Texas Mandated Benefit Cost and Utilization Summary Report

October 2009 - September 2010 Reporting Period

Texas Department of Insurance

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EXECUTIVE SUMMARY

Texas Insurance Code (TIC) 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 2009 through September 2010. It also includes revised data for the previous reporting period of October 2008 through September 2009, following the identification and correction of reporting errors.

Data was collected for both group and individual fully insured health benefit plans. Insurers with $10 million or more in annual group premiums or at least $2 million in individual premiums were required to submit data. Health Maintenance Organizations (HMOs) with at least $10 million in premiums for basic-service plans were also required to submit data. This 2010 report shows data for individual and group health benefit plans submitted by 38 health plan issuers.

2010 Highlights

Most notable in the 2010 data are overall increases in premiums for mandated benefits and offers, some of which can be explained by the inclusion of data elements that were excluded as outliers in previous years. As described in more detail below, TDI conducted a review and revision of data for 2009, which led to a similar and even more thorough review of data for 2010. While the tables comparing data for 2009 and 2010 generally reflect the expected year-to-year market fluctuations, some of the differences undoubtedly reflect the changes from the data revision process, with some issuers changing reporting methods and revising data, as well as the inclusion of data omitted as outliers in past years.

2010 Data Collection

For 2010, 51 issuers submitted responses to the data call. Following the revision of 2009 data, TDI reviewed the 2010 data to identify similar reporting discrepancies. TDI developed a comprehensive list of potentially erroneous data, and contacted issuers about reviewing their data. They either confirmed their data or responded with revised data. Prior to contacting issuers to review outlier data, TDI excluded some issuers from the data set that were not originally subject to the data call. This included issuers that were withdrawing from the market, had already withdrawn from the market, or failed to meet the requirements to be subject to the data call. TDI used data from the remaining 38 issuers to develop the 2010 tables in this report.

Data Revisions and Methodology

TDI compared data submitted for 2010 to data originally submitted for 2009 and found inconsistencies that indicated erroneous submissions for 2009. TDI contacted the issuers with inconsistent data, and they responded either to confirm the accuracy of the data originally sent or to submit revised data. In cases where they were reporting data incorrectly, TDI provided guidance to facilitate accurate reporting. All tables in this report displaying 2009 data reflect these revisions, with the revised 2009 data superseding and replacing the 2009 data originally published in the Texas Mandated Benefit Cost and Utilization Summary Report for the October 2008 - September 2009 Reporting Period.

Group Benefits Summary

Table 1 demonstrates the overall trends in mandated benefits and offers for group plans. For mandated benefits, the number of claims and the total dollar amount of those claims fell from 2009. This may be due in part to the number of issuers that had withdrawn from the market, or were withdrawing from the market. For mandated offers, the number of claims paid fell, but the dollar value paid for those claims increased slightly from 2009.

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

	2009	2010	% Change
Overall Group Accident and Health Data			
Total Premiums Written	$11,640,403,068	$11,148,642,478	-4.22%
Total Claims Paid	$9,669,087,885	$9,238,961,621	-4.45%
Mandated Benefit Data*			
Total Mandated Benefit Claims Paid	$479,884,791	$458,935,664	-4.37%
Number of Mandated Benefit Claims Paid	3,254,491	2,971,362	-8.70%
Mandated Benefit Costs as a Percentage of Total Claims Paid	4.96%	4.97%	0.20%
Mandated Benefit Costs as a Percentage of Total Premiums Written	4.12%	4.12%	0.00%
Average Annual Premium Cost Estimate of Mandated Benefits - Single (usually employee only) Coverage	$183.19	$233.98	27.73%
Average Annual Premium Cost Estimate of Mandated Benefits - Family (employee, spouse, and children) Coverage	$414.06	$504.33	21.80%
Total Estimated Administrative Costs for Mandated Benefits	$69,136,204	$74,792,248	8.18%
Mandated Benefit Administrative Costs as a Percentage of Total Claims Paid	0.72%	0.81%	12.50%
Mandated Offer Data**			
Total Mandated Offer Claims Paid	$10,532,626	$10,673,740	1.34%
Number of Mandated Offer Claims Paid	99,463	94,124	-5.37%
Mandated Offer Costs as a Percentage of Total Claims Paid	0.11%	0.12%	9.09%
Mandated Offer Costs as a Percentage of Total Premiums Written	0.09%	0.10%	11.11%
Average Annual Premium Cost Estimate of Mandated Offers - Single (usually employee only) Coverage	$7.26	$15.62	115.15%
Average Annual Premium Cost Estimate of Mandated Offers - Family (employee, spouse, and children) Coverage	$15.71	$22.98	46.28%
Total Estimate Administrative Costs for Mandated Offers	$1,563,707	$1,233,545	-21.11%
Mandated Offer Administrative Costs as a Percentage of Total Claims Paid	0.02%	0.01%	-50.00%

*Represents 20 mandated benefits for which data was collected.

**Represents 2 mandated offers for which data was collected.

As shown in Table 1, the combined average premiums for all mandated benefits increased more than 20 percent for both single coverage and family coverage. Some issuers reported comparatively high average premiums for a few mandates in both single and family plans. After contacting these issuers to review these numbers, they confirmed their submissions. TDI's inclusion of these figures in the data set, rather than omitting them as outliers, resulted in a higher overall average premium amount for some benefits. Mandated offers saw an even greater average premium increase, more than doubling for single plans. While the data provided for mandated offers reflects both normal market fluctuation and data revision, the acceptance of the offered benefits is voluntary and may be additionally subject to antiselection influence.

Individual Benefits Summary

Table 2 summarizes the mandated benefits data for individual plans, which, like group plans, had higher average premium amounts in 2010. Again, a significant factor contributing to the increase in premiums for individual plans was data revision, as well as TDI including data excluded as outliers in previous years. An additional factor unique to the individual market is that coverage is underwritten, and health plan issuers may choose to decline to provide coverage, resulting in lower claims figures.

Table 2 – Overview of Individual Mandated Benefit Plans

	2009	2010	% Change
Overall Individual Accident and Health Data			
Total Premiums Written	$1,416,123,543	$1,361,682,171	-3.84%
Total Claims Paid	$1,176,946,234	$869,081,459	-26.16%
Mandated Benefit Data*			
Total Mandated Benefit Claims Paid	$33,248,813	$33,429,144	0.54%
Number of Mandated Benefit Claims Paid	392,515	364,594	-7.11%
Mandated Benefit Costs as a Percentage of Total Claims Paid	2.83%	3.85%	36.04%
Mandated Benefit Costs as a Percentage of Total Premiums Written	2.35%	2.45%	4.26%
Average Annual Premium Cost Estimate of Mandated Benefits - Single Coverage	$76.88	$98.46	28.07%
Average Annual Premium Cost Estimate of Mandated Benefits - Family Coverage	$152.91	$218.85	43.12%
Total Estimated Administrative Costs	$10,527,873	$9,162,621	-12.97%
Administrative Costs as a Percentage of Total Claims Paid	0.89%	1.05%	17.98%

*Represents 13 mandated benefits for which data was collected.

SURVEY OVERVIEW

Governing Statutes

TIC Chapter 38, Subchapter F, requires TDI to 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 (TAC) Chapter 21, Subchapter Z, contains rules addressing the reporting of mandated benefits and offers. Under these rules, health insurers and HMOs are required to submit mandated benefit premium and claims data annually in an electronic format developed by TDI. Insurers must submit data for group policies if they report $10 million or more in direct premiums in Texas for group accident and health insurance policies on their most recent annual statement. An insurer must also submit data for individual policies if 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. By statute, TDI cannot require issuers to report data that might lead to the identification of individual enrollees, or that would violate confidentiality laws applicable to an enrollee.

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 make 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 insurer 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. For example, one mandated benefit requires plans that cover children to cover any newborn child that has health problems on the same basis as any healthy newborn child. In other words, the issuer 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. This list would vary among issuers, depending on the seriousness of the medical condition, the child's prognosis, and the issuer's underwriting requirements for various conditions. In addition, the issuer must continue to provide coverage for as long as the child 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 26. Consequently, issuers cover newborns whether they are born healthy or with medical problems, making it impossible for issuers to identify those individuals who are covered under this particular mandated benefit provision, and to identify which of the services they received due

specifically to the mandated benefit requirement. As a result, the reporting rule requires issuers to submit data for those mandated benefits and offers that are more measurable. 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
- oral contraceptives (if prescription drugs are covered)
- 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 – limited to 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 some benefits be offered 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 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.

Additionally, issuers are required to report enrollment, as well as total premium and total claims data 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 health plan 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 may 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 higher claims costs being reported. 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 does not audit the data reported by issuers. While issuers are responsible for assuring that the information they report is accurate and complete, TDI normally reviews data submitted by issuers to identify extreme data anomalies and outliers suggesting data collection or entry errors. TDI then contacts issuers submitting questionable data to verify the accuracy of the information and correct any errors. Substantial differences between data reported for 2009 and 2010 resulted in TDI contacting issuers for additional review of 2009 data in order to correct inaccurate data. Following the collection and evaluation of revised 2009 data, TDI conducted an extensive analysis of data submitted for 2010 and coordinated with the issuers to provide for a close review of all identified outliers.

GROUP COVERAGE TABLES

Group Benefit Plans - Mandated Benefit Claims Costs

Claims data reported to TDI for 2010 was generally consistent with data reported for 2009. However, due to changes in federal parity requirements for serious mental illness, some issuers changed how they reported serious mental illness data in 2010. Data reported shows that each mandated benefit accounts for less than one percent of the total claims cost, as illustrated by Table 3. Claims paid for psychiatric day treatment represented the highest percentage of claims dollars at 0.60 percent of total claims paid, while claims for nutritional supplements for PKU and other heritable diseases and telemedicine services had the lowest costs, with both having less than 0.01 percent of total claims paid.

Table 3 – Group Benefit Plans – Mandated Benefit Claims Costs

Mandated Benefit	Dollar Amount of Mandated Benefit Claims Paid		Claims as a Percentage of Total Claims Paid	
	2009	2010	2009	2010
Acquired Brain Injury	$31,624,562	$30,237,711	0.33%	0.33%
AIDS, HIV, and Related Illnesses	$33,480,516	$28,550,718	0.35%	0.31%
Chemical Dependency	$24,709,543	$26,734,270	0.26%	0.29%
Childhood Immunizations	$36,122,410	$37,211,159	0.37%	0.40%
Colorectal Cancer Testing	$35,120,987	$28,396,192	0.36%	0.31%
Craniofacial Surgery for Children	$1,375,978	$1,223,175	0.01%	0.01%
Diabetes Education and Supplies	$54,106,920	$53,615,937	0.56%	0.58%
Hearing Screening for Children	$43,471,717	$41,789,836	0.45%	0.45%
Mammography Screening	$38,596,728	$39,488,245	0.40%	0.43%
Nutrition Supplements for PKU and Other Heritable Diseases	$169,561	$357,053	0.00%	0.00%
Oral Contraceptives	$20,317,933	$20,554,352	0.21%	0.22%
Osteoporosis Detection	$3,152,221	$2,658,547	0.03%	0.03%
Prescription Contraceptive Drugs, Devices, and Related Services	$10,005,597	$7,528,849	0.10%	0.08%
PSA Testing for Prostate Cancer	$6,944,298	$6,597,843	0.07%	0.07%
Psychiatric Day Treatment	$66,029,936	$55,303,364	0.68%	0.60%
Reconstructive Breast Surgery	$24,851,314	$27,282,971	0.26%	0.30%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	$41,505,750	$30,725,056	0.43%	0.33%
Serious Mental Illness - Full Parity for Universities and Local Governments	$5,718,422	$18,578,487	0.06%	0.20%
Telemedicine Services	$117,468	$172,129	0.00%	0.00%
TMJ Treatment	$2,462,931	$1,929,770	0.03%	0.02%
TOTAL*	**$479,884,792**	**$458,935,664**	**4.96%**	**4.97%**

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

The dollar amounts paid for mandated offer claims changed minimally from 2009 to 2010, with in vitro fertilization claims increasing slightly and treatment of speech or hearing loss decreasing slightly, as illustrated by Table 4. Combined claims for mandated offers as a percentage of total claims paid did not make much movement from 2009 to 2010, increasing from 0.11 percent of total claims paid to 0.12 percent.

Table 4 – Group Benefit Plans – Mandated Offer Claims Costs

Mandated Offer	Dollar Amount of Claims Paid		Claims as a Percentage of Total Claims Paid	
	2009	2010	2009	2010
In Vitro Fertilization	$4,482,899	$5,246,985	0.05%	0.06%
Treatment of Speech or Hearing Loss	$6,049,727	$5,426,755	0.06%	0.06%
TOTAL	**$10,532,626**	**$10,673,740**	**0.11%**	**0.12%**

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 oral contraceptives 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 2010 generally followed the same trends as 2009, with the exception of serious mental illness, which is likely due to the scope of coverage being broadened to comply with federal parity requirements.

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	
	2009	2010	2009	2010
Acquired Brain Injury	203,193	192,702	6.24%	6.49%
AIDS, HIV, and Related Illnesses	59,217	50,919	1.82%	1.71%
Chemical Dependency	27,867	31,885	0.86%	1.07%
Childhood Immunizations	335,020	284,881	10.29%	9.59%
Colorectal Cancer Testing	95,141	77,104	2.92%	2.59%
Craniofacial Surgery for Children	795	634	0.02%	0.02%
Diabetes Education and Supplies	472,782	434,799	14.53%	14.63%
Hearing Screening for Children	244,299	220,913	7.51%	7.43%
Mammography Screening	311,424	289,250	9.57%	9.73%
Nutrition Supplements for PKU and Other Heritable Diseases	879	1,923	0.03%	0.06%
Oral Contraceptives	788,271	683,724	24.22%	23.01%
Osteoporosis Detection	31,140	25,217	0.96%	0.85%
Prescription Contraceptive Drugs, Devices, and Related Services	163,827	145,966	5.03%	4.91%
PSA Testing for Prostate Cancer	184,157	177,976	5.66%	5.99%
Psychiatric Day Treatment	45,586	45,176	1.40%	1.52%
Reconstructive Breast Surgery	29,042	30,903	0.89%	1.04%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	210,004	153,690	6.45%	5.17%
Serious Mental Illness - Full Parity for Universities and Local Governments	46,913	118,273	1.44%	3.98%
Telemedicine Services	362	407	0.01%	0.01%
TMJ Treatment	4,572	5,020	0.14%	0.17%
TOTAL*	**3,254,491**	**2,971,362**	**100.00%**	**100.00%**

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

Mandated offers experienced a shift in utilization between the two offers for which data is collected, as illustrated by Table 6. While the number of in vitro fertilization claims increased from 2009 to 2010, the number of claims for treatment of speech or hearing loss decreased.

Table 6 – Group Benefit Plans – Mandated Offer Utilization

Mandated Offer	Number of Mandated Offer Claims Paid		Percentage of the Total Number of Mandated Offer Claims	
	2009	2010	2009	2010
In Vitro Fertilization	30,521	37,566	30.69%	39.91%
Treatment of Speech or Hearing Loss	68,942	56,558	69.31%	60.09%
TOTAL	**99,463**	**94,124**	**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 shown is the percentage of the number of claims incurred for each benefit in relation to the total number of claims paid for all mandated benefits (as is also illustrated in Table 5). The other view 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. For example, telemedicine services accounted for only 0.01 percent of the total number of mandated benefits claims, but it made up 0.04 percent of the total dollars paid for mandated benefits. Conversely, while oral contraceptives accounted for 23.01 percent of all mandated benefit claims, it only comprised 4.48 percent of the dollars spent.

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	
	2009	2010	2009	2010
Acquired Brain Injury	6.24%	6.49%	6.59%	6.59%
AIDS, HIV, and Related Illnesses	1.82%	1.71%	6.98%	6.22%
Chemical Dependency	0.86%	1.07%	5.15%	5.83%
Childhood Immunizations	10.29%	9.59%	7.53%	8.11%
Colorectal Cancer Testing	2.92%	2.59%	7.32%	6.19%
Craniofacial Surgery for Children	0.02%	2.00%	0.29%	0.27%
Diabetes Education and Supplies	14.53%	14.63%	11.27%	11.68%
Hearing Screening for Children	7.51%	7.43%	9.06%	9.11%
Mammography Screening	9.57%	9.73%	8.04%	8.60%
Nutrition Supplements for PKU and Other Heritable Diseases	0.03%	0.06%	0.04%	0.08%
Oral Contraceptives	24.22%	23.01%	4.23%	4.48%
Osteoporosis Detection	0.96%	0.85%	0.66%	0.58%
Prescription Contraceptive Drugs, Devices, and Related Services	5.03%	4.91%	2.08%	1.64%
PSA Testing for Prostate Cancer	5.66%	5.99%	1.45%	1.44%
Psychiatric Day Treatment	1.40%	1.52%	13.76%	12.05%
Reconstructive Breast Surgery	0.89%	1.04%	5.18%	5.94%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	6.45%	5.17%	8.65%	6.69%
Serious Mental Illness - Full Parity for Universities and Local Governments	1.44%	3.98%	1.19%	4.05%
Telemedicine Services	0.01%	0.01%	0.02%	0.04%
TMJ Treatment	0.14%	0.17%	0.51%	0.42%
TOTAL*	**100.00%**	**100.00%**	**100.00%**	**100.00%**

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

While in vitro fertilization accounted for less than 40 percent of the total claims paid for mandated offers, it made up nearly half of the claims dollars paid, as illustrated by Table 8. Treatment of speech or hearing loss made up over 60 percent of the number of mandated offer claims, but accounted for the other half of claims paid by dollar amount.

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	
	2009	2010	2009	2010
In Vitro Fertilization	30.69%	39.91%	42.56%	49.16%
Treatment of Speech or Hearing Loss	69.31%	60.09%	57.44%	50.84%
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 was later expanded to include additional benefits in 1998. Other mandated benefits were later added through subsequent legislation. Although the current reporting requirements are more extensive and include more issuers, the aggregated claims cost data has not varied much since 2001. 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 2004-2010

Mandated Benefit	Mandated Benefit Claims Costs as a Percentage of Total Claims						
	2004	2005	2006	2007	2008	2009	2010
Acquired Brain Injury	0.37%	0.19%	0.18%	0.18%	0.33%	0.33%	0.33%
AIDS, HIV, and Related Illnesses	0.19%	0.32%	0.22%	0.35%	0.61%	0.35%	0.31%
Chemical Dependency	0.21%	0.21%	0.18%	0.19%	0.20%	0.26%	0.29%
Childhood Immunizations	0.46%	0.39%	0.37%	0.41%	0.41%	0.37%	0.40%
Colorectal Cancer Testing	0.30%	0.47%	0.42%	0.45%	0.21%	0.36%	0.31%
Craniofacial Surgery for Children	0.02%	0.02%	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%
Hearing Screening for Children	0.38%	0.44%	0.41%	0.39%	0.46%	0.45%	0.45%
Mammography Screening	0.29%	0.36%	0.33%	0.34%	0.38%	0.40%	0.43%
Nutrition Supplements for PKU and Other Heritable Diseases	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%
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%
Prescription Contraceptive Drugs, Devices, and Related Services	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%
Psychiatric Day Treatment	0.08%	0.10%	0.07%	0.07%	0.06%	0.68%	0.60%
Reconstructive Breast Surgery	0.66%	0.66%	0.62%	0.60%	0.58%	0.26%	0.30%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	0.54%	0.54%	0.56%	0.49%	0.45%	0.43%	0.33%
Serious Mental Illness - Full Parity for Universities and Local Governments	0.04%	0.05%	0.04%	0.03%	0.06%	0.06%	0.20%
Telemedicine Services	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%
TOTAL*	**4.69%**	**4.92%**	**4.40%**	**4.58%**	**4.94%**	**4.96%**	**4.97%**

*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. While the two premium estimates provided show the range of costs, they do not show data for the middle cost categories. Table 10 shows that from 2009 to 2010, the premiums for most of the mandated benefits increased. As stated previously, the increase reflects market changes, but is due in part to data revisions.

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	
	2009	2010	2009	2010
Acquired Brain Injury	$13.93	$14.91	$29.95	$36.51
AIDS, HIV, and Related Illnesses	$14.04	$27.12	$13.44	$17.43
Chemical Dependency	$9.13	$13.63	$29.86	$29.39
Childhood Immunizations	$14.86	$16.34	$43.62	$45.89
Colorectal Cancer Testing	$9.66	$13.83	$21.84	$35.57
Craniofacial Surgery for Children	$1.07	$0.97	$3.16	$2.85
Diabetes Education and Supplies	$20.18	$23.84	$53.53	$61.08
Hearing Screening for Children	$15.52	$16.28	$28.84	$31.78
Mammography Screening	$13.53	$14.96	$29.91	$29.17
Nutrition Supplements for PKU and Other Heritable Diseases	$0.51	$0.50	$1.17	$1.35
Oral Contraceptives	$6.88	$7.56	$13.25	$16.78
Osteoporosis Detection	$1.89	$1.80	$2.77	$2.56
Prescription Contraceptive Drugs, Devices, and Related Services	$4.39	$4.57	$11.71	$10.05
PSA Testing for Prostate Cancer	$3.84	$5.34	$6.32	$11.08
Psychiatric Day Treatment	$3.20	$12.16	$7.56	$31.64
Reconstructive Breast Surgery	$9.62	$16.00	$22.57	$35.17
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	$28.88	$26.23	$68.70	$62.03
Serious Mental Illness - Full Parity for Universities and Local Governments	$9.36	$14.10	$21.04	$35.22
Telemedicine Services	$0.64	$0.69	$1.29	$1.48
TMJ Treatment	$2.06	$3.15	$3.53	$7.30
TOTAL	**$183.19**	**$233.98**	**$414.06**	**$504.33**

Premiums for mandated offers saw a marked increase, as illustrated by Table 11. Large increases were evident in both in vitro fertilization and treatment of speech or hearing loss. In all cases where issuers reported large average premium amounts, TDI contacted the issuers and requested additional review.

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	
	2009	2010	2009	2010
In Vitro Fertilization	$4.33	$11.17	$8.66	$10.67
Treatment of Speech or Hearing Loss	$2.93	$4.45	$7.05	$12.31
TOTAL	**$7.26**	**$15.62**	**$15.71**	**$22.98**

Group Benefit Plans - A Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Benefit in 2010

Table 12 compares each benefit's claims costs per certificate and premium figures. A certificate is a proof of insurance document that verifies coverage. A single certificate may be issued 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, 2010 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 2010

Mandated Benefit	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates - Single Coverage	Average Annual Premium Cost Estimates - Family Coverage
	2010	2010	2010
Acquired Brain Injury	$13.65	$14.91	$36.51
AIDS, HIV, and Related Illnesses	$12.89	$27.12	$17.43
Chemical Dependency	$11.88	$13.63	$29.39
Childhood Immunizations	$19.27	$16.34	$45.89
Colorectal Cancer Testing	$14.67	$13.83	$35.57
Craniofacial Surgery for Children	$0.63	$0.97	$2.85
Diabetes Education and Supplies	$24.37	$23.84	$61.08
Hearing Screening for Children	$18.90	$16.28	$31.78
Mammography Screening	$17.81	$14.96	$29.17
Nutrition Supplements for PKU and Other Inheritable Diseases	$0.16	$0.50	$1.35
Oral Contraceptives	$9.69	$7.56	$16.78
Osteoporosis Detection	$1.20	$1.80	$2.56
Prescription Contraceptive Drugs, Devices, and Related Services	$3.43	$4.57	$10.05
PSA Testing for Prostate Cancer	$2.98	$5.34	$11.08
Psychiatric Day Treatment	$32.12	$12.16	$31.64
Reconstructive Breast Surgery Following a Mastectomy	$12.31	$16.00	$34.07
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	$18.92	$26.23	$62.03
Serious Mental Illness - Full Parity for Universities and Local Governments	$27.79	$14.10	$35.22
Telemedicine Services	$0.09	$0.69	$1.48
TMJ Treatment	$0.88	$3.15	$7.30
TOTAL	**$243.65**	**$233.99**	**$503.24**

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

For mandated offers, the total average annual claim cost per certificate was $9.64, as shown in Table 13. Average annual premiums for single and family plans were $15.62 and $22.97 respectively.

Table 13 – Group Benefit Plans – A Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Offers in 2010

Mandated Offer	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates - Single Coverage	Average Annual Premium Cost Estimates - Family Coverage
	2010	2010	2010
In Vitro Fertilization	$6.24	$11.17	$10.67
Treatment of Speech or Hearing Loss	$3.40	$4.45	$12.31
TOTAL	**$9.64**	**$15.62**	**$22.97**

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

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. In considering marketing materials and policy forms, issuers were instructed to only include first-year re-printing expenses if the costs were incurred in that year.

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. Table 14 shows the total administrative costs associated with these mandated benefits increased from $69,136,204 in 2009 to $74,792,248 in 2010, resulting in a slight increase as a percentage of the total claims paid.

Table 14 – Group Benefit Plans – Mandated Benefit Administrative Cost Estimates

Mandated Benefit	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2009	2010	2009	2010
Acquired Brain Injury	$6,535,301	$6,562,201	0.07%	0.07%
AIDS, HIV, and Related Illnesses	$4,338,988	$4,040,540	0.04%	0.04%
Chemical Dependency	$4,163,885	$4,891,847	0.04%	0.05%
Childhood Immunizations	$5,395,890	$6,323,182	0.06%	0.07%
Colorectal Cancer Testing	$3,797,598	$2,990,206	0.04%	0.03%
Craniofacial Surgery for Children	$260,935	$236,393	0.00%	0.00%
Diabetes Education and Supplies	$5,976,550	$5,751,052	0.06%	0.06%
Hearing Screening for Children	$8,615,261	$8,786,242	0.09%	0.10%
Mammography Screening	$7,139,554	$7,687,680	0.07%	0.08%
Nutrition Supplements for PKU and Other Heritable Diseases	$76,451	$93,366	0.00%	0.00%
Oral Contraceptives	$2,528,300	$2,504,554	0.03%	0.03%
Osteoporosis Detection	$472,458	$413,043	0.00%	0.00%
Prescription Contraceptive Drugs, Devices, and Related Services	$1,603,425	$1,231,360	0.02%	0.01%
PSA Testing for Prostate Cancer	$1,179,727	$1,188,891	0.01%	0.01%
Psychiatric Day Treatment	$6,219,020	$9,019,788	0.06%	0.10%
Reconstructive Breast Surgery	$4,245,761	$4,929,150	0.04%	0.04%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	$5,275,897	$3,558,097	0.05%	0.03%
Serious Mental Illness - Full Parity for Universities and Local Governments	$900,233	$4,182,257	0.01%	0.04%
Telemedicine Services	$66,548	$77,777	0.00%	0.00%
TMJ Treatment	$344,422	$324,622	0.00%	0.00%
TOTAL*	**$69,136,204**	**$74,792,248**	**0.72%**	**0.76%**

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

As shown in Table 15, total administrative costs associated with mandated offers decreased from $1,563,707 in 2009 to $1,233,545 in 2010. Administrative costs as a percentage of total claims paid also saw a reduction from 0.02 percent in 2009 to 0.01 percent in 2010.

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

Mandated Offer	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2009	2010	2009	2010
In Vitro Fertilization	$512,000	$504,359	0.01%	0.00%
Treatment of Speech or Hearing Loss	$1,051,707	$729,186	0.01%	0.01%
TOTAL	**$1,563,707**	**$1,233,545**	**0.02%**	**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 administrative costs are calculated as a percentage of claims costs. This results in higher claims costs being tied to higher administrative costs. Although this is a reasonable methodology, it does not take into account that administrative costs may vary among benefits. The administrative costs depend 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. The table shows that there was little year-to-year movement outside of serious mental illness.

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	
	2009	2010	2009	2010
Acquired Brain Injury	0.07%	0.07%	0.33%	0.33%
AIDS, HIV, and Related Illnesses	0.04%	0.04%	0.35%	0.31%
Chemical Dependency	0.04%	0.05%	0.26%	0.29%
Childhood Immunizations	0.06%	0.07%	0.37%	0.40%
Colorectal Cancer Testing	0.04%	0.03%	0.36%	0.31%
Craniofacial Surgery for Children	0.00%	0.00%	0.01%	0.01%
Diabetes Education and Supplies	0.06%	0.06%	0.56%	0.58%
Hearing Screening for Children	0.09%	0.10%	0.45%	0.45%
Mammography Screening	0.07%	0.08%	0.40%	0.43%
Nutrition Supplements for PKU and Other Heritable Diseases	0.00%	0.00%	0.00%	0.00%
Oral Contraceptives	0.03%	0.03%	0.21%	0.22%
Osteoporosis Detection	0.00%	0.00%	0.03%	0.03%
Prescription Contraceptive Drugs, Devices, and Related Services	0.02%	0.01%	0.10%	0.08%
PSA Testing for Prostate Cancer	0.01%	0.01%	0.07%	0.07%
Psychiatric Day Treatment	0.06%	0.10%	0.68%	0.60%
Reconstructive Breast Surgery	0.04%	0.04%	0.26%	0.30%
Serious Mental Illness - 45 Inpatient and 60 Outpatient Days	0.05%	0.03%	0.43%	0.33%
Serious Mental Illness - Full Parity for Universities and Local Governments	0.01%	0.04%	0.06%	0.20%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%
TMJ Treatment	0.00%	0.00%	0.03%	0.02%
TOTAL*	**0.72%**	**0.76%**	**4.96%**	**4.97%**

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

As shown in Table 17, the relationship between administrative costs and claims costs as a percentage of total claims paid was nearly the same from 2009 to 2010.

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	
	2009	**2010**	**2009**	**2010**
In Vitro Fertilization	0.01%	0.01%	0.05%	0.06%
Treatment of Speech or Hearing Loss	0.01%	0.01%	0.06%	0.06%
TOTAL	**0.02%**	**0.02%**	**0.11%**	**0.12%**

INDIVIDUAL COVERAGE TABLES

Individual Benefit Plans - Mandated Benefit Claims Costs

Table 18 demonstrates that for individual plans, mandated benefits accounted for an increased portion of the total value of claims paid in 2010. While the value of claims paid for mandated benefits increased only slightly from $33,248,813 in 2009 to $33,429,144 in 2010, this is relative to the total dollar amount of all individual plan claims paid out by issuers, which decreased 26.16 percent from 2009 to 2010, as illustrated in Table 2. This resulted in roughly a 1 percent increase in the portion that mandated benefit claims represent of the total claims paid for individual plans.

Table 18 – Individual Benefit Plans – Mandated Benefit Claims Costs

Mandated Benefit	Mandated Benefit Claims Paid		Mandated Benefit Claims as a Percentage of Total Claims	
	2009	2010	2009	2010
Acquired Brain Injury	$775,246	$1,140,315	0.07%	0.13%
AIDS, HIV, and Related Illnesses	$3,039,476	$2,173,057	0.26%	0.25%
Childhood Immunizations	$11,358,726	$9,886,596	0.97%	1.14%
Colorectal Cancer Testing	$691,126	$4,444,494	0.06%	0.05%
Craniofacial Surgery for Children	$128,399	$70,866	0.01%	0.01%
Diabetes Education and Supplies	$399,967	$136,134	0.03%	0.02%
Hearing Screening for Children	$7,915,625	$9,339,211	0.67%	1.07%
Mammography Screening	$4,993,042	$5,979,958	0.42%	0.69%
Oral Contraceptives	$1,373,965	$1,613,826	0.12%	0.19%
Prescription Contraceptive Drugs, Devices, and Related Services	$622,603	$254,513	0.05%	0.03%
PSA Testing for Prostate Cancer	$484,362	$470,275	0.04%	0.05%
Reconstructive Breast Surgery	$1,446,273	$1,899,017	0.12%	0.22%
Telemedicine Services	$20,003	$20,882	0.00%	0.00%
TOTAL*	**$33,248,813**	**$33,429,144**	**2.83%**	**3.85%**

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

Individual Benefit Plans - Mandated Benefit Utilization

Table 19 shows an overall reduction in the mandated benefit utilization. As previously mentioned, oral contraceptives tend to be refilled monthly, with each refill counting as a claim filed. This benefit accounted for nearly 35 percent of all mandated benefit claims. Telemedicine accounted for the fewest claims. The largest year-to-year reduction came from prescription contraceptive drugs, devices, and related services. The reduction, in large part, resulted from an issuer that had reported significant contraceptive claims in 2009 leaving the market.

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	
	2009	2010	2009	2010
Acquired Brain Injury	2,567	2,551	0.65%	0.70%
AIDS, HIV, and Related Illnesses	4,129	2,539	1.05%	0.70%
Childhood Immunizations	93,037	75,853	23.70%	20.80%
Colorectal Cancer Testing	4,722	3,976	1.20%	1.09%
Craniofacial Surgery for Children	81	85	0.02%	0.02%
Diabetes Education and Supplies	5,835	1,523	1.49%	0.42%
Hearing Screening for Children	47,061	55,202	11.99%	15.14%
Mammography Screening	55,532	61,577	14.15%	16.89%
Oral Contraceptives	123,138	127,014	31.37%	34.84%
Prescription Contraceptive Drugs, Devices, and Related Services	25,710	4,080	6.55%	1.12%
PSA Testing for Prostate Cancer	29,102	28,086	7.41%	7.70%
Reconstructive Breast Surgery	1,587	2,078	0.40%	0.57%
Telemedicine Services	14	30	0.00%	0.01%
TOTAL*	**392,515**	**364,594**	**100.00%**	**100.00%**

*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 the mandated benefits data usage in two different ways. The first view shows the percentage of the number of claims incurred by each benefit in relation to the total number of claims paid for all mandated benefits. The second view examines the percentage of the combined dollar amount for all claims incurred by 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 of those claims. This is evidenced by oral contraceptives, which, while accounting for more than a third of the mandated benefit claims, represents less than 5 percent of the dollar amount of these 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	
	2009	2010	2009	2010
Acquired Brain Injury	0.65%	0.70%	2.33%	3.41%
AIDS, HIV, and Related Illnesses	1.05%	0.70%	9.14%	6.50%
Childhood Immunizations	23.70%	20.80%	34.16%	29.57%
Colorectal Cancer Testing	1.20%	1.09%	2.08%	1.33%
Craniofacial Surgery for Children	0.02%	0.02%	0.39%	0.21%
Diabetes Education and Supplies	1.49%	0.42%	1.20%	0.41%
Hearing Screening for Children	11.99%	15.14%	23.81%	27.94%
Mammography Screening	14.15%	16.89%	15.02%	17.89%
Oral Contraceptives	31.37%	34.84%	4.13%	4.83%
Prescription Contraceptive Drugs, Devices, and Related Services	6.55%	1.12%	1.87%	0.76%
PSA Testing for Prostate Cancer	7.41%	7.70%	1.46%	1.41%
Reconstructive Breast Surgery	0.40%	0.57%	4.35%	5.68%
Telemedicine Services	0.00%	0.01%	0.06%	0.06%
TOTAL*	**100.00%**	**100.00%**	**100.00%**	**100.00%**

*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, TDI collected premium data from the 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, issuers were given flexibility in estimating the premium amount for each benefit. Generally, premium amounts trended up in 2010, but as with other data reported for 2010, the revision process and inclusion of all data were additional factors influencing the year-to-year change in premiums for some benefits. Table 21 presents changes in premium data from 2009 to 2010.

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	
	2009	2010	2009	2010
Acquired Brain Injury	$2.74	$9.56	$5.10	$23.13
AIDS, HIV, and Related Illnesses	$2.54	$3.80	$1.26	$7.14
Childhood Immunizations	$22.59	$23.02	$44.76	$47.96
Colorectal Cancer Testing	$4.21	$4.24	$8.74	$9.50
Craniofacial Surgery for Children	$0.57	$0.55	$0.41	$1.27
Diabetes Education and Supplies	$1.84	$1.20	$4.94	$3.20
Hearing Screening for Children	$12.32	$12.13	$27.78	$31.45
Mammography Screening	$8.12	$7.91	$15.98	$15.99
Oral Contraceptives	$5.70	$5.40	$10.76	$13.47
Prescription Contraceptive Drugs, Devices, and Related Services	$8.24	$5.32	$16.73	$10.01
PSA Testing for Prostate Cancer	$1.39	$1.87	$2.49	$3.83
Reconstructive Breast Surgery	$6.44	$23.01	$13.55	$50.83
Telemedicine Services	$0.18	$0.04	$0.43	$1.08
TOTAL	**$76.88**	**$98.05**	**$152.91**	**$218.85**

Individual Benefit Plans - A Comparison of Actual Claims Costs per Certificate with Average Annual Premium Costs per Mandated Benefit in 2010

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 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 2010

Mandated Benefit	Average Annual Claim Cost Per Certificate*	Average Annual Premium Cost Estimates - Single Coverage	Average Annual Premium Cost Estimates - Family Coverage
	2010	2010	2010
Acquired Brain Injury	$3.11	$9.56	$23.13
AIDS, HIV, and Related Illnesses	$5.92	$3.80	$7.14
Childhood Immunizations	$26.94	$23.02	$47.96
Colorectal Cancer Testing	$1.21	$4.24	$9.50
Craniofacial Surgery	$0.19	$0.55	$1.27
Diabetes Education	$0.37	$1.20	$3.20
Hearing Screening	$25.44	$12.13	$31.45
Mammography Screening	$16.29	$7.91	$15.99
Oral Contraceptives	$4.41	$5.40	$13.47
Prescription Contraceptives	$0.70	$5.32	$10.01
PSA Testing for Prostate Cancer	$1.28	$1.87	$3.83
Reconstructive Breast Surgery	$5.17	$23.01	$50.83
Telemedicine Services	$0.06	$0.04	$1.08
TOTAL	**$91.09**	**$98.05**	**$218.85**

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

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 administrative costs are calculated differently among the issuers. Table 23 displays these costs alongside the percentage that these costs represent of the total for all claims paid. Notably, while the dollar amount of these costs declined in 2010, the percentage of administrative cost in relation to the total claims paid rose by about 0.16 percent. This is partly due to responding issuers reporting an overall reduction in total claims dollars paid from 2009 to 2010, as illustrated in Table 2.

Table 23 – Individual Benefit Plans – Mandated Benefit Administrative Cost Estimates

Mandated Benefit	Total Administrative Costs		Administrative Costs as a Percentage of Total Claims Paid	
	2009	2010	2009	2010
Acquired Brain Injury	$230,259	$211,791	0.02%	0.02%
AIDS, HIV, and Related Illnesses	$888,989	$642,728	0.08%	0.07%
Childhood Immunizations	$3,370,313	$2,767,646	0.29%	0.32%
Colorectal Cancer Testing	$116,039	$82,034	0.01%	0.01%
Craniofacial Surgery for Children	$30,825	$19,168	0.00%	0.00%
Diabetes Education and Supplies	$37,863	$14,023	0.00%	0.00%
Hearing Screening for Children	$2,764,148	$2,602,342	0.23%	0.30%
Mammography Screening	$1,981,422	$1,810,529	0.17%	0.21%
Oral Contraceptives	$454,679	$435,762	0.04%	0.05%
Prescription Contraceptive Drugs, Devices, and Related Services	$115,710	$79,375	0.01%	0.01%
PSA Testing for Prostate Cancer	$153,164	$141,293	0.01%	0.02%
Reconstructive Breast Surgery	$380,241	$348,855	0.03%	0.04%
Telemedicine Services	$4,221	$7,075	0.00%	0.00%
TOTAL	**$10,527,873**	**$9,162,621**	**0.89%**	**1.05%**

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 generally percentage increases for benefits in both categories, due in part to the reduced total dollar amount of all claims paid in the individual market in 2010, as illustrated in Table 2.

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	
	2009	2010	2009	2010
Acquired Brain Injury	0.02%	0.02%	0.07%	0.13%
AIDS, HIV, and Related Illnesses	0.08%	0.07%	0.26%	0.25%
Childhood Immunizations	0.29%	0.32%	0.97%	1.14%
Colorectal Cancer Testing	0.01%	0.01%	0.06%	0.05%
Craniofacial Surgery for Children	0.00%	0.00%	0.01%	0.01%
Diabetes Education and Supplies	0.00%	0.00%	0.03%	0.02%
Hearing Screening for Children	0.23%	0.30%	0.67%	1.07%
Mammography Screening	0.17%	0.21%	0.42%	0.69%
Oral Contraceptives	0.04%	0.05%	0.12%	0.19%
Prescription Contraceptive Drugs, Devices, and Related Services	0.01%	0.01%	0.05%	0.03%
PSA Testing for Prostate Cancer	0.01%	0.02%	0.04%	0.05%
Reconstructive Breast Surgery	0.03%	0.04%	0.12%	0.22%
Telemedicine Services	0.00%	0.00%	0.00%	0.00%
TOTAL*	**0.89%**	**1.05%**	**2.83%**	**3.85%**

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

CONCLUSION

Data received for 2010 generally showed an increase in premiums from 2009. For this 2010 report, TDI did not exclude any outlier data as was done in previous years. Instead, TDI contacted all issuers with outlier data to confirm or revise their data. Several high premium figures that would have been excluded in previous years were confirmed by the issuers and included in the 2010 calculations, which led to higher overall premium figures than in previous years. Other issuers submitted revised premium figures, resulting in figures that were closer to the average. The average premium figures presented in this report are the aggregate of a broad range of premium rates reported to TDI.

Another trend for 2010 was a reduction in the overall numbers of claims paid. While several issuers reduced their claims numbers during data revisions, this reduction might also be due to fewer issuers submitting data for this report compared to last year's report. A small number of issuers either withdrew or were in the process of withdrawing from the market at the time TDI reviewed 2010 figures.

This report demonstrates the impact of mandated benefit provisions on claims costs and premium costs for both group and individual insurance plans sold in Texas. The data shows 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 (currently below 5 percent).

This study does not take into account the cost savings that accompany some mandated benefits. Mandated benefits can be 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 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 Section 1352.003 and TIC Section 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. 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 3.80001-3.8030. 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 Section 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 rotavirus; 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. 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 11.506(2) and Section 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. 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 21.2601-21.2607, 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 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 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 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 and coinsurance requirements, but may not be subject to a deductible requirement or dollar limits. These limitations and requirements must be stated in the EOC or policy. 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 Chapter 11

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

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

Legal Basis: 28 TAC Section 21.404

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

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 or device approved by the United States Food and Drug Administration; or 2) an outpatient contraceptive service. Coverage for abortifacients or any other drug or device that terminates a pregnancy is not required to be covered. Any deductible, copayment, or other cost-sharing provision applicable to prescription contraceptive drugs or devices or outpatient contraceptive services may not exceed that required for other prescription drugs or devices or outpatient services covered under the benefit plan. This mandate applies to both individual and group accident and health plans and HMO plans.

Legal Basis: TIC Section 1369.104

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 or HMO plans, but does not apply to a benefit plan issued to a small employer.

Legal Basis: TIC Section 1362.003 and Section 1575.159; 28 TAC Section 11.508(a)(9)(E)

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 Sections 1355.101 – 1355.106

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

Serious Mental Illness – 45 Inpatient Days and 60 Outpatient Visits – An HMO plan or accident and health policy must a) 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. This mandate applies to group accident and health plans and HMO plans. This mandate applies to small employer benefit plans.

Legal Basis: TIC Section 1355.004 and Section 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 Section 1355.151 and Section 1601.109

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 co-payment 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 Section 1455.004; 28 TAC Section 11.1607(i), (j), and (k)

Temporomandibular Joint (TMJ) Treatment – 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

Mandated Offers

In Vitro Fertilization – 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

Treatment of Speech or Hearing Loss – 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)