Reconstructive Breast Surgery Following Mastectomy	$5,797,793	0.10%
Telemedicine Services	$105,322	0.00%
TOTAL	**$122,096,797**	**2.19%**

The sum of the percentages may not exactly match the total shown due to rounding.

Individual Benefit Plans - Mandated Benefit Utilization

Issuers reported the total number of separate claims paid for each mandated benefit during the reporting period. As shown in Table 11, claims figures vary significantly among mandated benefits. Utilization reflects how common the medical condition is and whether the benefit applies to a limited population based on age or gender. Of the individual mandated benefits, prescription contraceptive drugs, devices, and related services had the highest percentage of the total mandated benefits claims paid at 41 percent. The benefit with the next highest percentage was mammography screening at almost 18 percent. The contraception category is significantly higher than the other benefits due to frequent refills, since each refill initiates a new claim. The benefits with the lowest number of claims paid were craniofacial surgery for children (0.02 percent) and telemedicine services (0.15 percent).

Table 11 - Individual Mandated Benefit Utilization

Mandated Benefit	Number of Mandated Benefit Claims Paid	Percentage of Total Number of Mandated Benefit Claims Paid
Acquired Brain Injury	46,685	4.28%
AIDS, HIV, and Related Illnesses	22,049	2.02%
Childhood Immunizations	103,043	9.45%
Colorectal Cancer Testing	16,778	1.54%
Craniofacial Surgery for Children	223	0.02%
Diabetes Education and Testing Supplies	45,704	4.19%
Hearing Screening for Children	102,462	9.40%
Mammography Screening	195,455	17.93%
Prescription Contraceptive Drugs, Devices, and Related Services	447,067	41.00%
PSA Testing for Prostate Cancer	102,584	9.41%
Reconstructive Breast Surgery Following Mastectomy	6,738	0.62%
Telemedicine Services	1,610	0.15%
TOTAL	**1,090,398**	**100.00%**

The sum of the percentages may not total to 100% due to rounding.

Individual Benefit Plans - Mandated Benefit Claims Cost Comparison 2006 - 2015

Table 12 displays the mandated benefit claims costs percentages for individual benefit plans for the past 10 years. The totals have been decreasing for each of the past three years.

Table 12 - Individual Mandated Benefit Claims Cost Comparison 2006 - 2015

Mandated Benefit	Mandated Benefit Claims Costs as a Percentage of Total Claims Paid									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Acquired Brain Injury	0.12%	0.10%	0.14%	0.07%	0.13%	0.13%	0.24%	0.16%	0.24%	0.10%
AIDS, HIV, and Related Illnesses	0.15%	0.32%	0.35%	0.26%	0.25%	0.10%	0.27%	0.16%	0.30%	0.19%
Childhood Immunizations	0.40%	0.58%	1.26%	0.97%	1.14%	1.07%	1.00%	0.93%	0.45%	0.31%
Colorectal Cancer Testing	0.21%	0.23%	0.24%	0.06%	0.05%	0.09%	0.11%	0.08%	0.06%	0.12%
Craniofacial Surgery for Children	0.01%	0.01%	0.02%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
Diabetes Education and Testing Supplies	0.44%	0.42%	0.19%	0.03%	0.02%	0.07%	0.04%	0.04%	0.24%	0.15%
Hearing Screening for Children	0.33%	0.53%	0.75%	0.67%	1.07%	1.09%	1.29%	1.05%	0.74%	0.43%
Mammography Screening	0.25%	0.31%	0.48%	0.42%	0.69%	0.77%	0.92%	0.79%	0.62%	0.45%
Oral Contraceptives	0.19%	0.24%	0.30%	0.12%	0.19%					
Prescription Contraceptive Drugs, Devices, and Related Services	0.02%	0.02%	0.01%	0.05%	0.03%					
Prescription Contraceptive Drugs, Devices, and Related Services						0.54%	0.59%	0.62%	0.40%	0.29%
PSA Testing for Prostate Cancer	0.02%	0.03%	0.05%	0.04%	0.05%	0.06%	0.06%	0.04%	0.03%	0.03%
Reconstructive Breast Surgery Following Mastectomy	1.46%	1.68%	1.23%	0.12%	0.22%	0.23%	0.35%	0.14%	0.24%	0.10%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TOTAL	**3.60%**	**4.47%**	**5.02%**	**2.82%**	**3.85%**	**4.16%**	**4.88%**	**4.03%**	**3.32%**	**2.19%**

Notes: TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011. The sum of the each year's figures may not exactly match the totals shown due to rounding.

Individual Benefit Plans - Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Benefit

Table 13 compares each benefit's average annual claim cost per certificate to the average annual premium cost of the benefit. A certificate is a proof of insurance document that verifies coverage. Issuers may issue one certificate to an individual or to a family. TDI calculated the average annual claim cost per certificate using aggregate claims data submitted by the issuers. Issuers reported the average annual premium cost estimates for single and family coverage. Family coverage premiums reflect multiple enrollees covered under a single certificate. Seven of the single coverage estimates were lower than the average annual claim cost per certificate for the mandated benefits, and one family coverage estimate was lower.

Table 13 - Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Individual Mandated Benefit

Mandated Benefit	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates	
		Single Coverage	Family Coverage
Acquired Brain Injury	$6.55	$5.69	$11.68
AIDS, HIV, and Related Illnesses	$12.20	$13.08	$18.16
Childhood Immunizations	$20.64	$9.62	$25.93
Colorectal Cancer Testing	$8.21	$13.61	$26.34
Craniofacial Surgery for Children	$0.52	$0.49	$0.99
Diabetes Education and Testing Supplies	$9.83	$17.58	$35.68
Hearing Screening for Children	$28.43	$10.19	$29.63
Mammography Screening	$29.72	$16.58	$27.18
Prescription Contraceptive Drugs, Devices, and Related Services	$18.91	$18.39	$31.87
PSA Testing for Prostate Cancer	$1.80	$1.43	$3.85
Reconstructive Breast Surgery Following Mastectomy	$6.82	$9.78	$31.93
Telemedicine Services	$0.12	$0.17	$0.27
TOTAL	**$143.75**	**$116.61**	**$243.51**

* Figures represent all claims, including those occurring under both single and family coverage.

Individual Benefit Plans - Mandated Benefit Administrative Costs and Claims Costs Comparison

Issuers reported an estimate of the annual administrative costs incurred due to the mandated benefit requirements. Common administrative costs include expenses for processing claims payments, treatment authorizations, and specialist referrals. In addition, administrative costs include the cost of revising policy forms and marketing materials when legislation adds new mandated benefits. Administrative costs depend on such factors as the number of claims processed and whether certain benefits require additional administrative services like

authorizations and referrals. As with premium cost estimates, TDI gave issuers discretion in determining the value of the administrative costs associated with each mandated benefit. Table 14 shows the total administrative costs reported for each mandated benefit, as well as the administrative costs as a percentage of total claims dollars paid. The table also includes the claims costs as a percentage of total claims dollars paid. The comparison shows a correlation between higher claims costs and higher administrative costs that is consistent with many of the issuers calculating the administrative costs as a percentage of claims costs.

Table 14 - Individual Mandated Benefit Administrative Costs and Claims Costs Comparison

Mandated Benefit	Total Administrative Costs	Administrative Costs as a Percentage of Total Claims Paid	Claims Costs as a Percentage of Total Claims Paid
Acquired Brain Injury	$1,194,940	0.02%	0.10%
AIDS, HIV, and Related Illnesses	$2,402,228	0.04%	0.19%
Childhood Immunization	$3,741,397	0.07%	0.31%
Colorectal Cancer Testing	$850,255	0.02%	0.12%
Craniofacial Surgery for Children	$97,413	0.00%	0.01%
Diabetes Education and Testing Supplies	$929,991	0.02%	0.15%
Hearing Screening for Children	$5,064,254	0.09%	0.43%
Mammography Screening	$5,925,052	0.11%	0.45%
Prescription Contraceptive Drugs, Devices, and Related Services	$3,158,361	0.06%	0.29%
PSA Testing for Prostate Cancer	$317,147	0.01%	0.03%
Reconstructive Breast Surgery Following Mastectomy	$1,125,460	0.02%	0.10%
Telemedicine Services	$24,354	0.00%	0.00%
TOTAL	**$24,830,852**	**0.44%**	**2.19%**

The sum of the percentages may not exactly match the totals shown due to rounding.

APPENDIX A: SURVEY OVERVIEW

Governing Statutes

Texas Insurance Code Chapter 38, Subchapter F, requires TDI to collect information on mandated benefits and offers and directs the agency to establish rules for the collection of this data. Texas Administrative Code, Title 28, Chapter 21, Subchapter Z, contains rules addressing the reporting of mandated benefits and offers. Under these rules, health insurers and health maintenance organizations (HMOs) are required to submit mandated benefit premium and claims data annually in an electronic format developed by TDI. Insurers must submit data for group policies if they report $10 million or more in direct premiums in Texas for group accident and health insurance policies on their most recent annual statement. An insurer must also submit data for individual policies if it reports $2 million or more in direct premiums for individual accident and health policies in Texas. HMOs are subject to the reporting requirements if they collect $10 million or more in direct commercial premiums for basic-service benefit plans.

Explanation of Mandated Benefits and Reporting Limitations

Mandated benefits are health benefits required by state law, which cover a specific medical condition, illness, or medical service. The mandated benefits data collection and reporting rule does not require issuers to report data on all mandated benefits. The lack of specific standardized medical codes for some mandated benefits makes it difficult, if not impossible, to report certain data. The availability of precise benefit and premium cost data is limited to those mandated benefits that are identified using information provided on insurance claim forms, including standard medical diagnosis and procedure codes. Issuers require that all claims filed by physicians and providers include these codes, which are used to identify the patient's medical condition and treatment. These codes allow an issuer to determine if the medical condition and subsequent treatment are covered benefits under the policy and enable an issuer to pay a claim under the terms of the insurance contract. Use of these standardized codes also assists issuers in collecting and reporting mandated benefit cost and utilization data to TDI in a uniform manner.

Some mandated benefits, however, do not require coverage of a specific illness or medical treatment for which there are standard diagnosis or procedure codes that allow issuers to identify the appropriate claims. As a result, the reporting rule requires issuers to submit data for those mandated benefits and offers that are easier to measure. TDI collects data on the following mandated benefits:

- benefits related to the treatment of acquired brain injury,
- AIDS, HIV, and related illnesses,
- chemical dependency,
- childhood immunization,
- colorectal cancer testing,
- craniofacial surgery for children,
- diabetes education and testing supplies,
- hearing screenings for children,
- mammography screening,

- nutritional supplements for phenylketonuria (PKU) and other heritable diseases,
- osteoporosis detection,
- prescription contraceptive drugs, devices, and related services (if prescription drugs are covered),
- prostate-specific antigen (PSA) testing for prostate cancer,
- psychiatric day treatment,
- reconstructive breast surgery following a mastectomy,
- serious mental illness – not less than 45 inpatient days of treatment and 60 outpatient visits,
- serious mental illness – full parity for universities and local governments,
- telemedicine services, and
- treatment of temporomandibular joint conditions (TMJ).

Prior to the 2011 data call, issuers reported contraceptive data in two separate categories – "Prescription Contraceptive Drugs, Devices, and Related Services" and "Oral Contraceptives." Issuers were erroneously reporting oral contraceptives under both categories. TDI reviewed the concerns of the issuers and applicable statutory references and decided to combine the two categories for future data calls, beginning in 2011.

In addition to the mandated benefits listed above, state law also requires group plan issuers to offer some benefits to enrollees. The law allows the purchaser to decide whether to accept or decline the offered benefits. The two "mandatory offers" for which data is collected are:

- in vitro fertilization, and
- treatment for loss of speech or hearing.

This report aggregates all data to provide industry-wide averages for each benefit listed. Appendix B includes a comprehensive list and explanation of each of these benefits along with its legal basis.

Data Collection Methodology

For each of the mandated benefits subject to the reporting requirements, issuers are required to report the following information for both group and individual plans:

- the number of claims paid for each mandated benefit,
- the total claims dollars paid for each mandated benefit,
- the average annual premium cost for each mandated benefit, and
- the estimated annual administrative cost attributed to each mandated benefit.

In addition, issuers are required to report enrollment, as well as data pertaining to total premiums and total claims for both group and individual plans. This data allows additional analysis on an issuer-level basis as well as on an aggregated, industry-wide basis. To the extent possible, TDI provided specific directions to assure uniform reporting across issuers. Due to common industry practices for claims payment forms and the use of standardized codes for medical diagnoses and services, the method for collecting and calculating claims data is relatively straightforward.

Calculating average claim estimates per benefit involves factoring the total claims amount paid for a given benefit with the number of claims reported for that benefit. However, the process used to determine premium costs and administrative costs varies from issuer to issuer. Although all issuers use similar actuarial principles, technical variances among issuers result in differences in the way they develop cost estimates. Accordingly, each issuer reports its premium and administrative cost data to TDI using its internal guidelines instead of an industry-wide standard. While all issuers use similar actuarial methodologies to establish premium rates, the exact process and underlying data assumptions used are proprietary information that are not generally subject to public disclosure. Issuers have discretion in determining how they develop premium costs. In calculating average premiums, TDI averages all issuer premium amounts with each issuer weighted equally. In calculating average claims, TDI combines all claims dollar amounts reported by all issuers and divides this by the combined number of actual claims reported by all issuers. While these two methods differ, the estimated premiums should have a reasonable relationship to the claims actually paid for the same benefit.

Some issuers previously explained that claims costs for mandated benefits sometimes include other costs not specifically related to the mandated benefit requirements due to the common practice of "bundling" services into one claim or procedure code. A certain procedure may include charges related to the mandated benefit procedure, but not part of the mandated benefit. This can occur when a provider performs two related services at once and submits one bill for both charges. Some issuers prorate the claims reported to TDI or use another methodology to estimate only those costs attributed to the mandated benefit. Others do not, which results in them reporting higher claims costs. Though it is difficult to know the extent to which this occurs, the additional expenses should be considered when evaluating the cost of each benefit.

TDI did not audit the data reported by issuers. Issuers are responsible for ensuring that the information reported is accurate and complete. TDI reviews the data submitted by issuers to identify extreme data anomalies and outliers suggesting data collection or entry errors. TDI contacted issuers submitting questionable data to verify the accuracy of the information. In some instances, issuers provided explanations, while others submitted revised reports.

Project to Enhance Data Collection

In 2002, TDI adopted the rule creating the mandated benefits data call, and amended the rule in 2003 to clarify the reporting periods and revise the reporting deadlines. Since that time, the Texas Legislature passed additional mandated benefits and offers not reflected in the current rule.

The rule change process for this data call began in the fall of 2015. The intent is to improve the integrity of the data collected and reported by the issuers. TDI has reviewed the existing requirements, assessed which data elements are necessary to measure the cost and utilization of the mandates, and issued an informal working draft of the proposed rule changes. As with any rule change, stakeholders will have the opportunity to comment on the proposed changes as part of the process. The anticipated adoption date is late summer of 2017. The 2016 data call will follow the current methodology.

APPENDIX B: DEFINITIONS OF MANDATED BENEFITS AND OFFERS

Mandated Benefits

Acquired Brain Injury – A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury. Coverage may be subject to deductibles, copayments, and annual or maximum payment limits that are consistent with other similar coverage under the policy. This mandate applies to both individual and group accident and health plans and HMO benefit plans, including plans issued to a small employer.

Legal Basis: TIC Sections 1352.003 and 1352.0035; 28 TAC Sections 21.3101 – 21.3105

AIDS, HIV, and Related Illnesses – A health benefit plan may not exclude, deny, or cancel coverage for HIV, AIDS, or HIV-related illnesses. This mandate applies to group accident and health plans and HMO benefit plans.

Legal Basis: TIC Sections 1364.001 – 1364.053, 1364.101, 1551.205, and 1601.109; 28 TAC Section 3.3057(d), Exhibit A

Chemical Dependency – A health benefit plan that provides coverage for the necessary care and treatment of chemical dependency must provide the coverage on the same basis as other physical illnesses. Benefits for treatment of chemical dependency may be limited to three separate series of treatments for each covered individual and must be in accordance with the standards adopted under 28 TAC Sections 3.8001 - 3.8030. This mandate applies to group insurance plans and HMO benefit plans.

Legal Basis: TIC Chapter 1368; 28 TAC Sections 3.8001 – 3.8030, and 11.509(3)

Childhood Immunizations – A health benefit plan that provides coverage for a family member of an insured or enrollee must provide for each covered child from birth through the date the child is six years of age for: (1) immunizations against diphtheria, haemophilus influenzae type b: hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and rotavirus (HMO only); and (2) any other immunization that is required for the child by law. Immunizations may not be subject to a deductible or copayment requirement. This mandate applies to both individual and group accident and health plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Section 1367.053; 28 TAC Section 11.508(a)(1)(H)(ii)

Colorectal Cancer Testing – A health benefit plan that provides coverage for screening medical procedures must provide coverage for each person enrolled in the plan, who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. An insured

must have the choice of at least one of the following: (1) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or (2) a colonoscopy performed every 10 years. This mandate applies to both individual and group accident and health plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Section 1363.003; 28 TAC Section 11.508(a)(1)(H)(vi)

Craniofacial Surgery for Children – A health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" in the evidence of coverage or policy to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. This mandate applies to both individual and group accident and health plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Section 1367.153

Diabetes Education and Supplies – A health benefit plan that provides coverage for the treatment of diabetes and associated conditions must provide coverage to each qualified enrollee for diabetes equipment, supplies, and self-management training programs. The coverage must be in accordance with the standards adopted under 28 TAC Sections 21.2601 - 21.2606, Subchapter R. This mandate applies to both individual and group accident and health plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Chapter 1358; 28 TAC Sections 11.508(b)(3), 21.2601 – 21.2606

Hearing Screening for Children – A health benefit plan that provides coverage for a family member of an insured or enrollee must provide to each covered child coverage for: (1) a screening test for hearing loss from birth through the date the child is 30 days old, as provided by Health and Safety Code Chapter 47; and (2) necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. Benefits may be subject to copayment and coinsurance requirements, but may not be subject to a deductible requirement or dollar limits. The evidence of coverage or policy must state these limitations. This mandate applies to both individual and group accident and health plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Section 1367.103

Mammography Screening – A health benefit plan must provide an annual screening by low-dose mammography for females 35 years of age or older on the same basis as other radiological examinations under the plan. This mandate applies to both individual and group accident and health plans and HMO benefit plans.

Legal Basis: TIC Section 1356.005; 28 TAC Section 11.508(a)(1)(H)(iv)

Nutritional Supplements for Phenylketonuria (PKU) and Other Heritable Diseases – A health benefit plan that provides coverage for prescription drugs must include dietary formulas for the treatment of PKU or other heritable diseases. This mandate applies to group insurance plans and HMO benefit plans.

Legal Basis: TIC Section 1359.003

Osteoporosis Detection – A health benefit plan must provide coverage to qualified enrollees for medically accepted bone mass measurement to determine the enrollee's risk of osteoporosis and fractures associated with osteoporosis. This mandate applies to group accident and health plans and HMO benefit plans.

Legal Basis: TIC Section 1361.003; 28 TAC Section 11.509(4)

Prescription Contraceptive Drugs, Devices, and Related Services – A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for: (1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration, or (2) an outpatient contraceptive service. Plans are not required to cover abortifacients or any other drug or device that terminates a pregnancy. Any deductible, copayment, or other cost-sharing provision applicable to prescription contraceptive drugs or devices or outpatient contraceptive services may not exceed that required for other prescription drugs or devices or outpatient services covered under the benefit plan. This mandate applies to both individual and group accident and health plans and HMO benefit plans, including plans issued to a small employer.

Legal Basis: TIC Section 1369.104; 28 TAC Section 21.404(3)

PSA Testing for Prostate Cancer – A health benefit plan that provides coverage for diagnostic medical procedures must provide coverage to each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer. Minimum coverage must include: (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is: (a) at least 50 years of age and asymptomatic, or (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor. This mandate applies to both individual and group accident and health plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Section 1362.003

Psychiatric Day Treatment – A health benefit plan that provides coverage for treatment of mental illness in a hospital must also provide coverage for treatment in a psychiatric day treatment facility. Determination of policy benefits and benefit maximums will consider each full day of treatment in a psychiatric day treatment facility equal to one-half day of treatment in a hospital or inpatient program. On rejection of mandated benefits, the insurer shall offer and the policyholder may select an alternate level of benefits, but any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for

treatment in a hospital. This mandate applies to group accident and health plans and HMO benefit plans.

Legal Basis: TIC Chapter 1355, Subchapter C, Section 1355.104; 28 TAC Sections 11.509(5) and 11.510(3)

Reconstructive Breast Surgery Following a Mastectomy – A health benefit plan that provides coverage for mastectomy must provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and (3) prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy. The coverage may be subject to copayments that are consistent with other benefits under the evidence of coverage or policy, but may not be subject to dollar limitations other than the lifetime maximum benefits under the plan. This mandate applies to both individual and group accident and health plans and HMO benefit plans.

Legal Basis: TIC Section 1357.004; 28 TAC Section 11.508(b)(1)

Serious Mental Illness – 45 Inpatient Days and 60 Outpatient Visits – A health benefit plan must: (1) provide coverage for not less than 45 days of inpatient treatment, and not less than 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (2) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and (3) must include the same amount limits and deductibles for serious mental illness as for physical illness. This mandate applies to group accident and health plans and HMO benefit plans. Small employers must be offered this coverage, but the employer is allowed to reject the coverage.

Legal Basis: TIC Sections 1355.004 and 1551.205

Serious Mental Illness – Full Parity for Universities and Local Governments – A health benefit plan provided under the Texas State College and University Employees Uniform Insurance Benefits Act or to certain specific governmental employee groups must provide benefits for serious mental illness that are as extensive as for any other physical illness. This mandate applies to group health plans and HMO benefit plans. Small employers must be offered this coverage, but the employer is allowed to reject the coverage.

Legal Basis: TIC Sections 1355.151 and 1601.109

Telemedicine Services – A health benefit plan may not exclude telemedicine medical services or a telehealth service from coverage solely because the service is not provided through a face-to-face consultation. Telemedicine medical services and telehealth services may be subject to a deductible or copayment requirement; however, the deductible or copayment may not exceed the amount that is required for a comparable medical service provided through a face-to-face consultation. This mandate applies to both individual and group accident and health plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Section 1455.004; 28 TAC Section 11.1607(m)

Temporomandibular Joint (TMJ) Treatment – A health benefit plan that provides benefits for diagnostic or surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint that is necessary due to: (1) an accident, (2) a trauma, (3) a congenital defect, (4) a developmental defect, or (5) a pathology. This mandate applies to group accident and health plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Section 1360.004; 28 TAC Section 11.509(6)

Mandated Offers

In Vitro Fertilization – Unless rejected in writing by the group contract holder, a health benefit plan providing coverage for pregnancy-related procedures must offer and make available coverage for outpatient expenses that may arise from in vitro fertilization procedures. This mandate applies to group accident and health plans and HMO benefit plans.

Legal Basis: TIC Sections 1366.003 – 1366.004; 28 TAC Section 11.510(1)

Treatment of Speech or Hearing Loss – A health benefit plan shall offer and make available coverage for the necessary care and treatment of loss or impairment of speech or hearing. Coverage may not be less favorable and must be subject to the same limits and deductibles as coverage for physical illness generally under the plan. The group contract holder may reject this coverage and select an alternative level of benefits if the insurer offers such coverage. This mandate applies to group health plans and HMO benefit plans.

Legal Basis: TIC Sections 1365.003 – 1365.004; 28 TAC Section 11.510(2)