Texas Mandated Benefit Cost and Utilization Summary Report

October 2010 – September 2011 Reporting Period

Texas Department of Insurance

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EXECUTIVE SUMMARY

Texas Insurance Code Chapter 38, Subchapter F, instructs the Texas Department of Insurance to collect data to determine the costs associated with mandated health benefits. This report summarizes the data covering twenty mandated benefits and two mandated offers collected for the 12-month reporting period of October 2010 through September 2011.

2011 Overview

This 2011 mandated benefits data call report reflects data submitted by 37 health plan issuers. While mandated benefits data for the group market saw comparatively modest year-to-year shifts, the data for the individual market saw a pattern of increased expenses related to mandated benefits. Where possible, TDI has provided explanations for the changes in the data. There are fewer issuers of individual plans than group plans, so a significant change in one issuer's data will have a greater impact on the overall numbers for individual plans than it would for group plans.

Change in Reporting of Contraceptives

Due to prior confusion expressed by some issuers, the 2011 data call allowed issuers to report contraceptive information in one category. Previously, issuers reported contraceptive data in two separate categories consisting of "Prescription Contraceptive Drugs, Devices, and Related Services" and "Oral Contraceptives." In previous data calls, some issuers reported oral contraceptives redundantly in both categories, or they combined both categories into a single category. TDI reviewed the concerns of the issuers and applicable statutory references before deciding to combine both categories in the 2011 data call.

Additionally, one large issuer reported significantly higher contraceptive claims in 2011 compared to 2010. TDI contacted the issuer and the issuer responded that it began using a more comprehensive list of pharmacy codes in 2011, which resulted in higher claims numbers reported to TDI for both group and individual health plans.

Group Benefits Summary

Table 1 (on next page) demonstrates the overall trends in mandated benefits and offers for group plans. While the number of mandated benefit claims paid held steady from 2010 to 2011, there was a slight reduction in the total dollars paid for those claims. There was also a marked reduction in mandated benefit premiums, particularly for family coverage. Upon closer review, it was clear that this resulted from most issuers reporting a reduced amount of premium per benefit in 2011. Administrative costs of mandated benefits rose in 2011.

Table 1 - Overview of Group Mandated Benefit and Mandated Offer Plans

	2010	2011	% Change
Overall Group Accident and Health Data			
Total Premiums Written	$11,148,642,478	$10,738,674,320	-3.68%
Total Claims Dollars Paid	$9,238,961,621	$8,625,613,153	-6.70%
Mandated Benefit Data*			
Total Mandated Benefit Claims Dollars Paid	$458,935,664	$445,492,505	-2.93%
Number of Mandated Benefit Claims Paid	2,971,362	2,971,872	0.02%
Mandated Benefit Costs as a Percentage of Total Claims Paid	4.97%	5.17%	4.02%
Mandated Benefit Costs as a Percentage of Total Premiums Written	4.12%	4.15%	0.73%
Average Annual Premium Cost Estimate of Mandated Benefits - Single (usually employee only) Coverage	$233.98	$223.17	-4.62%
Average Annual Premium Cost Estimate of Mandated Benefits - Family (employee, spouse, and children) Coverage	$504.33	$425.57	-15.62%
Total Estimated Administrative Costs for Mandated Benefits	$74,792,248	$76,755,602	2.63%
Mandated Benefit Administrative Costs as a Percentage of Total Claims Paid	0.81%	0.89%	9.88%
Mandated Offer Data†			
Total Mandated Offer Claims Dollars Paid	$10,673,740	$6,392,349	-40.11%
Number of Mandated Offer Claims Paid	94,124	51,430	-45.36%
Mandated Offer Costs as a Percentage of Total Claims Dollars Paid	0.12%	0.07%	-41.67%
Mandated Offer Costs as a Percentage of Total Premiums Written	0.10%	0.06%	-40.00%
Average Annual Premium Cost Estimate of Mandated Offer - Single (usually employee only) Coverage	$15.62	$29.47	88.67%
Average Annual Premium Cost Estimate of Mandated Offer - Family (employee, spouse, and children) Coverage	$22.98	$19.81	-13.79%
Total Estimated Administrative Costs for Mandated Offers	$1,233,545	$994,581	-19.37%
Mandated Offer Administrative Costs as a Percentage of Total Claims Paid	0.01%	0.01%	0.00%

*Represents 20 mandated benefits for which TDI collected data.

†Represents 2 mandated offers for which TDI collected data.

Mandated offers showed a sharp reduction in the numbers of claims paid, as well as the dollar amount paid out for these claims. At the same time, the premiums for mandated offers showed a sharp increase for single plans, but a moderate decrease for family premiums. This resulted from

two issuers submitting data that was considerably different from data they submitted in 2010 and previous years. TDI contacted these issuers about their data, and both confirmed their submissions.

Individual Benefits Summary

Table 2 summarizes the mandated benefits data for individual plans, which, unlike group plans, had higher premiums and claims amounts in 2011. This is primarily due to an increase in the number of issuers offering individual health plans that responded with data for 2011. Table 2 shows an increase in the total number of mandated benefit claims paid, which reflects increases in claims paid for all mandated benefits in the survey, the largest of which came from prescription contraceptive drugs, devices, and related services. This was due in part to a large issuer using an expanded pharmacy code list to report contraceptive claims to TDI. Average annual premiums for mandated benefits also showed an increase, due primarily to an increase in premium estimates for diabetes.

Table 2 - Overview of Individual Mandated Benefit Plans

	2010	2011	% Change
Overall Individual Accident and Health Data			
Total Premiums Written	$1,361,682,171	$1,590,384,014	16.80%
Total Claims Dollars Paid	$869,081,459	$1,039,880,375	19.65%
Mandated Benefit Data*			
Total Mandated Benefit Claims Dollars Paid	$33,429,144	$43,152,444	29.09%
Number of Mandated Benefit Claims Paid	364,594	539,424	47.95%
Mandated Benefit Costs as a Percentage of Total Claims Dollars Paid	3.85%	4.15%	7.84%
Mandated Benefit Costs as a Percentage of Total Premiums Written	2.45%	2.71%	10.61%
Average Annual Premium Cost Estimate of Mandated Benefits - Single Coverage	$98.46	$116.17	17.98%
Average Annual Premium Cost Estimate of Mandated Benefits - Family Coverage	$218.85	$222.28	1.57%
Total Estimated Administrative Costs	$9,162,621	$13,161,034	43.64%
Administrative Costs as a Percentage of Total Claims Paid	1.05%	1.27%	20.95%

*Represents 13 mandated benefits for which TDI collected data

SURVEY OVERVIEW

Governing Statutes

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

Definition of Mandated Benefits and Reporting Limitations

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

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

- benefits related to the treatment of acquired brain injury
- AIDS, HIV, and related illnesses
- chemical dependency
- childhood immunization
- colorectal cancer testing
- craniofacial surgery for children
- diabetes education and testing supplies
- hearing screenings for children
- mammography screening
- nutritional supplements for phenylketonuria (PKU) and other heritable diseases
- osteoporosis detection
- prescription contraceptive drugs, devices, and related services (if prescription drugs are covered)

- prostate-specific antigen (PSA) testing for prostate cancer
- psychiatric day treatment
- reconstructive breast surgery following a mastectomy
- serious mental illness – not less than 45 inpatient days of treatment and 60 outpatient visits
- serious mental illness – full parity for universities and local governments
- telemedicine services, and
- treatment of temporomandibular joint conditions (TMJ).

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

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

This report aggregates all data to provide industry-wide averages for each benefit listed. 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, issuers were required to report the following information for both group and individual plans:

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

Additionally, issuers are required to report enrollment, as well as data pertaining to total premiums and total claims for both group and individual plans. This data allows additional analysis on an issuer-level basis as well as on an aggregated, industry-wide basis. To the extent possible, TDI provided specific directions to assure uniform reporting across issuers. Due to common industry practices for claims payment forms and the use of standard codes for medical diagnoses and services, the method for collecting and calculating claims data is relatively straightforward. Calculating average claim estimates per benefit involves factoring the total claims amount paid for a given benefit with the number of claims reported for that benefit. However, the process issuers use to determine premium costs and administrative costs varies from issuer to issuer. Although all issuers use similar actuarial principles, there are technical variances among issuers that result in differences in the way they develop cost estimates. Accordingly, each issuer reports its premium and administrative cost data to TDI using its internal guidelines instead of an industry-wide standard. While all issuers use similar actuarial methodologies to establish premium rates, the exact process and underlying data assumptions used are protected trade secrets that are not generally subject to public disclosure. Issuers have discretion in determining how they develop premium costs. In calculating average premiums, TDI averages all issuer premium amounts, with each issuer weighted equally. In calculating average claims, TDI combines all claims dollar amounts reported by all issuers and divides this by the combined number of actual claims reported by all issuers. While these two methods differ, the estimated premiums should have a reasonable relationship to the claims actually paid for the same benefit.

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

TDI did not conduct any audits of the data reported by issuers. Issuers are responsible for assuring that the information reported is accurate and complete. TDI reviews the data submitted by issuers to identify extreme data anomalies and outliers suggesting data collection or entry errors. TDI contacted issuers submitting questionable data to verify the accuracy of the information and correct any errors.

GROUP COVERAGE TABLES

Group Benefit Plans - Mandated Benefit Claims Costs

Claims data reported to TDI for 2011 was generally consistent with data reported for 2010. Most benefits accounted for a slightly higher percentage of total claims paid, but data reported shows that each mandated benefit still accounts for less than one percent of the total claims cost. As previously mentioned, one large issuer reported significantly higher claims for contraceptives in 2011 due to a more comprehensive pharmacy code list, as reflected in Table 3.

Table 3 - Group Benefit Plans Mandated Benefit Claims Costs

Mandated Benefit	Mandated Benefit Claims Dollars Paid		Claims as a Percentage of Total Claims Paid	
	2010	2011	2010	2011
Acquired Brain Injury	$30,237,711	$27,042,818	0.33%	0.31%
AIDS, HIV, and Related Illnesses	$28,550,718	$22,914,361	0.31%	0.27%
Chemical Dependency	$26,734,270	$23,095,842	0.29%	0.27%
Childhood Immunizations	$37,211,159	$37,525,147	0.40%	0.44%
Colorectal Cancer Testing	$28,396,192	$32,492,317	0.31%	0.38%
Craniofacial Surgery for Children	$1,223,175	$1,118,820	0.01%	0.01%
Diabetes Education and Supplies	$53,615,937	$53,364,839	0.58%	0.62%
Hearing Screening for Children	$41,789,836	$43,567,868	0.45%	0.51%
Mammography Screening	$39,488,245	$40,554,711	0.43%	0.47%
Nutrition Supplements for PKU and Other Heritable Diseases	$357,053	$1,227,132	0.00%	0.01%
Oral Contraceptives*	$20,554,352		0.22%	
Osteoporosis Detection	$2,658,547	$2,440,072	0.03%	0.03%
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		$32,054,831		0.37%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	$7,528,849		0.08%	
PSA Testing for Prostate Cancer	$6,597,843	$6,111,668	0.07%	0.07%
Psychiatric Day Treatment	$55,303,364	$49,455,942	0.60%	0.57%
Reconstructive Breast Surgery Following a Mastectomy	$27,282,971	$19,373,780	0.30%	0.22%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	$30,725,056	$29,230,734	0.33%	0.34%
Serious Mental Illness - Full Parity for Universities and Local Governments	$18,578,487	$22,250,684	0.20%	0.26%
Telemedicine Services	$172,129	$203,880	0.00%	0.00%
TMJ Treatment	$1,929,770	$1,467,059	0.02%	0.02%
TOTAL	**$458,935,664**	**$445,492,505**	**4.96%**	**5.17%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

The dollar amounts paid for mandated offer claims changed substantially from 2010 to 2011, with in vitro fertilization decreasing considerably, as illustrated by Table 4. In reviewing this trend, TDI identified a major reduction in the in vitro fertilization claims reported by one large issuer. The issuer reported far fewer claims than in previous years, which resulted in a significant change to aggregate claims data. TDI contacted the issuer about this change, and the issuer confirmed that the 2011 data was correct, explaining that they revised the list of procedure codes used for in vitro claims to avoid over-reporting the number of claims.

Table 4 - Group Benefit Plans Mandated Offer Claims Costs

Mandated Offer	Claims Dollars Paid		Claims as a Percentage of Total Claims Paid	
	2010	2011	2010	2011
In Vitro Fertilization	$5,246,985	$1,183,688	0.06%	0.01%
Treatment of Speech or Hearing Loss	$5,426,755	$5,208,661	0.06%	0.06%
TOTAL	**$10,673,740**	**$6,392,349**	**0.12%**	**0.07%**

Group Benefit Plans - Mandated Benefit Utilization

Issuers were required to report the number of claims paid for each mandated benefit. As illustrated by Table 5, claims figures vary 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 over). For example, claims for prescription contraceptive drugs, devices, and related services had the highest utilization due in part to the fact that the prescriptions are routinely filled on a monthly basis. Each prescription refill corresponds to a separate claim. Claim utilization for 2011 generally followed the same trends as 2010.

Table 5 - Group Benefits Plans Mandated Benefit Utilization

Mandated Benefit	Number of Mandated Benefit Claims Paid		Percentage of the Total Number of Mandated Benefit Claims	
	2010	2011	2010	2011
Acquired Brain Injury	192,702	167,338	6.49%	5.63%
AIDS, HIV, and Related Illnesses	50,919	41,387	1.71%	1.39%
Chemical Dependency	31,885	29,123	1.07%	0.98%
Childhood Immunizations	284,881	264,587	9.59%	8.90%
Colorectal Cancer Testing	77,104	82,552	2.59%	2.78%
Craniofacial Surgery for Children	634	526	0.02%	0.02%
Diabetes Education and Supplies	434,799	334,065	14.63%	11.24%
Hearing Screening for Children	220,913	196,897	7.43%	6.63%
Mammography Screening	289,250	286,609	9.73%	9.64%
Nutrition Supplements for PKU and Other Heritable Diseases	1,923	1,301	0.06%	0.04%
Oral Contraceptives*	683,724		23.01%	
Osteoporosis Detection	25,217	22,741	0.85%	0.77%
Prescription Contraceptive Drugs, Devices and Related Services – 2011*		1,008,924		33.95%
Prescription Contraceptive Drugs, Devices and Related Services – before 2011*	145,966		4.91%	
PSA Testing for Prostate Cancer	177,976	172,716	5.99%	5.81%
Psychiatric Day Treatment	45,176	35,852	1.52%	1.21%
Reconstructive Breast Surgery Following a Mastectomy	30,903	23,211	1.04%	0.78%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	153,690	168,419	5.17%	5.67%
Serious Mental Illness - Full Parity for Universities and Local Governments	118,273	130,398	3.98%	4.39%
Telemedicine Services	407	952	0.01%	0.03%
TMJ Treatment	5,020	4,274	0.17%	0.14%
TOTAL†	**2,971,362**	**2,971,872**	**100.00%**	**100.00%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

†The sum of subtotals may not exactly add to the stated total due to rounding.

For mandated offer utilization, a large issuer reporting considerably fewer in vitro fertilization claims affected the total number of claims by a significant amount, as illustrated in Table 6.

Table 6 - Group Benefit Plans Mandated Offer Utilization

Mandated Offer	Number of Claims Paid		Percentage of the Total Number of Mandated Offer Claims	
	2010	2011	2010	2011
In Vitro Fertilization	37,566	4,012	39.91%	7.80%
Treatment of Speech or Hearing Loss	56,558	47,418	60.09%	92.20%
TOTAL	**94,124**	**51,430**	**100.00%**	**100.00%**

Group Benefit Plans - Comparison of Mandated Benefit Utilization and Mandated Benefit Claims Costs

Table 7 provides two views of mandated benefits usage. First, the table shows the percentage of the number of claims paid for each benefit in relation to the total number of claims paid for all mandated benefits in the survey (as is also illustrated in Table 5). Second, the table shows the percentage of the combined dollar amount paid for each mandated benefit, in relation to the total dollar amount paid for all mandated benefits. While some benefits represent a relatively small number of claims, they may represent a comparatively larger portion of claims dollars paid.

Table 7 - Group Benefits 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	
	2010	2011	2010	2011
Acquired Brain Injury	6.49%	5.63%	6.59%	6.07%
AIDS, HIV, and Related Illnesses	1.71%	1.39%	6.22%	5.14%
Chemical Dependency	1.07%	0.98%	5.83%	5.18%
Childhood Immunizations	9.59%	8.90%	8.11%	8.42%
Colorectal Cancer Testing	2.59%	2.78%	6.19%	7.29%
Craniofacial Surgery for Children	2.00%	0.02%	0.27%	0.25%
Diabetes Education and Supplies	14.63%	11.24%	11.68%	11.98%
Hearing Screening for Children	7.43%	6.63%	9.11%	9.78%
Mammography Screening	9.73%	9.64%	8.60%	9.10%
Nutrition Supplements for PKU and Other Heritable Diseases	0.06%	0.04%	0.08%	0.28%
Oral Contraceptives*	23.01%		4.48%	
Osteoporosis Detection	0.85%	0.77%	0.58%	0.55%
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		33.95%		7.20%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	4.91%		1.64%	
PSA Testing for Prostate Cancer	5.99%	5.81%	1.44%	1.37%
Psychiatric Day Treatment	1.52%	1.21%	12.05%	11.10%
Reconstructive Breast Surgery Following a Mastectomy	1.04%	0.78%	5.94%	4.35%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	5.17%	5.67%	6.69%	6.56%
Serious Mental Illness - Full Parity for Universities and Local Governments	3.98%	4.39%	4.05%	4.99%
Telemedicine Services	0.01%	0.03%	0.04%	0.05%
TMJ Treatment	0.17%	0.14%	0.42%	0.33%
TOTAL†	**100.00%**	**100.00%**	**100.00%**	**100.00%**

* Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

†The sum of subtotals may not exactly add to the stated total due to rounding.

While the reduced number of claims for in vitro fertilization accounted for 7.80 percent of the total number of mandated offer claims in 2011, it accounted for 18.52 percent of the dollars paid for those claims as illustrated by Table 8.

Table 8 - Group Benefit Plans Comparison of Mandated Offer Utilization and Mandated Offer Claims Costs

Mandated Offer	Percentage of the Total Number of Mandated Offer Claims		Percentage of the Total Dollars Paid for Mandated Offer Claims	
	2010	2011	2010	2011
In Vitro Fertilization	39.91%	7.80%	49.16%	18.52%
Treatment of Speech or Hearing Loss	60.09%	92.20%	50.84%	81.48%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Group Benefit Plans - 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 issuers and HMOs. The initial data set was limited to only 10 mandated benefits, but TDI later expanded the data set to include additional benefits in 1998. TDI added other mandated benefits through subsequent legislation. Table 9 summarizes mandated benefit claims costs since 2004 and demonstrates that claims costs have remained generally consistent over time.

Table 9 - Group Benefit Plans Mandated Benefit Claims Costs Comparison 2004-2011

Mandated Benefit	Mandated Benefit Claims Costs as a Percentage of Total Claims Paid							
	2004	2005	2006	2007	2008	2009	2010	2011
Acquired Brain Injury	0.37%	0.19%	0.18%	0.18%	0.33%	0.33%	0.33%	0.31%
AIDS, HIV, and Related Illnesses	0.19%	0.32%	0.22%	0.35%	0.61%	0.35%	0.31%	0.27%
Chemical Dependency	0.21%	0.21%	0.18%	0.19%	0.20%	0.26%	0.29%	0.27%
Childhood Immunizations	0.46%	0.39%	0.37%	0.41%	0.41%	0.37%	0.40%	0.44%
Colorectal Cancer Testing	0.30%	0.47%	0.42%	0.45%	0.21%	0.36%	0.31%	0.38%
Craniofacial Surgery for Children	0.02%	0.02%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
Diabetes Education and Supplies	0.65%	0.74%	0.60%	0.71%	0.75%	0.56%	0.58%	0.62%
Hearing Screening for Children	0.38%	0.44%	0.41%	0.39%	0.46%	0.45%	0.45%	0.51%
Mammography Screening	0.29%	0.36%	0.33%	0.34%	0.38%	0.40%	0.43%	0.47%
Nutrition Supplements for PKU and Other Heritable Diseases	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.01%
Oral Contraceptives*	0.27%	0.18%	0.18%	0.16%	0.21%	0.21%	0.22%	
Osteoporosis Detection	0.02%	0.05%	0.04%	0.04%	0.03%	0.03%	0.03%	0.03%
Prescription Contraceptive Drugs, Devices, and Related Services –2011*								0.37%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	0.10%	0.09%	0.07%	0.06%	0.08%	0.10%	0.08%	
PSA Testing for Prostate Cancer	0.08%	0.07%	0.06%	0.06%	0.07%	0.07%	0.07%	0.07%
Psychiatric Day Treatment	0.08%	0.10%	0.07%	0.07%	0.06%	0.68%	0.60%	0.57%
Reconstructive Breast Surgery Following a Mastectomy	0.66%	0.66%	0.62%	0.60%	0.58%	0.26%	0.30%	0.22%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	0.54%	0.54%	0.56%	0.49%	0.45%	0.43%	0.33%	0.34%
Serious Mental Illness - Full Parity for Universities and Local Governments	0.04%	0.05%	0.04%	0.03%	0.06%	0.06%	0.20%	0.26%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TMJ Treatment	0.03%	0.02%	0.04%	0.02%	0.03%	0.03%	0.02%	0.02%
TOTAL†	**4.69%**	**4.92%**	**4.40%**	**4.58%**	**4.94%**	**4.96%**	**4.96%**	**5.17%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

†The sum of subtotals may not exactly add to the stated total due to rounding.

Group Benefit Plans - Mandated Benefit Annual Premium Cost Estimates

The reporting rule also requires issuers 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 the most expensive forms of coverage. "Single coverage" as used in this report refers to coverage provided to a single enrolled individual (usually an employee in an employer-sponsored group health plan) and does not include any dependent coverage for children or a spouse. "Family coverage" refers to coverage provided to the enrollee and a spouse plus children. 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. Other enrollment options for which TDI did not collect premium estimates include enrollee plus spouse only, and enrollee plus children only.

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	
	2010	2011	2010	2011
Acquired Brain Injury	$14.91	$12.58	$36.51	$30.34
AIDS, HIV, and Related Illnesses	$27.12	$10.50	$17.43	$9.96
Chemical Dependency	$13.63	$13.88	$29.39	$24.59
Childhood Immunizations	$16.34	$29.90	$45.89	$48.85
Colorectal Cancer Testing	$13.83	$15.96	$35.57	$22.63
Craniofacial Surgery for Children	$0.97	$0.98	$2.85	$2.48
Diabetes Education and Supplies	$23.84	$19.55	$61.08	$48.05
Hearing Screening for Children	$16.28	$33.47	$31.78	$41.40
Mammography Screening	$14.96	$13.79	$29.17	$28.09
Nutrition Supplements for PKU and Other Heritable Diseases	$0.50	$0.76	$1.35	$1.80
Oral Contraceptives*	$7.56		$16.78	
Osteoporosis Detection	$1.80	$1.40	$2.56	$2.02
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		$10.59		$21.75
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	$4.57		$10.05	
PSA Testing for Prostate Cancer	$5.34	$4.14	$11.08	$6.98
Psychiatric Day Treatment	$12.16	$19.90	$31.64	$52.64
Reconstructive Breast Surgery Following a Mastectomy	$16.00	$9.93	$35.17	$22.18
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	$26.23	$14.97	$62.03	$37.56
Serious Mental Illness - Full Parity for Universities and Local Governments	$14.10	$7.74	$35.22	$17.40
Telemedicine Services	$0.69	$1.20	$1.48	$2.82
TMJ Treatment	$3.15	$1.93	$7.30	$4.03
TOTAL	**$233.98**	**$223.17**	**$504.33**	**$425.57**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

While the mandated offer of the treatment of speech or hearing loss saw a reduction in premiums in 2011, in vitro fertilization saw a substantial increase, as illustrated by Table 11. Review of this data revealed that one large issuer considerably increased its premium estimate for in vitro fertilization. When contacted by TDI, the issuer confirmed its originally submitted data, and responded that the premium estimates had increased for in vitro fertilization because the claims had become more expensive. The issuer advised that the increase in premium estimates was proportional to the increase in claims costs.

Table 11 - Group Benefit Plans Mandated Offer Average Annual Premium Cost Estimates

Mandated Offer	Average Annual Premium Cost Estimates - Single Coverage		Average Annual Premium Cost Estimates - Family Coverage	
	2010	2011	2010	2011
In Vitro Fertilization	$11.17	$26.28	$10.67	$11.73
Treatment of Speech or Hearing Loss	$4.45	$3.19	$12.31	$8.08
TOTAL	**$15.62**	**$29.47**	**$22.98**	**$19.81**

Group Benefit Plans - A Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Benefit in 2011

Table 12 compares each benefit's claims costs per certificate to the premium cost of the benefit. A certificate is a proof of insurance document that verifies coverage. Issuers may issue a single certificate to an individual or to a family. The claim cost column provides TDI's calculation of the average annual claim cost per certificate using aggregate claims data submitted by the issuers. The next column provides the average premium cost as reported by issuers for single coverage. The last column provides the average premium cost as reported by issuers for family coverage. As with data reported in previous years, 2011 premium amounts reported for each mandated benefit frequently varied, sometimes without discernible relationship to the corresponding claim amount.

Table 12 - Group Benefit Plans - A Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Benefit in 2011

Mandated Benefit	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates - Single Coverage	Average Annual Premium Cost Estimates - Family Coverage
	2011	2011	2011
Acquired Brain Injury	$13.90	$12.58	$30.34
AIDS, HIV, and Related Illnesses	$11.76	$10.50	$9.96
Chemical Dependency	$11.85	$13.88	$24.59
Childhood Immunizations	$22.47	$29.90	$48.85
Colorectal Cancer Testing	$19.46	$15.96	$22.63
Craniofacial Surgery for Children	$0.67	$0.98	$2.48
Diabetes Education and Supplies	$27.33	$19.55	$48.05
Hearing Screening for Children	$22.53	$33.47	$41.40
Mammography Screening	$20.57	$13.79	$28.09
Nutrition Supplements for PKU and Other Heritable Diseases	$0.62	$0.76	$1.80
Osteoporosis Detection	$1.25	$1.40	$2.02
Prescription Contraceptive Drugs, Devices, and Related Services†	$17.28	$10.59	$21.75
PSA Testing for Prostate Cancer	$3.12	$4.14	$6.98
Psychiatric Day Treatment	$25.42	$19.90	$52.64
Reconstructive Breast Surgery Following a Mastectomy	$9.81	$9.93	$22.18
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	$22.50	$14.97	$37.56
Serious Mental Illness - Full Parity for Universities and Local Governments	$22.83	$7.74	$17.40
Telemedicine Services	$0.12	$1.20	$2.82
TMJ Treatment	$0.75	$1.93	$4.03
TOTAL	**$254.25**	**$223.17**	**$425.57**

*This figure represents all claims, including those occurring under both single and family coverage.
†2011 numbers include data previously reported under Oral Contraceptives.

For mandated offers, the total average annual claim cost per certificate was $5.28, as shown in Table 13. Average annual premiums for single and family plans were $29.47 and $19.81, respectively. Again, this increase is due primarily to a large issuer reporting higher premium estimates for in vitro fertilization in 2011.

Table 13 - Group Benefit Plans - A Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Offers in 2011

Mandated Offer	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates - Single Coverage	Average Annual Premium Cost Estimates - Family Coverage
	2011	2011	2011
In Vitro Fertilization	$1.35	$26.28	$11.73
Treatment of Speech or Hearing Loss	$3.93	$3.19	$8.08
TOTAL	**$5.28**	**$29.47**	**$19.81**

*This figure represents all claims, including those occurring under both single and family coverage.

Group Benefit Plans - Mandated Benefit Administrative Cost Estimates

Issuers were required to provide an estimate of the annual administrative costs incurred due to the mandated benefit requirements. Administrative costs generally include such expenses as administering claims payments, processing authorizations and referrals, and revisions of marketing materials and policy forms to include new mandated benefits. As with premium cost estimates, TDI gave issuers discretion in determining the value of the administrative costs associated with a specific mandated benefit. The result was variation in the costs reported, as shown in Table 14.

Table 14 - Group Benefit Plans Mandated Benefit Administrative Cost Estimates

Mandated Benefit	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2010	2011	2010	2011
Acquired Brain Injury	$6,562,201	$6,143,953	0.07%	0.07%
AIDS, HIV, and Related Illnesses	$4,040,540	$3,246,450	0.04%	0.04%
Chemical Dependency	$4,891,847	$4,794,330	0.05%	0.06%
Childhood Immunizations	$6,323,182	$6,567,115	0.07%	0.08%
Colorectal Cancer Testing	$2,990,206	$3,795,225	0.03%	0.04%
Craniofacial Surgery for Children	$236,393	$242,080	0.00%	0.00%
Diabetes Education and Supplies	$5,751,052	$6,944,102	0.06%	0.08%
Hearing Screening for Children	$8,786,242	$9,486,020	0.10%	0.11%
Mammography Screening	$7,687,680	$8,034,834	0.08%	0.09%
Nutrition Supplements for PKU and Other Heritable Diseases	$93,366	$288,503	0.00%	0.00%
Oral Contraceptives*	$2,504,554		0.03%	
Osteoporosis Detection	$413,043	$424,543	0.00%	0.00%
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		$5,137,934		0.06%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	$1,231,360		0.01%	
PSA Testing for Prostate Cancer	$1,188,891	$1,138,175	0.01%	0.01%
Psychiatric Day Treatment	$9,019,788	$7,067,766	0.10%	0.08%
Reconstructive Breast Surgery Following a Mastectomy	$4,929,150	$4,169,984	0.04%	0.05%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	$3,558,097	$3,809,604	0.03%	0.04%
Serious Mental Illness - Full Parity for Universities and Local Governments	$4,182,257	$5,078,032	0.04%	0.06%
Telemedicine Services	$77,777	$105,477	0.00%	0.00%
TMJ Treatment	$324,622	$281,475	0.00%	0.00%
TOTAL†	**$74,792,248**	**$76,755,602**	**0.76%**	**0.89%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

†The sum of subtotals may not exactly add to the stated total due to rounding.

As shown in Table 15, the total administrative costs associated with mandated offers decreased from $1,233,545 in 2010 to $994,581 in 2011. Administrative costs as a percentage of total claims paid stayed the same.

Table 15 - Group Benefit Plans Mandated Offer Administrative Cost Estimates

Mandated Offer	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2010	2011	2010	2011
In Vitro Fertilization	$504,359	$227,231	0.00%	0.00%
Treatment of Speech or Hearing Loss	$729,186	$767,350	0.01%	0.01%
TOTAL	**$1,233,545**	**$994,581**	**0.01%**	**0.01%**

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

Table 16 compares the administrative cost per benefit as a percentage of total claims dollars paid with the average claim cost per benefit as a percentage of total claims dollars paid. The results of this comparison are consistent with statements from many issuers that they calculate administrative costs as a percentage of claims costs. This results in higher claims costs correlating to higher administrative costs. Administrative costs depend on such factors as the volume of claims processed and whether certain benefits require additional administrative services like treatment authorizations and specialist referrals.

Table 16 - Group 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	
	2010	2011	2010	2011
Acquired Brain Injury	0.07%	0.07%	0.33%	0.31%
AIDS, HIV, and Related Illnesses	0.04%	0.04%	0.31%	0.27%
Chemical Dependency	0.05%	0.06%	0.29%	0.27%
Childhood Immunizations	0.07%	0.08%	0.40%	0.44%
Colorectal Cancer Testing	0.03%	0.04%	0.31%	0.38%
Craniofacial Surgery for Children	0.00%	0.00%	0.01%	0.01%
Diabetes Education and Supplies	0.06%	0.08%	0.58%	0.62%
Hearing Screening for Children	0.10%	0.11%	0.45%	0.51%
Mammography Screening	0.08%	0.09%	0.43%	0.47%
Nutrition Supplements for PKU and Other Heritable Diseases	0.00%	0.00%	0.00%	0.01%
Oral Contraceptives*	0.03%		0.22%	
Osteoporosis Detection	0.00%	0.00%	0.03%	0.03%
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		0.06%		0.37%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	0.01%		0.08%	
PSA Testing for Prostate Cancer	0.01%	0.01%	0.07%	0.07%
Psychiatric Day Treatment	0.10%	0.08%	0.60%	0.57%
Reconstructive Breast Surgery Following a Mastectomy	0.04%	0.05%	0.30%	0.22%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	0.03%	0.04%	0.33%	0.34%
Serious Mental Illness - Full Parity for Universities and Local Governments	0.04%	0.06%	0.20%	0.26%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%
TMJ Treatment	0.00%	0.00%	0.02%	0.02%
TOTAL	**0.76%**	**0.89%**	**4.96%**	**5.17%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

As shown in Table 17, the relationship between administrative costs and claims costs as a percentage of total claims paid for treatment of speech or hearing loss was nearly the same from 2010 to 2011, while in vitro fertilization costs declined due primarily to a large issuer revising its procedure codes, as mentioned previously.

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

Mandated Offer	Administrative Costs as a Percentage of Total Claims Paid		Claims Costs as a Percentage of Total Claims Paid	
	2010	2011	2010	2011
In Vitro Fertilization	0.01%	0.00%	0.06%	0.01%
Treatment of Speech or Hearing Loss	0.01%	0.01%	0.06%	0.06%
TOTAL	**0.02%**	**0.01%**	**0.12%**	**0.07%**

INDIVIDUAL COVERAGE TABLES

Individual Benefit Plans - Mandated Benefit Claims Costs

Table 18 demonstrates that for individual plans, the total amount paid out for the mandated benefits in the survey increased from 2010 to 2011. Mandated benefits also accounted for an increased portion of the total claims paid. As mentioned previously, one large issuer reported considerably higher contraceptive claims in 2011 due to the use of a broader pharmacy code list. Another issuer reported high claims and premiums for diabetes education and supplies. When contacted by TDI, these issuers confirmed that the data submitted was correct. Table 18 shows the impact of these higher diabetes-related claims.

Table 18 - Individual Benefit Plans Mandated Benefit Claims Costs

Mandated Benefit	Mandated Benefit Claims Paid		Mandated Benefit Claims as a Percentage of Total Claims	
	2010	2011	2010	2011
Acquired Brain Injury	$1,140,315	$1,392,042	0.13%	0.13%
AIDS, HIV, and Related Illnesses	$2,173,057	$1,046,143	0.25%	0.10%
Childhood Immunizations	$9,886,596	$11,141,075	1.14%	1.07%
Colorectal Cancer Testing	$4,444,494	$900,807	0.05%	0.09%
Craniofacial Surgery for Children	$70,866	$105,443	0.01%	0.01%
Diabetes Education and Supplies	$136,134	$684,601	0.02%	0.07%
Hearing Screening for Children	$9,339,211	$11,313,659	1.07%	1.09%
Mammography Screening	$5,979,958	$7,973,076	0.69%	0.77%
Oral Contraceptives*	$1,613,826		0.19%	
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		$5,621,084		0.54%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	$254,513		0.03%	
PSA Testing for Prostate Cancer	$470,275	$574,126	0.05%	0.06%
Reconstructive Breast Surgery Following a Mastectomy	$1,899,017	$2,391,134	0.22%	0.23%
Telemedicine Services	$20,882	$9,254	0.00%	0.00%
TOTAL	**$33,429,144**	**$43,152,444**	**3.85%**	**4.16%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

Individual Benefit Plans - Mandated Benefit Utilization

Table 19 shows an overall increase in the number of mandated benefit claims, due in large part to a significant increase in contraceptive claims reported by one large issuer. Oral contraceptives, while relatively inexpensive compared to other benefits on a claim-to-claim basis, are frequently refilled, thus adding to the total number of prescription contraceptive drugs, devices, and related services claims in 2011. This newly combined category of claims accounted for over half of the total number of mandated benefit claims paid for individual benefit plans in 2011. Also, as previously stated, claims for diabetes education and supplies showed a marked increase due to one issuer reporting higher claims.

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	
	2010	2011	2010	2011
Acquired Brain Injury	2,551	3,647	0.70%	0.68%
AIDS, HIV, and Related Illnesses	2,539	2,565	0.70%	0.48%
Childhood Immunizations	75,853	82,597	20.80%	15.31%
Colorectal Cancer Testing	3,976	4,395	1.09%	0.81%
Craniofacial Surgery for Children	85	87	0.02%	0.02%
Diabetes Education and Supplies	1,523	4,238	0.42%	0.79%
Hearing Screening for Children	55,202	57,081	15.14%	10.58%
Mammography Screening	61,577	72,973	16.89%	13.53%
Oral Contraceptives*	127,014		34.84%	
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		276,609		51.28%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	4,080		1.12%	
PSA Testing for Prostate Cancer	28,086	32,899	7.70%	6.10%
Reconstructive Breast Surgery Following a Mastectomy	2,078	2,243	0.57%	0.42%
Telemedicine Services	30	90	0.01%	0.02%
TOTAL†	**364,594**	**539,424**	**100.00%**	**100.00%**

* Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

†The sum of subtotals may not exactly add to the stated total due to rounding.

Individual Benefit Plans - Comparison of Mandated Benefit Utilization and Mandated Benefit Claims Costs

Table 20 displays mandated benefits data usage in two different ways. The first view shows the percentage of the number of claims paid for each benefit in relation to the total number of claims paid for all mandated benefits in the survey. The second view examines the percentage of the combined dollar amount for all claims paid for each benefit in relation to the total dollar amount paid for all mandated benefits. In comparing the two views, it is apparent that number of claims paid does not always correspond to the dollar amount paid for those claims. This is evidenced by the prescription contraceptive drugs, devices, and related services benefit, which, while it accounts for more than half of the total number of mandated benefit claims paid, represents only 13 percent of the total dollar amount of mandated benefit claims paid.

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	
	2010	2011	2010	2011
Acquired Brain Injury	0.70%	0.68%	3.41%	3.23%
AIDS, HIV, and Related Illnesses	0.70%	0.48%	6.50%	2.42%
Childhood Immunizations	20.80%	15.31%	29.57%	25.82%
Colorectal Cancer Testing	1.09%	0.81%	1.33%	2.09%
Craniofacial Surgery for Children	0.02%	0.02%	0.21%	0.24%
Diabetes Education and Supplies	0.42%	0.79%	0.41%	1.59%
Hearing Screening for Children	15.14%	10.58%	27.94%	26.22%
Mammography Screening	16.89%	13.53%	17.89%	18.48%
Oral Contraceptives*	34.84%		4.83%	
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		51.28%		13.03%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	1.12%		0.76%	
PSA Testing for Prostate Cancer	7.70%	6.10%	1.41%	1.33%
Reconstructive Breast Surgery Following a Mastectomy	0.57%	0.42%	5.68%	5.54%
Telemedicine Services	0.01%	0.02%	0.06%	0.02%
TOTAL†	**100.00%**	**100.00%**	**100.00%**	**100.00%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

†The sum of subtotals may not exactly add to the stated total due to rounding.

Individual Benefit Plans - Mandated Benefit Annual Premium Cost Estimates

As described previously for group benefit plans, TDI collected premium data from issuers for single (enrollee only) and family (enrollee and spouse plus children) coverage types, as this provides a range of premium costs. As with group premiums, TDI gave issuers flexibility in estimating the premium amount for each benefit. Overall, premium amounts trended up in 2011. As previously stated, one issuer reported high claims and premium amounts for diabetes education and supplies. Table 21 reflects these higher premium amounts.

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	
	2010	2011	2010	2011
Acquired Brain Injury	$9.56	$13.79	$23.13	$32.50
AIDS, HIV, and Related Illnesses	$3.80	$2.15	$7.14	$2.85
Childhood Immunizations	$23.02	$32.21	$47.96	$55.39
Colorectal Cancer Testing	$4.24	$7.39	$9.50	$14.96
Craniofacial Surgery for Children	$0.55	$0.82	$1.27	$1.34
Diabetes Education and Supplies	$1.20	$6.97	$3.20	$21.51
Hearing Screening for Children	$12.13	$17.46	$31.45	$34.93
Mammography Screening	$7.91	$13.78	$15.99	$21.82
Oral Contraceptives*	$5.40		$13.47	
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		$9.99		$15.66
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	$5.32		$10.01	
PSA Testing for Prostate Cancer	$1.87	$2.29	$3.83	$3.37
Reconstructive Breast Surgery Following a Mastectomy	$23.01	$9.25	$50.83	$17.84
Telemedicine Services	$0.04	$0.06	$1.08	$0.11
TOTAL	**$98.05**	**$116.16**	**$218.85**	**$222.28**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

Individual Benefit Plans - A Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Benefit in 2011

Table 22 compares average claims costs with premium figures for both single and family plans. As with group plan data in Table 12, the claims costs shown reflect the average claim amount for all individual health plan types, including single (enrollee only), enrollee and spouse, enrollee and children, and family coverage (enrollee and spouse plus children). The premium data displayed only shows single and family figures, representing the lowest and highest expected premium costs.

Table 22 - Individual Benefit Plans - A Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs for Single and Family Coverage in 2011

Mandated Benefit	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates - Single Coverage	Average Annual Premium Cost Estimates - Family Coverage
	2011	2011	2011
Acquired Brain Injury	$3.54	$13.79	$32.50
AIDS, HIV, and Related Illnesses	$2.32	$2.15	$2.85
Childhood Immunizations	$27.86	$32.21	$55.39
Colorectal Cancer Testing	$2.24	$7.39	$14.96
Craniofacial Surgery for Children	$0.26	$0.82	$1.34
Diabetes Education and Supplies	$1.71	$6.97	$21.51
Hearing Screening for Children	$28.30	$17.46	$34.93
Mammography Screening	$19.84	$13.78	$21.82
Prescription Contraceptive Drugs, Devices, and Related Services†	$14.29	$9.99	$15.66
PSA Testing for Prostate Cancer	$1.43	$2.29	$3.37
Reconstructive Breast Surgery Following a Mastectomy	$5.56	$9.25	$17.84
Telemedicine Services	$0.02	$0.06	$0.11
TOTAL	**$107.37**	**$116.16**	**$222.28**

*This figure represents all claims, including those occurring under both single and family coverage.
†2011 numbers include data previously reported under Oral Contraceptives.

Individual Benefit Plans - Mandated Benefit Administrative Cost Estimates

Issuers were required to estimate the average annual administrative cost associated with each mandated benefit. TDI did not prescribe a specific methodology since issuers calculate administrative costs differently. Table 23 displays these costs alongside the percentage that these costs represent of the total for all claims paid. From 2010 to 2011, there was an overall increase in administrative costs, as well as an increase in the percentage that these costs accounted for in relation to total claims paid.

As previously stated, one large issuer used a broader pharmacy code list for prescription contraceptive drugs, devices, and related services, which resulted in higher costs being reported for this benefit, including higher administrative costs. Table 23 reflects the impact of this higher administrative cost estimate.

Table 23 - Individual Benefit Plans Mandated Benefit Administrative Cost Estimates

Mandated Benefit	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2010	2011	2010	2011
Acquired Brain Injury	$211,791	$324,949	0.02%	0.03%
AIDS, HIV, and Related Illnesses	$642,728	$317,882	0.07%	0.03%
Childhood Immunizations	$2,767,646	$3,294,421	0.32%	0.32%
Colorectal Cancer Testing	$82,034	$169,030	0.01%	0.02%
Craniofacial Surgery for Children	$19,168	$31,847	0.00%	0.00%
Diabetes Education and Supplies	$14,023	$67,188	0.00%	0.01%
Hearing Screening for Children	$2,602,342	$3,878,392	0.30%	0.37%
Mammography Screening	$1,810,529	$2,583,983	0.21%	0.25%
Oral Contraceptives*	$435,762		0.05%	
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		$1,630,822		0.16%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	$79,375		0.01%	
PSA Testing for Prostate Cancer	$141,293	$192,689	0.02%	0.02%
Reconstructive Breast Surgery Following a Mastectomy	$348,855	$667,930	0.04%	0.06%
Telemedicine Services	$7,075	$1,901	0.00%	0.00%
TOTAL	**$9,162,621**	**$13,161,034**	**1.05%**	**1.27%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

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

Table 24 compares the administrative cost per benefit as a percentage of total claims dollars paid with the average claim cost per benefit as a percentage of total claims dollars paid. There were overall percentage increases for benefits in both categories.

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	
	2010	2011	2010	2011
Acquired Brain Injury	0.02%	0.03%	0.13%	0.13%
AIDS, HIV, and Related Illnesses	0.07%	0.03%	0.25%	0.10%
Childhood Immunizations	0.32%	0.32%	1.14%	1.07%
Colorectal Cancer Testing	0.01%	0.02%	0.05%	0.09%
Craniofacial Surgery for Children	0.00%	0.00%	0.01%	0.01%
Diabetes Education and Supplies	0.00%	0.01%	0.02%	0.07%
Hearing Screening for Children	0.30%	0.37%	1.07%	1.09%
Mammography Screening	0.21%	0.25%	0.69%	0.77%
Oral Contraceptives*	0.05%		0.19%	
Prescription Contraceptive Drugs, Devices, and Related Services – 2011*		0.16%		0.54%
Prescription Contraceptive Drugs, Devices, and Related Services – before 2011*	0.01%		0.03%	
PSA Testing for Prostate Cancer	0.02%	0.02%	0.05%	0.06%
Reconstructive Breast Surgery Following a Mastectomy	0.04%	0.06%	0.22%	0.23%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%
TOTAL	**1.05%**	**1.27%**	**3.85%**	**4.16%**

*Due to inconsistent reporting by issuers, TDI combined Oral Contraceptives and Prescription Contraceptive Drugs, Devices, and Related Services into a single category in 2011.

CONCLUSION

Data received for 2011 showed mixed changes in costs related to mandated benefits in group plans from 2010, while data for individual plans showed an overall increase in mandated benefits costs during the same period. As mentioned previously in this report, changes in how a single issuer reports its data can have a measurable impact on the aggregated numbers as a whole, particularly when the issuer makes up a significant portion of the market. In addition to usual market factors, changes in data reporting by a couple of large issuers caused aggregate data for some benefits to vary from 2010.

This report demonstrates the impact of mandated benefit provisions on claims costs and premium costs for both group and individual health benefit plans sold in Texas. The data shows that each added benefit results in some additional cost to both the issuer and the purchaser of a health benefit plan. However, as a percentage of total claims paid by issuers, the expense associated with the mandated benefits surveyed is relatively small (historically around 5 percent or lower).

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

APPENDIX: DEFINITIONS OF MANDATED BENEFITS AND MANDATED OFFERS

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, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury. Coverage may be subject to deductibles, copayments, and annual or maximum payment limits that are consistent with other similar coverage under the policy. This mandate applies to both group and individual health plans.

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

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. This mandate applies to group insurance plans and HMO benefit plans.

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

Chemical Dependency – 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 28 TAC Sections 3.8001-3.8030. This mandate applies to group insurance plans and HMO benefit plans, but does not apply to a plan issued to a small employer.

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

Childhood Immunizations – Any 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 influenzae type b: hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and rotavirus (HMO only); and 2) any other immunization that is required by law for the child. Immunizations may not be subject to a deductible or copayment requirement. This mandate applies to individual and group insurance plans and HMO benefit plans, but does not apply to plans issued to a small employer.

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

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 sigmoidoscopy performed every five years; or 2) a colonoscopy performed every 10 years. This mandate applies to individual and group insurance plans and HMO benefit plans, but does not apply to plans issued to a small employer.

Legal Basis: TIC Chapter 1363

Craniofacial Surgery for Children – A health benefit plan that provides 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.

Legal Basis: TIC Section 1367.153

Diabetes Education and Supplies – Any HMO plan or accident and health policy providing 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 28 TAC Sections 21.2601-21.2606, Subchapter R. This mandate applies to individual and group insurance plans and HMO benefit plans. This mandate does not apply to a plan issued to a small employer.

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

Hearing Screening for Children – Any HMO plan or accident and health policy that provides benefits for a family member of the enrollee or 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 Health and Safety Code Chapter 47; and 2) necessary follow-up care related to the screening test from birth through the date the child is 24 months old. Benefits may be subject to copayment and coinsurance requirements, but may not be subject to a deductible requirement or dollar limits. The EOC or policy must state these limitations. This mandate applies to both individual and group insurance policies and HMO plans. This mandate does not apply to a plan issued to a small employer.

Legal Basis: TIC Section 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. This mandate applies to both individual and group insurance plans and HMO plans.

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

Nutritional Supplements for PKU and Other Heritable Diseases – Any HMO plan or accident and health policy that provides benefits for prescription drugs must include dietary formulas for the treatment of PKU or other heritable diseases. This mandate applies to group insurance policies and HMO plans.

Legal Basis: TIC Chapter 1359

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

Legal Basis: TIC Chapter 1361; 28 TAC Section 11.509(4)

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

Legal Basis: TIC Section 1369.104; 28 TAC Section 21.404

PSA Testing for Prostate Cancer – An HMO plan or accident and health policy 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. This mandate applies to both individual and group accident and health policies and HMO plans, but does not apply to a benefit plan issued to a small employer.

Legal Basis: TIC Section 1362.003

Psychiatric Day Treatment – An HMO plan or accident and health policy 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 may select an alternate level of benefits, but any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that

provided for treatment in hospital facilities. This mandate applies to group accident and health policies and HMO plans.

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

Reconstructive Breast Surgery Following a Mastectomy – An HMO plan or accident and health policy 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 copayments 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 accident and health. This mandate applies to individual and group accident and health policies and HMO plans.

Legal Basis: TIC Sections 1357.003 and 1357.004; 28 TAC Section 11.508(b)(1)

Serious Mental Illness – 45 Inpatient Days and 60 Outpatient Visits – An HMO plan or accident and health policy must: a) provide coverage for not less than 45 days of inpatient treatment, and not less than 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; 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. This mandate applies to group accident and health plans and HMO plans. This mandate applies to small employer benefit plans.

Legal Basis: TIC Sections 1355.004 and 1551.205

Serious Mental Illness – Full Parity for Universities and Local Governments – HMO plans and accident and health policies 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.

Legal Basis: TIC Sections 1355.151 and1601.109

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

Legal Basis: TIC Chapter 1455; 28 TAC Section 11.1607(m)

<u>Temporomandibular Joint (TMJ) Treatment</u> – An HMO plan or accident and health policy 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. This mandate applies to both individual and group accident and health policies and HMO plans, but does not apply to a benefit plan issued to a small employer.

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

Mandated Offers

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

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

<u>Treatment of Speech or Hearing Loss</u> – An HMO plan or accident and health policy 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. This mandate applies to group accident and health policies and HMO plans.

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