Texas Mandated Benefit Cost and Utilization Summary for Calendar Year 2003

Texas Department of Insurance

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EXECUTIVE SUMMARY

In order to measure the costs associated with mandated health benefits, the 77th Texas Legislature enacted HB 1610 directing TDI to collect data annually, authorizing the Commissioner of Insurance to adopt necessary rules. The statute also requires the Department to issue an annual report using aggregated data that does not identify specific companies.

Pursuant to HB 1610, TDI adopted rules establishing web-based reporting requirements for certain mandated benefits under group and individual health benefit plans offered by insurance companies and health maintenance organizations (HMOs). Shortly thereafter, an insurance trade association petitioned TDI to change the reporting date to a later time in order to avoid conflicts with annual financial filings required of all companies. TDI subsequently amended the rule to move the reporting date from March 1 to December 1, which is a more useful date for legislative purposes as well. The reporting deadline for the first report, however, remained at March 1, 2004.

The adopted rule provided companies an implementation period to develop the databases necessary to collect and report the required cost and utilization data. Despite this provsion, several companies had problems meeting the first year deadline. Additional allowances were made to ensure the quality of the data sets was not adversely affected.

Although obvious errors were corrected, TDI did not audit the data submissions (i.e., conduct exam-type audits of carrier reporting systems or the integrity of the underlying data). Throughout the report we note numerous instances where some companies' data were not consistent with data other insurers provided, or were well outside the range of reasonable variation. This inconsistency is particularly evident with regard to premium and administrative cost estimates. Some companies' estimates were clearly questionable based on both the claims paid and in comparison to the aggregated averages. TDI will be reviewing additional information from some carriers in order to evaluate the accuracy of the underlying data and the methodology used to develop their data submissions.

The tables below provide an overview of the mandated benefit data collected for this report. However, this data must be reviewed in the context of the other information provided in this report in order to fully understand its value and limitations.

GROUP BENEFIT PLANS*	
Total Premiums	$9,463,068,260
Total Value of All Claims Paid	$7,564,759,618
Total Value of Mandated Benefit Claims Paid	$337,574,913
Mandated Benefit Costs as a Percentage of Total Claims	4.5 percent
Mandated Benefit Costs as a Percentage of Total Premiums	3.5 percent
Total Value of Mandated Offering Claims Paid	$10,502,233
Mandated *Offering* Benefit Costs as a Percentage of Total Claims	0.14 percent
Mandated *Offering* Benefit Costs as a Percentage of Total Premiums	0.11 percent
Average Annual Premium Cost Estimate of Mandated Benefits– Single (i.e., Employee-only) Coverage	$87.18
Average Annual Premium Cost Estimate of Mandated Benefits – Family (i.e., Employee and Family) Coverage	$231.41
Total Estimated Administrative Costs	$51,966,845
Administrative Costs as a Percentage of Total Claims	0.68 percent

* Represents 20 mandated benefits and 2 mandated offerings for which data is available.

As indicated in the chart above, claims costs for the 20 mandated benefits for which data was collected represent 4.5 percent of all claims paid under group benefit plans. Mandated *offerings* resulted in an additional cost of $10.5 million, or 0.14 percent of claims. The average annual premium cost of including the 20 benefits was estimated at $87.18 for an individual with single coverage (i.e., employee-only) and $231.41 for family coverage. Administrative expenses accounted for an added $51.9 million in costs, or 0.68 percent of total claims paid. While, these figures represent a relatively small percentage of the total claims paid and total premium costs, additional costs would likely be attributed to the mandated benefits that are not included in this report.

INDIVIDUAL BENEFIT PLANS*	
Total Premiums	$1,103,989,888
Total Value of All Claims Paid	$727,770,864
Total Value of Mandated Benefit Claims Paid	$26,376,292
Mandated Benefit Costs as a Percentage of Total Claims	3.62 percent
Mandated Benefit Costs as a Percentage of Total Premiums	2.39 percent
Average Annual Premium Cost Estimate of Mandated Benefits– Single Coverage	$42.29
Average Annual Premium Cost Estimate of Mandated Benefits – Family Coverage	$83.76
Total Estimated Administrative Costs	$8,732,632
Administrative Costs as a Percentage of Total Claims	1.19 percent

*Represents 13 mandated benefits for which data is available.

It is important to note that TDI did not collect data on every mandated benefit. As discussed in the first section of the report, some mandated benefits that require coverage of groups of people (such as newborns with birth defects) are not associated with a specific list of medical procedure or diagnoses codes, and cannot generally be identified by insurers based on the information included in the standard insurance claim format, which is the source of the data reported to TDI. As such, the cost estimates provided in this report represent ***only*** the costs attributed to the 20 specific mandated benefits and two mandated offerings listed herein (see page 5).

Finally, this report also does not provide a cost-benefit analysis of the mandates, which is necessary to identify any cost savings that occur as a result of improved health status or a reduction in future health costs due to the medical care associated with a mandated benefit. These costs savings would, to some extent, offset the total cost of the mandates.

SURVEY OVERVIEW

Legislation

In an effort to evaluate the cost of mandated health insurance benefits and their impact on health benefit coverage, the Texas Legislature in 2001 enacted HB 1610, adding Subchapter F, Chapter 38 to the Texas Insurance Code. The new law directs the Texas Department of Insurance (TDI) to collect cost and utilization data on certain mandated benefits. Under rules subsequently adopted by TDI, 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 premium in the state of Texas for **group** accident and health insurance policies on their most recent annual statement. An insurer must also submit data for individual policies if an insurer 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. This report summarizes the data collected for benefit plans in effect during calendar year 2003.

Definition of Mandated Benefits – Reporting Limitations

For purposes of this report, the mandated benefits which are subject to data collection and reporting include those benefits required by state law that cover a specific medical condition or illness or a specific medical service. As directed by the enabling legislation, TDI adopted by rule the requirements and specifications for mandated benefit data collection and reporting. However, the rule does not require insurers to report data on ***all*** mandated benefits due to the lack of specific standardized medical codes for some mandated benefits, or other detailed information that insurers require to identify such claims. Throughout the legislative process and subsequent rule development, TDI acknowledged that the availability of precise benefit and premium cost data is limited to those mandated benefits that can be identified using information provided on insurance claim forms, including standard medical diagnosis and procedure codes. Insurers and HMOs require that all claims filed by physicians and providers include these codes, which are used to identify the patient's medical condition and treatment. For claims processing requirements, these codes allow an insurer/HMO to determine if the medical condition and subsequent treatment are covered benefits under the policy, and enable an insurer to pay a claim under the terms of the insurance contract. All providers and payers use these standardized codes, which allows insurers/HMOs to collect and report mandated benefit cost and utilization data to TDI in a uniform manner. For example, there is a specific procedure code that a physician uses to file a claim for a mammogram. Insurers/HMOs can use this procedure code to identify all mammography mandated benefit claims and can easily report that data to TDI in a manner that is consistent across all companies/HMOs.

Some mandated benefits, however, do not require coverage of a specific illness or medical treatment for which there is a standard medical or procedure code that allows

insurers/HMOs to identify the appropriate claims. For example, one mandated benefit requires coverage of any newborn child that has health problems on the same basis as any healthy newborn child. In other words, the insurer/HMO cannot decline coverage for a newborn child if the child is born with medical problems. However, the list of possible congenital birth defects or health conditions that would normally result in an insurer's decision to decline coverage for a newborn child (in the absence of the mandated benefit) is extensive and would vary among companies depending on the seriousness of the medical condition and the child's prognosis. In addition, the insurer/HMO must continue to provide coverage for the child as long as he/she is eligible as a dependent, so many of the children still covered as a result of the mandated benefit are no longer newborns but may be any age up to 18. As such, it is impossible for insurers/HMOs to identify those individuals who are covered under this particular mandated benefit provision and to identify which of the services they received (i.e., claims paid) are due specifically to the mandated benefit requirement. Due to these data limitations, the rule does not require insurers/HMOs to report data on **all** mandated benefits, just those mandated benefits for which specific diagnosis and procedure codes exist. After significant evaluation of existing mandated benefits and input from numerous interested parties, the final rule requires data reporting for the following mandated benefits:

- Benefits Related to the Treatment of Acquired Brain Injury
- AIDS and HIV Related Care
- Chemical Dependency
- Childhood Immunizations
- Colorectal Cancer Testing
- Craniofacial Surgery for Children
- Diabetes Education and Testing Supplies
- Hearing Screenings for Children
- Mammography Screening
- Nutritional Supplements for PKU and Other Inheritable Diseases
- Oral Contraceptives (if prescription drugs are covered)
- Osteoporosis Detection
- Prescription Contraceptive Drugs, Devices and Related Services (if prescription drugs are covered)
- PSA Testing for Prostate Cancer
- Psychiatric Day Treatment
- Reconstructive Breast Surgery Following a Mastectomy
- Serious Mental Illness – Limited to 45 Inpatient and 60 Outpatient Days of Service
- Serious Mental Illness – Full Parity for Universities and Local Governments
- Telemedicine Services
- Treatment of Temporomandibular Joint Procedures (TMJ)

In addition to the mandated benefits above, state law also requires that some benefits be *offered* to insureds, but allows the purchaser to decide whether to accept or decline the offer. The two "mandatory offerings" for which data is collected include:

- In-Vitro Fertilization
- Treatment for Loss of Speech or Hearing.

The Appendix at the end of this report includes a comprehensive list and explanation of each of these benefits along with its legal basis.

Data Collected

For each of the mandated benefits subject to the reporting requirements, insurers/HMOs must report the following information for both group insurance plans and individual insurance plans:

- number of claims paid for each mandated benefit;
- total dollar value of claims 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, carriers report enrollment, total premium and total claim data for both group and individual plans that allows additional analysis on a company-level basis as well as on an aggregated, industry-wide basis. To the extent possible, TDI provided specific directions to assure uniform reporting across companies. Due to standard industry practices for claims payment forms and the use of standard codes for medical diagnoses and services, the data collected for the total number of claims paid and the total dollar value of claims paid are consistent across carriers. However, the process insurers/HMOs use to determine premium costs and administrative costs for mandated benefits varies from company to company. Although all companies use similar actuarial methodologies, there are variances among carriers that result in methodological differences in the way they develop data. As such, the data reported for premium and administrative costs attributed to mandated benefits are, in some cases, inconsistent and of questionable accuracy. More in-depth analysis of this issue will be provided later in this report.

The rule also requires carriers to provide premium cost estimates separately for "single coverage" and "family coverage" to demonstrate the cost impact of mandated benefits on the least expensive and most expensive forms of coverage. "Single coverage" as used in this report refers to coverage provided to a single individual, and does not include any dependent coverage for children or a spouse. "Family coverage" refers to coverage provided to the employee/enrollee plus children and a spouse. Single coverage is the least expensive category since it insures only one individual, and family coverage is the most expensive type since it insures the entire family. The rule does not require collection or reporting of other types of coverage such as "employee/enrollee and spouse" (which does not include coverage for any children), or "employee/enrollee and children" (which does not include coverage for a spouse).

It must also be noted that the data reported by carriers is not audited by TDI. Upon review of the data, extreme data anomalies and outliers suggesting data entry errors were

identified and the carriers contacted to verify the accuracy of the data and correct any errors. Companies are responsible for assuring that the information they report is accurate and complete and will be asked to provide supporting documentation if the data appears to be inconsistent or inaccurate.
Finally, the statute prohibits TDI from publishing data that identifies any specific company. As such, all data reported in this reported is aggregated and represents industry-wide average data.

Company Participation

A total of 53 insurers and HMOs with premiums totaling more than $10.5 billion filed data included in this report. Insurance companies must submit data if their most recently filed annual financial statement indicates Texas business of $10 million or more in direct premiums for group accident and health insurance policies, or $2 million or more in direct premiums for individual accident and health insurance policies. HMOs must report if their most recently filed annual statement shows a total of $10 million or more in direct commercial premiums earned in Texas. Companies that do not meet the minimum premium requirements are not required to file a report.

In addition, TDI exempted from reporting companies that met the $10 million or $2 million threshold but wrote insurance plans that are not subject to the mandated benefit requirements. Many companies focus on specialized types of accident and health insurance such as long-term care coverage, accident-only policies, or credit accident and health plans. These benefit plans are not required to include the mandated benefits and are not, therefore, subject to the mandated benefit reporting requirements. Although the premiums for these plans are reported on the annual statement as part of the total group or individual accident and health premiums, the annual statement data does not provide enough detail to allow TDI to identify and automatically exclude those companies from reporting. However, prior to the reporting due date, TDI allowed companies to inform the Department of the nature of their business and request an exemption. For the 2003 report, a total of 81 individual insurers and 37 group insurers were granted an exemption.

Of the 53 insurers and HMOs that submitted data, 41 provided information on group benefit plans and 22 provided information on individual benefit plans. Twelve of the carriers reported only individual data, 31 reported only group data, and the remaining 10 provided both group and individual benefit plan data. The 41 group carriers reported total Texas premiums of $9,463,068,260 for calendar year 2003. The 22 carriers providing data on individual benefit plans reported total premiums of $1,103,989,888. Following is a summary of the data results reported separately for group benefit plans and individual benefit plans.

GROUP BENEFIT PLAN RESULTS

Mandated Benefit Claims Costs and Utilization

As explained earlier, TDI provided insurers and HMOs a specific list of standard diagnosis and procedure codes associated with each of the mandated benefits for which data is collected. Using these codes, the companies can uniformly identify and report the claims costs associated with each benefit. For each of the mandated benefits, insurers and HMOs were required to provide the total dollar value of claims paid and the number of claims paid. Aggregate claims data is reported for all group policies subject to the mandated benefit requirements.

The 41 insurers and HMOs providing group data reported a total of 4,161,659 separate mandated benefit claims, representing a total claims value of $337,574,913 (Table 1). The total value of **all** claims paid (including mandated benefits and all other claims), was $7,564,759,618. **Thus, the reported mandated benefit claims paid in 2003 represented a total of 4.5 percent of all claims paid.** An additional $10,502,333 was paid for mandated *offering* benefits, representing 0.14 percent of all claims paid.

A review of the data for each mandated benefit shows that each of the mandated benefits accounted for less than one percent of total claim costs. Claims paid for reconstructive breast surgery following a mastectomy represented the highest percentage of claims at 0.70 percent. Childhood immunizations accounted for the next highest percentage of costs at 0.60 percent of total claims, followed by claims paid for serious mental illness (0.50 percent), diabetes education and supplies (0.45 percent) and acquired brain injury (0.40 percent). The least costly benefits were nutritional supplements for PKU (Phynelketonuria) and other inheritable diseases, and telemedicine services; both benefits had claims totaling less than 0.00 percent of total claims paid.

Table 1 – Group Benefit Plans
Mandated Benefit Claims Costs

Mandated Benefit	Mandated Benefit Claims Paid	Claims as a Percentage of Total Claims
Acquired Brain Injury	$29,670,771	0.40%
AIDS/HIV Treatment	$7,760,569	0.10%
Chemical Dependency	$12,269,712	0.16%
Childhood Immunizations	$44,997,871	0.60%
Colorectal Cancer Testing	$18,928,889	0.25%
Craniofacial Surgery for Children	$1,405,244	0.02%
Diabetes Education and Supplies	$33,455,733	0.45%
Hearing Screening for Children	$28,099,938	0.38%
Mammography Screening	$21,969,154	0.29%
Nutritional Supplements for PKU and Other Inheritable Diseases	$130,388	0.00%
Oral Contraceptives	$18,329,883	0.25%
Osteoporosis Detection	$1,623,930	0.02%
Prescription Contraceptive Drugs, Devices and Related Services	$6,473,017	0.09%
PSA Testing for Prostate Cancer	$6,117,273	0.08%
Psychiatric Day Treatment	$10,661,264	0.14%
Reconstructive Breast Surgery Following a Mastectomy	$52,393,092	0.70%
Serious Mental Illness – 45 Inpatient and 60 Outpatient Days	$37,042,628	0.50%
Serious Mental Illness – Full Parity for Universities, Local Governments	$3,909,041	0.05%
Telemedicine Services	$143,899	0.00%
TMJ Treatment	$2,192,617	0.03%
TOTAL	**$337,574,913**	**4.51%**

Table 2 – Group Benefit Plans
Mandated Benefit Offerings Claims Costs

Mandated Benefit Offerings	Mandated Benefit Offering Claims Paid	Claims as a Percentage of Total Claims Paid
In-Vitro Fertilization	$1,443,205	0.02%
Treatment of Speech or Hearing Loss	$9,059,128	0.12%
TOTAL	**$10,502,333**	**0.14%**

Companies were also required to report the **number** of claims that were paid for each mandated benefit. The data varies significantly among benefits, since utilization of certain mandates is limited based on the prevalence of the medical condition, the frequency of the benefit, and whether the benefit applies to a limited population such as children only or men age 50 and older. For example, claims for prescription oral contraceptives recorded the highest utilization due to the fact that prescriptions are routinely filled on a monthly basis. Each time the prescription is refilled, a separate claim is noted. Thus, although there were more than one million claims representing nearly 29 percent of all mandated benefit claims, many of these were for repeat prescription refills. Other benefits, such as colorectal cancer screenings and PSA testing for prostate cancer, are generally limited to only one occurrence per year and are used primarily by older adults. The lower utilization rate of 2.43 percent for colorectal cancer screenings and 2.7 percent for PSA testing is not surprising given the limited population to which this benefit applies.

With regard to the mandated benefit offerings, treatments for speech or hearing loss were responsible for the vast majority of claims since this benefit is more widely applicable to the general population than are benefits for in-vitro fertilization. As a percentage of both the mandated benefits and mandated offerings *combined*, speech and hearing treatments accounted for 3.3 percent of the total number of claims and in-vitro fertilization was responsible for 0.18 percent of the total claims.

Table 3 – Group Benefit Plans
Mandated Benefit Utilization

Mandated Benefit	Number of Mandated Benefit Claims Paid	Percentage of the Total Number of Mandated Benefit Claims
Acquired Brain Injury	147,316	3.53%
AIDS/HIV Treatment	20,441	0.49%
Chemical Dependency – Total Expenditures (Inpatient and Outpatient Combined)	25,930	0.62%
Childhood Immunizations	639,227	15.35%
Colorectal Cancer Testing	101,236	2.43%
Craniofacial Surgery for Children	830	0.01%
Diabetes Education and Supplies	436,602	10.49%
Hearing Screening for Children	281,562	6.76%
Mammography Screening	336,904	8.09%
Nutritional Supplements for PKU and Other Inheritable Diseases	1,389	0.03%
Oral Contraceptives	1,186,568	28.51%
Osteoporosis Detection	10,545	0.25%
Prescription Contraceptive Drugs, Devices and Related Services	336,030	8.07%
PSA Testing for Prostate Cancer	115,797	2.78%
Psychiatric Day Treatment	32,733	0.78%
Reconstructive Breast Surgery Following a Mastectomy	151,346	3.63%
Serious Mental Illness – 45 Inpatient and 60 Outpatient Days	300,417	7.21%
Serious Mental Illness – Full Parity for Universities, Local Governments	27,024	0.64%
Telemedicine Services	981	0.02%
TMJ Treatment	8,781	0.21%
TOTAL	**4,161,659**	**100%**

Table 4 – Group Benefit Plans
Mandated Offerings Utilization

Mandated Benefit Offerings	Number of Mandated Benefit Claims Paid	Percentage of the Total Mandated Offering Claims Paid
In-Vitro Fertilization	8,168	5.4%
Treatment of Speech or Hearing Loss	144,672	94.6%
TOTAL	**152,840**	**100%**

It is important to note that mandated benefits with the highest claims costs are not necessarily the benefits most frequently used. Some of the more expensive mandated benefits affect a relatively small percentage of people, but result in high claims costs. The most costly mandated benefit – reconstructive breast surgery following a mastectomy – accounted for 15.52 percent of the claims costs, but only 3.63 percent of the number of claims. Oral contraceptives accounted for 28.51 percent of the total number of claims (again, most likely because of the repeat prescription refills on a regular basis), but only 5.43 percent of the claims costs.

Table 5 – Group Benefit Plans
Comparison of Mandated Benefit Utilization
and Mandated Benefit Claims Costs

Mandated Benefit	Percentage of the Total Number of Mandated Benefit Claims	Percentage of the Total Dollars Paid for Mandated Benefit Claims
Acquired Brain Injury	3.53%	8.78%
AIDS/HIV Treatment	0.49%	2.29%
Chemical Dependency	0.62%	3.63%
Childhood Immunizations	15.35%	13.32%
Colorectal Cancer Testing	2.43%	5.60%
Craniofacial Surgery for Children	0.01%	0.41%
Diabetes Education and Supplies	10.49%	9.91%
Hearing Screening for Children	6.76%	8.32%
Mammography Screening	8.09%	6.51%
Nutritional Supplements for PKU and Other Inheritable Diseases	0.03%	0.04%
Oral Contraceptives	28.51%	5.43%
Osteoporosis Detection	0.25%	0.48%
Prescription Contraceptive Drugs, Devices and Related Services	8.07%	1.92%
PSA Testing for Prostate Cancer	2.78%	1.81%
Psychiatric Day Treatment	0.78%	3.16%
Reconstructive Breast Surgery Following a Mastectomy	3.63%	15.52%
Serious Mental Illness – 45 Inpatient and 60 Outpatient Days	7.21%	10.97%
Serious Mental Illness – Full Parity for Universities, Local Governments	0.64%	1.16%
Telemedicine Services	0.02%	0.04%
TMJ Treatment	0.21%	0.65%
TOTAL	**100%**	**100%**

Comparability to Past Mandated Benefit Data Collected by TDI

Since 1992, TDI has been collecting mandated benefit cost and experience data from the largest insurance carriers (representing 65 to 75 percent of the health insurance premium volume) and all HMOs. The initial data set was limited to only 10 mandated benefits, but was later expanded in 1998 to include additional benefits. Other benefits were added following enactment of legislation adding new mandated benefits in 1999 and 2001. Although the current reporting requirements under Chapter 38, TIC, are more extensive and include more carriers, the claims cost data collected in previous years are comparable to the new data reporting for those benefits. Table 6 below summarizes mandated benefit claim costs since 1998 and demonstrates that claims costs have remained markedly consistent over time, which supports the premise that the reported data accurately represents the cost of the subject mandated benefits.

Table 6 – Group Benefit Plans
Mandated Benefit Claims Costs Comparison: 1998 - 2003

Mandated Benefit	Mandated Benefit Claims Costs as a Percentage of Total Claims				
	1998	1999	2001	2002	2003
Acquired Brain Injury					0.39%
AIDS/HIV Treatment	0.53%	0.95%	0.32	0.28	0.10%
Chemical Dependency – Total Expenditures (Inpatient and Outpatient)	0.36%	0.37%	0.30	0.23	0.16%
Childhood Immunizations	0.34%	0.31%	0.38	0.39	0.59%
Colorectal Cancer Testing					0.25%
Craniofacial Surgery for Children			0.02	0.02	0.02%
Diabetes Education and Supplies	0.17%	0.08%	0.81	0.81	0.44%
Hearing Screening for Children			0.43	0.43	0.37%
Mammography Screening	0.11%	0.13%	0.23	0.27	0.29%
Nutritional Supplements for PKU and Other Inheritable Diseases	0.00%	0.01%	0.00%	0.00%	0.00%
Oral Contraceptives	0.43%	0.35%	0.24%	0.27%	0.24%
Osteoporosis Detection	0.03%	0.05%	0.01%	0.01%	0.02%
Prescription Contraceptive Drugs, Devices and Related Services					0.09%
PSA Testing for Prostate Cancer	0.04%	0.06%	0.06%	0.06%	0.08%
Psychiatric Day Treatment			0.15%	0.09%	0.14%
Reconstructive Breast Surgery Following a Mastectomy			0.75%	1.01%	0.69%
Serious Mental Illness – 45 Inpatient and 60 Outpatient Days	0.54%	0.46%	0.74%	0.59%	0.49%
Serious Mental Illness – Full Parity for Universities, Local Governments					0.05%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%	0.00%
TMJ Treatment	0.00%	0.03%	0.08%	0.07%	0.03%
TOTAL	**2.55%**	**2.8%**	**4.52%**	**4.53%**	**4.51%**

Mandated Benefit Premium Costs

In addition to claims cost data, insurers and HMOs were also required to provide premium cost estimates for each mandated benefit. To compare the cost of coverage for a single-employee/enrollee and for individuals who select coverage for their entire family (the employee/enrollee, spouse and children), carriers were required to provide separate cost estimates for single coverage and for family coverage. These two benefit options represent the least expensive option and the most expensive option available under group benefit plans and thus provide a good representation of the premium cost differentials. Other enrollment options for which TDI did not collect data include employee/enrollee-plus-spouse and employee/enrollee-plus-children. Thus, while the premium estimates provided show the range of costs, they are not representative of all cost categories.

It is important to note that carriers have often reported that they do not routinely develop price estimates for each separate mandated benefit provided under an insurance plan. Although insurers and HMOs have testified both to the Legislature and TDI that each mandated benefit added to a policy increases the cost of the policy, the companies are usually unable to provide cost estimates. TDI has, through previous data calls, attempted to collect premium cost estimates for each mandated benefit, but the data was inconsistent or, according to most insurers, "unavailable."

Though all carriers use similar actuarial methodologies to establish health insurance premium rates, the exact process and underlying data assumptions used are highly protected trade secrets that are not generally subject to public disclosure. TDI does not routinely approve or review group health insurance rates, and a standardized methodology for setting rates does not exist. As such, to promote consistency in the reported data, the mandated benefit reporting instructions directed insurers and HMOs to estimate a premium cost for each benefit based on the company's actual claims experience. Accordingly, the estimated premium cost should have a reasonable relationship to the claims actually paid for the same benefit. Notwithstanding this instruction, insurers and HMOs have complete discretion in determining how they develop this cost.

Of the 41 companies who provided claims cost data, only 34 companies provided premium cost data that TDI determined to be valid. TDI excluded the remaining companies either because they reported aggregated cost data for all enrollees rather than the per-person cost estimate that was required, or the premium cost estimates they reported were 500 percent or higher than the average reported by all other companies.

As shown in Table 7, the cost estimates for each mandated benefit varied significantly. The least expensive mandated benefits for both single coverage and family coverage are telemedicine and nutritional supplements for PKU and other diseases. These two benefits also were the least costly based on claims paid by carriers. The most expensive benefits were slightly different for single coverage and family coverage. Under single coverage estimates, reconstructive breast surgery following a mastectomy was the most expensive at an annual total cost of $11.35. The second most expensive benefit was serious mental

illness at $10.12, followed by diabetes education and supplies at $9.42, and childhood immunizations at $8.71. For family coverage, the most expensive benefit was serious mental illness at an annual cost of $28.94. Childhood immunizations followed closely behind at $27.20, and diabetes education and supplies was estimated to cost an average of $26.00 per year. All benefits combined resulted in an average annual premium cost of $87.18 for single coverage and $231.41 for family coverage.

Table 7 – Group Benefit Plans
Mandated Benefit Annual Premium Cost Estimates

Mandated Benefit	Average Annual Premium Cost Estimates - Single Coverage	Average Annual Premium Cost Estimates – Family Coverage
Acquired Brain Injury	$6.07	$16.43
AIDS/HIV Treatment	$3.57	$6.72
Chemical Dependency	$6.35	$13.29
Childhood Immunizations	$8.71	$27.20
Colorectal Cancer Testing	$4.55	$10.81
Craniofacial Surgery for Children	$0.43	$1.19
Diabetes Education and Supplies	$9.42	$26.00
Hearing Screening	$5.35	$18.63
Mammography Screening	$5.63	$14.38
Nutritional Supplements for PKU and Other Diseases	$.03	$.08
Oral Contraceptives	$5.60	$16.13
Osteoporosis Detection	$.27	$0.55
Prescription Contraceptive Drugs, Devices and Services	$2.77	$6.47
PSA Testing for Prostate Cancer	$1.47	$3.40
Psychiatric Day Treatment	$.88	$6.33
Reconstructive Breast Surgery Following Mastectomy	$11.35	$23.27
Serious Mental Illness – 45 Inpatient Days/60 Outpatient	$10.12	$28.94
Serious Mental Illness – Full Parity (Applies to Gov't & University Employees Only)	$4.09	$10.35
Telemedicine	$.04	$.10
TMJ	$.48	$1.14
TOTAL	**$87.18**	**$231.41**

Table 8 – Group Benefit Plans
Mandated Offerings Average Annual Premium Cost Estimates

Mandated Benefit Offerings	Average Annual Premium Cost Estimates – Single Coverage	Average Annual Premium Cost Estimates – Family Coverage
In-Vitro Fertilization	$.41	$1.02
Speech/Hearing Therapy	$1.91	$4.00
TOTAL	**$2.32**	**$5.02**

Even with the exclusion of the seven companies that submitted unusable data, the range of premium costs reported by insurers/HMOs for each mandated benefit was extremely wide and raises questions regarding how some companies estimated premium costs. While **claims** costs data varied only marginally from company to company, premium cost estimates were anything but consistent. For example, among the companies that reported **usable** premium cost data, the range of estimated annual premium costs reported for family coverage varied as follows:

- acquired brain injury: $.02 to $77.57
- coverage of AIDS/HIV: $.06 to $41.25
- childhood immunizations: $.15 to $78.70
- mammography screening: $.37 to $58.39
- oral contraceptives: $.61 to $53.88
- prostate cancer testing: $.15 to $32.93
- reconstructive breast surgery: $.21 to $96.63.

Similar variations were reported for single-coverage estimates for each mandated benefit. The wide range in premium costs did not appear to follow any particular pattern or order. In some cases, an insurer had a relatively low or average premium estimate for most benefits but reported extremely high costs for other benefits relative to the other carriers. Though in some cases the higher premium estimate did correlate to a higher claim cost for that particular company, this was not generally the case. The variations also were not consistent depending on the size of the company. The largest carriers often reported both the highest premium estimates as well as the lowest premium estimates.

Although TDI does not generally review group insurance rates and thus has no data base against which to measure the "reasonableness" of the carriers' mandated benefit premium cost estimates, we can compare the **estimated** premium costs with the **actual** claim costs to determine whether the premium estimates bear any relationship to the value of the claims paid. Though not required to demonstrate that premium cost estimates for a mandated benefit are reasonable based on the actual claims paid, TDI instructed carriers to determine premium cost estimates based on the actual claims paid. For example, if a company paid less than $1,000 in claims for a particular benefit, the premium cost estimate should be relatively low. However, this was clearly not the case for all companies. For example, an insurer reported paying $0 claims for a particular mandated

benefit, but estimated the family premium for that same benefit to be $35.40. In another case, the carrier paid less than $6,000 in total claims for the benefit, but estimated the family premium at $102.94 for the benefit. The premiums collected for that benefit would have totaled $532,302 based on the number of family contracts issued by that carrier. Thus, the company would have collected $532,302 for a particular benefit, but paid less than $6,000 in claims. These are not isolated instances, but only examples of numerous high premium cost estimates relative to the total claims paid.

To evaluate whether the premium estimates were consistent with the value of the claims paid, TDI compared the actual claim cost-per-certificate of coverage with the premium estimates provided by the companies. Using the number of certificates of coverage issued and the total claims paid for each benefit, TDI calculated an average claim cost per certificate of coverage. While this data is not a premium calculation and does not account for other operating expenses besides claims costs, it does compare, for each mandated benefit, the relative balance between premium cost estimates with the actual claims paid. In Table 9, the first column provides TDI's calculation of the average annual claim cost-per-certificate using data submitted by the insurers and HMOs. The second column provides the average premium cost as reported by carriers for single coverage. The third column provides the average premium cost as reported by carriers for family coverage. As the table shows, the average premium estimates appear consistent with the average claims paid using the aggregated data. The total average annual claim cost per all certificates (single coverage, employee/enrollee and spouse, employee/enrollee and children, and family coverage) is $126.97, compared to a total estimated premium cost of $87.18 for single coverage and $231.41 for family coverage. However, again we note that while the aggregated averages for all companies are reasonable, the data submitted by some insurers were well outside the average range and showed no relationship between claims paid and premium cost estimates.

Although the total claims costs and premium estimates show a reasonable relationship, it is interesting to note that the mandated benefits that had the highest claims costs did not necessarily translate into the highest premium. For example, reconstructive breast surgery had the highest average *claim cost* per certificate at $20.90, but was not the most expensive mandate for family coverage based on insurers' premium estimates. The premium estimate for reconstructive breast surgery was $23.27, compared to $28.94 for serious mental illness coverage, $27.20 for childhood immunizations, and $26.00 for diabetes education and supplies.

Also worth noting is that five mandated benefits accounted for more than half of both the premium costs and the total average claim costs per certificate. For family coverage, the following mandates accounted for 53 percent of the premium costs: childhood immunizations, diabetes education and supplies, hearing screening, reconstructive breast surgery following a mastectomy, and serious mental illness. For single coverage, four of the same mandates just mentioned plus one added benefit were responsible for 52 percent of the total premium costs: acquired brain injury, childhood immunizations, diabetes education and supplies, reconstructive breast surgery, and serious mental illness. Five benefits also accounted for 55 percent of the total average annual claim costs per

certificate: childhood immunizations, diabetes education and supplies, reconstructive breast surgery, serious mental illness (45 inpatient /60 outpatient days), and full parity for serious mental illness.

Table 9 – Group Benefit Plans
Mandated Benefit Costs:
A Comparison of Actual Claims Costs-per-Certificate with
Average Annual Premium Costs Per Mandated Benefit

Mandated Benefit	Average Annual Claim Cost Per Certificate	Average Annual Premium Cost Estimates – Single Coverage	Average Annual Premium Cost Estimates – Family Coverage
Acquired Brain Injury	$7.73	$6.07	$16.43
AIDS/HIV Treatment	$3.92	$3.57	$6.72
Chemical Dependency	$7.54	$6.35	$13.29
Childhood Immunizations	$12.51	$8.71	$27.20
Colorectal Cancer Testing	$3.16	$4.55	$10.81
Craniofacial Surgery for Children	$0.79	$0.43	$1.19
Diabetes Education and Supplies	$12.71	$9.42	$26.00
Hearing Screening	$8.94	$5.35	$18.63
In-Vitro Fertilization	$.83		
Mammography Screening	$9.33	$5.63	$14.38
Nutritional Supplements for PKU and Other Diseases	$.09	$.03	$.08
Oral Contraceptives	$6.77	$5.60	$16.13
Osteoporosis Detection	$.72	$.27	$0.55
Prescription Contraceptive Drugs, Devices and Services	$2.54	$2.77	$6.47
PSA Testing for Prostate Cancer	$2.23	$1.47	$3.40
Psychiatric Day Treatment	$1.89	$.88	$6.33
Reconstructive Breast Surgery Following a Mastectomy	$20.90	$11.35	$23.27
Serious Mental Illness – 45 Inpatient Days/60 Outpatient Days	$13.99	$10.12	$28.94
Serious Mental Illness – Full Parity (Applies to Gov't & University Employees Only)	$9.99	$4.09	$10.35
Telemedicine	$.04	$.04	$.10
TMJ	$1.18	$.48	$1.14
TOTAL	**$126.97**	**$87.18**	**$231.41**

Table 10 – Group Benefit Plans
Mandatory Offers of Coverage Costs:
A Comparison of Actual Claims Costs-per-Certificate with
Average Annual Premium Costs Per Mandated Benefit

Mandated Benefit Offerings	Average Annual Claim Cost Per Certificate	Average Annual Premium Cost Estimates- Single Coverage	Average Annual Premium Cost Estimates – Family Coverage
In-Vitro Fertilization	$.83	$.41	$1.02
Speech/Hearing Therapy	$3.43	$1.91	$4.00
TOTAL	**$4.26**	**$2.32**	**$5.02**

Mandated Benefit Administrative Costs

Finally, insurers and HMOs were required to provide an estimate of the annual administrative costs incurred as a result of the mandated benefit requirements. Administrative costs generally include such expenses as claims payment, processing preauthorizations and referrals, and revisions of marketing materials and policy forms to include new mandated benefits. The insurers/HMOs were instructed to only include first-year re-printing expenses if the costs were incurred within that year. For example, if a mandate was enacted in 2001, the additional costs incurred with new marketing and material printing requirements would only be reported for the first year the benefit took effect.

As with premium cost estimates, TDI gave insurers/HMOs wide discretion to determine the value of the administrative costs associated with a specific mandated benefit. The result was huge variation in the reports of those costs. On a company-by-company basis, TDI analyzed the data in a number of different ways to determine whether there was a consistent methodology or pattern to the expenses reported, including: average administrative costs per claim for each mandated benefit; average administrative cost per mandated benefit based on the dollar value of the claims paid for each benefit; and aggregated total administrative costs for all mandated benefit relative to total claims dollars. In some cases, it was apparent that companies used one of these methods to estimate administrative costs. However, other companies' data suggests that some other process was used that resulted in inconsistent data.

Because TDI has never before requested administrative cost data, there is no existing data against which to compare or verify the accuracy of the reported information. Although TDI is requiring several insurers to provide additional information on the methodology used to calculate their expenses, TDI decided not to exclude any of the data despite the wide variations. Table 11 shows that the total administrative costs associated with these mandated benefits was $51,966,845. This represents 15 percent of the total mandated benefit claims costs and 0.68 percent of all claims paid.

Table 11 – Group Benefit Plans
Mandated Benefit Administrative Cost Estimates

Mandated Benefit	Total Administrative Costs	Administrative Costs as a Percentage of Total Claims Paid
Acquired Brain Injury	$4,723,998	0.06%
AIDS/HIV Treatment	$806,504	0.01%
Chemical Dependency	$2,826,111	0.03%
Childhood Immunizations	$4,969,018	0.06%
Colorectal Cancer Testing	$2,609,929	0.03%
Craniofacial Surgery for Children	$201,452	0.00%
Diabetes Education and Supplies	$5,756,992	0.07%
Hearing Screening	$4,696,770	0.06%
Mammography Screening	$3,416,235	0.04%
Nutritional Supplements for PKU and Other Diseases	$54,989	0.00%
Oral Contraceptives	$2,751,256	0.03%
Osteoporosis Detection	$238,469	0.00%
Prescription Contraceptive Drugs, Devices and Services	$1,186,411	0.01%
PSA Testing for Prostate Cancer	$1,102,175	0.01%
Psychiatric Day Treatment	$1,149,787	0.01%
Reconstructive Breast Surgery Following a Mastectomy	$8,030,801	0.10%
Serious Mental Illness – 45 Inpatient Days/60 Outpatient Days	$6,430,879	0.08%
Serious Mental Illness – Full Parity (Applies to Gov't & University Employees Only)	$449,549	0.00%
Telemedicine	$58,267	0.00%
TMJ	$507,253	0.00%
TOTAL	**$51,966,845**	**0.68%**

Table 12 – Group Benefit Plans
Mandated Offer Administrative Cost Estimates

Mandated Benefit Offerings	Total Administrative Costs	Administrative Costs as a Percentage of Total Claims Paid
In-Vitro Fertilization	$1,443,205	0.01%
Speech/Hearing Therapy	$2,313,880	0.03%
TOTAL	**$3,757,085**	**0.04%**

Although TDI has no previous data with which to compare the administrative cost estimates, benefits that accounted for a higher percentage of the total number of claims would logically also account for higher administrative costs due to increased costs associated with processing higher claim volumes. Also, companies could consider added costs associated with certain mandated benefits that require additional administrative services for specialist referrals and treatment authorizations. Most companies, however, appeared to determine administrative costs using claims costs rather than claims volume. With a few exceptions, insurers did not appear to vary cost estimates based on the different levels of administrative services required for individual mandated benefits.

To measure the relationship between administrative costs and claims paid, we compared the administrative costs as a percentage of total claims paid with the mandated benefit claims costs as a percentage of total claims paid. The results appear in Table 13. The data generally support the concept that carriers estimated administrative expenses based on claims dollars paid rather than on the number of claims paid. For example, reconstructive breast surgery accounted for the highest percentage of claims costs (0.70 percent) and the highest percentage of administrative costs (0.10 percent), but had one of the lowest claim volumes. However, while these trends are obvious on an aggregate basis, it should be noted that the same relationship was not always apparent on a company-by-company basis.

Table 13 – Group Benefit Plans
Mandated Benefit Administrative Costs and Claims Costs Comparison

Mandated Benefit	Administrative Cost as a Percentage of Total Claims Paid	Claims Costs as a Percentage of Total Claims Paid
Acquired Brain Injury	0.06%	0.40%
AIDS/HIV Treatment	0.01%	0.10%
Chemical Dependency	0.03%	0.16%
Childhood Immunizations	0.06%	0.60%
Colorectal Cancer Testing	0.03%	0.25%
Craniofacial Surgery for Children	0.00%	0.02%
Diabetes Education and Supplies	0.07%	0.45%
Hearing Screening	0.06%	0.38%
Mammography Screening	0.04%	0.29%
Nutritional Supplements for PKU and Other Diseases	0.00%	0.00%
Oral Contraceptives	0.03%	0.25%
Osteoporosis Detection	0.00%	0.02%
Prescription Contraceptive Drugs, Devices and Services	0.01%	0.09%
PSA Testing for Prostate Cancer	0.01%	0.08%
Psychiatric Day Treatment	0.01%	0.14%
Reconstructive Breast Surgery Following a Mastectomy	0.10%	0.70%
Serious Mental Illness – 45 Inpatient Days/60 Outpatient Days	0.08%	0.50%
Serious Mental Illness – Full Parity (Gov't & University Employees Only)	0.00%	0.05%
Telemedicine	0.00%	0.00%
TMJ	0.00%	0.03%
TOTAL	**0.68%**	**4.51%**

Table 14 – Group Benefit Plans
Mandated Offer - Administrative Costs and Claims Costs Comparison

Mandated Benefit Offerings	Administrative Cost as a Percentage of Total Claims Paid	Claims Costs as a Percentage of Total Claims Paid
In-Vitro Fertilization	0.01%	0.02%
Speech/Hearing Therapy	0.03%	0.12%
TOTAL	**0.04%**	**0.14%**

INDIVIDUAL BENEFIT PLAN RESULTS

Insurers who reported $2 million or more in individual insurance premiums for benefit plans that are subject to the mandated benefit requirements are required to file a mandated benefit cost and utilization report. Most HMOs do not offer individual coverage, but were required to file a report if they offered individual coverage and their combined individual and group premiums totaled $10 million or more. One HMO and 21 insurance companies met the minimum financial threshold for a total of 22 survey respondents. These 22 companies issued more than 700,000 individual insurance policies totaling $1,103,989,888 in premiums for calendar year 2003. Because individual plans are not required to provide the same mandated benefits as are group plans, the individual carriers provided data on 13 mandated benefits and no mandated offerings. A summary and analysis of the data is provided below.

Mandated Benefit Claims Costs and Utilization

Mandated benefit claims costs for individual benefit plans totaled $26,376,292 (Table 15). This figure represents 3.62 percent of all claims paid, which totaled $727,770,864. As a percentage of the total premiums collected, mandated benefits cost 2.39 percent. These numbers reflect a slightly lower percentage than the group mandated benefits, as would be expected since not all mandated benefits apply to individual benefit plans. As with group benefits, reconstructive breast surgery following a mastectomy was the most expensive mandated benefit, followed by childhood immunizations. The least expensive mandated benefits were telemedicine services and craniofacial surgery for children.

Table 15 – Individual Benefit Plans
Mandated Benefit Claims Costs

Mandated Benefit	Mandated Benefit Claims Paid	Claims as a Percentage of Total Claims
Acquired Brain Injury	$1,031,402	0.14%
AIDS/HIV Treatment	$1,530,054	0.21%
Childhood Immunizations	$5,131,344	0.71%
Colorectal Cancer Testing	$363,018	0.05%
Craniofacial Surgery for Children	$150,450	0.02%
Diabetes Education and Supplies	$1,766,823	0.24%
Hearing Screening for Children	$2,619,508	0.36%
Mammography Screening	$1,469,872	0.20%
Oral Contraceptives	$1,851,156	0.25%
Prescription Contraceptive Drugs, Devices and Related Services	$209,191	0.03%
PSA Testing for Prostate Cancer	$1,158,417	0.16%
Reconstructive Breast Surgery Following a Mastectomy	$9,072,141	1.25%
Telemedicine Services	$22,916	0.00%
TOTAL	**$26,376,292**	**3.62%**

Utilization of mandated benefits under individual plans also closely followed claims for group plans. As explained earlier, oral contraceptives accounted for more than half the number of all mandated benefit claims filed, due to the fact that each monthly prescription refill counts for a separate claim. Childhood immunizations was a distant second, with 10.68 percent of the total claims filed. Telemedicine services and craniofacial surgery for children accounted for the least number of claims.

Table 16 – Individual Benefit Plans
Mandated Benefit Utilization

Mandated Benefit	Number of Mandated Benefit Claims Paid	Percentage of the Total Number of Mandated Benefit Claims
Acquired Brain Injury	1,384	0.35%
AIDS/HIV Treatment	2,745	0.69%
Childhood Immunizations	42,242	10.68%
Colorectal Cancer Testing	2,489	0.62%
Craniofacial Surgery for Children	88	0.02%
Diabetes Education and Supplies	14,803	3.70%
Hearing Screening for Children	20,753	5.24%
Mammography Screening	39,988	10.11%
Oral Contraceptives	214,177	54.08%
Prescription Contraceptive Drugs, Devices and Related Services	27,139	6.86%
PSA Testing for Prostate Cancer	13,666	3.45%
Reconstructive Breast Surgery Following a Mastectomy	15,897	4.02%
Telemedicine Services	12	0.00%
TOTAL	**395,383**	**100%**

As with group benefit plans, we also compared the relationship between claim volume and claim costs to determine whether higher claims utilization resulted in higher total claims costs (Table 17). Though there was some correlation, there also were some noted exceptions. Oral contraceptives represented the highest number of claims, but was not the most expensive mandated benefit. Again, this is due to the fact that oral contraceptives result in multiple prescription refills throughout the year, but are a relatively low cost medical expenditure. In contrast, reconstructive breast surgery accounted for only 4.02 percent of claims, but was clearly the most expensive mandated benefit with more than one third (34.39 percent) of all costs. For the remaining benefits, however, higher utilization generally resulted in higher claims costs.

Table 17 – Individual Benefit Plans
Comparison of Mandated Benefit Utilization
and Mandated Benefit Claims Costs

Mandated Benefit	Percentage of the Total Number of Mandated Benefit Claims	Percentage of the Total Dollars Paid for Mandated Benefits
Acquired Brain Injury	0.35%	3.91%
AIDS/HIV Treatment	0.69%	5.80%
Childhood Immunizations	10.68%	19.45%
Colorectal Cancer Testing	0.62%	2.41%
Craniofacial Surgery for Children	0.02%	0.57%
Diabetes Education and Supplies	3.70%	6.69%
Hearing Screening for Children	5.24%	9.93%
Mammography Screening	10.11%	5.57%
Oral Contraceptives	54.08%	7.01%
Prescription Contraceptive Drugs, Devices and Related Services	6.86%	0.79%
PSA Testing for Prostate Cancer	3.45%	4.39%
Reconstructive Breast Surgery Following a Mastectomy	4.02%	34.39%
Telemedicine Services	0.00%	0.08%
TOTAL	**100%**	**100%**

Mandated Benefit Premium Costs

Insurers and HMOs also provided annual premium cost data for two categories: single coverage (which insures one individual only), and family coverage (which insures both parents and any children). These two categories represent the least expensive coverage available and the most expensive. As explained earlier in the report, TDI did not give insurers and HMOs a specific methodology to use in calculating premium costs for each mandated benefit. While companies generally follow the same guidelines in establishing premium costs, there are many variations. Because there is no "standard", TDI allowed carriers to use their own formula for developing premium cost estimates, but also instructed them to base their estimate on the actual claims experience for each mandated benefit.

Of the 22 companies that provided individual policy data, five either did not provide premium cost estimates or submitted inaccurate data. The remaining 17 companies did provide usable estimates which are summarized below. As shown in Table 18, insurers and HMOs charged the most for childhood immunizations, at a cost of $10.35 per year for single coverage and $16.34 per year for family coverage. Coverage for mammography screenings followed at an annual cost of $14.52 for family coverage and

$9.60 for single coverage. It is significant to note that neither of these two benefits accounted for the highest claims costs, which suggests that the estimated premium costs provided by insurers do not necessarily reflect actual claim costs. This is true on an aggregated, average basis and particularly so on an individual company basis. In some cases, companies'premium estimates for specific mandated benefits were extremely high relative to the actual cost of providing the benefit as indicated by claims paid. Despite the inconsistencies in premium cost estimates for certain mandated benefits, however, the overall total annual premium costs on an aggregated basis did appear reasonable based on the claims paid. All mandated benefits combined resulted in a total annual premium of $42.29 for single coverage and $83.76 for family coverage.

Table 18 – Individual Benefit Plans
Mandated Benefit Annual Premium Cost Estimates

Mandated Benefit	Average Premium Cost Estimates - Single Coverage	Average Premium Cost Estimates – Family Coverage
Acquired Brain Injury	$3.20	$8.01
AIDS/HIV Treatment	$3.10	$3.83
Childhood Immunizations	$10.35	$16.34
Colorectal Cancer Testing	$2.90	$4.21
Craniofacial Surgery for Children	$0.42	$0.42
Diabetes Education and Supplies	$3.91	$12.30
Hearing Screening	$2.02	$6.94
Mammography Screening	$9.60	$14.52
Oral Contraceptives	$0.57	$3.88
Prescription Contraceptive Drugs, Devices and Services	$0.70	$2.29
PSA Testing for Prostate Cancer	$1.93	$3.55
Reconstructive Breast Surgery Following a Mastectomy	$3.51	$7.26
Telemedicine	$0.08	$0.21
TOTAL	**$42.29**	**$83.76**

To further evaluate the reasonableness of the premium estimates with the actual claims paid, we also compared the average annual claim cost-per-certificate of coverage with the premium estimates provided by carriers. Using enrollment data and claims cost data provided by each insurer/HMO, TDI calculated the average claim cost-per-certificate as shown in column two in Table 19. This average cost is calculated based on all claims paid for all categories of coverage combined (single, family, parent and child, and adult plus spouse) so the cost should fall somewhere between the premium estimates reported by carriers for single coverage and family coverage. As the table shows, this clearly is the case, with the total average annual premium of $64.14 for all policies combined. It is also interesting to note that based on the actual claims paid, the most expensive mandated benefit is reconstructive breast surgery following a mastectomy, and not childhood

immunizations as estimated by carriers. Again, these are average figures so data for individual companies will vary somewhat from the aggregated results.

Table 19 – Individual Benefit Plans
Mandated Benefit Costs:
A Comparison of Actual Claims Costs-per-Certificate with
Average Annual Premium Costs for Single and Family Coverage

Mandated Benefit	Average Annual Claim Cost Per Certificate	Average Premium Cost Estimates - Single Coverage	Average Premium Cost Estimates – Family Coverage
Acquired Brain Injury	$10.56	$3.20	$8.01
AIDS/HIV Treatment	$2.47	$3.10	$3.83
Childhood Immunizations	$11.82	$10.35	$16.34
Colorectal Cancer Testing	$4.65	$2.90	$4.21
Craniofacial Surgery for Children	$0.46	$0.42	$0.42
Diabetes Education and Supplies	$0.65	$3.91	$12.30
Hearing Screening	$6.62	$2.02	$6.94
Mammography Screening	$7.10	$9.60	$14.52
Oral Contraceptives	$3.23	$0.57	$3.88
Prescription Contraceptive Drugs, Devices and Services	$1.16	$0.70	$2.29
PSA Testing for Prostate Cancer	$2.10	$1.93	$3.55
Reconstructive Breast Surgery Following a Mastectomy	$13.32	$3.51	$7.26
Telemedicine	$0	$0.08	$0.21
TOTAL	**$64.14**	**$42.29**	**$83.76**

Mandated Benefit Administrative Costs

Finally, the participating insurers and HMOs were asked to estimate the average annual premium cost associated with each mandated benefit. TDI did not prescribe a specific methodology since administrative costs are calculated differently by different carriers. As such, TDI allowed each carrier to make their own determination, but specified that the carrier should only report the initial implementation costs associated with a newly enacted mandated benefit (i.e, new training materials for agents, policy re-prints) if it actually incurred those costs during the reporting year.

Total costs for all mandated benefits combined are $8,732,632, which represents 1.19 percent of the total cost of all claims paid and 0.79 percent of total premiums (Table 20). These numbers are consistent with the data reported by the group carriers. However, the

actual estimates provided by some carriers were extremely high relative to the total claims paid. One carrier in particular estimated that administrative costs totaled 48 percent of the actual claims paid for each mandated benefit. All other carriers combined estimated that administrative costs totaled less than 5 percent of the actual claims paid. While the aggregated data is reasonable, the varying methodologies used by companies to calculate their own administrative costs resulted in some extreme cost estimates on a company-level basis.

Table 20 – Individual Benefit Plans
Mandated Benefit Administrative Cost Estimates

Mandated Benefit	Total Administrative Costs	Administrative Costs as a Percentage of Total Claims Paid
Acquired Brain Injury	$66,020	0.01%
IDS/HIV Treatment	$391,517	0.05%
Childhood Immunizations	$1,989,784	0.27%
Colorectal Cancer Testing	$32,298	0.00%
Craniofacial Surgery for Children	$40,606	0.00%
Diabetes Education and Supplies	$425,431	0.06%
Hearing Screening for Children	$1,130,370	0.16%
Mammography Screening	$554,138	0.08%
Oral Contraceptives	$507,246	0.07%
Prescription Contraceptive Drugs, Devices and Related Services	$51,416	0.00%
PSA Testing for Prostate Cancer	$518,435	0.07%
Reconstructive Breast Surgery Following a Mastectomy	$3,024,381	0.42%
Telemedicine Services	$990	0.00%
TOTAL	**$8,732,632**	**1.19%**

To determine whether mandated benefits with higher claims costs also resulted in higher administrative costs, Table 21 compares the average administrative costs as a percentage of total claims with the average claims costs as a percentage of total claims. For the most part, the two are consistent, with reconstructive breast surgery accounting for the highest percentage of claims costs and administrative costs. Following are childhood immunizations and hearing screening for children. These data are consistent with many companies' calculation of administrative costs strictly as a percentage of the claims costs, which necessarily ties higher claims costs to higher administrative costs. Although this is a reasonable methodology, it does not take into account that administrative costs may vary among benefits depending on such factors as the volume of claims processed and a cost-per-claim factor, or whether certain benefits require additional administrative services such as treatment authorizations or specialists referrals.

Table 21 – Individual Benefit Plans
Mandated Benefit Administrative Costs and Claims Costs Comparison

Mandated Benefit	Administrative Costs as a Percentage of Total Claims Paid	Claims Costs as a Percentage of Total Claims Paid
Acquired Brain Injury	0.01%	0.14%
AIDS/HIV Treatment	0.05%	0.21%
Childhood Immunizations	0.27%	0.71%
Colorectal Cancer Testing	0.00%	0.05%
Craniofacial Surgery for Children	0.00%	0.02%
Diabetes Education and Supplies	0.06%	0.24%
Hearing Screening for Children	0.16%	0.36%
Mammography Screening	0.08%	0.20%
Oral Contraceptives	0.07%	0.25%
Prescription Contraceptive Drugs, Devices and Related Services	0.00%	0.03%
PSA Testing for Prostate Cancer	0.07%	0.16%
Reconstructive Breast Surgery Following a Mastectomy	0.42%	1.25%
Telemedicine Services	0.00%	0.00%
TOTAL	**1.19%**	**3.62%**

In conclusion, this report demonstrates the impact of mandated benefit provisions on claims costs and premium costs. The data show that each added benefit results in some additional cost to both the insurer and the purchaser of a health benefit plan. This study does not, however, take into account the cost savings that accompany some mandated benefits. As has been documented in previous studies, the treatment and care associated with many mandated benefits are expected to improve and maintain the health of insured Texans. As such, any meaningful discussion of mandated benefits should consider both the economic impact as well as the equally important impact on health status.

APPENDIX: DEFINITIONS OF MANDATED BENEFITS AND MANDATED OFFERINGS

Mandated Benefits

Acquired Brain Injury – an HMO plan or accident and health policy may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioural, neurophysiological, neuropsychological and psychophyisiological 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 benefit applies to both group and individual HMO and accident and health plans.

Legal Basis
Accident and Health: Article 3.70-2(G), Texas Insurance Code
HMO: Article 3.70-2(G), Texas Insurance Code; Section 11.510(2), Subchapter F, Title 28, Texas Administrative Code

AIDS, HIV and Related Illnesses - an HMO plan or accident and health policy may not exclude, deny or cancel coverage for HIV, AIDS, or HIV-related illnesses. Applies to group insurance plans and HMO benefit plans.

Legal Basis
Accident and Health: Article 3.51-6, Section 3C, 3.51-6D; 3.50-2, Section 5(j)(1); 3.50-3, Section 4C(1); and 3.51-5A(a)(1), Texas Insurance Code; Section 3.3057(d), Exhibit A, Subchapter S, Title 28, Texas Administrative Code.
HMO: Article 3.51-6, Section 3C, Texas Insurance Code.

Chemical Dependency – benefits for the necessary care and treatment of chemical dependency must be provided on the same basis as other physical illnesses generally. 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 Sections 3.80001-3.8030, Texas Administrative Code. Applies to group insurance plans and HMO benefit plans. Does not apply to a plan issued to a small employer.

Legal Basis
Accident and Health/HMO: Article 3.51-9, Texas Insurance Code; Sections 3.80001-3.8030, Subchapter HH, Title 28, Texas Administrative Code.

Childhood Immunizations –any HMO plan or accident and health policy that provides benefits for a family member of the enrollee must provide coverage for each covered child from birth through the date the child is six years old for (1) immunizations against diphtheria; haemophilus influenza type b: hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; and rotovirus; and 2) any other immunization that is required by law for the child. Immunizations may not be subject to a deductible or copayment requirement. Applies to individual and group insurance plans and HMO benefit plans; does not apply to plans issued to a small employer.

Legal Basis
Accident and Health: Article 21.53F, Texas Insurance Code
HMO: Articles 21.53F, and 20A.09F, Texas Insurance Code; Section 11.506(2) & 11.508(a)(9)(G), Subchapter F, Title 28, Texas Administrative Code.

Colorectal Cancer Testing – an HMO plan or accident and health policy that provides benefits 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 signoidoscopy performed every five years, or (2) a colonoscopy performed every 10 years. Applies to individual and group insurance plans and HMO benefit plans; does not apply to plans issued to a small employer.

Legal Basis
Accident and Health/HMO: Article 21.53S, Texas Insurance Code

Craniofacial Surgery for Children – any HMO plan or accident and health policy that provide benefits to 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. Any EOC must provide coverage for reconstructive surgery for craniofacial abnormalities for a child who: (1) is younger than 18 years of age; and (2) has maintained continuous coverage from the date of birth in accordance with laws relating to portability. Applies to individual and group benefit plans and HMO benefit plans; does not apply to plans issued to a small employer.

Legal Basis
Accident and Health/HMO: Article 21.53W, Texas Insurance Code

Diabetes Education and Supplies – any HMO plan or accident and health policy which provides benefits for the treatment of diabetes and associated conditions must provide coverage to each qualified enrollee for diabetes self-management training programs. The coverage must be in accordance with the standards adopted under Sections 21.2601-21.2607, Subchapter R, Title 28, Texas Administrative Code. Applies to individual and group insurance plans and HMO benefit plans. Does not apply to a plan issued to a small employer.

Legal Basis
Accident and Health/HMO: Articles 21.53D and 21.53G, Texas Insurance Code; Sections 21.2601-21.2607, Subchapter R, Title 28, Texas Administrative Code

Hearing Screening for Children – any HMO plan or accident and health policy that provides benefits for a family member of the enrollee/insured must provide coverage for each covered child for: (1) a screening test for hearing loss from birth through the date the child is 30 days old, as provided by Chapter 47, Health and Safety Code; and (2) necessary 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/coinsurance requirements, but may not be subject to a deductible requirement or dollar limits. These limitations and requirements must be stated in the EOC/policy. Applies to both individual and group insurance policies and HMO plans. Does not apply to a plan issued to a small employer.

Legal Basis
Accident and Health/HMO: Article 21.53F, Texas Insurance Code

Mammography Screening – any HMO plan or accident and health policy must provide an annual screening by low-dose mammography for females 35 years old or older on the same basis as other radiological examinations. Applies to both individual and group insurance plans and HMO plans.

Legal Basis
Accident and Health: Article 3.70-2(H), Texas Insurance Code
HMO: Articles 20A.02(b) & 20A.09E, Texas Insurance Code; Chapter 11, Subchapter F, Title 28, Texas Administrative Code.

Nutritional Supplements for PKU and Other Inheritable Diseases – any accident and health policy or HMO plan that provides benefits for prescription drugs must include dietary formulas for the treatment of phynelketonuria (PKU) or other heritable diseases. Applies to group insurance policies and HMO plans.

Legal Basis
Accident and Health/HMO: Article 3.79, Texas Insurance Code

Oral Contraceptives – an accident and health policy or HMO plan must provide benefits for oral contraceptives when all other prescription drugs are covered. Applies to individual and group accident and health plans and HMO benefit plans.

Legal Basis
Accident and Health/HMO: Section 21.404, Subchapter E, Title 28, Texas Administrative Code

Osteoporosis Detection – an accident and health policy or HMO 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. Applies to group accident and health plans and HMO plans.

Legal Basis
Accident and Health/HMO: Article 21.53C, Texas Insurance Code

Prescription Contraceptive Drugs, Devices and Related Services – an accident and health policy and HMO plan that provides benefits for prescription drugs or devices may not exclude or limit benefits for: (1) a prescription contraceptive drug or device or device approved by the United States Food and Drug Administration; or (2) an outpatient contraceptive service. Coverage for abortifacients or any other drug or device that terminates a pregnancy is not required to be covered. 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. Applies to both individual and group accident and health plans and HMO plans.

Legal Basis
Accident and Health/HMO: Article 21.52L, Texas Insurance Code

PSA Testing for Prostate Cancer – an accident and health policy or HMO plan that provides benefits for diagnostic medical procedures must provide coverage for each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer. Minimum benefits 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. Applies to both individual and group accident and health policies or HMO plans. Does not apply to a benefit plan issued to a small employer.

Legal Basis
Accident and Health: Article 21.53F, Texas Insurance Code
HMO: Articles 21.53F & 3.50-4, Sec. 18D, Texas insurance Code; Section 11.508(a)(9)(E), Subchapter F, Title 28, Texas Administrative Code

Psychiatric Day Treatment – an accident and health policy or HMO plan that provides benefits for treatment of mental illness in a hospital must include benefits 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 in-patient program. On rejection of mandated benefits, the insurer shall offer and the policyholder can 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 hospital facilities. Applies to a group accident and health policy and HMO plan.

Legal Basis
Accident and Health: Article 3.70-2(F), Texas Insurance Code
HMO: Article 3.70-2(F), Texas Insurance Code; Sections 11.509(5) & 11.510(3), Subchapter F, Title 28, Texas Administrative Code

Reconstructive Breast Surgery Following a Mastectomy – an accident and health policy and HMO plan that provides benefits 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 co-payments that are consistent with other benefits under the EOC or policy, but may not be subject to dollar limitations other than the policy lifetime maximum for A&H. Applies to individual and group accident and health policies and HMO plans.

Legal Basis
Accident and Health: Article 21.53I, Texas Insurance Code
HMO: Article 21.53I, Texas Insurance Code; Section 11.508(a)(5)(A), Subchapter F, Title 28, Texas Administrative Code

Serious Mental Illness – 45 Inpatient and 60 Outpatient Days – a group accident and health plan and HMO plan must provide coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (b) 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 (c) must include the same amount limits and deductibles for serious mental illness as for physical illness. Applies to group accident and health plans and HMO plans. Is a mandated offer for small employer benefit plans.

Legal Basis
Accident and Health: Article 3.51-14, Texas Insurance Code
HMO: Article 3.51-5A(a)(2) & 3.51-14 and Section 1551.205 & 1601.109, Texas Insurance Code; Section 11.509(5), Subchapter F, Title 28, Texas Administrative Code

Serious Mental Illness – Full Parity for Universities, Local Governments – accident and health policies and HMO benefit plans 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. Applies to any policy offered under the Texas State Employees Uniform Group Insurance Benefits Act (Article 3.50-2, TIC) and the Texas State College and University Employees Uniform Insurance Benefits Act – Section 1601.109, and Local Governments, Article 3.51-5A(a)(2), Texas Insurance Code.

Legal Basis
Accident and Health: Article 3.51-14, Texas Insurance Code
HMO: Article 3.51-5A(a)(2) & 3.51-14 and Section 1551.205 & 1601.109, Texas Insurance Code; Section 11.509(5), Subchapter F, Title 28, Texas Administrative Code

Telemedicine Services – an accident and health policy and HMO 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 when provided through a face-to-face consultation. Applies to an individual or group accident and health policy and HMO plan. Does not apply to a benefit plan issued to a small employer.

Legal Basis
Accident and Health: Article 21.53F, Texas Insurance Code
HMO: Article 21.53F, Texas Insurance Code; Section 11.1607(i),(j) & (k), Subchapter Q, Title 28, Texas Administrative Code

Temporomandibular Joint (TMJ) Treatment - an accident and health policy or HMO plan that provides benefits for diagnostic or surgical treatment of 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. Applies to both individual and group accident and health policies and HMO plans. Does not apply to a benefit plan issued to a small employer.

Legal Basis
Accident and Health: Article 21.53A, Texas Insurance Code
HMO: Article 21.53A, Texas Insurance Code; Section 11.509(6), Subchapter F, Title 28, Texas Administrative Code

Mandated Offerings

In-Vitro Fertilization – unless rejected in writing by the group contract holder, any accident and health policy and HMO 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. Applies to a group accident and health policy and HMO benefit plan.

Legal Basis
Accident and Health: Article 3.51-6, Section 3A, Texas Insurance Code
HMO: Article 3.51-6, Section 3A, Texas Insurance Code; Section 11.510(1), Subchapter F, Title 28, Texas Administrative Code

Treatment of Speech and Hearing Loss – an accident and health policy and HMO plan shall offer, and the group contract holder shall have the right to reject, coverage for the necessary care and treatment of loss or impairment of speech or hearing that is not less favorable than for physical illness generally. The group contract holder may select an alternative level of coverage if the insurer or HMO offers such coverage. Applies to group accident and health policies and HMO plans.

Legal Basis
Accident and Health: Article 3.70-2(G), Texas Insurance Code
HMO: Article 3.70-2(G), Texas Insurance Code; Section 11.510(2), Subchapter F, Title 28, Texas Administrative Code