Texas Mandated Benefit Cost and Utilization Summary Report

October 2008 - September 2009 Reporting Period

Texas Department of Insurance

Table of Contents

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 and authorizing the Commissioner of Insurance to adopt necessary rules. This report summarizes the data collected for the 12-month reporting period of October 2008 through September 2009.

Data is collected for both group and individual fully-insured health insurance plans. Insurers with $10 million or more in annual group premiums and/or at least $2 million in individual premiums are required to file a report. HMOs (Health Maintenance Organizations) with at least $10 million in premiums for basic-service plans must also submit a report. For 2009, a total of 51 insurers and HMOs submitted the data summarized in this report. Separate data is provided for mandated **benefits** which must be included in all benefit plans and for mandated **offerings** which the purchaser decides to include or decline.

The first two tables provide an overview of the 2009 mandated benefit data collected for this report and includes 2008 data for comparison purposes. However, this summary data must be considered in the context of the other information provided in this report in order to fully understand its value and limitations.

As indicated in Table 1, claims costs for the 20 mandated benefits for which data was collected total $462.76 million, or 4.79 percent of all claims paid under group benefit plans. Mandated *offerings* resulted in an additional cost of $7.70 million, or 0.08 percent of total claims paid. The average annual premium cost of including the 20 benefits was estimated at $140.12 for an individual with single coverage (i.e., employee-only) and $364.56 for family coverage. Administrative expenses for mandated benefits accounted for an added $84.22 million in costs, or 0.87 percent of total claims paid, while administrative expenses for mandated offerings accounted for $1.56 million, or 0.02 percent of 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 other mandated benefits for which data is not collected.

Though much of the data reported in 2009 were consistent with 2008 data submissions, several changes for both mandated benefits and mandated offerings are worth noting. The average annual premium estimate for family mandated benefit coverage increased by 6.59 percent from $342 in 2008 to $365 in 2009, while the average annual premium estimate for single mandated benefit coverage increased by 4.04 percent from $135 to $140. The value of mandated benefit claims increased by 2.57 percent ($451.18 million to $462.76 million), while the number of mandated benefit claims decreased by 6.02 percent (3.73 million to 3.51 million).

Mandated offers experienced increases of 36.59 percent in the number of claims and 29.34 percent in the value of claims. Also, mandated offers experienced increased premium costs for both single and family coverage (6.34 percent and 1.34 percent, respectively) from 2008 to 2009.

Table 1 – Overview of Group Mandated Benefit and Mandated Benefit Offering Plans in 2008-2009*

	2008	2009	% Change
Overall Group Accident and Health Data			
Total Premiums Earned	$11,473,857,505	$11,640,403,068	1.45%
Total Claims Paid	$9,138,883,834	$9,669,087,885	5.80%
Mandated Benefit Data*			
Total Mandated Benefit Claims Paid	$451,176,043	$462,764,209	2.57%
Number of Mandated Benefit Claims Paid	3,732,964	3,508,214	-6.02%
Mandated Benefit Costs as a Percentage of Total Claims Paid	4.94%	4.79%	-3.04%
Mandated Benefit Costs as a Percentage of Total Premiums Earned	3.93%	3.98%	1.27%
Average Annual Premium Cost Estimate of Mandated Benefits– Single (i.e., Employee-only) Coverage	$134.68	$140.12	4.04%
Average Annual Premium Cost Estimate of Mandated Benefits – Family (i.e., Employee and Family) Coverage	$342.02	$364.56	6.59%
Total Estimated Administrative Costs for Mandated Benefits	$78,558,121	$84,216,386	7.20%
Mandated Benefit Administrative Costs as a Percentage of Total Claims	0.86%	0.87%	1.16%
Mandated Benefit Offering Data**			
Total Mandated Benefit *Offering* Claims Paid	$5,949,825	$7,695,692	29.34%
Number of Mandated Benefit *Offering* Claims Paid	72,816	99,463	36.59%
Mandated Benefit *Offering* Costs as a Percentage of Total Claims Paid	0.07%	0.08%	14.29%
Mandated Benefit *Offering* Costs as a Percentage of Total Premiums Earned	0.05%	0.07%	40.00%
Average Annual Premium Cost Estimate of Mandated Benefit *Offerings*– Single (i.e., Employee-only) Coverage	$3.63	$3.86	6.34%
Average Annual Premium Cost Estimate of Mandated Benefit *Offerings* – Family (i.e., Employee and Family) Coverage	$8.97	$9.09	1.34%
Total Estimated Administrative Costs for Mandated Benefit *Offerings*	$978,413	1,563,707	59.82%
Mandated Benefit *Offering* Administrative Costs as a Percentage of Total Claims Paid	0.01%	0.02%	100.00%

** Represents 20 mandated benefits for which data was collected.*

*** Represents 2 mandated offerings for which data was collected*

For individual (non-group) benefit plans, total premiums earned increased by 2.58 percent to $1.416 billion in 2009, while total claims paid increased by 36.75 percent to $1.177 billion. Mandated benefit costs were $51.6 million, which represented 3.64 percent of total premiums and 4.38 percent of total claims (Table 2). Premium costs for single coverage decreased by 0.17 percent from 2008 to 2009, while premium costs for family coverage decreased by 1.74 percent. In dollar terms, the average annual premium cost for single coverage decreased from $75.22 in 2008 to $75.09 in 2009, while family coverage decreased from $168.73 to $165.80.

Table 2 – Overview of Individual Mandated Benefit Plans in 2008-2009*

	2008	2009	% Change
Overall Individual Accident and Health Data			
Total Premiums Earned	$1,380,461,742	$1,416,123,543	2.58%
Total Value of All Claims Paid	$860,656,490	$1,176,946,234	36.75%
Mandated Benefit Data			
Total Value of Mandated Benefit Claims Paid	$43,287,363	$51,598,450	19.20%
Total Number of Mandated Benefit Claims Paid	498,058	437,408	-12.18%
Mandated Benefit Costs as a Percentage of Total Claims	5.03%	4.38%	-12.92%
Mandated Benefit Costs as a Percentage of Total Premiums	3.14%	3.64%	15.92%
Average Annual Premium Cost Estimate of Mandated Benefits– Single Coverage	$75.22	$75.09	-0.17%
Average Annual Premium Cost Estimate of Mandated Benefits – Family Coverage	$168.73	$165.80	-1.74%
Total Estimated Administrative Costs	$17,444,249	$18,686,523	7.12%
Administrative Costs as a Percentage of Total Claims	2.03%	1.59%	-21.68%

**Represents 13 mandated benefits for which data was collected.*

It is important to note that TDI did not collect data on every mandated benefit. Some mandated benefits that require coverage of groups of people (such as newborns with birth defects) are not associated with a specific medical procedure or diagnosis code. Therefore, they 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 pages 6-7).

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 cost savings would, to some extent, offset the total cost of the mandates. The report also does not measure the "marginal cost" of benefits, which is usually significantly lower than the full cost. Even without a mandate provision, many carriers would voluntarily provide some mandated coverages. The marginal cost is the cost of new coverage added only because of the benefit requirement.

SURVEY OVERVIEW

Legislation

To evaluate the cost of mandated health insurance benefits and their impact on health benefit coverage, state law requires the Texas Department of Insurance (TDI) to collect cost and utilization data on certain mandated benefits. Under rules 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 they report $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 from October 2008 through September 2009.

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. 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. Use of these standardized codes also 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 an insurance claim for a mammogram. Insurers/HMOs 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, the child's prognosis, and the insurers' underwriting requirements for various conditions. 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 25. 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. Because of these and other 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; and
- Treatment of Temporomandibular Joint Conditions (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, and
- 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 Collection Methodology

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:

- The number of claims paid for each mandated benefit;
- The 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. This data 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 varies from company to company. Although all companies use similar actuarial principles, there are technical variances among carriers that result in methodological differences in the way they develop cost estimates. As such, the data reported for premium and administrative costs are collected according to each company's internal guidelines rather than an industry-wide standard. More discussion of this issue is provided later in this report.

The reporting 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 premium estimates of other categories of coverage, including "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. However, TDI does review all data submitted by each company to identify extreme data anomalies and outliers suggesting data collection or entry errors. Carriers submitting questionable

data are contacted to verify the accuracy of the information and correct any errors. Companies are responsible for assuring that the information they report is accurate and complete and are asked to provide supporting documentation if TDI determines the data may be inconsistent or inaccurate.

All data in this report is aggregated and represents industry-wide averages. The statute specifically prohibits TDI from publishing data that identifies any specific company.

Company Participation

A total of 51 insurers and HMOs 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.

TDI exempted from reporting those 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.

Of the 51 insurers and HMOs that submitted data, 37 provided information on group benefit plans and 24 provided information on individual benefit plans. Fourteen of the carriers reported only individual data, 27 reported only group data, and the remaining 10 provided both group and individual benefit plan data. The 37 carriers providing data on group benefit plans reported total Texas premiums of $11.64 billion for 2009, while the 24 carriers providing data on individual benefit plans reported total premiums of $1.42 billion. 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 37 insurers and HMOs that provided information on group benefit plans issued 3,033,203 group insurance certificates that generated $11,640,403,068 in total premiums for calendar year 2009. These companies reported a total of 3,508,214 mandated benefit claims, representing a total claims value of $462,764,209 (Table 3). The total value of **all** claims paid (including mandated benefits and all other claims), was $9,669,087,885. **Thus, the reported mandated benefit claims paid in 2009 represented a total of 4.79 percent of all claims paid.** An additional $7,695,692 was paid for mandated *offering* benefits, representing 0.08 percent of all claims paid.

A review of the data for each mandated benefit shows that each benefit accounted for less than one percent of total claim costs. Claims paid for diabetes education and supplies represented the highest percentage of claims at 0.81 percent. Reconstructive breast surgery following a mastectomy accounted for the next highest percentage of costs at 0.59 percent of total claims, followed by hearing screening for children (0.45 percent), serious mental illness - 45 inpatient days/60 outpatient days (0.44 percent) and mammography screening (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 0.01 percent of total claims paid.

A review of the claims data filed by all carriers indicated several companies submitted claims that were considerably higher than the industry average reported by all other companies for certain benefits, including: reconstructive surgery following a mastectomy; diabetes education and supplies; and childhood hearing and screening. In response to TDI's request for additional information, carriers explained that claim costs for these benefits may sometimes include other costs not specifically related to the mandated benefit requirements due to the common practice of "bundling" certain services into one claim or procedure code. For example, reconstructive surgery following a mastectomy may also include some charges related to the actual mastectomy (which is NOT a mandated benefit) if both procedures are performed at once. A surgeon performing both procedures may submit one claim that includes both the mastectomy fee and the reconstructive surgery fee. The hospital bill also will likely be submitted as one claim including the patient's costs related to both the mastectomy and the reconstructive surgery. When trying to identify those costs related solely to the mandated benefit requirement for reconstructive surgery, some health plans pro-rate the claims reported to

TDI or use some other methodology to estimate only those costs attributed to the mandated benefit requirement. Others do not, however, which results in significantly higher claims costs. As such, the claim costs reported for reconstructive surgery following a mastectomy *does* include some costs attributed to the mastectomy procedure.

Similarly, claims for childhood hearing and screening tests and for diabetes education and supplies are often submitted as part of a claim that includes other services. A patient may see a physician for several medical problems, including diabetes. As part of that visit, the patient may receive advice and educational information and/or training which is noted on the claim as diabetes educational services. The cost of that service may be "bundled" with other services provided during that visit and is submitted under one single procedure code. When collecting the claims date for this particular benefit, the insurer may include the cost of the entire "bundled" claim, which includes services not related to the mandated benefit. Likewise, if a child receives the hearing and screening test as part of a well-child visit that includes other services, the entire claim may be counted as attributed to the hearing and screening mandated benefit if it is "bundled" with other services. Though it is impossible to estimate the extent to which this occurs, the additional expenses are an added factor that should be acknowledged when evaluating the true cost of each mandated benefit.

Finally, when the mandated benefit claims in 2009 are compared to 2008 data, the vast majority of benefits had consistent ratios to total claims paid. AIDS/HIV treatment, childhood immunizations, diabetes education and supplies, and psychiatric day treatment were the major exceptions. AIDS/HIV treatment costs decreased from 0.61 percent to 0.35 percent of claims paid, and childhood immunization costs decreased from 0.41 percent to 0.37 percent. Meanwhile, costs for diabetes education and supplies increased from 0.75 percent to 0.81 percent of claims paid, and psychiatric day treatment increased from 0.06 percent to 0.10 percent.

Table 3 – Group Benefit Plans
Mandated Benefit Claims Costs

Mandated Benefit	Mandated Benefit Claims Paid		Claims as a Percentage of Total Claims Paid	
	2008	2009	2008	2009
Acquired Brain Injury	$29,778,676	$31,624,562	0.33%	0.33%
AIDS/HIV Treatment	$55,527,216	$33,480,516	0.61%	0.35%
Chemical Dependency	$17,829,285	$22,718,789	0.20%	0.23%
Childhood Immunizations	$37,892,978	$36,122,410	0.41%	0.37%
Colorectal Cancer Testing	$19,287,693	$17,905,090	0.21%	0.19%
Craniofacial Surgery for Children	$1,307,876	$1,375,978	0.01%	0.01%
Diabetes Education and Supplies	$68,369,725	$78,553,339	0.75%	0.81%
Hearing Screening for Children	$42,417,697	$43,471,717	0.46%	0.45%
Mammography Screening	$35,100,705	$38,596,728	0.38%	0.40%
Nutritional Supplements for PKU and Other Inheritable Diseases	$1,161,320	$169,561	0.01%	0.00%
Oral Contraceptives	$18,907,888	$20,317,933	0.21%	0.21%
Osteoporosis Detection	$2,792,175	$3,152,221	0.03%	0.03%
Prescription Contraceptive Drugs, Devices and Related Services	$7,468,481	$10,005,597	0.08%	0.10%
PSA Testing for Prostate Cancer	$6,196,331	$6,960,328	0.07%	0.07%
Psychiatric Day Treatment	$5,721,762	$10,064,429	0.06%	0.10%
Reconstructive Breast Surgery Following a Mastectomy	$52,661,880	$57,444,547	0.58%	0.59%
Serious Mental Illness – 45 Inpatient and 60 Outpatient Days	$41,136,252	$42,810,408	0.45%	0.44%
Serious Mental Illness – Full Parity for Universities, Local Governments	$5,082,634	$5,718,422	0.06%	0.06%
Telemedicine Services	$156,897	$27,154	0.00%	0.00%
TMJ Treatment	$2,378,572	$2,244,480	0.03%	0.02%
TOTAL	**$451,176,043**	**$462,764,209**	**4.94%**	**4.79%**

For mandated benefit offerings, in-vitro fertilization accounted for 0.02 percent of total claims in 2009, while treatment of speech or hearing loss accounted for 0.06 percent. Total claims for treatment of speech or hearing loss increased by $1.65 million from 2008 to 2009, while total claims for in-vitro fertilization increased by $97,000.

Table 4 – Group Benefit Plans
Mandated Benefit Offering Claims Costs

Mandated Benefit Offering	Mandated Benefit Offering Claims Paid		Claims as a Percentage of Total Claims Paid	
	2008	2009	2008	2009
In-Vitro Fertilization	$1,549,320	$1,645,965	0.02%	0.02%
Treatment of Speech or Hearing Loss	$4,400,505	$6,049,727	0.05%	0.06%
TOTAL	**$5,949,825**	**$7,695,692**	**0.07%**	**0.08%**

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 788,000 claims representing 22.47 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 3.40 percent for colorectal cancer screenings and 5.25 percent for PSA testing is not surprising given the limited population to which these benefits apply.

In most cases, the 2009 utilization data is relatively consistent with the data submitted in 2008. Notable increases were observed in the number of serious mental illness – full parity claims (from 0.66 percent of all mandated benefit claims to 1.34 percent), and in the number of psychiatric day treatment claims (0.43 percent to 0.87 percent). Notable decreases occurred for telemedicine services (0.03 percent to 0.01 percent) and for AIDS/HIV treatment (3.42 percent to 1.69 percent).

As in 2008, oral contraceptives remained the most frequently used benefit despite a slight decrease from 22.89 percent to 22.47 percent of total claims. Other benefits with the highest utilization rates included diabetes education and supplies (18.88 percent), childhood immunizations (9.55 percent), and mammography screening (8.88 percent). These four benefits combined accounted for nearly 60 percent of the number of mandated benefits paid.

Table 5 – Group Benefit Plans
Mandated Benefit Utilization

Mandated Benefit	Number of Mandated Benefit Claims Paid		Percentage of the Total Number of Mandated Benefit Claims	
	2008	2009	2008	2009
Acquired Brain Injury	141,433	203,193	3.79%	5.79%
AIDS/HIV Treatment	127,844	59,217	3.42%	1.69%
Chemical Dependency – Total Expenditures (Inpatient and Outpatient Combined)	20,450	27,867	0.55%	0.79%
Childhood Immunizations	338,128	335,020	9.06%	9.55%
Colorectal Cancer Testing	135,067	119,360	3.62%	3.40%
Craniofacial Surgery for Children	894	795	0.02%	0.02%
Diabetes Education and Supplies	695,452	662,380	18.63%	18.88%
Hearing Screening for Children	251,474	244,299	6.74%	6.96%
Mammography Screening	309,610	311,424	8.29%	8.88%
Nutritional Supplements for PKU and Other Inheritable Diseases	1,534	879	0.04%	0.03%
Oral Contraceptives	854,569	788,271	22.89%	22.47%
Osteoporosis Detection	26,443	31,140	0.71%	0.89%
Prescription Contraceptive Drugs, Devices and Related Services	258,290	163,827	6.92%	4.67%
PSA Testing for Prostate Cancer	177,905	184,157	4.77%	5.25%
Psychiatric Day Treatment	16,015	30,426	0.43%	0.87%
Reconstructive Breast Surgery Following a Mastectomy	90,544	83,255	2.43%	2.37%
Serious Mental Illness – 45 Inpatient and 60 Outpatient Days	253,040	210,004	6.78%	5.99%
Serious Mental Illness – Full Parity for Universities, Local Governments	24,601	46,913	0.66%	1.34%
Telemedicine Services	950	362	0.03%	0.01%
TMJ Treatment	8,721	5,425	0.23%	0.15%
TOTAL	**3,732,964**	**3,508,214**	**100.00%**	**100.00%**

With regard to the mandated benefit offerings, treatment of speech or hearing loss was responsible for the vast majority of claims in both 2008 and 2009 since this benefit is more widely applicable to the general population than are benefits for in-vitro fertilization. However, it is important to note that the number of claims paid for in-vitro fertilization tripled from 2008 to 2009.

Table 6 – Group Benefit Plans
Mandated Benefit Offering Utilization

Mandated Benefit Offering	Number of Mandated Offering Benefit Claims Paid		Percentage of the Total Number of Mandated Offering Claims Paid	
	2008	2009	2008	2009
In-Vitro Fertilization	9,848	30,521	13.52%	30.69%
Treatment of Speech or Hearing Loss	62,968	68,942	86.48%	69.31%
TOTAL	**72,816**	**99,463**	**100.00%**	**100.00%**

Claims Costs vs. Claims Utilization

Mandated benefits with the highest claims costs are not necessarily the benefits most frequently used. While this is not the case with diabetes education and supplies – the most expensive benefit – some of the other more expensive benefits are used by a relatively small percentage of people but result in relatively high claims costs. Reconstructive breast surgery following a mastectomy and serious mental illness – 45 inpatient days/60 outpatient days accounted for 12.41 percent and 9.25 percent, respectively, of all mandated benefit claims costs, but combined they represent just 8.36 percent of the total number of mandated benefits claims. Oral contraceptives accounted for 22.47 percent of the total number of claims (again, most likely because of the repeat prescription refills on a regular basis), but only 4.39 percent of the claims costs. Table 7 illustrates the variable relationship between claims costs and utilization of services.

Table 7 – 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	
	2008	2009	2008	2009
Acquired Brain Injury	3.79%	5.79%	6.60%	6.83%
AIDS/HIV Treatment	3.42%	1.69%	12.31%	7.23%
Chemical Dependency	0.55%	0.79%	3.95%	4.91%
Childhood Immunizations	9.06%	9.55%	8.40%	7.81%
Colorectal Cancer Testing	3.62%	3.40%	4.27%	3.87%
Craniofacial Surgery for Children	0.02%	0.02%	0.29%	0.30%
Diabetes Education and Supplies	18.63%	18.88%	15.15%	16.97%
Hearing Screening for Children	6.74%	6.96%	9.40%	9.39%
Mammography Screening	8.29%	8.88%	7.78%	8.34%
Nutritional Supplements for PKU and Other Inheritable Diseases	0.04%	0.03%	0.26%	0.04%
Oral Contraceptives	22.89%	22.47%	4.19%	4.39%
Osteoporosis Detection	0.71%	0.89%	0.62%	0.68%
Prescription Contraceptive Drugs, Devices and Related Services	6.92%	4.67%	1.66%	2.16%
PSA Testing for Prostate Cancer	4.77%	5.25%	1.37%	1.50%
Psychiatric Day Treatment	0.43%	0.87%	1.27%	2.17%
Reconstructive Breast Surgery Following a Mastectomy	2.43%	2.37%	11.67%	12.41%
Serious Mental Illness – 45 Inpatient and 60 Outpatient Days	6.78%	5.99%	9.12%	9.25%
Serious Mental Illness – Full Parity for Universities, Local Governments	0.66%	1.34%	1.13%	1.24%
Telemedicine Services	0.03%	0.01%	0.03%	0.01%
TMJ Treatment	0.23%	0.15%	0.53%	0.49%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**

For mandated offerings, treatment of speech or hearing loss accounted for 69.31 percent of the total number of claims and 78.61 percent of the total dollars paid for mandated offerings (Table 8). In-vitro fertilization services were used much less frequently, representing 30.69 percent of the number of claims and 21.39 percent of mandated offering costs. Treatment of speech or hearing loss is still responsible for the vast majority of total claim numbers and claim costs for mandated offerings, and the claim costs for this benefit increased by 4.65 percent from 2008 to 2009.

Table 8 – Group Benefit Plans
Comparison of Mandated Benefit Offering Utilization
and Mandated Benefit Offering Claims Costs

Mandated Benefit Offering	Percentage of the Total Number of Mandated Offering Claims		Percentage of the Total Dollars Paid for Mandated Offering Claims	
	2008	2009	2008	2009
In-Vitro Fertilization	13.52%	30.69%	26.04%	21.39%
Treatment of Speech or Hearing Loss	86.48%	69.31%	73.96%	78.61%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**

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 it was later expanded to include additional benefits in 1998. Other benefits were later added due to the enactment of legislation in 1999 and 2001. Although the current reporting requirements under Chapter 38, TIC, are more extensive and include more carriers, the aggregated claims cost data has varied only slightly since 2001. Table 9 summarizes mandated benefit claim costs since 2004 and demonstrates that claims costs have remained markedly consistent over time.

Table 9 – Group Benefit Plans
Mandated Benefit Claims Costs Comparison: 2004 - 2009

Mandated Benefit	Mandated Benefit Claims Costs as a Percentage of Total Claims					
	2004	2005	2006	2007	2008	2009
Acquired Brain Injury	0.37%	0.19%	0.18%	0.18%	0.33%	0.33%
AIDS/HIV Treatment	0.19%	0.32%	0.22%	0.35%	0.61%	0.35%
Chemical Dependency – Total Expenditures (Inpatient and Outpatient)	0.21%	0.21%	0.18%	0.19%	0.20%	0.23%
Childhood Immunizations	0.46%	0.39%	0.37%	0.41%	0.41%	0.37%
Colorectal Cancer Testing	0.30%	0.47%	0.42%	0.45%	0.21%	0.19%
Craniofacial Surgery for Children	0.02%	0.02%	0.01%	0.01%	0.01%	0.01%
Diabetes Education and Supplies	0.65%	0.74%	0.60%	0.71%	0.75%	0.81%
Hearing Screening for Children	0.38%	0.44%	0.41%	0.39%	0.46%	0.45%
Mammography Screening	0.29%	0.36%	0.33%	0.34%	0.38%	0.40%
Nutritional Supplements for PKU and Other Inheritable Diseases	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%
Oral Contraceptives	0.27%	0.18%	0.18%	0.16%	0.21%	0.21%
Osteoporosis Detection	0.02%	0.05%	0.04%	0.04%	0.03%	0.03%
Prescription Contraceptive Drugs, Devices and Related Services	0.10%	0.09%	0.07%	0.06%	0.08%	0.10%
PSA Testing for Prostate Cancer	0.08%	0.07%	0.06%	0.06%	0.07%	0.07%
Psychiatric Day Treatment	0.08%	0.10%	0.07%	0.07%	0.06%	0.10%
Reconstructive Breast Surgery Following a Mastectomy	0.66%	0.66%	0.62%	0.60%	0.58%	0.59%
Serious Mental Illness – 45 Inpatient and 60 Outpatient Days	0.54%	0.54%	0.56%	0.49%	0.45%	0.44%
Serious Mental Illness – Full Parity for Universities, Local Governments	0.04%	0.05%	0.04%	0.03%	0.06%	0.06%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TMJ Treatment	0.03%	0.02%	0.04%	0.02%	0.03%	0.02%
TOTAL	**4.69%**	**4.92%**	**4.40%**	**4.58%**	**4.94%**	**4.79%**

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 provided 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 premium estimates 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 a health benefit 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 normally 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.

As shown in Table 10, premium cost estimates varied significantly by benefit. The least expensive mandated benefits for both single coverage and family coverage are telemedicine and nutritional supplements for PKU and other diseases. Diabetes education and supplies was the most costly benefit under a family plan at $53.53, followed by serious mental illness - 45 inpatient days/60 outpatient days ($49.43) and childhood immunizations ($46.54). Similarly, for single coverage, diabetes education and supplies, serious mental illness - 45 inpatient days/60 outpatient days, and childhood immunizations had the highest premium costs, at $22.20, $20.09, and $13.22 respectively.

When comparing 2009 premium estimates to 2008, the *total* **single** premium increased $134.68 to $140.12. Four benefits accounted for most of the cost increase. Mammography screening premiums increased from $10.58 to $12.68; chemical dependency increased from $7.60 to $9.01; oral contraceptives increased from $6.42 to $7.46; and acquired brain injury increased from $5.96 to $6.99. These increases were somewhat offset by several other benefits that declined in premium costs. Of note are colorectal cancer testing ($9.47 to $8.77), diabetes education and supplies ($22.82 to $22.20), and PSA testing for prostate cancer ($3.69 to $3.33). The *total* average cost of mandated benefits under a **family** policy increased from $342.02 in 2008 to $364.56 in

2009. The largest increases included serious mental illness - 45 inpatient days/60 outpatient days ($42.98 to $49.43), acquired brain injury ($15.53 to $19.90), mammography screening ($26.26 to $30.41), and chemical dependency ($19.31 to $22.66). The average annual premium costs of several other benefits decreased, the largest of which being reconstructive breast surgery following mastectomy ($29.29 to $28.14) and PSA testing for prostate cancer ($8.78 to $7.96).

Table 10 – 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	
	2008	2009	2008	2009
Acquired Brain Injury	$5.96	$6.99	$15.53	$19.90
AIDS/HIV Treatment	$3.24	$4.09	$8.25	$9.86
Chemical Dependency	$7.60	$9.01	$19.31	$22.66
Childhood Immunizations	$13.30	$13.22	$44.22	$46.54
Colorectal Cancer Testing	$9.47	$8.77	$24.32	$23.58
Craniofacial Surgery for Children	$0.44	$0.54	$1.18	$1.56
Diabetes Education and Supplies	$22.82	$22.20	$51.93	$53.53
Hearing Screening	$8.47	$9.18	$27.02	$26.99
Mammography Screening	$10.58	$12.68	$26.26	$30.41
Nutritional Supplements for PKU & Other Diseases	$0.21	$0.10	$0.46	$0.28
Oral Contraceptives	$6.42	$7.46	$15.35	$14.99
Osteoporosis Detection	$0.97	$0.68	$1.74	$1.58
Prescription Contraceptive Drugs, Devices and Services	$4.62	$4.75	$10.87	$11.41
PSA Testing for Prostate Cancer	$3.69	$3.33	$8.78	$7.96
Psychiatric Day Treatment	$3.13	$3.21	$7.06	$7.78
Reconstructive Breast Surgery Following Mastectomy	$10.95	$10.80	$29.29	$28.14
Serious Mental Illness – 45 Inpatient Days/60 Outpatient	$20.07	$20.09	$42.98	$49.43
Serious Mental Illness – Full Parity (Applies to Gov't & University Employees Only)	$2.22	$2.40	$5.94	$6.38
Telemedicine	$0.07	$0.05	$0.19	$0.12
TMJ	$0.47	$0.57	$1.31	$1.47
TOTAL	**$134.68**	**$140.12**	**$342.02**	**$364.56**

From 2008 to 2009, the average annual premium for mandated offerings increased from $3.63 to $3.86 for single coverage and from $8.97 to $9.09 for family coverage (Table 11). The average annual premium cost decreased for in-vitro fertilization from $1.64 to $1.50 for single coverage and from $3.55 to $3.21 for family coverage. Costs for treatment of speech or hearing loss increased from $1.99 to $2.37 for single coverage and from $5.42 to $5.88 for family coverage.

Table 11 – Group Benefit Plans
Mandated Benefit Offering Average Annual Premium Cost Estimates

Mandated Benefit Offering	Average Annual Premium Cost Estimates – Single Coverage		Average Annual Premium Cost Estimates – Family Coverage	
	2008	2009	2008	2009
In-Vitro Fertilization	$1.64	$1.50	$3.55	$3.21
Treatment of Speech or Hearing Loss	$1.99	$2.37	$5.42	$5.88
TOTAL	**$3.63**	**$3.86**	**$8.97**	**$9.09**

The range of premium costs reported by insurers/HMOs for each mandated benefit was extremely wide, which raises questions regarding how some companies estimated premium costs. While **claims** cost data varied only marginally from company to company, **premium** cost estimates were much less consistent. For example, the range of estimated annual premium costs reported for single coverage for certain benefits varied as follows:

- Reconstructive breast surgery following a mastectomy ($0-$119);
- Diabetes education and supplies ($0-$111);
- Chemical dependency treatment ($0-$128); and
- Serious mental illness – full parity ($0-$179);

Similar variations were reported for family-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.

Multiple companies also submitted premium amounts for all or specific benefits that were clearly inaccurate upon further analysis. For example, some companies submitted single coverage premiums that were the same as, or even higher than, the family premiums for a specific benefit. In other cases, the premium reported by a company for a specific benefit

could be five, ten, or even twenty times the industry average. Since some of these numbers were clear outliers that significantly skewed the industry average, these figures were removed from the survey sample to make the data in Tables 10-13 and 21-22 more reliable.

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, TDI instructed carriers to determine premium cost estimates based on the actual 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 12, 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 $184.09, compared to a total estimated premium cost of $364.56 for family coverage and $140.12 for single coverage. 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 <u>total</u> claims costs and premium estimates show a reasonable relationship, it is interesting to note that several mandated benefits had average claim costs per certificate that did not fall between the estimated annual premiums for single and family coverage. For example, the certificate cost of $15.10 for serious mental illness – full parity was significantly higher than the estimated annual premiums of $2.40 and $6.38. Conversely, per-certificate costs for colorectal cancer testing; nutritional supplements for PKU and other inheritable diseases; prescription contraceptive drugs, devices and services; PSA testing for prostate cancer; serious mental illness - 45 inpatient days/60 outpatient days; and telemedicine services all fell below the single and family premium estimates.

Table 12 – Group Benefit Plans
A Comparison of Actual Claims Costs-per-Certificate with
Average Annual Premium Costs per Mandated Benefit in 2009

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	$11.24	$6.99	$19.90
AIDS/HIV Treatment	$11.90	$4.09	$9.86
Chemical Dependency	$7.94	$9.01	$22.66
Childhood Immunizations	$14.42	$13.22	$46.54
Colorectal Cancer Testing	$6.98	$8.77	$23.58
Craniofacial Surgery for Children	$0.54	$0.54	$1.56
Diabetes Education and Supplies	$28.10	$22.20	$53.53
Hearing Screening	$15.53	$9.18	$26.99
Mammography Screening	$13.72	$12.68	$30.41
Nutritional Supplements for PKU and Other Diseases	$0.06	$0.10	$0.28
Oral Contraceptives	$7.21	$7.46	$14.99
Osteoporosis Detection	$1.12	$0.68	$1.58
Prescription Contraceptive Drugs, Devices and Services	$3.59	$4.75	$11.41
PSA Testing for Prostate Cancer	$2.47	$3.33	$7.96
Psychiatric Day Treatment	$4.62	$3.21	$7.78
Reconstructive Breast Surgery Following a Mastectomy	$20.50	$10.80	$28.14
Serious Mental Illness – 45 Inpatient Days/60 Outpatient Days	$18.22	$20.09	$49.43
Serious Mental Illness – Full Parity (Applies to Gov't & University Employees Only)	$15.10	$2.40	$6.38
Telemedicine	$0.01	$0.05	$0.12
TMJ	$0.80	$0.57	$1.47
TOTAL	**$184.09**	**$140.12**	**$364.56**

For mandated offerings (Table 13), the average annual claim cost per certificate of $3.90 fell between the single premium of $3.86 and the family premium of $9.09. The claim cost per certificate for in-vitro fertilization was below the single and family premiums, while the claim cost per certificate for speech and hearing therapy fell between the single and family premiums.

Table 13 – Group Benefit Plans
A Comparison of Actual Claims Costs-per-Certificate with
Average Annual Premium Costs per Mandated Offering in 2009

Mandated Benefit Offering	Average Annual Claim Cost Per Certificate	Average Annual Premium Cost Estimates- Single Coverage	Average Annual Premium Cost Estimates – Family Coverage
In-Vitro Fertilization	$1.22	$1.50	$3.21
Treatment of Speech or Hearing Loss	$2.68	$2.37	$5.88
TOTAL	**$3.90**	**$3.86**	**$9.09**

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 pre-authorizations 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 benefits 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.

Table 14 shows that the total administrative costs associated with these mandated benefits increased from $78,558,121 in 2008 to $84,216,386 in 2009. This represents 18.20 percent of the total mandated benefit claims costs and 0.87 percent of total claims costs in 2009.

Table 14 – Group Benefit Plans
Mandated Benefit Administrative Cost Estimates

Mandated Benefit	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2008	2009	2008	2009
Acquired Brain Injury	$4,327,362	$6,535,301	0.05%	0.07%
AIDS/HIV Treatment	$9,590,503	$4,338,988	0.10%	0.04%
Chemical Dependency	$3,137,453	$4,163,885	0.03%	0.04%
Childhood Immunizations	$5,977,171	$5,395,890	0.07%	0.06%
Colorectal Cancer Testing	$5,235,183	$5,120,591	0.06%	0.05%
Craniofacial Surgery for Children	$257,900	$260,935	0.00%	0.00%
Diabetes Education and Supplies	$10,739,753	$11,829,740	0.12%	0.12%
Hearing Screening	$8,401,508	$8,615,261	0.09%	0.09%
Mammography Screening	$6,140,393	$7,139,554	0.07%	0.07%
Nutritional Supplements for PKU and Other Diseases	$926,809	$76,451	0.01%	0.00%
Oral Contraceptives	$2,580,398	$2,528,300	0.03%	0.03%
Osteoporosis Detection	$385,091	$472,458	0.00%	0.00%
Prescription Contraceptive Drugs, Devices and Services	$1,174,574	$1,603,425	0.01%	0.02%
PSA Testing for Prostate Cancer	$1,065,150	$1,179,727	0.01%	0.01%
Psychiatric Day Treatment	$1,261,382	$6,219,020	0.01%	0.06%
Reconstructive Breast Surgery Following a Mastectomy	$10,839,082	$12,028,061	0.12%	0.12%
Serious Mental Illness – 45 Inpatient Days/60 Outpatient Days	$4,971,579	$5,275,897	0.05%	0.05%
Serious Mental Illness – Full Parity (Applies to Gov't & University Employees Only)	$875,776	$900,233	0.01%	0.01%
Telemedicine	$65,065	$66,548	0.00%	0.00%
TMJ	$605,989	$466,121	0.01%	0.00%
TOTAL	**$78,558,121**	**$84,216,386**	**0.86%**	**0.87%**

The total administrative costs associated with mandated offerings increased from $978,413 in 2008 to $1,563,707 in 2009. These costs accounted for 20.32 percent of total mandated offering claims paid and 0.02 percent of total claims paid in 2009.

Table 15 – Group Benefit Plans
Mandated Benefit Offering Administrative Cost Estimates

Mandated Benefit Offerings	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2008	2009	2008	2009
In-Vitro Fertilization	$244,450	$512,000	0.00%	0.01%
Treatment of Speech or Hearing Loss	$733,963	$1,051,707	0.01%	0.01%
TOTAL	**$978,413**	**$1,563,707**	**0.01%**	**0.02%**

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 16. 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, diabetes education and supplies and reconstructive breast surgery following a mastectomy accounted for the highest percentage of claims costs (0.81 percent and 0.59 percent) and had the highest percentage of administrative costs (each at 0.12 percent). As demonstrated previously in Table 7, diabetes education and supplies had a high claim volume (18.88 percent), while reconstructive breast surgery accounted for only 2.37 percent of the total claim volume. These trends are obvious on an aggregate basis, but it should be noted that the same relationship was not always apparent on a company-by-company basis.

Table 16 – 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	
	2008	2009	2008	2009
Acquired Brain Injury	0.05%	0.07%	0.33%	0.33%
AIDS/HIV Treatment	0.10%	0.04%	0.61%	0.35%
Chemical Dependency	0.03%	0.04%	0.20%	0.23%
Childhood Immunizations	0.07%	0.06%	0.41%	0.37%
Colorectal Cancer Testing	0.06%	0.05%	0.21%	0.19%
Craniofacial Surgery for Children	0.00%	0.00%	0.01%	0.01%
Diabetes Education and Supplies	0.12%	0.12%	0.75%	0.81%
Hearing Screening	0.09%	0.09%	0.46%	0.45%
Mammography Screening	0.07%	0.07%	0.38%	0.40%
Nutritional Supplements for PKU and Other Diseases	0.01%	0.00%	0.01%	0.00%
Oral Contraceptives	0.03%	0.03%	0.21%	0.21%
Osteoporosis Detection	0.00%	0.00%	0.03%	0.03%
Prescription Contraceptive Drugs, Devices and Services	0.01%	0.02%	0.08%	0.10%
PSA Testing for Prostate Cancer	0.01%	0.01%	0.07%	0.07%
Psychiatric Day Treatment	0.01%	0.06%	0.06%	0.10%
Reconstructive Breast Surgery Following a Mastectomy	0.12%	0.12%	0.58%	0.59%
Serious Mental Illness – 45 Inpatient Days/60 Outpatient Days	0.05%	0.05%	0.45%	0.44%
Serious Mental Illness – Full Parity (Gov't & University Employees Only)	0.01%	0.01%	0.06%	0.06%
Telemedicine	0.00%	0.00%	0.00%	0.00%
TMJ	0.01%	0.00%	0.03%	0.02%
TOTAL	**0.86%**	**0.87%**	**4.94%**	**4.79%**

When the 2008 mandated offering data is compared to 2009 (Table 17), administrative costs as a percentage of total claims paid increased from 0.01 percent to 0.02 percent. Claims costs as a percentage of total claims paid also increased slightly from 0.07 percent to 0.08 percent.

Table 17 – Group Benefit Plans
Mandated Offer - Administrative Costs and Claims Costs Comparison

Mandated Benefit Offerings	Administrative Costs as a Percentage of Total Claims Paid		Claims Costs as a Percentage of Total Claims Paid	
	2008	2009	2008	2009
In-Vitro Fertilization	0.00%	0.01%	0.02%	0.02%
Treatment of Speech or Hearing Loss	0.01%	0.01%	0.05%	0.06%
TOTAL	**0.01%**	**0.02%**	**0.07%**	**0.08%**

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 23 insurance companies met the minimum financial threshold for a total of 24 survey respondents. These companies issued 367,328 individual insurance contracts that generated $1,416,123,543 in total premiums for calendar year 2009. 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 $51,598,450 (Table 18). This figure represents 4.38 percent of all claims paid, which totaled $1,176,946,234. Mandated benefit claims also accounted for 3.64 percent of the total premiums collected. These numbers reflect a slightly lower percentage than the group mandated benefits. The most expensive mandated benefit was childhood immunizations (1.08 percent of total claims paid), followed by reconstructive breast surgery following a mastectomy (1.05 percent). The least expensive mandated benefits were telemedicine services and craniofacial surgery for children, which both accounted for less than 0.02 percent of total claims paid.

A comparison of 2008 and 2009 data shows that mandated benefit claims increased by $8.3 million during that period. The ratio of mandated benefit claims to total claims decreased from 5.03 percent to 4.38 percent. Among the noteworthy findings, reconstructive breast surgery following a mastectomy increased from $10.54 million to $12.32 million; childhood immunizations increased from $10.81 million to $12.75 million; hearing screening for children increased from $6.49 million to $9.33 million; and prescription contraceptive drugs, devices and related services increased from $123,000 to $623,000. Conversely, oral contraceptives decreased from $2.58 million to $1.37 million.

Table 18 – Individual Benefit Plans
Mandated Benefit Claims Costs

Mandated Benefit	Mandated Benefit Claims Paid		Mandated Benefit Claims as a Percentage of Total Claims	
	2008	2009	2008	2009
Acquired Brain Injury	$1,198,362	$1,191,270	0.14%	0.10%
AIDS/HIV Treatment	$3,032,247	$3,173,505	0.35%	0.27%
Childhood Immunizations	$10,806,452	$12,750,026	1.26%	1.08%
Colorectal Cancer Testing	$2,108,519	$2,918,609	0.24%	0.25%
Craniofacial Surgery for Children	$180,614	$166,449	0.02%	0.01%
Diabetes Education and Supplies	$1,638,469	$1,910,102	0.19%	0.16%
Hearing Screening for Children	$6,487,057	$9,329,121	0.75%	0.79%
Mammography Screening	$4,133,733	$5,287,335	0.48%	0.45%
Oral Contraceptives	$2,575,588	$1,373,965	0.30%	0.12%
Prescription Contraceptive Drugs, Devices and Related Services	$122,696	$622,603	0.01%	0.05%
PSA Testing for Prostate Cancer	$452,284	$543,745	0.05%	0.05%
Reconstructive Breast Surgery Following a Mastectomy	$10,543,084	$12,321,717	1.23%	1.05%
Telemedicine Services	$8,258	$10,003	0.00%	0.00%
TOTAL	**$43,287,363**	**$51,598,450**	**5.03%**	**4.38%**

Utilization of mandated benefits under individual plans also closely followed claims for group plans (Table 19). Due to the fact that they are repeatedly refilled, oral contraceptives and prescription contraceptive drugs and devices and related services accounted for 34.03 percent of the total number of mandated benefit claims filed. Telemedicine services and craniofacial surgery for children accounted for the least number of claims, with 14 and 81 total claims, respectively.

A comparison of 2008 and 2009 data shows marginal change in the benefit utilization patterns of most mandated benefits, although there were a few important exceptions. The total number of claims for hearing screening for children increased from 39,702 in 2008 to 47,061 in 2009, while claims for prescription contraceptive drugs, devices and related services rose from 6,706 to 25,710. There was a significant reduction in the number of oral contraceptive claims, from 216,365 in 2008 to 123,138 in 2009.

Table 19 – Individual Benefit Plans
Mandated Benefit Utilization

Mandated Benefit	Number of Mandated Benefit Claims Paid		Percentage of the Total Number of Mandated Benefit Claims	
	2008	2009	2008	2009
Acquired Brain Injury	4,316	2,567	0.87%	0.59%
AIDS/HIV Treatment	3,781	4,129	0.76%	0.94%
Childhood Immunizations	91,141	93,037	18.30%	21.27%
Colorectal Cancer Testing	19,447	18,271	3.90%	4.18%
Craniofacial Surgery for Children	355	81	0.07%	0.02%
Diabetes Education and Supplies	19,638	21,566	3.94%	4.93%
Hearing Screening for Children	39,702	47,061	7.97%	10.76%
Mammography Screening	51,678	55,532	10.38%	12.70%
Oral Contraceptives	216,365	123,138	43.44%	28.15%
Prescription Contraceptive Drugs, Devices and Related Services	6,706	25,710	1.35%	5.88%
PSA Testing for Prostate Cancer	27,950	29,102	5.61%	6.65%
Reconstructive Breast Surgery Following a Mastectomy	16,938	17,200	3.40%	3.93%
Telemedicine Services	41	14	0.01%	0.00%
TOTAL	**498,058**	**437,408**	**100.00%**	**100.00%**

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 20). Though there was some correlation, there also were some noted exceptions. When combined, prescription contraceptive drugs, devices and related services and oral contraceptives accounted for 34.03 percent of the total number of mandated benefit claims, but in dollar terms they only accounted for 3.87 percent of claims. In contrast, reconstructive breast surgery accounted for only 3.93 percent of the total number of claims. It was clearly the most expensive mandated benefit, however, with 23.88 percent of all mandated benefit claims paid. Similarly, AIDS/HIV treatment accounted for only 0.94 percent of the total number of claims, but had a value of 6.15 percent of all mandated benefit costs. For the remaining benefits, however, higher utilization generally resulted in higher claims costs.

A comparison of 2008 data to 2009 shows that the total dollars paid for prescription contraceptive drugs, devices and related services increased from 0.28 percent to 1.21 percent of total mandated benefit claims, while hearing screening for children increased from 14.99 percent to 18.08 percent. Oral contraceptives decreased significantly from 5.95 percent to 2.66 percent of total mandated benefit claims, while craniofacial surgery for children decreased from 0.42 percent to 0.32 percent.

Table 20 – 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	
	2008	2009	2008	2009
Acquired Brain Injury	0.87%	0.59%	2.77%	2.31%
AIDS/HIV Treatment	0.76%	0.94%	7.00%	6.15%
Childhood Immunizations	18.30%	21.27%	24.96%	24.71%
Colorectal Cancer Testing	3.90%	4.18%	4.87%	5.66%
Craniofacial Surgery for Children	0.07%	0.02%	0.42%	0.32%
Diabetes Education and Supplies	3.94%	4.93%	3.79%	3.70%
Hearing Screening for Children	7.97%	10.76%	14.99%	18.08%
Mammography Screening	10.38%	12.70%	9.55%	10.25%
Oral Contraceptives	43.44%	28.15%	5.95%	2.66%
Prescription Contraceptive Drugs, Devices and Related Services	1.35%	5.88%	0.28%	1.21%
PSA Testing for Prostate Cancer	5.61%	6.65%	1.04%	1.05%
Reconstructive Breast Surgery Following a Mastectomy	3.40%	3.93%	24.36%	23.88%
Telemedicine Services	0.01%	0.00%	0.02%	0.02%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Mandated Benefit Premium Costs

Insurers and HMOs also provided annual premium cost data for two enrollment categories of coverage under individual benefit plans: single coverage (which insures one

individual only), and family coverage (which insures parents and 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 actuarial principles to establish premium costs, there are many methodological variations. Because there is no "standard" process, TDI allowed carriers to use their own formula for developing premium cost estimates, but also instructed them to evaluate how their estimate relates to the actual claims experience for each mandated benefit.

Of the 24 companies that provided individual policy data, 21 companies provided mandated benefit premium estimates. Four of these companies provided materially inaccurate premium data, and the remaining 17 responses are summarized below. As shown in Table 21, insurers and HMOs reported the highest premium charge for childhood immunizations, at $50.23 per-contract-per-year for family coverage. Mammography screening was the second most expensive benefit at $18.03 per year, followed by oral contraceptives at $16.53 per year. For single coverage, companies charged the highest premiums for childhood immunizations, at $22.59 per-contract-per-year. Mammography screening had the second highest premium at $7.49, followed by reconstructive breast surgery following a mastectomy at $7.46.

As with the group benefit plans, 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 value of total mandated benefit claims paid. All mandated benefits combined resulted in a total annual premium of $75.09 for single coverage and $165.80 for family coverage.

When the 2009 data is compared to 2008, the average single premium decreased by 0.17 percent from $75.22 to $75.09. The most notable decreases for single coverage were for acquired brain injury ($3.43 to $2.72), oral contraceptives ($6.98 to $6.32), and childhood immunizations ($24.10 to $22.59). The benefits with the most significant increases for single coverage were reconstructive breast surgery following a mastectomy ($5.05 to $7.46), diabetes education and supplies ($5.87 to $7.00), and hearing screening for children ($5.53 to $6.01).

The average family premium decreased by 1.74 percent from $168.73 to $165.80. The most notable decreases for family coverage were for acquired brain injury ($8.50 to $5.61), prescription contraceptive drugs, devices and related services ($14.56 to $11.02), and colorectal cancer testing ($16.21 to $13.25). The benefits with the largest increases for family coverage were reconstructive breast surgery following a mastectomy ($12.48 to $16.16), hearing screening for children ($12.21 to $15.46), and oral contraceptives ($14.84 to $16.53).

Table 21 – Individual Benefit Plans
Mandated Benefit Annual Premium Cost Estimates

Mandated Benefit	Average Annual Premium Cost Estimates – Single Coverage		Average Annual Premium Cost Estimates – Family Coverage	
	2008	2009	2008	2009
Acquired Brain Injury	$3.43	$2.72	$8.50	$5.61
AIDS/HIV Treatment	$1.49	$1.01	$1.82	$2.00
Childhood Immunizations	$24.10	$22.59	$52.40	$50.23
Colorectal Cancer Testing	$6.42	$6.23	$16.21	$13.25
Craniofacial Surgery for Children	$0.27	$0.40	$0.56	$0.82
Diabetes Education and Supplies	$5.87	$7.00	$12.98	$12.35
Hearing Screening	$5.53	$6.01	$12.21	$15.46
Mammography Screening	$8.01	$7.49	$18.59	$18.03
Oral Contraceptives	$6.98	$6.32	$14.84	$16.53
Prescription Contraceptive Drugs, Devices and Services	$6.65	$6.41	$14.56	$11.02
PSA Testing for Prostate Cancer	$1.31	$1.32	$3.29	$4.04
Reconstructive Breast Surgery Following a Mastectomy	$5.05	$7.46	$12.48	$16.16
Telemedicine	$0.11	$0.13	$0.28	$0.28
TOTAL	**$75.22**	**$75.09**	**$168.73**	**$165.80**

To further evaluate the reasonableness of the premium estimates in relation to 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 of Table 22. 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). As the table shows, the total average claim cost per certificate is actually higher than either the single or family premium averages, suggesting that higher claims costs do not necessarily correlate with the relative value of premium estimates. For example, based on claims paid, reconstructive breast surgery following a mastectomy was the most costly benefit at an average cost of $40.45 per certificate, but its premium estimates were $7.46 for single coverage and $16.16 for family coverage. Again, these are average figures; premium estimates for some individual companies corresponded more closely to the actual claims costs than is reflected in the aggregated average.

Table 22 – Individual Benefit Plans
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 Annual Premium Cost Estimates – Single Coverage	Average Annual Premium Cost Estimates – Family Coverage
Acquired Brain Injury	$3.91	$2.72	$5.61
AIDS/HIV Treatment	$10.41	$1.01	$2.00
Childhood Immunizations	$39.73	$22.59	$50.23
Colorectal Cancer Testing	$9.38	$6.23	$13.25
Craniofacial Surgery for Children	$0.55	$0.40	$0.82
Diabetes Education and Supplies	$6.28	$7.00	$12.35
Hearing Screening	$30.19	$6.01	$15.46
Mammography Screening	$17.01	$7.49	$18.03
Oral Contraceptives	$4.51	$6.32	$16.53
Prescription Contraceptive Drugs, Devices and Services	$2.02	$6.41	$11.02
PSA Testing for Prostate Cancer	$1.73	$1.32	$4.04
Reconstructive Breast Surgery Following a Mastectomy	$40.45	$7.46	$16.16
Telemedicine	$0.03	$0.13	$0.28
TOTAL	**$166.19**	**$75.09**	**$165.80**

Mandated Benefit Administrative Costs

Finally, the participating insurers and HMOs were asked to estimate the average annual administrative 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.

The administrative costs for all mandated benefits combined are $18,686,523, which represents 1.59 percent of the total cost of all claims paid (Table 23) and 1.32 percent of total premiums. These numbers are slightly higher than the data reported by the group carriers. However, the actual estimates provided by some carriers were extremely high relative to the total 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.

A comparison of 2009 data to 2008 shows that administrative costs as a percentage of total claims paid decreased for the majority of benefits. The largest percentage decreases were for reconstructive breast surgery following a mastectomy (0.56 percent to 0.41 percent), AIDS/HIV treatment (0.24 percent to 0.08 percent), and oral contraceptives (0.09 percent to 0.04 percent).

Table 23 – Individual Benefit Plans
Mandated Benefit Administrative Cost Estimates

Mandated Benefit	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2008	2009	2008	2009
Acquired Brain Injury	$391,004	$438,481	0.05%	0.04%
AIDS/HIV Treatment	$2,053,454	$956,071	0.24%	0.08%
Childhood Immunizations	$3,021,356	$4,066,666	0.35%	0.35%
Colorectal Cancer Testing	$893,912	$1,185,302	0.10%	0.10%
Craniofacial Surgery for Children	$101,475	$49,869	0.01%	0.00%
Diabetes Education and Supplies	$729,151	$756,312	0.08%	0.06%
Hearing Screening for Children	$2,491,119	$3,471,610	0.29%	0.29%
Mammography Screening	$1,811,970	$2,128,717	0.21%	0.18%
Oral Contraceptives	$740,170	$454,679	0.09%	0.04%
Prescription Contraceptive Drugs, Devices and Related Services	$110,060	$115,710	0.01%	0.01%
PSA Testing for Prostate Cancer	$228,974	$182,886	0.03%	0.02%
Reconstructive Breast Surgery Following a Mastectomy	$4,861,018	$4,875,999	0.56%	0.41%
Telemedicine Services	$10,586	$4,221	0.00%	0.00%
TOTAL	**$17,444,249**	**$18,686,523**	**2.03%**	**1.59%**

To determine whether mandated benefits with higher claims costs also resulted in higher administrative costs, Table 24 compares the average administrative costs as a percentage of total claims with the average claims costs as a percentage of total claims. Childhood immunizations account for the highest claims cost (1.08 percent of total claims paid) and second highest administrative cost (0.35 percent of total claims paid). Reconstructive breast surgery following a mastectomy had the highest administrative cost (0.41 percent of total claims paid) and the second highest claims cost (1.05 percent of total claims paid). These data are consistent with many companies' calculations 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 specialist referrals. Overall, administrative costs as a percentage of total claims paid decreased from 2.03 percent in 2008 to 1.59 percent in 2009, while mandated benefit claims costs as a percentage of total claims paid decreased from 5.03 percent to 4.38 percent.

Table 24 – 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	
	2008	2009	2008	2009
Acquired Brain Injury	0.05%	0.04%	0.14%	0.10%
AIDS/HIV Treatment	0.24%	0.08%	0.35%	0.27%
Childhood Immunizations	0.35%	0.35%	1.26%	1.08%
Colorectal Cancer Testing	0.10%	0.10%	0.24%	0.25%
Craniofacial Surgery for Children	0.01%	0.00%	0.02%	0.01%
Diabetes Education and Supplies	0.08%	0.06%	0.19%	0.16%
Hearing Screening for Children	0.29%	0.29%	0.75%	0.79%
Mammography Screening	0.21%	0.18%	0.48%	0.45%
Oral Contraceptives	0.09%	0.04%	0.30%	0.12%
Prescription Contraceptive Drugs, Devices and Related Services	0.01%	0.01%	0.01%	0.05%
PSA Testing for Prostate Cancer	0.03%	0.02%	0.05%	0.05%
Reconstructive Breast Surgery Following a Mastectomy	0.56%	0.41%	1.23%	1.05%
Telemedicine Services	0.01%	0.00%	0.00%	0.00%
TOTAL	**2.03%**	**1.59%**	**5.03%**	**4.38%**

CONCLUSION

This report demonstrates the impact of mandated benefit provisions on claims costs and premium costs for both group and individual insurance plans sold to Texans during the period of October 2008 through September 2009. The data show that each added benefit results in some additional cost to both the insurer and the purchaser of a health benefit plan. However, as a percentage of total claims paid by insurers, mandated benefit expenses are relatively small.

This study does not take into account the cost savings that accompany some mandated benefits. As has been documented in various studies, the treatment and care associated with many mandated benefits are expected to improve and maintain the health of insured Texans and may reduce the need for future medical treatment in some cases, thus lowering the long-term cost of care. As such, any meaningful discussion of mandated benefits should consider both the short and long term economic impact as well as the equally important impact on health status.

The following appendix provides detailed definitions for the mandated benefits and mandated offerings that are included in this report, as well as citations in the Texas Insurance Code and the Texas Administrative Code.

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, co-payments, 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: TIC §1352.003; TIC §1352.0035

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: TIC §§1364.001 – 1364.053, 1364.101, 1551.205, and 1601.109; 28 TAC §3.3057(d), Exhibit A

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: TIC Chapter 1368; 28 TAC §§3.8001 – 3.8030

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 co-payment requirement. Applies to individual and group insurance plans and HMO benefit plans; does not apply to plans issued to a small employer.

Legal Basis: TIC §1367.053; 28 TAC §11.506(2) and §11.508(a)(9)(G)

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: TIC Chapter 1363

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: TIC §1367.153

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: TIC Chapter 1358; 28 TAC §§21.2601 – 21.2607

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 co-payment/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: TIC §1367.103

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: TIC §1356.005; 28 TAC Chapter 11

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: TIC Chapter 1359

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: 28 TAC §21.404

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: TIC Chapter 1361

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, co-payment 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: TIC §1369.104

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: TIC §1362.003 and §1575.159; 28 TAC §11.508(a)(9)(E)

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: TIC §§1355.101 – 1355.106

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: TIC §1357.003 and §1357.004; 28 TAC §11.508(a)(5)(A)
Note: This benefit is also required under federal law.

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. This is a mandated offer for small employer benefit plans.

Legal Basis: TIC §1355.004 and §1551.205

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: TIC §1355.151 and §1601.109

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 co-payment requirement; however, the deductible or co-payment 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: TIC §1455.004; 28 TAC §11.1607(i), (j) and (k)

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: TIC §1360.004

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: TIC §§1366.003 – 1366.004

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: TIC §§1365.003 – 1365.004; 28 TAC §11.510(2)