Health Insurance Regulation in Texas
The Impact of Mandated Health Benefits

Texas Department of Insurance
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EXECUTIVE SUMMARY

- Increasing health insurance costs are largely dictated by increasing health care expenditures. Though significant cost increases in both areas were common during the 1980's, since 1990, the overall rate of growth in health spending has slowed significantly, largely due to managed care. However, while most categories of health care expenses have seen limited increases, some areas have experienced significant growth, including prescription drugs and home health care. In 1990, national health care expenditures totaled $699.5 billion; by 1996, health spending totaled $1.04 trillion and by 1997, the figure was nearly $1.1 trillion. By comparison, employer spending for health insurance has increased at a relatively slower rate than overall health care spending, totaling $188.6 billion in 1990 and rising to $262.7 billion in 1996.

- Employers have aggressively pursued efforts to reduce expenses for employee health insurance. Most employers have reduced insurance contributions for dependents and spouses of employees; many have also reduced payments for employee-only benefits, requiring employees to contribute larger shares towards their insurance plan. Employers have also strongly encouraged employers to enroll in managed care plans as a way of reducing overall health care costs.

- Though a number of states have collected mandated benefit cost data, the results vary significantly from state to state. Differences in mandated benefit policy provisions, disagreement on the definition of mandated benefits, varying data collection methods and dated statistical information are some of the reasons why studies reach conflicting conclusions. Researchers frequently disagree on the cost impact of mandated benefits with some estimating the costs at more than 20 percent of all claims and others estimating cost impact of less than five percent. However, many of the reports frequently cited are outdated and do not reflect changes, such as small employer market reforms and the growth of managed care, that are credited with the reduction of health insurance claims and costs.

- Insurers report they are unable to predict the cost of new mandates and many are unable to provide detailed claims data on existing mandated benefits. In the absence of reliable cost information, legislators have relied on a variety of economic and social indicators when considering the merits of mandated benefit proposals. Mandated benefit review panels have been used as a way of providing legislators with projected cost impact information; but review panels have experienced limited success due to a lack of useful data, and budget and time constraints.

- A survey of Texas insurers shows that nine mandated benefits represented 3.25 percent of all claims paid in 1996 and 3.55 percent in 1995. As a percentage of total claims, costs attributed to these nine benefits have decreased by more than half since 1992, when claims totaled 5.53 percent of all claims paid.

- Numerous studies of self-funded health plans report that most of the benefits mandated by state law are voluntarily included in self-funded plans. While there are a number of advantages and disadvantages to self-insuring, employers report they self-fund to save money, to have more control of plan benefits, and because it enables them to offer a single plan to employees in multiple states. A survey of self-funded Texas employers shows that about 15 percent self-fund specifically to avoid certain mandated benefits. However, the vast majority of employers reported they include all the Texas mandates in their benefit plans.

- Texas has the highest uninsured population rate in the country; in 1997, 24.5 percent of Texans were without health insurance compared to a national average of 16.1 percent. Individuals who are most likely to be uninsured include young adults between the ages of 18-24; persons of Hispanic origin; individuals with lower levels of education; part-time workers; and persons not born in the United States. Most uninsured people work full-time, but some industries are less likely than others to provide insurance. In Texas, workers are most likely to be uninsured if they work in personal services businesses (57.3% are uninsured), agriculture (47.6%) or construction (44.3%). Many employers do not offer health insurance benefits to low income workers, seasonal or part-time employees, or workers in jobs with high-turnover rates.

- A number of studies conclude that factors other than mandated benefits are mainly responsible for increasing uninsured rates. There does not appear to be any correlation between premium costs and uninsured rates, or between prevalence of mandated benefits and uninsured rates (i.e., states with a high number of mandated benefits do not have higher uninsured rates than states with a low number of mandates).

- Small employer insurance reforms have met with limited success in most states. However, Texas data shows that the number of small employers with insurance has more than doubled since the first reforms were enacted in 1993. Employers have generally not chosen plans that exclude most mandated benefits, but have instead opted to purchase the full-coverage plans sold to large employers. Research indicates that premium reduction attributed to small employer insurance reforms are primarily due to increased deductible and coinsurance contributions and limits on hospital and doctor benefits, not elimination of mandated benefits.

- Attempts in other states to develop subsidy programs for uninsured citizens have met with varying degrees of success. Studies show that, in order to reach the most number of people, subsidies must be substantial. When premium costs are one percent of income, 57 percent of eligible participants will enroll; but when premium costs increase to five percent of income, enrollment drops to only 18 percent.

- Mandated benefit review panels have been widely supported by insurers as a way of measuring cost impact of newly proposed mandated benefits. Other factors must also be considered in order to judge the relative merits of proposed benefits. Efforts to base health care decisions solely on cost are unrealistic and have proven very unpopular in some cases. While cost-effectiveness studies provide useful information in some cases, cost alone should not be the determining factor.

INTRODUCTION

In recent years, access to affordable health care has emerged as a leading concern for both federal and state policymakers. Nowhere is that concern any greater than in Texas. With the highest percentage of uninsured state residents in the country, our state faces a crisis that continues to get worse, despite efforts to reach the uninsured. Recent estimates of significant increases in health insurance costs will likely place the cost of insurance beyond the reach of even more employers and individuals, creating an even larger number of uninsured Texans.

As one of the primary payers of health care insurance in this country, increasing costs are particularly troublesome for employers. Both employers and insurers claim that mandated health insurance benefits are a primary contributor to rising insurance costs and have suggested that the financial impact of such requirements on health insurance costs must be a primary consideration when debating legislative proposals that add new benefits. Although numerous studies have been conducted on the cost and consequences of mandated benefits, the findings are often conflicting and confusing. Insurers generally maintain that data is not available, making it difficult to determine the significance of costs associated with specific benefits.

This report is intended to address some of these questions by providing timely information on mandated benefits in Texas and how they affect the health insurance market. Every effort has been made to provide the most recent data available; where appropriate, outdated information that does not accurately reflect recent insurance market conditions has intentionally been omitted. Information is provided on the cost of specific mandated benefits as reported by insurers in Texas. Information is also included on the self-funded market and how mandated benefits influence employers' decision to self-insure. While this report certainly does not answer all the questions about mandated benefits, it does provide some insight into current market conditions and the relationship between mandated benefits and the uninsured.

CHAPTER ONE
HEALTH INSURANCE COSTS AND MARKET REFORMS

Health Insurance Costs – A Review of Market Conditions

Unlike other countries that use strict regulations to control both the provision and cost of health care, the United States has traditionally relied primarily on market forces and competition. The result is a health care system that provides perhaps the highest quality of health care in the world but is also one of the most expensive. As illustrated in Table 1-1, 1990 national health care expenditures totaled $699.5 billion, or 12.2 percent of the Gross Domestic Product (GDP). By 1997, health care spending reached nearly $1.1 trillion; this figure represents 13.5 percent of the GDP, down slightly from the previous three years. Recent estimates predict health care costs will double during the next decade to about $2.1 trillion by 2007. Health care costs will then represent about 16.6 percent of the GDP. Because more than half of all Americans receive health care benefits through employment-based insurance plans, these cost increases are of concern not only to government officials responsible for public health care programs such as Medicare and Medicaid, but also to employers who purchase health insurance for their employees.

Analysts point out that the pace of health spending increases has steadily slowed since 1990. Between 1960 and 1990, health care expenditures increased an average of more than 10 percent per-year. Since 1990, the rate of growth has slowed significantly, down to only 4.9 percent in 1995 and 1996 and 4.8 percent in 1997 (Table 1-2). This trend is attributed to several factors: the movement of insureds to managed care; low general and medical inflation; and increased competition among providers as a result of excess capacity.[1] Private payers (insurers and individuals) continued to fund the majority of costs at 53.6 percent of health care expenses in 1997, down from 59.9 percent in 1990. However, public programs continued to pay an increasing proportion of health expenses funding 46.4 percent, up from 40.5 percent in 1990.

Economists with the Health Care Financing Administration segregate increasing health care costs into three measurable factors: economy-wide inflation as measured by the GDP price index, specific medical cost inflation that is in addition to the overall inflation index ("excess" medical inflation), and changes in the utilization of medical services.[2] Spending for hospital and physician services generally accounts for most personal health care expenses, but in recent years the percentage being spent on these services has declined in relation to other expenses (Tables 1-1 and 1-2). From 1995 through 1997, costs paid for hospital services increased a total of 10.2 percent and physician services increased by 12 percent. Managed care is largely credited for the slowed growth in both areas. Insurers have developed incentives for providers to choose less expensive treatment in ambulatory settings when possible and have closely monitored in-patient lengths of stay in an effort to curb hospital expenses. Since 1990, hospital admissions per capita have declined by six percent and inpatient days in community hospitals have dropped by 16 percent.[3]

Home health care expenditures represent one of the fastest growing categories of health care costs, but have leveled off considerably over the past three years. Between 1970 and 1980, home

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[1] Levit, Katharine, Cathy Cowan, Bradley Braden, Jean Stiller, Arthur Sensenig, and Helen Lazenby, "National Health Expenditures in 1997: More Slow Growth," *Health Affairs*, November/December 1998: 99-110.
[2] Ibid, p.100.
[3] American Hospital Association, National Hospital Panel Survey, various years.

health care costs grew from $0.2 billion to $2.4 billion. Costs continued to grow at a slightly lower rate over the next 10 years, reaching $13.1 billion in 1990. By 1997, home health care costs had again more than doubled, totaling $32.2 billion. The recent slowdown in the annual growth rate of these expenses (spending growth increased only 3.7 percent in 1997, down from 28.2 percent in 1990) is attributed to Medicare cost controls and fraud-and-abuse detection activities. Medicare finances about 40 percent of all home health services; Medicaid financed an additional 14.7 percent while private sources paid for 45.5 percent.[4]

Spending for physician services totaled $218 billion in 1997, increasing 4.4 percent from the previous year. Managed care is again responsible for the slow growth; 92 percent of physicians had managed care contracts in 1997 compared to 88 percent in 1996. Average annual net income growth for physicians dropped from 7.2 percent for 1986-1992 to 1.7 percent for 1993-1996.[5]

Payments for prescription drugs are currently the fastest growing category of medical expenditures. Total dollars spent for prescription drugs more than doubled between 1990 and 1997, from $37.7 billion to $78.9 billion. Over the past three years, annual spending has increased at double-digit rates: 10.6 percent in 1995, 13.2 percent in 1996, and 14.1 percent in 1997. Drug costs accounted for 6.14 percent of all personal health care expenditures in 1990 but increased to 8.15 percent in 1997. Analysts suggest that one of the most significant reasons for the increased growth in prescription spending is change in the sources of payment. Only ten years ago, out-of-pocket consumer payments accounted for about 51 percent of total drug spending. However, in 1997, third-party payers (insurers, Medicare, Medicaid, etc.) funded 71 percent of payments. Growth in managed care plans that require a small copayment per prescription is largely responsible for this financing switch.

In addition, the number of prescriptions dispensed also increased significantly. Historical data shows an average 2.0 percent annual increase in the number of drugs sold; increases of 6.0 percent in 1995 and 4.2 percent in both 1996 and 1997 are well above normal. Some increases in drug use are due to the record number of new drugs approved by the Food and Drug Administration (FDA) over the last two years. Fifty-three new drugs were approved in 1996 and 39 in 1997. New drugs are generally sold at higher prices compared to existing drugs. Though new drugs released after 1992 represented only 16.8 percent of 1997 utilization, they accounted for 30.6 percent of prescription drug costs.[6]

[4] Levit, et al.; p. 103.
[5] Ibid, p.103.
[6] Ibid, p.105.

Table 1–1
National Health Expenditures for Selected Calendar Years 1960-1997

Spending Category	1960	1970	1980	1990	1994	1995	1996	1997
Total National Health Expenditures (Billions)	$26.9	$73.2	$247.3	$699.4	$947.7	$993.7	$1,042.5	$1,092.4
HEALTH SERVICES AND SUPPLIES:	**25.2**	**67.9**	**235.6**	**674.8**	**917.2**	**963.1**	**1,010.6**	**1,057.5**
Personal Health Care	23.6	63.8	217.0	614.7	834.0	879.3	924.0	969.0
Hospital Care	9.3	28.0	102.7	256.4	335.7	347.2	360.8	371.1
Physician Services	5.3	13.6	45.2	146.3	193.0	201.9	208.5	217.6
Dental Services	2.0	4.7	13.3	31.6	42.4	45.0	47.5	50.6
Other Professnl. Srvcs.	0.6	1.4	6.4	34.7	49.6	53.6	57.5	61.9
Home Health Care	0.1	0.2	2.4	13.1	26.2	29.1	31.2	32.3
Prescription Drugs	2.7	5.5	12.0	37.7	55.2	61.1	69.1	78.9
Other Medical Non-Durables	1.5	3.3	9.6	22.2	26.4	27.8	29.2	59.2
Vision Products & Other Durables	0.6	1.6	3.8	10.5	12.5	13.1	13.4	13.9
Nursing Home Care*	0.8	4.2	17.6	50.9	71.1	75.5	79.4	82.8
Other Personal Hlth. Care	0.7	1.3	4.0	11.2	21.9	25.1	27.4	29.9
Program Administration And Net Cost of Private Health Insurance	1.2	2.7	11.9	40.5	55.1	53.3	52.5	50.0
Govt. Public Health Activities	0.4	1.3	6.7	19.6	28.2	30.4	34.0	38.5
Research and Construction (Billions)	1.7	5.3	11.6	24.5	30.5	30.6	32.0	34.9
Research**	0.7	2.0	5.5	12.2	15.9	16.7	17.2	18.0
Construction	1.0	3.4	6.2	12.3	14.6	13.9	14.8	16.9
National Health Expenditures Per Capita (Dollars)	$141	$341	$1,052	$2,690	$3,500	$3,637	$3,781	$3,925
Population (Millions)	190	215	235	260	271	273	276	278
National Health Expenditures As Percentage of GDP	5.1%	7.1%	8.9%	12.2%	13.6%	13.7%	13.6%	13.5%

Sources: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group: U.S. Department of Commerce, Bureau of Economic Analysis; and the Social Security Administration

*Freestanding facilities only. Additional services are provided in hospital facilities and are counted as hospital care.

** Research and development expenditures of drug companies and other manufacturers of medical equipment and supplies are excluded from "research expenditures and are included in the category in which the product falls.

Table 1-2
National Health Expenditures Average Annual Growth From Prior Year Shown - Selected Calendar Years 1960-1997

Spending Category	1970	1980	1990	1994	1995	1996	1997
Total National Health Expenditures	10.6%	12.9%	11.0%	7.9%	4.9%	4.9%	4.8%
Health Services and Supplies	10.4	13.3	11.1	8.0	5.0	4.9	4.6
Personal Health Care	10.5	13.0	11.0	7.9	5.4	5.1	4.9
Hospital Care	11.7	13.9	9.6	7.0	3.4	3.9	2.9
Physician Services	9.9	12.8	12.5	7.2	4.6	3.3	4.4
Dental Services	9.1	11.1	9.0	7.7	6.1	5.6	6.5
Other Professnl. Srvcs.	8.8	16.3	18.5	9.4	8.1	7.2	7.7
Home Health Care	14.5	26.9	18.6	18.9	11.0	7.1	3.7
Drugs and Other Medical Nondurables	7.6	9.4	10.7	8.0	9.0	10.6	10.7
Prescription Drugs	7.5	8.2	12.1	10.0	10.6	13.2	14.1
Vision Products and Other Medical Non-Durables	9.6	8.8	10.7	4.5	4.9	2.3	3.6
Nursing Home Care*	17.4	15.4	11.2	8.7	6.2	5.2	4.3
Other Personal Health Care	6.5	12.0	10.8	18.2	14.5	9.5	9.0
Program Administration and Net Cost of Private Health Insurance	8.9	15.9	13.1	8.0	-3.2	-1.5	-4.8
Government Public Health Activities	13.9	17.5	11.3	9.5	8.0	11.9	13.1
Research and Construction	12.2	8.1	7.7	5.6	0.5	4.3	9.2
Research**	10.9	10.8	8.4	6.8	5.2	2.6	4.7
Construction	12.9	6.2	7.1	4.4	-4.6	6.3	14.3
National Health Expenditures Per Capita	9.2	11.9	9.8	6.8	3.9	4.0	3.8
GDP	7.0	10.4	7.5	4.9	4.6	5.4	5.9

Source: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis

The increases in health care costs as summarized above are directly responsible for a large portion of the growth of insurance premium costs and claims payments. Because employers fund the majority of these insurance costs, they have become increasingly concerned over rising insurance expenses and have been one of the primary drivers behind the shift towards managed care and cost utilization controls. Employers have generally supported the provision of health insurance for their employees because it contributes to both their health and financial security, which in turn directly benefits the employer. Today employment-based health insurance plans provide coverage to nearly two-thirds of the non-elderly population. About 34 percent of individuals age 65 and older also have some type of health insurance (usually in the form of Medicare supplement protection) as a condition of their retirement.[7] In Texas, an estimated 10 million citizens are covered under insurance plans provided as a benefit by employers.

The growth of employment based health coverage dates back more than 50 years. During World War II, employers used health insurance benefits to entice new employees during a period when available workers were scarce. Since wage increases were frozen by the National War Labor Board, employers began offering comprehensive health insurance coverage in lieu of increased wages. Whereas only 32 million people were covered by private health insurance in 1940 (less than 10 percent of the population), by 1950, 77 million had coverage.[8] In 1987, a total of 162.8 million Americans (76 percent of the population) had private insurance; 148.5 million (69 percent) received that coverage as a benefit of employment.

However, between 1987 and 1993, the percentage of people with employment-based insurance declined from 69 percent to 63.5 percent. While that number has been on the upswing in recent years, this decrease caught the attention of federal, state and local officials concerned with an increasing population of uninsured residents who turn to publicly financed health care systems when they are ill. While a number of factors are responsible for the decreasing coverage, the most significant cause is cost.

From the late 1980s through 1994, the cost of employment based health insurance increased considerably. As shown in Table 1-3 employer spending for health insurance more than doubled over a ten year period, increasing from $61 billion in 1980 (representing 1.2 percent of the GDP) to $188.6 billion in 1990 (2.8 percent of the GDP). From 1990 through 1996, employer spending for health care leveled off somewhat, showing relatively smaller increases. For the past three years, the cost of employer based coverage has risen an average of 1.6 percent per year. The real effect of these increases has been minimal considering other economic factors. During this same time, the slowdown in inflation has resulted in record profits, soaring stock market prices, a growing labor force, and growing inflation-adjusted earnings for workers.[9]

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[7] Fronstin, Paul. "Features of Employment Based Health Plans." *EBRI Issue Brief No. 201*, Employee Benefit Research Institute, September 1998.

[8] Health Insurance Association of America. *Source Book of Health Insurance Data, 1996*. Washington, D.C., Health Insurance Association of America, 1996.

[9] *Health Benefits in 1997*. KPMG Peat Marwick Survey of Employer-Sponsored Health Benefits, 1997. KPMG Peat Marwick, June 1998, p. 14.

Table 1-3
Employer Spending for Health Insurance

Year	Employer Spending On Health Insurance ($Billions)	Employer Spending as a Percentage of Total Compensation	Employer Spending as a Percentage of GDP
1959	$ 3.0	1.1%	Unavail.
1960	3.4	1.1	0.1%
1970	12.1	2.0	0.3
1980	61.0	3.7	1.2
1990	188.6	6.2	2.8
1991	205.4	5.9	3.1
1992	228.8	6.3	3.4
1993	249.6	6.6	3.6
1994	259.8	6.5	3.6
1995	256.7	6.1	3.5
1996	262.7	5.9	3.4

Source: Employee Benefit Research Institute tabulations based on U.S. Department Of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, August 1997, US Government Printing Office, 1996; and *The National Income and Product Accounts of The United States: Statistical Supplement 1929-1994*. U.S. Government Printing Office, 1998.

Countless committees, task forces and working groups have examined the forces affecting health care costs in recent years and many innovative recommendations and programs have been implemented as a result. Managed care in the form of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) has been particularly effective in controlling cost increases. As indicated in Table 1-4 the average health plan costs for HMOs and PPOs is generally lower than traditional indemnity plans. In fact data from the last four years shows that managed care premiums have even slightly decreased in some cases, evidence of the fierce competition between health plans anxious to increase their enrollment. Between 1994 and 1997, the average annual cost of an HMO plan dropped from $3,487 to $3,307.

Unfortunately the same market competition factors that resulted in lower insurance rates for HMO members are at least partly to blame for the considerable rate increases expected in Texas within the next year. In an attempt to attract new members, many HMOs priced their products too low in 1997 and 1998. Coupled with increasing health

Table 1-4
Average Annual Health Plan Costs By Plan Type
National Data: 1994-1997

Plan Type	1994	1995	1996	1997
Total Cost Per Employee	$3,741	$3,821	$3,915	$3,924
Small Employers	$3,452	$3,448	$3,380	$3,357
Large Employers	$4,040	$4,181	$4,332	$4,369
Indemnity	$3,497	$3,686	$3,928	$3,759
Health Maintenance Org.	$3,487	$3,410	$3,350	$3,307
Preferred Provider Org.	$3,334	$3,242	$3,434	$3,518
Point-of-Service Plan	$3,454	$3,572	$3,584	$3,588

Source: William M. Mercer, National Survey of Employer Sponsored Health Plans, 1997, William M. Mercer, 1998

care costs and new treatment technology, increasing prescription drug prices, and provider demands for improved compensation, managed care plans has been forced to raise rates anywhere from five to 13 percent. Smaller companies may experience even greater increases, possibly as high as 40 percent.[10]

As the primary payer of these costs, employers are understandably concerned how these increases will affect their profits and their continuing ability to provide insurance benefits. Recent studies indicate that as health insurance premium costs increase, employers begin to reevaluate their obligation to provide coverage to employees; this is particularly true of coverage extended to dependents of employees. A survey of 600 businesses found that 40 percent would prefer to pay no more than half of employee-only insurance premiums, and only a minority believed they should continue to pay the full cost of employee premiums. Of those who thought employers should be required or encouraged to provide insurance to dependents of employers, nearly half agreed that employers should contribute a smaller share for family coverage than employee-only coverage.[11]

Some benefit consultants suggest that employers are also concerned about the inequities that arise when employers pay higher premiums for employees with family coverage than for employees who insure only themselves. Companies that pay the full cost of employee health insurance premiums for both individual and family coverage are in effect providing higher benefits for employees with families than those without. As shown in Table 1-5 the cost difference between plans is considerable. And while both family and employee coverage have experienced considerable cost increases over the past 10 years, family coverage has increased at a greater rate.

Table 1-5
Average Monthly Health Insurance Premiums for Employer-Sponsored Coverage, 1989-1996

Plan Type	1989	1992	1994	1996	% Increase 1989-1996
Conventional					
Employee Only	$119	$154	$181	$174	46%
Family	$268	$384	$463	$449	68%
HMO					
Employee Only	$116	$148	$166	$157	35%
Family	$267	$377	$450	$423	58%
PPO					
Employee Only	$119	$157	$177	$181	52%
Family	$271	$412	$453	$448	65%

Source: "Employment Based Health Insurance: Costs Increase and Family Coverage Decreases," Government Accounting Office, February 1997.

This concern is partly responsible for the recent trend among employers to decrease or even discontinue payments for dependent coverage. Employees who want to continue covering family members are responsible for all or part of the premium cost above the amount for employee-only coverage. For some families, the increase in required premium contributions for family coverage has meant dropping coverage for family members. Low-income families are particularly hard-hit

[10] Ornstein, Charles, "Health insurers to increase fees in North Texas". *The Dallas Morning News*, October 13, 1998, pg. 1A.
[11] "Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases." Government Accounting Office, 1997.

by increasing premium contribution requirements. For example, employee premium costs of $150 a month represent nine percent of the gross income for a family with an annual income of $20,000. As indicated in Table 1-6 employees electing family coverage must typically pay insurance costs that are three times higher than employees with employee-only coverage.

Table 1-6
Average Annual Employee Contributions for Health Insurance, By Plan Type

Plan Type	1994	1995	1996	1997
Indemnity				
Employee Only	$468	$444	$516	$552
Family Covg.	$1,476	$1,512	$1,596	$1,692
Health Maintenance Org.				
Employee Only	$456	$456	$396	$492
Family Covg.	$1,572	$1,704	$1,596	$1,584
Preferred Provider Org.				
Employee Only	$468	$492	$492	$492
Family Covg.	$,1596	$1,824	$1,764	$1,704
Point-of-Service Plan				
Employee Only	$468	$432	$504	$504
Family Covg.	$1,608	$1,572	$1,704	$1,692

Note: "Family Coverage" includes the employee plus spouse and dependents.

Source: William M. Mercer, National Survey of Employer-Sponsored Health Plans, 1997, William M. Mercer, 1998

The growing trend among employers to drop payments for dependent coverage is believed by some to be largely responsible for the increasing number of uninsured people. While the number of adults without insurance actually decreased from 1995, the percentage of uninsured children increased from 13.8 percent to 14.8 percent. Studies suggest that the decline in coverage for children is likely due to a decline in employer-funded premium contributions for family coverage. Unable to afford the cost of continuing dependent coverage without employer assistance, many employees have no choice but to drop family benefits.

While periods of rising insurance costs tend to follow cyclical patterns of relatively high cost increases followed by price stabilization, the continued growth of the number of uninsured people has been fairly constant regardless of cost fluctuations. This is particularly alarming since insurance cost increases have been relatively low the past few years and, in some cases, have actually decreased. Addressing the needs of the uninsured population will obviously require serious consideration of the many factors that contribute to the problem. Care must also be taken to ensure that, in solving the problems of one group, harm to others is minimized.

Evolution of Mandated Benefits in Health Insurance Policies

Traditionally, regulation of health insurance has primarily been left to state governments. State involvement in health insurance activities generally began in the 1930s and was originally focused on the creation of nonprofit Blue Cross and Blue Shield plans. However, as the availability of employment-based insurance grew during and after World War II, states began to take a more active role in the regulation of health insurance. As more and more people relied on their health insurance policies for payment of their health care costs, states' regulatory involvement continued to grow. By the 1960s, health insurance plans were subject to a number of requirements intended to protect both consumers and insurers.

In an attempt to provide access to health care for the growing number of low-income citizens who could not afford or did not have access to health insurance, in 1965 Congress established the

Medicaid program. States subsequently became more conscious of the cost of health care as they took on the role of a major provider of health care services under Medicaid. As the cost of Medicaid gradually increased, concern over the uninsured also grew. Within a few years, state lawmakers began enacting the first mandated benefit requirements in an effort to expand availability of health insurance and the scope of services provided.[12]

Since the first mandated benefit legislation was considered, over one thousand separate mandated benefit legislative proposals have been considered by state legislatures. While most proposals are introduced in response to constituents' personal experiences, the underlying reasons usually share some common factors. Generally, opponents and proponents of mandates strongly disagree on most aspects concerning mandated coverage, including whether a specific coverage is appropriately covered by private insurance plans, whether there is a justified need for the coverage, and what the cost impact will be.

Despite consistent opposition to mandates by insurers and, more recently, employers, legislators have continued to address what is perceived as an absence of necessary benefits through the adoption of mandates. According to an annual survey conducted by Blue Cross and Blue Shield Association, most states have mandated coverage of about 18 specific benefits.[13] Excluding provisions requiring the offering of certain benefits, the survey shows that 16 states have enacted more than 20 mandated benefits; five states have less than 10. States with the most mandated benefits are Maryland (30), Minnesota (29) and Florida (27). At the other end, Idaho has only six mandated benefits while Delaware, Wyoming and Kentucky each have eight. These numbers include treatment and provider mandated benefits as well as requirements that insurers provide coverage for specific populations.

Regardless of the exact number of benefits, there is no question that mandated benefits have continued to proliferate, despite attempts in recent year to limit such proposals by requiring fairly extensive reviews of newly proposed benefits. Insurance benefits that have been adopted by virtually all states include preventive treatments such as mammograms, well-child care and immunizations, and coverage of mental illness and chemical dependency. Most states also have provisions requiring coverage for some types of providers (i.e., chiropractors, psychologists, optometrists) and virtually every state has enacted laws requiring minimum hospital stays following the birth of a child and for mastectomy patients.

The Social and Financial Perspectives of Mandated Benefits

Two of the most influential factors in the evolution of insurance as we know it today are changes in the cost of health care and society's view of the role of health insurance in meeting individual health care needs. While insurers and employers generally suggest that the association between the two must be separated in order to adequately address the problems of high insurance costs, attempts to do so have largely failed. This is particularly true as it applies to consideration of mandated benefits.

In establishing criteria for evaluating newly proposed mandated benefit laws, states have recognized that both social concerns and financial impact must be considered when determining

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[12] McDonnell, Ken, Paul Fronstin, Kelly Olsen, Pamela Ostuw, Jack VanDerhei, Paul Yakoboski; *EBRI Databook on Employee Benefits*. Employee Benefit Research Institute, Washington, D.C., 1997.

[13] Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 1997 Survey of Plans* . Washington, D.C., 1997.

whether a justified need exists for the creation of a new mandated benefit. While many of the early studies of mandated benefits focused exclusively on the cost of coverage, critics pointed out that decisions regarding health care should not be made based solely on cost. Other factors which are more philosophical in nature must also be considered to reach a balanced decision that is in line with how typical consumers view the provision of health care and the role of health insurance in meeting those needs.

In opposition, insurers argue that the business of health insurance is a competitive, free market enterprise motivated primarily by profit, the success of which hinges on attracting generally healthy people and excluding those people who are most likely to need medical care. Insurance was not designed to address the broader social problem of providing health care for sick people. Employers who are opposed to mandated benefits argue such requirements restrict their freedom of choice to decide which benefits they desire to provide for their employees, and impose unfair obligations on employers when they are not even required to provide insurance at all. However, some employers have welcomed government mandates as a way of guaranteeing benefits that would otherwise be unavailable or unaffordable. This is particularly true of small employers who have historically encountered serious problems obtaining comprehensive health care at prices competitive with larger employers.

While some have argued that mandates restrict the ability of insurers to respond to changing needs in the marketplace, others argue that it is because of insurers' failure to address these needs that mandated benefits are sometimes necessary. Fifteen years ago, the concept of "preventive health care" was fairly new and there was originally no widespread expectation that insurers would pay such expenses. Over time, however, the benefits of certain screening and diagnoses interventions were widely recognized by both medical providers and public health agencies as an effective way of detecting potential medical problems in early stages when treatment is less expensive and medical outcomes are more favorable. Many insurers also recognized the financial and physical benefits of good health and a few began to actively promote "healthy lifestyles" among their insureds. However, most insurers were not initially receptive to some aspects of the preventive health care movement, and resisted providing coverage for such services as mammography screening, PAP tests, immunizations for children, and annual physicals. Facing pressure from both consumers and physicians, lawmakers in many states responded by mandating coverage for these benefits. Thus, whereas ten years ago few insurance policies covered these medical treatments that were not "medically necessary" by insurers' definitions, these benefits are widely available today as a result of legislative intervention in the form of mandated benefit requirements.

These conflicts over the perceived role of insurance illustrate how societal perceptions and expectations differ among proponents and opponents of mandated benefits. Both sides have provided convincing arguments for their position, but generally lack evidence or concrete data that supports their conclusion. Failure to agree on this important issue has resulted in the adoption of specific review criteria used by various states to address questions regarding the "social impact" of mandated benefits in a more logical, objective manner. Generally these criteria identify the need or level of demand for the mandate, the financial and physical problems created for individuals not receiving the benefits, and the level of demand or public support for inclusion of the benefit. These criteria allow lawmakers to consider the broader issue of whether a mandate is in the best interest of the public for reasons other than simply economic factors.

While in theory the measurement of the financial impact of mandated benefits is more simplistic than determining the social impact, in reality the financial consequences are often just as difficult to discern. Insurers usually are unable to provide data on premium costs of new mandates and

often lack the ability to collect specific claims information. And in those cases where mandated benefits are anticipated to save insurers in the long run (for example, by identifying illnesses in an earlier stage when treatment is less expensive), estimates of cost savings are virtually impossible to obtain.

In many cases, the social and financial consequences are impossible to separate, particularly when measuring accessibility and affordability. In an effort to provide access to more benefits for more people, one of the unintended consequences of mandated benefits may be that some employers or employees will drop their insurance entirely due to increases in costs as a result of the improved, but more expensive, insurance benefits. Other employers may elect to increase deductibles or coinsurance requirements, or may eliminate the contribution for dependent coverage, both of which may contribute to the growing number of people who are either uninsured or under-insured.

Aside from the obvious financial indicators of claims costs and premium charges, other financial considerations also play a significant role in determining whether a mandated benefit is desirable from a public policy perspective, particularly when a mandated benefit directly impacts government programs. This is especially true of mandates passed in an attempt to shift the burden of financing health care from the public health care system to the private sector. For example, requirements that insurers provide coverage for newborns with congenital defects and handicapped dependents who would normally lose coverage when they become adults were enacted because insurers generally excluded such individuals due to their relatively high medical costs. As a result, parents of these children were often forced to rely on public health care programs to obtain health care. There was never any question that these individuals needed treatment, but insurers understandably did not want to pay the expenses. Traditional underwriting practices that excluded these children were justified as practical business decisions.

However, as medical technology for treating these children improved rapidly during the 1960's and 70's, the cost of care also increased substantially. Pre-mature and sick babies that could not be treated five years earlier suddenly stood a good chance of survival through the use of newly developed medical techniques that carried a high price tag. Reports of hospital bills that frequently exceeded $100,000 focused both consumers' and lawmakers' attention on the need to address this growing problem. Shifting these costs to the privately financed insurance system by mandating coverage made good fiscal sense for state legislatures throughout the country and appealed to the general public's sense of fairness.

Despite insurers' arguments against the use of mandated benefits to achieve public policy goals, both state and federal lawmakers have insisted that health insurance is distinctly different from other types of insurance and is, therefore, subject to somewhat different standards of regulation. In discussing state policy on health insurance, the New York State Council on Health Care Financing noted,

> "Health insurance is not simply insurance in the conventional sense. It is fundamentally different from other types of insurance because it forms the base for allocating an essential social good and because its existence has a profound effect on the availability, costs, and use of medical services. Health insurance today is a form of social budgeting

and State policy must recognize it as such in order to better guide the medical care system and to ensure an equitable health insurance system."[14]

Balancing Adequacy of Coverage With Affordability

Concern about the adequacy of existing health insurance policies has added fuel to both sides of the debate over mandated benefits. Proponents of mandates argue that mandated benefit laws are necessary to guarantee that health plans provide at least a minimum level of coverage that will assure policyholders receive both adequate and necessary medical care that insurers otherwise would exclude. In passing new laws requiring the inclusion of certain benefits in health insurance plans, state legislators make a determination that, in theory, specific benefits are desirable and necessary and should be covered by insurers. If experience indicates that insurers are routinely excluding these benefits, mandated benefit supporters argue that they have no choice but to petition legislators to force insurers to provide these benefits, leading to the adoption of new mandated benefit laws.

Supporters of specific mandated benefit requirements argue that these actions would not be necessary if insurers provided adequate benefits that cover all medically necessary treatments.

Insurers, consumers, employers, and providers often have different ideas about what is "medically necessary." Failure to agree on this issue has resulted in several mandated benefit laws and will undoubtedly lead to future proposals, particularly as new medical treatments are discovered. One of the more recent mandated benefit laws that addresses conflicts over "medically necessary" interpretations concerns insurers' exclusions of coverage for investigational therapies. In a recent *Wall Street Journal* letter to the editor, Dr. Jane Bick blames the difficulty of enrolling participants in clinical trials on insurers' refusal to provide even routine care to patients who participate in such trials.[15] In response to an article discussing promising new cancer treatments, Dr. Bick points to a study published in the Journal of the American Medical Association citing the decline of patient participation in clinical trials. Dr. Bick points out that "most health-insurance language excludes investigational therapies and precertification people enforce those exclusions despite the fact that insurers are primary beneficiaries when new therapies reduce toxicity, minimize morbidity, shorten hospital stays and saves lives." To address this problem, Rhode Island, Georgia and Maryland have enacted laws guaranteeing that cancer patients on clinical trials continue to receive insurance coverage for routine medical costs such as doctor visits, blood tests and x-rays which would normally be covered under standard therapy.

Opponents of mandates argue that, by imposing these and other requirements on insurers, lawmakers are in effect "playing doctor" and interfering with the natural forces of free market competition by deciding who and what should be covered by private health insurance policies. In addition, by requiring the coverage of new benefits or health treatments, opponents offer convincing arguments that lawmakers are making insurance unaffordable for large numbers of people. Instead of increasing access to health insurance for more people, opponents claim that the cost of each added mandated benefit means some people will be forced to drop existing insurance coverage, leaving them completely uninsured.

Finding the balance between "adequate" health insurance coverage and affordability has been a constant struggle for regulators and policymakers. Definitions of adequacy of coverage vary widely and often depend on numerous factors that are difficult to measure. Individual incomes

[14] New York State Subcommittee on Health Insurance*, Health Insurance, Public Policy in New York.* Albany, NY, 1984, pg. 6.

[15] "Denials of Treatment Hurt Cancer Research", Wall Street Journal, May 26, 1998.

and the portion of medical care that a person can reasonably be expected to pay out-of-pocket differ considerably, even among the employees that work for the same company. An annual deductible of $1,000 or a required monthly premium contribution of $100 may be perfectly reasonable for an upper-level manager, but excessive for entry-level employees making minimum wage. Because wide differences in pay often exist among employees working for one company, providing an insurance plan that is equally "affordable" to all employees is a difficult challenge. A single health plan offered to all employees may be "adequate" for some but "inadequate" for others.

In addition, certain benefits may be both desirable and medically necessary for some employees but useless to others. Individuals who need but do not have those benefits are then "under-insured" while others covered by the same plan may have adequate coverage. Single male employees have no use for pregnancy benefits while policies that exclude such would definitely be inadequate for a large number of women. Policies with relatively low limits for the treatment of AIDS are not a problem for most Texans, but present a significant problem for an individual diagnosed with the disease. In both cases, the question of adequacy of insurance hinges largely on the needs of the individual rather than the needs of the majority.

Inadequate coverage has several undesirable and unintended consequences that sometimes result in higher medical costs. Ironically, insurance policies often cover the more expensive costs that insureds incur when they delay treatment because they cannot afford care in an earlier stage due to inadequate health insurance coverage. Numerous studies have shown that underinsured persons are less likely to seek care at early stages of illness due to high out-of-pocket costs or exclusions for certain types of screening or treatment. However, when the illness becomes more advanced and the individual is forced to seek medical care, the cost of that care is substantially higher than if the person had sought care sooner. This phenomenon is part of the reason behind the recent trend in mandating benefits for preventive care and the waiver of deductibles and copayments for certain treatments such as immunizations for children. Although insurers traditionally refused payment for such benefits, recent studies indicating improved health outcomes and long-term cost savings have convinced state legislatures across the country that mandating coverage in some cases will actually save money in the long run while at the same time improving the adequacy of health insurance protection.

Clearly there is a trade-off between balancing the adequacy of insurance coverage with the cost of coverage and the effect of these two factors on the population of people without any insurance protection. However, because of conflicting indicators, there is no methodology for determining when regulatory attempts to guarantee adequacy of coverage interfere with the equally important affordability of insurance. While everyone generally agrees that some insurance – even if inadequate – is better than no insurance, addressing both problems has become increasingly difficult. This trend is likely to continue as new technological and pharmaceutical discoveries enable physicians to treat more illnesses but at increasing costs. While no one likes to consider the prospect of "rationing" health care, particularly when life-threatening conditions exist, to some extent these choices are already being made on the basis of insurance status. Future medical advances will likely lead to proposals of more mandated benefits for new, improved treatments, forcing legislators in some cases to determine who has access to such care based on whether their insurance plan provides coverage. Access to care may eventually depend not only on who has insurance, but who has the best, most comprehensive coverage and whether that plan covers the treatment or service that is needed.

CHAPTER TWO
MANDATED BENEFITS IN TEXAS

Previous Studies of Mandated Benefits in Texas

Concern over the cost and impact of mandated benefits is not a new subject to Texas legislators. At least two previous House Insurance Committees have conducted studies of mandated benefits, prompted by concern over the rising cost of health insurance and claims that legislative insurance mandates were partly to blame. In 1984, the House Insurance Committee reviewed several studies of mandated benefits and received testimony on the cost impact, but was unable to obtain information on the cost of specific Texas mandated benefits. The committee noted that evidence did exist indicating that mandated benefits do increase the cost of insurance and recommended that the Legislature adopt guidelines for reviewing future mandated benefit proposals to determine the impact on premiums. The committee did not recommend who should conduct the analysis, but did suggest the following guidelines be used:

1. Does the proposal fill an unmet need? The issues to be considered in determining whether there is a clear unmet need include the following:

    A. What is the current geographical distribution of pertinent providers/health care personnel?
    B. What are other alternatives to meeting the identified need?
    C. How will the proposed benefit contribute to the quality of patient care and the health status of the populace?
    D. Is this a medical need or a broader social need, and does it fit in with the role of health insurance?
    E. Is proposed mandated benefit legislation advocated by providers or consumers?
    F. What evidence and /or experience in other states is there to demonstrate the likelihood of achieving the stated objectives of meeting a consumer need?
    G. How is the service currently being paid for?

2. What is the cost impact of this proposal? This must be analyzed in terms of additional premium expense to consumers and the impact on total health care expenditures:

    A. What is the projected utilization of the service to be covered by the mandated benefit over the next five years?
    B. What are the anticipated fees/rates for the next five years, and how do they compare with alternative providers?
    C. What is the estimated increase in insurance premiums for the proposed benefit over the next five years?
    D. What is the probably magnitude of the impact of the total health care expenditure?

3. Is there control of overutilization, and what is the impact on costs and fees? Changes in coverage or payment of new practitioners must be accompanied by measures to minimize unnecessary utilization and excessive growth of costs. This chiefly pertains to payment of new practitioners.

    A. How will non-physicians be reimbursed: fee-for-service, costs, or

other; and which one minimizes costs?

B. Will the appropriate professional organization maintain a registry with standards to assure a high degree of clinical proficiency?
C. Is the quality of services proposed to be offered by non-physician practitioners an acceptable substitute for, or better than, that delivered by a physician?

4. Is the mandated benefit legislation applicable to all payers, including self insurers?

5. Can the problem be solved by mandating availability of the coverage, rather than mandating inclusion of the coverage in all plans?

Despite the committee's recommendations, the Legislature declined to implement a review process. However, concern over the cost of mandated benefits remained a critical issue for insurers and some employers and, in 1988, the House Insurance Committee was directed to conduct another study of mandated benefits. The Committee looked at existing cost studies and recommendations of other states and agreed that mandated benefits increase the cost of health insurance, but again concluded that determining the actual cost is difficult due to a lack of data. The Committee acknowledged that newly proposed mandated benefits should be "vigorously and systematically reviewed" and recommended that the review guidelines proposed in the Committee's previous report to the 69th Legislature be adopted. The Committee further recommended that the following review criteria should be added in order to determine the social impact of new benefits:

1. The extent to which the treatment or service is generally utilized by a significant portion of the population.
2. The extent to which the insurance coverage is already generally available.
3. If coverage is not generally available, the extent to which the lack of coverage results in persons avoiding necessary health care treatments.

It was not until 1993 that the Legislature actually approved legislation that established evaluation procedures for both existing and newly proposed mandated benefits. The statutory review process differed significantly from that outlined above. The panel was directed to evaluate mandated benefits on the basis of cost, cost effectiveness, efficacy and necessity. The activities of the Mandated Benefit Review Panel and problems encountered during its four year existence are discussed in detail in Chapter Six.

Defining Mandated Benefits

One of the most significant areas of disagreement with regard to mandated benefits concerns defining which regulatory provisions are appropriately classified as mandated benefits. Mandates and mandated benefits are frequently discussed as major contributors to the cost of health insurance, and everyone agrees that these benefits cost money. But there is little agreement as to how much they cost and whether this cost is significant. One of the primary reasons for varying cost estimates is a lack of consensus on what is a mandated benefit.

While the terms "mandate" and "mandated benefit" may seem logically interchangeable, the two words often mean very different things to different people. When used in the general sense, the term "mandates" commonly refers to a very broad category of governmental requirements that affect any provision included in a health insurance policy. "Mandates" would include, for example, the small group health insurance reforms that limit rate increases from year to year and

require insurers to accept all applicants regardless of health condition. These types of requirements deal with policy provisions and administrative requirements and usually have some cost associated with their inclusion in health insurance policies. However, they do not mandate a specific benefit for insureds, but instead address broader underwriting and contract issues.

A more traditional approach to defining mandates limits the list to those regulations that require coverage of a specific medical condition or illness, a particular service or provider, or a particular group of people that would otherwise be excluded. This definition is consistent with that most often used by regulators. In a 1984 report by the National Association of Insurance Commissioners, mandated benefits were categorized as follows:

- Regulations requiring coverage of certain persons;
- Regulations requiring coverage of specific illnesses, procedures or types of treatment;
- Regulations mandating that care by certain providers be reimbursed if it is a covered expense when provided by a medical doctor.[16]

As defined above, mandated benefits would include, for example, those laws that guarantee coverage of newborns with congenital problems and handicapped dependents regardless of age; those that require chemical dependency treatment, mammography screening, or mental health benefits; and those requiring coverage of providers such as optometrists and podiatrists. These mandates are considered more directly tied to specific types of health benefits under the policy and are, therefore, commonly referred to as mandated benefits.

While this discussion of the difference between mandates and mandated benefits may seem rather elementary, it is important because *how* you define a mandate or mandated benefit determines how you review the costs and benefits of such provisions, and accounts for some of the huge differences in cost estimates. Studies that use the broader definition usually include the costs of government regulations that are not included in studies that use the more focused definition of "mandated benefits." Those studies that examine the cost of "mandates" as opposed to "mandated benefits" would understandably predict higher costs in association with these regulations than a study that uses the traditional, more narrow definition.

Although this report does not suggest that other types of government requirements have no cost impact, those expenses should be analyzed separately from mandated benefits.
Consistent with other states' studies of mandated benefit costs, for purposes of this report the traditional definition of mandated benefits is used. This study does not address the broader issue of the cost of government regulation in general as more accurately described by the term "mandate".

Distinctions between "mandated benefits" and "mandated offerings" are also responsible for some of the differences in cost studies of mandated benefits. Laws that offer the purchaser the option of accepting or declining the mandated benefit are referred to as "mandated offerings". By law, the insurer must *offer* the benefit, but the purchaser decides whether to accept or decline the offer. In contrast, mandated benefit laws do not allow the purchaser the option of excluding the benefit; the insurer *must* include the benefit in all applicable policies. While most studies do note the important difference between mandated benefits and mandated offerings, some cost estimates include the cost of both. Because mandated offerings are often relatively more costly than

[16] "NAIC Compendium of State Laws on Insurance Topics." Mandated Benefits Summary, National Association of Insurance Commissioners; September 1998

mandated benefits (in part due to the smaller number of people sharing the cost of such benefits), inclusion of these costs in mandated benefit studies is misleading. Studies that combine data for mandated benefits and mandated offerings will report higher costs than studies that appropriately separate costs on mandated benefits from mandated offerings.

Mandated Benefits and Coverages in Texas

Using the categories recognized by the NAIC, mandated benefits currently required in Texas group health insurance policies are outlined below. A note is included indicating those mandated benefits that do not apply to small employer plans. Please note that this information is simply a brief summary description and does not necessarily include the exact provisions or technical requirements. For a complete description of the benefit and its applicable statutory citation, please see Appendix A.

Table 2-1
Mandated Benefits Requiring Coverage of Specific Illness, Procedures or Types of Treatment

Mandated Benefit	Summary of Statute or Rule
Chemical Dependency	Requires the inclusion of benefits for the treatment of chemical dependency based on specific criteria established by TDI rule.
Complications of Pregnancy	Benefits for complications of pregnancy must be provided on the same basis as for other illnesses.
Diabetes	Policies that cover the treatment of diabetes and associated conditions must provide coverage for diabetes equipment, supplies and self-management training programs. **Small employers exempt**.
Emergency Care	Policies that include preferred provider benefits must reimburse certain emergency care services at the preferred provider level if an insured cannot reasonably reach a preferred
Immunizations	Policies that provide benefits for a family member of the insured must cover specified immunizations for Immunizations may not be subject to a deductible, copayment or coinsurance requirement. **Small employer plans are exempt**.
Mammography	Annual mammography screening for females 35 and older must be provided on the same basis as other radiological examinations.
Reconstructive Surgery for Mastectomy	Policies that provide coverage for mastectomy must provide coverage for breast reconstruction. **Small employers are exempt**.
Minimum Hospital Stay for Mastectomy or Lymph Node Dissection	Policies that provide treatment of breast cancer must cover inpatient care for at least 48 hours after a mastectomy and 24 hours after lymph node dissection unless both the patient and doctor determine a shorter stay is appropriate. **Small employers are exempt**.
Minimum Hospital Stay for Maternity	Policies providing maternity benefits must include inpatient care for mother and child for at least 48 hours following uncomplicated vaginal delivery and 96 hours after an uncomplicated C-section. Policies with in-home postdelivery care are not subject to this requirement unless medically necessary or requested by the mother.
Oral Contraceptives	Benefits for oral contraceptives must be provided when all other prescription drugs are covered.
Osteoporosis Detection and Prevention	Policies must provide benefits for medically accepted bone mass measurement to determine risk of osteoporosis when indicated for certain qualified individuals.
Phenylketonuria (PKU)	Policies that cover prescription drugs must include formulas for the treatment of PKU or other heritable diseases.
Prostate Testing (PSA)	Policies must include benefits for diagnostic tests used in the detection of prostate cancer, including physical exams and prostate-specific antigen (PSA) test. **Small employer plans are exempt**.
Serious Mental Illness	Specific benefits must be provided for the treatment of serious mental illness, including both inpatient and outpatient services.
Telemedicine	Policies may not exclude any service solely because it is provided via telemedicine. **Small employer plans are exempt.**
Temporomandibular Joint	Benefits for TMJ must be provided when treatment of skeletal joints is covered. **Note: Small Employer Plans are exempt**.

Table 2-2
Mandated Benefits Requiring Coverage of Certain Persons

Continuation of Coverage Provisions	Certain dependents must be allowed to continue coverage for a period of three years after coverage would normally be discontinued due to divorce, retirement or death of the insured. Continuation of coverage is required for six months after cessation of work during a labor dispute. Policies must provide continuation of coverage for a period of six months upon termination for any reason, except due to gross misconduct; insurers may offer a conversion policy in lieu of continuation. **NOTE:** In all cases described above, the insured is responsible for continuing payment of premiums in order for coverage to continue.
Adopted Children	Policies that provide coverage for the immediate family or children of an insured may not exclude or limit coverage for adopted children.
Certain Grandchildren	Policies that provide coverage for dependents must provide coverage for grandchildren if the children are legally dependents for federal income tax purposes.
Certain students	Policies that cover full-time students age 21 or older must provide coverage for an entire academic term, even if the child's number of hours or reduced to less than that of a full-time student. **Small employer plans are exempt.**
Medical Support Orders	Policies that provide coverage of children must allow a parent to add a child to that policy when the parent is ordered to do so under order of a court in this state, even if the parent does not have legal custody of the child.
Mentally/Physically Handicapped Children	Policies that normally discontinue coverage of children at a certain age must allow continuation of the coverage if the child is incapable of self-employment due to mental retardation or physical handicap.
Newborn Children	Policies that provide maternity coverage or dependent coverage must automatically cover newborns for the first 31 days and must continue coverage if the insured pays the required premium and provides notification of the added child within the first 31 days.
Extension of benefits for totally disabled persons	If a policy is cancelled or terminated for any reason, the insurer must extend benefits for a period of 90 days for totally disable persons; payment of premiums is required.
HIV, AIDS	Policies may not exclude or deny coverage, or cancel a policy based on a diagnosis of AIDS, HIV, or HIV-Related illness

Table 2-3
Mandated Benefits that Require Coverage of Certain Providers

Public Institutions	Policies may not exclude benefits when services are provided by tax supported institutions when services would otherwise be covered.
Psychiatric Day Treatment Facilities	Policies providing benefits for treatment of mental illness in a hospital must also include benefits for treatment in a psychiatric day treatment in lieu of hospitalization.
Chemical Dependency Treatment Facilities	Treatment of chemical dependency in a chemical dependency treatment facility must be covered on the same basis as treatment when provided in a hospital.
Alternative Providers	Policies must cover services provided by the following appropriately licensed practitioners if the benefits would normally be covered when provided by a medical doctor: podiatrist, optometrist, chiropractor, dentist, audiologist, speech-language pathologist, master social worker, dietitian, professional counselor, psychologist, marriage and family therapist, hearing aid fitter and dispenser, occupational therapist, chemical dependency counselor, physical therapist, psychological associate, advanced practice nurse, physician assistant

CHAPTER THREE
THE COST OF MANDATES

Over the years, state legislatures across the country have considered increasing numbers of proposals for mandated insurance benefits. Concern over the cost impact of these benefits and their effect on the quality of care has led to numerous studies of mandated benefits. However, these studies have generally failed to provide definitive information on the cost of mandated benefits for a number of reasons. Lack of adequate data is a primary concern. Methodology problems also raise questions about the validity of certain studies. Because there is no standard methodology for measuring mandated benefit costs, both the research methods and types of cost data reviewed vary considerably from study to study. Legislators looking for reliable cost information are often forced to wade through conflicting studies and draw their own conclusions regarding the accuracy of the information.

These differences of opinion on benefit costs persist even among nationally recognized consulting firms. As Congress recently debated various managed care reform proposals this summer, consultants studying the proposals predicted widely disparate costs. For example, a provision requiring improved access to emergency care for HMO enrollees was predicted to cost 60 cents per-person per-month by Milliman and Robertson, but only 13 cents in a study conducted by Coopers and Lybrand for the Kaiser Family Foundation. Elimination of a requirement for prior authorization for specialist referrals was estimated to cost 24 cents per-member per-month by Milliman and Robertson, but was priced at only two cents a month in the Kaiser report.

Cost predictions at the state level have been equally conflicting. Texas insurers estimating the cost of mandated benefits in Texas have reported significantly different estimates. For example, a recent news article quotes one large Texas insurer as saying mandates raise the price of insurance by as much as 20%. In the same article, another large insurer estimates the cost to be only about 2%.[17] Such wide differences of opinion only add to the confusion surrounding mandated benefits and continue to fuel the debate over the true cost of such proposals and how they affect the availability and affordability of health insurance.

Methodology and Data Availability Issues

Despite the interest in mandated benefit costs over the past 20 years, virtually every study reports two continuing problems that have been largely responsible for inconsistent results: 1) lack of reliable data and 2) difficulties in predicting future costs that are based largely on theory rather than experience. The obvious primary source of data for analyzing the cost of existing mandated benefit provisions is insurance companies. Because they process claims and determine the premiums charged for specific benefits, it is logical to assume that they can provide data on specific mandated benefits. In reality, however, insurers often insist that the information cannot be provided. Although most insurers have fairly sophisticated computer systems with large data processing capabilities, these computers are designed to process claims and provide administrative services. While theoretically the data on specific claim costs are maintained and can be retrieved, insurers report that collecting such information requires the development of specially designed computer programs that are costly and time consuming. Though many large insurers have been able to develop such programs, most smaller companies have not.

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[17] Fuquay, Jim, "HMO realities spotlighted by Kaiser's plight," *Star Telegram*, February 18, 1998; Section C, Pg. 1.

Even companies that have comprehensive claims retrieval systems in place report that information is limited to mandated benefits that are associated with a specific diagnosis or medical treatment. For example, claims costs of mandated benefits that require coverage of particular illness or medical condition (i.e., diabetes or pregnancy complications) can be determined using uniform diagnosis codes used by all insurers. However, mandated benefits that require coverage of certain groups of people or certain providers are much more difficult to track.

Other types of data are also not available. One of the most frequent criticisms of mandated benefit studies is failure to determine cost savings that insurers experience as a result of certain requirements. Since these savings offset the actual cost of the mandated benefit, this information may significantly impact the final cost. While on occasion there is medical research that provides information on the cost or cost savings of a specific medical intervention (such as immunizations or prenatal care), most mandated benefits have not been the subject of such extensive research. Because these studies involve long-term analyses and tracking of the medical needs and expenses of specific individuals, insurers are unable to make such determinations. In some cases, ethical and privacy issues make such studies impossible under any circumstances.

States that have tried to collect mandated benefit data report experiences that are similar to those described by Virginia Bureau of Insurance. When Virginia attempted to collect cost related data on mandated benefits during 1988-1990, insurers were surveyed to obtain cost-related data.[18] The first survey attempt resulted in such poor information that the Bureau revised their request and allowed insurers additional time to respond to the survey. Even so, the results were disappointing. Insurers commonly reported the information was not available and could not be provided. Some of the comments received from insurance companies were included in the report:

> "Our claims system does not capture the necessary data to analyze claims by type of provider and procedure codes."
>
> "We do not keep records that would allow us to respond on this detailed survey."
>
> "Unfortunately, we do not have the resources necessary to keep track of the state mandated benefits."
>
> "After I reviewed the enclosed questionnaire, I was truly amazed at the level of naivety [sic] that exists within the committee of people who created the questionnaire…Now, think of the compound effect of 25 'base' policies x 35 variations x 219 mandated benefits/provisions x 5 years. Do you really believe a company can maintain an accurate record of the experience for each possible combination? Do you really think a prudent expense conscious company would want to maintain such a record?… All that we can do is monitor the overall claims experience for each of our products for each of our states in which we operate. And, on a retrospective basis, we adjust our rates for the experience that develops."[19]

[18] *The Financial and Social Impact of Mandated Benefits and Mandated Providers*. State Corporation Commision's Bureau of Insurance. Senate Document No. 15, Commonwealth of Virginia, Richmond; 1990.
[19] Ibid, pp. 19-20.

Of those insurers that did respond to the Virginia survey, only four used actual claims experience, and only two of the four completed a majority of the questions. The report notes that these two companies had the largest share of the Virginia market.

The Texas Department of Insurance experienced similar difficulties collecting mandated benefit cost data from Texas insurers. TDI has been collecting fairly detailed cost information on specific types of health insurance costs and coverages – including mandated benefits - for nearly 10 years. While the data provided by insurers has improved considerably over time, the information available is still limited to claims that are tied to a specific diagnosis or medical treatment. Even with these relatively simple requests for data, some insurers are still unable to provide fairly basic information. For example, in 1997, among the 34 largest accident and health insurers in Texas, three could not provide the total number of people they insure, five could not provide data on the amount of prescription drug claims paid, and one could not segregate premiums collected for group health insurance from all other types of health insurance policies (such as individual plans, disability coverage, or Medicare supplement). This is important because it limits the type of data available to determine the cost impact of mandated benefits. While in theory it may sound simple to determine these costs, the reality is that much of the data needed for an accurate assessment is either unavailable or can only be developed at considerable cost to insurers.

Impact of HIPAA Requirements on Insurance Claims Data

Data capabilities are likely to improve considerably as an indirect result of the federal Health Insurance Portability and Accountability Act (HIPAA) passed by Congress in 1996. Subtitle F of HIPAA contains provisions for administrative simplification of the health care system through the standardization of certain health care transactions. These standards, when implemented, will require all medical care providers and payers to use a standard, uniform claim form for the electronic processing of all health care claims, including those processed by insurers. Providers who previously had different claim forms and paperwork requirements for every insurer will now be able to use a standard, uniform claim form for filing all insurance claims.

While the primary intent of this requirement is to reduce administrative costs for providers and payers, one of the goals is to also provide data for long term health quality analysis. When implemented, these requirements will apply to every health care transaction filed electronically (which includes the vast majority of claims). Although insurers will have the option of deciding whether to collect certain data elements, a specific core data set will be required for all transactions. This includes diagnosis and treatment codes which are necessary for tracking mandated benefit claim costs.

Although mandatory compliance with these requirements is still at least two years away pending final adoption of rules by the U.S. Secretary of Health and Human Services, these standards should greatly improve the availability of information from insurers. Because participation is mandatory, insurers will have to develop computer systems capable of collecting and maintaining the standard data set. While it may be premature to assume that these standards will address all the data concerns regarding mandated benefits, the likelihood of improved data is certainly encouraging.

Review of Selected Studies on Mandated Benefit Costs

Over the past 15 years, a number of studies have been conducted by various states in an attempt to determine the cost and, in some cases, the social impact of mandated benefits. As discussed throughout this report, problems in obtaining reliable cost estimates have been a common theme

throughout most of these studies, particularly the earlier studies conducted during the 1980s or before. However, a number of states have been relatively more successful than others and provide some valuable information on both costs and methodology. Following is a summary of some of the more recent studies and their findings.

When reading these reviews, please note that mandated benefit requirements often vary considerably from state to state, even though the same names are often used to describe similar benefit requirements among various states. However, the benefit provisions may have significant differences that make comparisons among states meaningless. This is particularly true with certain mandated benefits, including those addressing coverage of mental health and chemical dependency treatment. The reader is cautioned that the findings apply only to the state in which the study is conducted; applications of the cost findings to other states may not be appropriate given differences in the statutory requirements of the mandated benefits.

HAWAII

The Hawaii Legislature has passed several resolutions directing the State Auditor's office to conduct studies of existing mandated benefits. The Auditor also is required to review all new mandate proposals prior to enactment. The Hawaii reviews are relatively comprehensive in comparison to other states' activities. Each report includes a statement that all work was performed in accordance with "generally accepted government auditing standards." No mention is made, however, concerning the scientific validity of the reviews. In some cases, private consulting firms assist with the studies at a cost not provided in the reports. However, the Hawaii Legislature appropriates specific funds annually for the purpose of conducting mandated benefit reviews. Following is a brief summary of findings from Hawaii reports that review mandates similar to Texas mandated benefit requirements.

Study of Proposed Mandatory Health Insurance for Contraceptive Services (1993)

The Hawaii proposal that was the subject of review would have required health insurance policies to provide coverage for any service related to contraceptive procedures that is within the lawful scope of practice of any practitioner licensed to practice medicine. (This proposal differs significantly from the Texas mandate which simply requires insurers to cover oral contraceptives under policies that provide prescription drug coverage.) The study found that inadequate data was available on the utilization, benefits and costs of privately insured contraceptive services. Data provided by the Hawaii Medical Service Association, the Blue Cross and Blue Shield insurer which insures about 56 percent of Hawaii's civilian population, showed "no dramatic changes in the premium of drug plans" when they began providing coverage of oral contraceptives. The report concluded that because of insufficient data and the vagueness of the legislative proposal, researchers could not fully assess what the impact of mandated contraceptive services might be.

Study of Proposed Mandatory Health Insurance for Temporo-Mandibular Joint Disorders (1993)

The Hawaii Legislature directed the State Auditor to assess the social and financial impact of mandated health insurance coverage for temporomandibular joint disorders. The resolution was not, however, based on a specific legislative proposal and was very vaguely worded. Because details describing the actual benefit were not provided, the study was based on an assumption that coverage would include treatment of any disorder involving the temporomandibular joint.

The report points out that the study was severely limited due to a lack of a well-defined directive and because no data existed on current utilization or costs. Researchers concluded that no

reasonable determination could be made as to the impact of TMJ services and suggested that no legislative action be taken to enact a mandate.

Study of Proposed Mandated Health Insurance for Mammography Screening (1990)
The Hawaii study of proposed mammography services was conducted jointly by the State Auditor's office and by a private actuarial firm, The Wyatt Company. The study involved a review of existing research studies; collection of data from insurers, providers and researchers in Hawaii; and interviews with employer groups, unions, advocacy groups and other interested parties. Insurers and the Hawaii Department of Health provided most of the data related to financial impact.

As with the other reviews from Hawaii, this study was not based on an existing mandate but rather a proposal to enact a new mandate. As such, all information is based on estimates and projections rather than actual experience. In summary, the report determined that periodic mammogram screening for women over 40 years is beneficial and a cost effective alternative to more expensive care. The report further determined that screening was currently used by a low percentage of women, partly due to costs. Other barriers besides costs exist, however, and insurance alone will not guarantee that women will regularly seek screening. The report concluded that mandated mammography benefits will add to the cost of health care, but the costs and related insurance rate increases should not be substantial. As the volume of screenings increases, the individual charge is expected to be reduced, thereby limiting to some extent the increased cost to insurers.

Using a computer modeling program that made numerous assumptions, specific cost estimates were provided as follows:

	Year One	**Mature Year**
Increase in costs to insurers*****	$2,428,078	$2,533,017
Number of adult insureds	488,843	488,843
Annual increase in premium	$4.92	$5.18
Monthly increase in premium	$0.41	$0.43

(*****Cost increases do not factor in cost-saving provisions such as copayments or deductibles. These provisions could reduce by half the cost of the screening procedure to the insurer.)

The report also summarized several scientific studies of mammography screening, all of which concluded that screening was found to reduce mortality.

NEVADA
The 1989 Nevada Legislature directed a subcommittee to conduct an overall study of the state's mandated health insurance benefits. One of the subcommittee's recommendations was that existing mandates should be reviewed to determine whether they should be retained, modified or repealed. In response, a special interim committee of legislators conducted a study of six existing mandates. The committee's work was based entirely on public hearings and information submitted by an ad hoc committee of health insurance industry organizations. The group of health insurers provided cost estimates (Table 3-1) but did not include any supporting data and no explanation of the methodology used to develop the cost information. No explanation was given for the wide variations in costs.

Table 3-1
Estimated Premium Costs of Nevada Mandated Benefits

Mandated Benefit	Cost Range (Per-Mbr-Per Year)	% of Avg Premium Cost
Drug/Alcohol Abuse	$9.60 to $62.28	0.9% to 5.1%
Home Health Care	$8.40 to $26.52	0.7% to 2.4%
Hospice Care	$0.96 to $5.40	0.1% to 0.4%
Chiropractor	$0.12 to $52.68	<0.1% to 4.3%
Certified Psychologist	$9.00 to $12.00	0.8% to 1.2%
Reconstructive Surgery After Mastectomy	$1.20 to $10.92	0.1% to 1.1%

MAINE

Maine originally established the Mandated Benefits Advisory Commission composed of state officials, legislators, and interest group representatives to review existing mental health and substance abuse mandates. The Commission hired the consulting firm Milliman & Robertson to conduct the actual study. The study findings were reviewed by the Commission and a report with varying recommendations was issued. After the report was finished, the Commission was abolished. Today the Maine Bureau of Insurance is required to conduct a review of proposed mandates and submit its report "in a timely manner," usually the next legislative session following the introduction of the new mandate. The statute requires that specific review criteria be used when evaluating new mandate proposals. Following is a brief summary of the findings from the reviews of mental health and substance abuse mandates.

State of Maine Mandated Benefits Advisory Commission Report on Mental Health Mandate (1992)

The Maine Advisory Commission was comprised of 22 members appointed by the Governor and the Legislature working primarily with a private consulting firm to review the state's mental health mandates. The mandates evaluated include both a coverage mandate and a provider mandate. Under the coverage mandate, insurers are required to include mental illness benefits under certain group health contracts. Benefits must be paid for inpatient, outpatient or day treatment settings. Specific minimum benefit levels were established by rule. The provider statute applies to all health insurance policies (group and individual) and requires insurers to include the services of a psychologist, social worker or psychiatric nurse to the extent those services would be covered by a physician.

Because Maine insurers are required by law to file annual claim reports showing data for mental health claims, the consulting actuaries had access to claim information not available in other states. Reviewing data from 1984 to 1990, the actuaries concluded that mental health benefits accounted for a relatively constant percentage of total health care costs - generally 3 to 4.5 percent. However, the report cautions that the data is limited and required certain judgments by insurers when reporting information. The report also points out numerous studies which claim that the "offset effect" of reducing future medical costs by treating mental illness would provide significant savings in utilization and charges for the non-psychiatric care of treated patients.

The report states that the Maine costs for mental health benefits are comparable to Milliman & Robertson Inc.'s Health Cost Guidelines, a proprietary, nationwide database providing information on the cost and utilization of numerous health insurance benefits. According to Milliman & Robertson, the 1991 expected average annual cost-per-person to provide coverage for mental health benefits in a group health insurance plan without managed care was as follows:

Percentage of Premium Attributed to Mental Health Costs

	U.S. Total	Maine Total
Inpatient Mental Health 2.10%	1.99%	
Outpatient Mental Health	2.45%	1.95%
Total Mental Health	4.55%	3.94%

The report also summarized mental health claims experience provided by insurers to the Maine Department of Insurance. Blue Cross and Blue Shield data showed mental health claims accounted for 3.4 and 3.1 percent of all claims in 1988 and 1989. All other insurance companies reported mental health claims represented 4.0 and 4.3 percent of claims for the same two years. A discussion of the economic costs associated with mental illness was included but no data was presented on how those costs are affected by treatment or lack of treatment. The study concluded with a series of options for the commission, but made no recommendation regarding the mandate for mental health care.

Mandated Benefits Advisory Commission Report on Substance Abuse Mandate (1992) The substance abuse mandate study closely follows the methodology used to study mental health benefits. The consulting firm of Milliman & Robertson performed the research and wrote the report, which was adopted by the Advisory Commission.

The alcoholism and drug dependency mandate requires insurers to include substance abuse benefits in all group policies except employer groups with twenty or fewer employees. Both outpatient and residential benefits must be provided. Minimum standards require annual benefits of at least 30 days residential treatment and at least $1000 in benefits for outpatient care.

The report includes utilization and cost data provided by insurers under a state requirement that such information be reported annually. From 1984 through 1990 substance abuse claims costs accounted for 1.5 to 1.8 percent of all claims paid. Inpatient claims accounted for the majority of claims costs. Actual premium costs were estimated by Milliman & Robertson to be $1.13 per person annually for group health plans without a managed care arrangement. The report also attempted to compare Maine's claims experience with that of other states similar in population and income. The comparison included both states with and without a substance abuse mandate. Though the data was limited, the report concluded the presence or absence of a mandate did not appear to strongly affect the variance of substance abuse insurance claims when compared to Maine's experience.

The study also cites a number of research papers that show reduced overall health care expenses for families where one member was treated for alcoholism. Elsewhere, the report discusses the high costs of not treating alcoholism; the economic cost of substance abuse is estimated at about $700 million per year in Maine based on data provided by the U.S. Department of Health and Human Services. The report did not reach any single conclusion, but instead provided a list of 19 options which the Advisory Commission voted on. No final recommendation was made.

VIRGINIA

Some of the most comprehensive mandated benefit cost data available is collected by the state of Virginia. In its 1990 report of findings to the General Assembly of Virginia, the Bureau of Insurance suggested that "…if the legislature desires more information about the costs of mandates, insurers should be required to collect and report, on a regular basis, information of the

type requested on the insurer survey."20 Subsequently, the Virginia Legislature enacted Section 38.2-3419.1 of the Code of Virginia, which requires insurers and HMOs to report annual cost and utilization information for each mandated benefit. Premium and claims data is reported separately for individual and group policies. Insurers with less than $500,000 in accident and sickness policy premiums are exempt from reporting requirements.

The most recent report issued by Virginia shows that mandated benefits represented approximately 8.82 percent of all claim payments under group policies issued in 1996.[21] Mandated coverages accounted for 5.79 percent; provider mandates represented 3.03 percent of claims. Table 3-2 indicates that mandates covering newborn children and mental illness account for almost half of all costs related to mandates (4.1 percent).

Table 3-2
State of Virginia Average Annual Claims Costs for Mandated Benefits Group Contracts, 1996

Mandated Benefits	Average Claim Cost per Certificate	Average Percent of Total Claims
Dependent Children (Handicapped)	$6.95	0.43%
Doctor/Dentist	7.04	0.44
Newborn Children	30.84	1.19
Mental/Emotional/Nervous (M/E/N) Disorders – Inpatient	20.48	1.19
M/E/N – Partial Hospitalization	1.56	0.07
M/E/N – Outpatient	28.54	1.65
Alcohol & Drug Inpatient	7.44	0.42
Alcohol & Drug Partial Hospitalize.	1.34	0.06
Alcohol & Drug Outpatient	2.61	0.16
Pregnancy due to Rape/Incest	.77	0.04
Bones/Joints	2.99	0.14
Subtotal:	**$110.56**	**5.79%**
Mandated Providers		
Chiropractor	$14.30	84%
Optometrist	1.44	0.08
Optician	.22	0.01
Psychologist	5.73	0.34
Clinical Social Worker	6.19	0.32
Podiatrist	6.30	0.38
Professional Counselor	4.99	0.26
Physical Therapist	10.37	0.66
Clinical Nurse Specialist	.96	0.06
Audiologist	1.28	0.06
Speech Pathologist	.43	0.02
Subtotal:	**$52.21**	**3.03%**
TOTAL: ALL MANDATES	**$162.77**	**8.82%**

Virginia also collected information on claims costs associated with mandated offers (i.e., benefits that must be offered by the insurer but may be rejected or accepted by the purchaser). In 1996, claims costs for benefits that must be **offered** totaled 6.31 percent of all claims paid (Table 3-3). The majority of those expenses were related to obstetrical care.

[20] Ibid, p.2.
[21] *The Financial Impact of Mandated Health Insurance Benefits and Providers.* Commonwealth of Virginia, House Document No. 10, 1998.

Table 3-3
State of Virginia Average Annual Claims Costs for Mandated Offers Group Contracts, 1996

Mandated Offers	Average Claim Cost per Certificate	Average Percent of Total Claims
Obstetrical – Normal	$20.58	1.20%
Obstetrical – All Other	64.87	3.80
Bone Marrow Transplants	9.52	.55
Mammography	2.91	.17
Child Health Supervision	10.36	.59
Total:	**$108.24**	**6.31%**

Insurers also reported average annual premium costs for each mandated benefit provisions. The report points out that, although companies do not usually rate mandated benefits separately, for this report insurers are required to assign a premium cost based on actual claim experience and other relevant actuarial information. Table 3-4 lists the corresponding percentage of overall premium costs for each mandated benefit required under group policies. Costs are provided separately for family and individual coverage.

It is interesting to note that, while mandated benefits account for 8.82 percent of all group claims (Table 3- 2), estimated premiums charged for these benefits are considerably higher (Table 3-4). Insurers estimate that the premium cost of mandated benefits is 16.72 percent of the cost of family coverage and 12.70 percent of the cost of individual coverage. No explanation was provided in the report for this difference in the premium charged relative to actual claims experience.

Table 3-4
Mandated Benefit Premium Costs – Group Policies, 1996

Mandated Benefit	Percent of Premium Cost – Single Cvg.	Percent of Premium Cost – Family Cvg.
Dependent Children (Handicapped)	NA	.34%
Doctor/Dentist	.52%	1.54
Newborn Children	NA	2.01
Mental/Emotional/Nervous (M/E/N) Disorders – Inpatient	2.87	2.68
M/E/N – Partial Hospitalization	.65	.68
M/E/N – Outpatient	.38	1.61
Alcohol & Drug Inpatient	1.41	1.27
Alcohol & Drug Partial Hospitaliz.	.61	.47
Alcohol & Drug Outpatient	.38	.38
Pregnancy due to Rape/Incest	.29	.34
Bones/Joints	.51	.75
Subtotal: Mandated Benefits	**7.62%**	**12.07%**
Mandated Providers		
Chiropractor	1.18	1.04
Optometrist	.30	.29
Optician	.50	.53
Psychologist	.84	.78
Clinical Social Worker	.47	.35
Podiatrist	.41	.36
Professional Counselor	.29	.29
Physical Therapist	.73	.67
Clinical Nurse Specialist	.10	.10
Audiologist	.14	.14
Speech Pathologist	.12	.10
Subtotal: Provider Mandates	**5.08%**	**4.65%**
TOTAL – ALL MANDATES	**12.70%**	**16.72%**

Virginia also conducted separate studies on mandated benefits requiring mammography screening and coverage of handicapped dependents who would normally lose coverage as adults under their parents' policies. Following is a brief summary of these reports.

Mammography study - Virginia law requires insurers to offer coverage for mammography for women age 35 and over. Benefits may be limited to $50 per mammogram. In 1994 the Special Advisory Commission on Mandated Health Insurance Benefits conducted a cursory study of the mammography mandated offer. The report relied entirely on the data supplied by insurers in the 1992 utilization and cost report. The report collected no additional data, and provided no new information. The Commission concluded that the mandated offer for mammography should be retained in its existing form.

Handicapped Dependents, Regardless of Age - Like the Texas mandate, the Virginia law requires individual and group contracts to continue coverage of mentally or physically handicapped individuals beyond the age contracts would normally terminate coverage. As part of its review of this mandate in 1992, the Commission held a public hearing to receive testimony. No public testimony or written comments were ever received. The report included a basic description of the benefit, background information, and information on the number of handicapped children in Virginia that would likely use the benefit. Cost data from Blue Cross and Blue Shield of Virginia indicated that 0.18 percent of its 1987 claims were due to the dependent children mandate. The report concluded that, although the Commission could not determine the cost of this mandate, available data indicated that the cost is not substantial. The Commission recommended that the mandate should be retained in its current form.

TDI Survey Findings: The Cost of Mandated Benefits in Texas

Since 1989, TDI has been collecting mandated benefit claims costs and premium information from Texas insurers and HMOs. Though few insurers were able to provide meaningful data in the original requests, compliance has improved significantly in the past five years. Changes in the way information is collected are at least partly responsible for the improvement:

- Rather than survey all licensed insurers, only the largest insurers representing 70 to 80 percent of the health insurance market (based on premium volume) are included in recent studies.
- Because about 90 percent of people with private insurance are covered under group plans, mandated benefit data is collected only on group accident and health business. Attempts to collect data on individual plans have not been successful due to relatively small volumes of experience per company and wide differences in policy provisions.

- Only those mandated benefits that are associated with specific diagnoses and treatment costs or those that apply to easily identified populations are included in the more recent surveys. While this does exclude some mandated benefits, insurers have repeatedly been unable to collect data on benefits that do not meet these criteria.

Using the criteria above, TDI limited its data collection for this study to the 34 largest insurers that write approximately 80% of the accident and health insurance policies in Texas; all licensed HMOs were also included in the survey. Data was requested on mandated benefits in effect from 1992 through 1996. New mandated benefits added after that date were not included in this study. In addition, there are some benefits that were excluded because previous attempts to collect information have been unsuccessful. Insurers and HMOs were asked to report annual claims information for each mandated benefit listed. Data was not collected on administrative costs

associated with mandated benefits or on estimated savings. While these survey findings do not, therefore, represent the entire cost of mandated benefits, they do provide valuable information on the cost of those mandated benefits that are included in this study.

A summary of the data collected provided in Table 3-5 shows that the total claims paid by group insurance plans for all nine mandated benefits has decreased from 5.53 percent in 1992 to 3.25 percent in 1996. Benefits paid for chemical dependency, complications of pregnancy and newborns with congenital defects accounted for more than half (2.52%) of the claims paid for all nine benefits combined. Seven of the benefits (mammography screening, PKU formula, oral contraceptives, handicapped dependents regardless of age, TMJ, newborns with congenital defects, osteoporosis detection) had claims costs that totaled less than one-half of one percent of all claims.

It is worth noting that claims costs declined across the board for all benefits except complications of pregnancy, which experienced a 0.01 percent increase in claims over a two year period. Costs for most mandates decreased by more than half. Claim paid for chemical dependency coverage experienced more than a 75 percent drop from 1992 to 1996. While no data was collected explaining the significant decline in benefit costs, a logical explanation is companies' increased use of cost containment controls such as pre-certification and prior approval for selected services. Reductions in fees paid to providers as a result of discounted fee-schedules and the use of provider networks are also likely contributors.

Table 3–5
Mandated Benefit Claims as a Percentage of Total Claims Paid Group Insurance Plans: 1992 - 1996

Mandated Benefit	1992	1993	1994	1995	1996
Chemical Dependency Cvg.	2.85%	1.65%	1.22%	0.61%	0.60%
Complications of Pregnancy	NA	NA	NA	1.42	1.43
Mammography Screening	0.65	0.22	0.64	0.13	0.16
PKU Formula	0.002	0.001	0.001	0.02	0.02
Oral Contraceptives	0.06	0.20	0.95	0.73	0.28
Handicapped Dependents Regardless of Age	0.57	0.57	0.19	0.17	0.15
Temporomandibular Joint	0.12	0.11	0.08	0.10	0.09
Newborns with Congenital Defects	1.28	1.20	1.06	0.36	0.49
Osteoporosis Detection	NA	NA	NA	0.01	0.03
TOTAL	**5.53**	**3.95**	**4.14**	**3.55**	**3.25**

Data on medical expenses paid by HMOs also shows relatively low costs for mandated benefits (Table 3-6). Total claims for the eight mandated benefits totaled 2.18 percent in 1996 and 2.56 percent in 1995. Complications of pregnancy accounted for the highest percentage of costs at 1.07 percent, followed by oral contraceptives (0.38%) and chemical dependency (0.33%). All but one mandated benefit (complications of pregnancy) accounted for less than one-half of one percent of all medical expenses paid in both 1995 and 1996.

Table 3–6
Mandated Benefit Expenses as a Percentage of Total Medical Expenses HMO Plans: 1995-1996

Mandated Benefit	1995	1996
Chemical Dependency Cvg.	0.38%	0.33
Complications of Pregnancy	1.28	1.07
PKU Formula	0.01	0.01
Oral Contraceptives	0.42	0.38
Handicapped Dependents Regardless of Age	0.13	0.09
Temporomandibular Joint	0.05	0.04
Newborns with Congenital Defects	0.28	0.24
Osteoporosis Detection	0.01	0.02
TOTAL	**2.56**	**2.18**

Insurance companies also reported claims costs associated with mandated provider requirements. (Although HMOs often include benefits for these alternative providers, they are generally not required to do so.) Combined claims for all 12 providers represented 1.94 percent of all claims paid in 1995 and 1.71 percent in 1996 (Table 3-7). The highest percentage of claims paid went to chiropractors (0.53% in 1996 and 0.63% in 1995) followed by osteopaths (0.35% and 0.38%) and podiatrists (0.28% and 0.30%). Providers responsible for the least amount of claims were licensed marriage counselors and family therapists, dietitians, audiologists, certified social workers, and speech-language pathologists.

Table 3-7
Mandated Provider Claims as a Percentage of Total Claims Paid Group Insurance Plans – 1995 and 1996

Mandated Provider	1995	1996
Podiatrist	0.30%	0.28%
Psychologist	0.28	0.24
Optometrist	0.05	0.08
Chiropractor	0.63	0.53
Audiologist	0.00	0.00
Dentist	0.12	0.10
Dietician	0.00	0.00
Certified Social Worker	0.07	0.01
Speech-language Pathologist	0.03	0.02
Licensed Professional Counselor	0.08	0.10
Osteopath	0.38	0.35
Licensed Marriage/Family Therapist	0.00	0.00
TOTAL	**1.94**	**1.71**

Premium Cost Information

Although insurers frequently contend that premiums cost data for specific mandated benefits is not available, insurers were asked to provide the information if they could. If the estimated

premium for specific mandated benefits was less than one percent of the total premium, insurers were asked to simply indicate so rather than provide an exact cost figure. In the majority of cases, insurers did agree that the premium costs for any single mandated benefit was less than one percent of the total annual premium. This information is consistent with the data provided on the actual cost of claims paid.

In those few cases where insurers provided a specific dollar amount of premium for certain mandated benefit, premium costs appear generally to be significantly over-estimated. In the majority of cases, reported premium costs had little relation to actual claims paid. Following are several examples:

- One insurer reported such extremely high premium costs for mandated provider requirements that the premium collected for provider benefits alone exceeded the company's entire annual premiums. For example, the insurer listed premiums for the podiatrist provider mandate at $132 per person, for a total of $6,935,676. Claims paid to podiatrists totaled only $185,237. The same insurer reported premium costs of $264 per person for chiropractor benefits, totaling $13,871,352 in annual premiums; claims paid to chiropractors totaled $276,917.

- One insurer reported an annual premium charge of $15.35 per person to cover claims paid to optometrist for a total $146,764 in premiums; claims paid to optometrist totaled only $12,358.

Of the five companies that provided specific premium costs, only two had premium expenses that were reasonable in relation to the actual claims paid. As indicated in Table 3-8, the actual premium costs varied considerably between the two companies. For example, company A reported a combined annual premium cost of $15.61 per person for mammography, TMJ, oral contraceptives and handicapped dependents compared to only $1.49 for company B. No explanation is available for this wide variation, but both companies reported actual claims costs that are consistent relative to the premium charge. This information underscores the difficulty of assessing the premium impact of mandated benefits on an industry-wide basis since actual experience can vary considerably from one company to another.

Table 3-8
Estimated Premium Costs for Selected Mandated Benefits as Reported by Two Texas Insurers, 1996

Mandated Benefit	Annual Premium Cost-Per-Person	Actual Claims Paid for Benefit	Total Premium Charged for Benefit
Company A:			
Complications of Pregnancy	$17.28	$4,068,802	$4,902,421
Mammography	$4.35	$1,025,353	$1,239,280
TMJ	$4.51	$1,080,882	$1,284,862
Oral Contraceptives	$3.08	$724,791	$877,467
Handicapped Depen.	$3.22	$757,549	$917,352
Company B:			
Complications of Pregnancy	$19.30	$756,897	$886,487
Mammography	$0.11	$4,441	$5,052
TMJ	$0.69	$26,940	$31,693
PKU Formula	$0.003	$113	$137
Oral Contraceptives	$0.46	$18,005	$21,128
Handicapped Depen.	$0.23	$8,903	$10,564
Newborns w/Cong. Defects	$2.31	$90,599	$106,102

CHAPTER FOUR
MANDATED BENFITS AND SELF-FUNDED HEALTH PLANS

Besides cost, perhaps the most compelling arguments raised in opposition to mandated benefit laws concern how government requirements affect employers' decisions to "self-insure" or "self-fund" their health insurance benefit plan.[22] Opponents of mandates insist that employers are leaving the state-regulated market specifically to avoid state requirements for mandated benefits. Insurers argue that they are unable to provide employers with the policy benefits they want and suggest that making mandated benefit provisions optional instead of mandatory would discourage employers from leaving the regulated market. Others suggest that mandated benefits are not a primary factor in an employer's decision to self-insure and argue that allowing employers to choose which mandates they want to include would eliminate the cost advantages of "spreading the risk" among large population groups. To more closely evaluate these two positions, this chapter provides a discussion of self-funded health plans' exemption from state regulation under ERISA and the relationship between mandated benefits and emloyers' decisions to self-insure. Also included are the results from a survey of Texas employers who have chosen to self-insure their health plans.

ERISA And Health Insurance Plans

In 1974, the federal government passed the Employee Retirement Income Security Act (ERISA) for the purpose of establishing uniform federal standards for pension and employee benefit plans, including health insurance plans. The primary force behind the ERISA legislation was Congressional concern over the solvency and security of employment-based pension plans.[23] However, ERISA also included language preempting all state laws related to employee benefit plans, including health insurance plans. While the statute specifically preserved the states' right to regulate the "business of insurance", a deemer clause prevents states from deeming employee benefit plans to be in the business of insurance for the purpose of state regulatory oversight. Since most employee benefit plans do not conduct the "business of insurance" directly (i.e., the policyholder does not transfer risk or spread risk across a pool larger than the policyholder itself), self-funded health insurance plans are by definition exempt from state regulatory requirements.

One of the more confusing aspects of ERISA has been the common practice of distinguishing self-funded plans as "ERISA" plans, and fully insured plans as "non-ERISA" plans. In fact, ERISA applies to virtually ***all*** private-sector employee benefit plans, regardless of whether the plan is self-funded or fully insured. The term "employee benefit plan" includes both employee welfare benefit plans (i.e. health plans) and employee pension plans. While state legislatures and insurance regulators have the authority to impose requirements on *insurers*, ERISA pre-empts regulators from imposing health benefit plan requirements on *employers*. Thus, if an employer purchases a health insurance plan from a licensed insurance company, that insurer must comply

[22] A few studies differentiate between the terms "self-funded" and "self-insured" depending on whether or not the plan has reinsurance protection. For purposes of this report, the two terms are used interchangeably.

[23] Copeland, Craig and Bill Pierron."Implications of ERISA for Health Benefits and the Number of Self-Funded ERISA Plans," *EBRI Issue Brief No. 193*. Washington, D.C.: Employee Benefit Research Institue, January 1998, p. 4.

with all applicable state insurance requirements. While these requirements ultimately affect the product that the employer can purchase, the requirements are NOT imposed on the employer; rather they affect the insurer and the health plan sold by the insurer.

Employers who self-insure their benefit plan assume the risk of paying for healthcare costs of insured members and either administer the plan themselves or pay a third party (often an licensed insurance carrier) to administer the plan. Usually those who self-insure contract with a licensed insurer to provide "reinsurance" or stop-loss as a hedge against excessive claim costs. If the employer's claims surpass a predetermined amount, the stop loss policy will assume the liability for any claims above this amount. This type of policy can be purchased based on either an individual claim cost basis or an aggregate basis. If the policy is per-person, the policy pays when a single individual's claims surpass a pre-determined amount; on an aggregate basis, the stop loss policy pays when the combined claims for all insureds reaches an established limit. Increasing use of stop-loss coverage has created concern among some regulators and lawmakers that suspect some employers and insurer may be circumventing state insurance regulatory requirements through the use of stop loss protection policies with relatively low attachment points (i.e., the claims loss level at which the policy begins paying).[24]

Self-Funded Health Plan Enrollment Data

One of the problems in assessing the impact of self-funded health plans is that there is no way of determining how prevalent these plans are. A number of studies provide national estimates, but numbers tend to fluctuate considerably within certain geographic regions of the country, making it difficult to determine how widespread the self-funded market is in Texas. Also, many employers that provide self-funded plans also offer other plans – such as HMO options – that are not self-funded, which adds to the difficulty in determining the number of employees enrolled in such plans.

In a national survey of employers, A. Foster Higgins collected data on the percentage of employers offering self-funded plans, but does not provide the number of employees covered. Consistent with other studies of self-funded employers, the Foster Higgins data indicates that employer size is an important factor in determining whether an employer offers a self-funded plan. Larger employers (5,000 – 9,999 employees) were most likely to provide some form of self-funded health plan while small employers rarely did so.

Table 4-1 also shows a consistent increase in the number of employers offering PPO plans and point-of-service plans in 1997 but a decrease in the number of fee-for-service and HMO self-funded plan offered.

[24] Ibid, p.18.

Table 4-1
Percentage of Employers Offering a Self-Funded Plan, By Plan Type and Employer Size

Plan Type	1993	1994	1995	1996
	10 or more Employees			
Fee-for-Service	11%	9%	7%	9%
PPO	1	6	9	11
POS	Not Avail.	4	2	3
HMO	Not Avail.	3	1	2
	500 or more Employees			
Fee for Service	43	44	38	36
PPO	22	31	35	42
POS	Not Avail.	15	14	19
HMO	Not Avail.	4	6	3
	5,000-9,999 Employees			
Fee for Service	54	46	54	49
PPO	41	43	47	50
POS	Not Avail.	20	25	34
HMO	Not Avail.	10	11	8

Source: A. Foster Higgins & Co., *National Survey of Employer-Sponsored Health Plans*, 1993, 1994, 1995, and 1996; Princeton, N.J.; A. Foster Higgins & Co., Inc., 1994-1997.

NOTE: Adding numbers of employers across plan types does not indicate the total percentage of employers offering self-funded plans since some employers offer multiple types of self-funded plan options and are included in more than one plan-type.

For estimates of the total number of participants in self-funded plans, the Employee Benefits Research Institute used data from the General Accounting Office (GAO), the Bureau of Labor Statistics employee benefits surveys, and the Current Population Survey conducted by the U.S. Census Bureau for calendar years 1989, 1993 and 1995. Combining data from these sources, they determined that approximately 44 million individuals (17 percent of the total US population) were enrolled in self-funded ERISA plans in 1993, up from 39 million in 1989 (Table 4-2). The number increased to approximately 18 percent of the population – 48 million people – in 1995. This figure represents approximately 39 percent of the total number of people covered under employment-based health benefit plans.

Table 4-2
Estimates of the Number of Participants in Self-Funded Health Plans National Data - 1989, 1993, 1995

	1989	1993	1995
Total Participants in Self-Funded Health Plans	39 Million	44 Million	48 Million
Total Participants in Employment Based Health Plans	117 Million	113.5 Million	124 Million
Percentage of Total Population Enrolled in Self-funded Plans	16%	17%	18%
Percentage of All Individuals w/ Employment Based Health Benefits that are Enrolled in Self-Funded Plans	33%	39%	39%

Texas Estimates of Self-Funded Plan Participants

Although data is not available on the number of Texans enrolled in self-funded plans, the information above and other available sources can be used to estimate the approximate number of Texans with self-funded health coverage and how this figure compares to other types of coverage in Texas. The 1997 CPS survey shows that 10 million Texans had employment-based health insurance in 1996. Enrollment figures reported to the Texas Department of Insurance by Health

Maintenance Organizations for 1996 shows that 2.3 million Texans were covered under HMO plans (excluding Medicare and Medicaid enrollees). Data from the Texas Department of Insurance 1996 Group Accident and Health Insurance Survey indicates that approximately 3.47 million Texans are insured under group policies issued by regulated insurers in Texas. Assuming that the national rate of enrollment in self-funded health plans (39%) shown in Table 4-2 above is the same for Texas, and assuming there was no change in the rate for 1996, an estimated 3.9 million Texans would be covered under self-funded health plans (Table 4-3). While this process leaves approximately 300,000 Texans that reportedly have insurance that is unaccounted for, it is a logical estimate based on the data that is available.

Table 4-3
1996 Texas Population Estimates of Health Insurance Coverage by Type of Plan

Number and Percentage of Texans with Employment Based Health Coverage	10 million	57.4%
Number and Percentage of Texans w/Employment-Based Health Coverage Enrolled in an HMO	2,315,069	23.2%
Number and Percentage of Texans w/Employment-Based Health Coverage Enrolled in a Fully-Insured Health Plan	3,470,398	34.8%
Number and Percentage of Texans w/Employment-Based Health Coverage Enrolled in a Self-Funded Health Plan	3,900,000	39.0%

Advantages and Disadvantages of ERISA

The ERISA pre-emption excluding self-funded health plans from state regulatory oversight has created a great deal of controversy. Proponents of self-funded plans – primarily employers and third party administrators – argue that pre-emption is necessary to guarantee employers the freedom they need to design innovative health care packages that are more cost effective than those offered by insurers. On the opposite side of the argument are regulators, state lawmakers and consumer advocates who argue that self-funded benefit plans do not provide adequate consumer protections and hamper effective insurance reform efforts intended to address the uninsured population.

Most employers cite cost savings as a major reason for self-funding.[25] Since these plans are exempt from state regulatory oversight, they are not subject to payment of state premium taxes or guaranty fund and high-risk pool assessments. Employers also report cost savings due to lower administrative expenses than those charged by insurers. Many employers have also been very successful in negotiating directly with providers for discounted services. Rather than pay insurers to establish networks and process claims, employers have found that they can often save money by performing those services themselves, or by contracting with third party administrators. By funding employees' actual medical costs on a pay-as-you-go basis rather than paying premiums in advance for services that may or may not be used, employers believe they are saving even more money, particularly when the money previously used to pay premiums is earning interest for the employer instead of an insurer.

Employers with multi-state locations find self-funding particularly beneficial. Because state insurance laws vary from state to state, employers would have to purchase separate health insurance plans for employees in each state under state-regulated insured plans. Establishing a

[25] Callahan, Cathi M., Stephen H. Long, M. Susan Marquis, James W. Mays, Pamela Farley Short, *"The Benefits and Risks of Self-Insuring",* Pension and Welfare Benefits Administration, Department of Labor, November 1997.

self-funded health plan avoids multi-state regulatory provisions and allows all employees to be covered under the same benefit plan. Employees moving from one state location to another remain under the same insurance program.

While opponents of ERISA pre-emptions recognize the benefits to employers, they also point to a number of concerns. Insurers in particular claim that they are unable to compete on a level playing field, and are losing valuable business because of the inequities created by ERISA. Premium tax exemptions for self-funded plans mean lost revenues for state governments. And because self-funded plans are not subject to assessments for high-risk pools, these costs are shifted entirely to fully insured plans and the employers who purchase them.

State policymakers also are concerned that employers are not required to comply with mandated benefits and may design health plans in a way that prevents participants from receiving the care they need. While studies suggest that most self-funded plans do actually include mandated benefits, there is no requirement that they do so. Ultimately if self-funded plans fail to provide adequate levels of coverage, some individuals may turn to public programs for necessary medical care. In addition, regulators and the National Association of Insurance Commissioners have repeatedly expressed concerns with the lack of solvency standards for self-funded plans. Unlike state regulated plans, employers with self-funded plans are not required to maintain minimum reserves for claims payments. If employers inadequately fund their health plan, a single catastrophic episode could bankrupt an employer's health plan and possibly the entire business. While many employers purchase reinsurance or stop-loss protection to protect such situations, there is no requirement that they do so. Consumer groups in particular are concerned that increasing costs of health care may result in more employees losing their coverage due to failures of inadequately funded self insured plans.

Mandated Benefits in Self-Funded Plans

Opponents of mandated benefits suggest that one of the primary reasons why employers opt for self-funded health plans is to avoid the inclusion of mandated benefits in their health plan. A number of studies, however, indicate that self-funded health plans typically include many of the benefits commonly mandated by states for fully insured plans, and often provide benefits that are even more generous than required. A survey of employer benefits conducted by KPMG Peat Marwick shows that self-funded plans are more likely to offer commonly mandated provisions (including well-child care, outpatient alcohol treatment, outpatient drug treatment, mental health benefits and chiropractic care) than fully insured plans.[26] The survey also found similar patterns for other benefits that are not typically mandated, including prescription drugs, adult physicals and dental benefits. (Table 4-4).

Table 4-4
Comparison of Mandated Benefits in Self-funded, Fully Insured Plans

Type of Benefit	Percent of Workers Covered in Fully Insured Plans	Percent of Workers Covered in Self Funded Funded Plans
Well-Child Care	60%	67%
Outpatient Alcohol Treatment	75%	96%
Outpatient Drug Treatment	82%	96%
Inpatient Mental Health Care	84%	97%
Chiropractic Care	72%	95%

[26] "Health Insurance Regulation – Varying State Requirements Affect Cost of Insurance." Government Accounting Office, August 1996.

Other studies report similar findings. A Wisconsin study that looked at specific mandated benefits also concluded that self-funded plans included the same mandates as required of fully insured plans, frequently at more generous levels.[27] In a more recent report researchers at RAND and the Urban Institute reviewed data from three separate employer surveys to compare benefit packages of self-funded and fully insured plans. Results showed many common benefits, leading the researchers to conclude, "… past state policies related to mandated benefits have not driven firms to self-insure in order to escape the cost of providing these benefits."[28] The researchers reported that they further concurred with the results of a previous study which determined that, while state mandates may have been a factor in employers' decisions to self-insure in the early 1980s, they have not been a major factor in more recent years.[29]

TDI Survey of Self-Funded Employers

To determine whether the findings of national studies mentioned above were applicable to Texas employers, the Texas Department of Insurance surveyed self-funded employers to determine how mandated benefits impacted their decision to self-insure. The survey was sent to approximately 1400 employers who filed notices with the U.S. Department of Labor indicating they had some type of self-funded benefit plan. Because this survey was specifically designed to determine why Texas insurers choose to self-fund, the survey sample did not include employers with fully-insured health plans.

Of the 1400 employers surveyed, a total of 177 returned their survey by the deadline for inclusion in this report. An additional 53 responded that they were unable to participate because they do not self-insure their health benefit plan. Subtracting these 53 employers from the 1400 shows that the remaining 177 employers who responded represent approximately 13 percent of the Texas self-funded insurers. Of the 177, a total of 174 employers reported 405,586 individuals were enrolled in their self-funded health insurance plans (Table 4-5). It is worth noting that, if we assume the survey participants represent approximately 13 percent of the total self-insured population, the estimate of the total self-funded Texas population reported in Table 4-3 is consistent with this additional information.

[27] Krohm, Gregory and Mary H. Grossman, "Mandated Benefits in Health Insurance Policies," *Benefit Quarterly*, Vol V, Number 4, 1990.

[28] Acs, Gregory, Stephen H. Long, M. Susan Marquis, and Pamela Farley Short, "Self-Insured Employer Heatlh Plans: Prevalence, Profile, Provisions, and Premiums," *Health Affairs*, Vol. 15, No. 2: Summer, 1996.

[29] Jensen, G.A., K.D. Cotter, and M.A. Morrisey, "State Insurance Regulation and Employers' Decisions to Self-Insure." *Journal of Risk and Insurance*, June 1995.

Table 4-5
Characteristics of Self-Insured Employers Participating in TDI Survey, 1997

Characteristics of Survey Participants	# of Employers Providing Info.
Total number of participating employers: **177**	177
Total number of health plan participants: **405,586**	174
Total cost of health insurance program: **$1,089,962,249**	145
Number of employers with stop-loss protection: **156 (88%)**	175
Number of employers with reinsurance protection: **61 (34%)**	120
Principle Type of Industry: Medical Services: **20** Financial/Real Estate/Insurance: **18** Retail: **20** Manufacturing: **35** Utilities: **4** Mining: **2** Professional Services: 5 Personal Services: **0** Repair Services: **0** Wholesale Trade: **5** Business Services: **6** Government: **5** Transportation: **3** Communication: **3** Agriculture: **0** Construction: **10** Food Services: **1** Computer Development: **0**	177

A total of 145 employers reported paying a combined total of $1.08 billion for costs related to their health insurance program. Expenses varied widely by individual employers from a low of $14,750 to a high of $223,761,859. Most employers reported they purchased stop-loss protection and/or reinsurance coverage to limit their financial liability.

The majority of employers reported their primary occupation as manufacturing (35 employers) followed by retail and medical services (20 each), and financial/real estate/insurance businesses (18). Four of the listed industries were not represented at all, including personal services, repair services, agriculture and computer development.
Consistent with national studies of the self-funded market, the majority of surveyed employers have at least 150 employees (Table 4-6). More than half (55 percent) had in excess of 500 employees, and one third had more than 1000. Only five businesses had 100 or fewer employees.

Table 4-6
Number of Employers Participating in Survey by Firm Size

Firm Size – Number of Employees	Number of Participating Employers
3-10	1
11-25	0
26-50	1
51-100	3
101-151	9
151-200	13
201-500	49
501-1000	37
1001-2000	22
2001-3000	9
3001-4000	7
4001-5000	5
5000 +	18

Employers were asked to indicate which factors influenced their decision to self-insure. A list of 14 possible reasons was provided based on the results of other studies of the self-insured market. Employers were asked to indicate as many factors as applied so multiple responses were common. Table 4-7 shows that the most commonly selected reasons were lower administrative costs, more control over premium charges, and more control over plan design. More than half the respondents also indicated they believed they could save money through lower claims costs. For a review of some of the comments provided in response to this question, please see Appendix B.

Table 4-7
Self-Insured Employers' Reasons for Deciding to Self-Insuring

Reasons Cited by Employers in Deciding to Self-Insure	Percentage of Employers Responding
Lower administrative costs	79%
More control over premium charges	74%
More control over plan design	72%
Lower claims costs	53%
Improved cash flow	47%
Lower costs due to no state premium taxes	38%
More control over provider charges	37%
Improved access to data	21%
Lower federal tax costs	15%
Reduced benefit plans compared to commercial policies	13%
Other	12%
Unable to obtain comprehensive coverage from a commercial insurer	4%
Unable to find the type of coverage needed from a commercial insurer	3%
Insurers' underwriting practices excluded certain employees or dependents	2%

After indicating all the factors that led them to self-insure, employers were asked to select the single most significant reason (Table 4-8). Consistent with the previous question, the most commonly selected responses were more control over premium charges (34%), more control over plan design (22%), and lower administrative costs (18%).

Table 4–8
Single Most Significant Factor in Decision to Self-Insure

Reason for Self-Insuring	Percentage of Employers
More control over premium charges	34%
More control over plan design	22%
Lower administrative costs	18%
Lower claims costs	10%
Improved cash flow; no up-front premiums	4%
More control over provider charges	3%
Unable to obtain comprehensive coverage from insurers	2%
Lower costs through avoidance of premium taxes	2%
Unable to find type of coverage needed from commercial insurer	1%

When asked if they were familiar with mandated benefit laws that require commercial insurers but not self-funded employers to include certain benefits in their group health plans, 85 percent indicated they were aware of such requirements. However, their knowledge of specific mandated benefit provisions varied greatly depending on the benefit requirement. A description of each benefit provision was included for their review in answering this question. Table 4-9 shows that less than half the employers were aware of the existence of 11 of the specific mandated benefit requirements for fully-insured plans.

Table 4-9
Employers' Knowledge of Mandated Benefit Requirements for Fully-Insured Plans

Mandated Benefit	Percentage of Employers Aware of Requirement
Chemical Dependency Treatment	76%
Newborn Children Coverage	68%
Maternity Minimum Length of Stay	62%
Continuation and Conversion	61%
Mammography Screening	60%
Psychiatric Day Treatment	57%
Complications of Pregnancy	53%
Alternative Mental Health Facilities	46%
Handicapped Dependents	43%
Practitioner Mandates	43%
Temporomandibular Joint	36%
Oral Contraceptives	36%
Prostate Testing	31%
Diabetes	29%
Mastectomy Min. Length of Stay	28%
Breast Reconstruction	20%
Osteoporosis Detection/Prevention	13%
Phenylketonuria Dietary Formula	11%

After indicating their familiarity with the mandates listed in Table 4-9, employers were asked whether they self-insure their health plan in order to avoid providing coverage for any of the listed mandates. Twenty-seven employers (15%) indicated they do self insure to avoid mandates whereas 146 employers (82%) do not (Table 4-10). Four employers did not respond to the question. Most employers reported that their health plan does include all mandated benefits; however, 23 percent exlude one or more. Of the 18 benefits listed in the survey, employers were most likely to exclude coverage of certain providers, (20 employers exclude coverage), treatment of TMJ (19 employers) and chemical dependency treatment or coverage of alternative mental health facilities (13 each). Employers were least likely to exclude coverage for diabetes (one employer), pregnancy complications (one employer), mammography (two employers) or breast reconstruction following mastectomy (two employers)

Table 4-10
Impact of Mandated Benefits on Employers' Decision to Self-Insure

Survey Results	Number/Percentage of Employers
Employers Who Self-Insure to Avoid Providing Coverage of Mandated Benefits	27 (15%)
Employers Who Do Not Self-Insure to Avoid Mandated Benefits	146 (82%)
Number of health plans that do **NOT** include specific mandated benefits (some companies checked more than one answer): Chemical Dependency Treatment: **13** Mammography Screening: 2 Alternative Mental Health Facilities: **13** Psychiatric Day Treatment Facilities: **8** Phenylketonuria Dietary Formula: **13** Temporomandibular Joint: **19** Oral Contraceptives: **9** Complications of Pregnancy: **1** Osteoporosis Detection/Prevention: **11** Newborn Children Coverage: **3** Handicapped Dependents: **3** Diabetes: **1** Mastectomy Minimum Length of Stay: **6** Breast Reconstruction: **2** Maternity Minimum Length of Stay: **3** Prostate Testing: **5** Continuation and Conversion: **4** Provider Mandates: **20**	41 (23%)

Employers were asked if they had ever asked a previous commercial insurer how much of their premium costs were attributed to the coverage of mandated benefits. Thirteen employers reported having asked for such information, but only three received an answer. One employer was told that mandates accounted for less than 10% of the total premium cost and another was told the cost was approximately five to seven percent of the total premium. A third employer was told that the costs were approximately $30-$40 per-person per-month.

When asked if they believe mandated benefits are necessary to guarantee individuals access to certain types of health insurance benefits, 76 employers (43%) answered yes, mandates are necessary; 90 employers (51%) believe they are not necessary. Employers were invited to provide additional comments on this question. Seventeen employers added comments that can be categorized as opposed to mandated benefits; 15 made comments that can be categorized as supportive of mandated benefits. An additional 21 comments were provided that were either neutral or did not directly address mandated benefits.

Employers were asked to indicate their opinion regarding whether specific mandates should or should not be repealed. Table 4-11 indicates that the majority of employers believe that the existing mandates should not be repealed or changed. While some would argue that the value of these opinions is limited since these employers are not in the regulated market, their opinions do shed some light on the whether mandated benefit requirements influenced their decision to self-insure. Most employers indicated they do NOT self-insure to avoid providing mandated benefits. The majority voluntarily provide coverage of mandated benefits in their self-funded policies.

Table 4-11
Employers' Recommendations Regarding Existing Mandates

***Column A**: Should be repealed only if there is a guaranteed reduction in premium*
***Column B**: Should be repealed only if this mandated is switched to a mandated offering*
***Column C**: Should not be changed or repealed*
***Column D**: Do not have an opinion on this particular mandate*

Mandated Benefit	# of Employers Responding			
	A	B	C	D
Chemical Dependency Treatment	38	30	47	25
Mammography Screening	9	14	101	20
Alternative Mental Health Facilities	28	27	44	44
Psychiatric Day Treatment Facilities	24	28	40	40
Phenylketonuria Dietary Formula	15	11	30	87
Temporomandibular Joint	27	26	41	46
Oral Contraceptives	17	21	72	33
Complications of Pregnancy	10	10	104	21
Osteoporosis Detection/Prevention	15	18	68	41
Newborn Children Coverage	11	6	106	17
Handicapped Dependents	14	12	87	30
Diabetes	8	16	94	25
Mastectomy Minimum Length of Stay	14	14	85	31
Breast Reconstruction	17	18	73	36
Maternity Minimum Length of Stay	13	11	89	29
Prostate Testing	10	12	99	23
Continuation and Conversion	24	17	71	31
Provider Mandates	34	30	42	35

Finally employers were asked if they would ever consider re-entering the commercial market and, if so, what changes would need to occur? Seventy-one employers (40%) indicated they would consider such an option while 95 (53%) answered they would not ever re-enter the commercial market. Of those who answered yes, the following conditions would first have to be met:

- Repeal All Mandated Benefits: 9 Employers
- Repeal Certain Specific Mandates: 8 Employers
- Guarantee a Minimum Savings of At Least:
  - 5%: 4 Employers
  - 10%: 7 Employers
  - 15%: 19 Employers
  - 20%: 15 Employers
- All annual rate increases were limited by law: 22 Employers
- Prohibit insurers from charging higher premiums for groups that have individuals with pre-existing conditions: 24 Employers
- Other changes that would be required: reasonable claims and administrative costs, guaranteed rebates based on experience, several years averaging of experience to determine rates, guaranteed provision of retiree coverage.

Employers were also given an opportunity to provide any additional comments about their opinions regarding re-entering the commercial market. Most of the comments can be categorized into three subject areas. First, employers have cost concerns and believe a self-insured plan is more cost-effective. Secondly, employers with multi-state operations find self-insuring easier and more cost-effective than providing separate policies for separate state employees. Third, employers have more plan-control with self-insured plans, which allows for better utilization information, lower deductibles than the commercial market can provide, and direct contracting with providers.

A few employers made additional comments. Because they cannot be easily categorized, the actual comments are shown below:

> "I'm afraid "health coverage" would include very few HEALTH conditions if not mandated. We went to self-funding so we could keep our employees healthy (by having the right to approve payments which might otherwise be denied) and to save money over commercial carriers at the same time. Changing carriers is often necessary due to unaffordable annual increases – and this is terribly disruptive to our employees. Also, it is currently much less expensive to partially self-fund despite the fact that we have a "high risk" employee health pool."
>
> "There is one important factor omitted from any discussion here – ERISA preemption protection in litigation situations; i.e., removal to federal court; thereby avoiding punitive damages."
>
> "No one factor would influence a change. Our company reviews, annually, the best options, insurance wise."
>
> "If our head count were to drop below 500, commercial insurance may be considered."
>
> "The only mandated benefits that we have ever been concerned with in terms of limiting benefits were those most subject to provider abuses."

CHAPTER FIVE
MANDATED BENFITS AND THE UNINSURED

Numerous groups have argued that the increased premium costs caused by mandated benefits are responsible for increasing numbers of uninsured Texans. The 1998 Current Population Survey reports that 4.8 million Texans were uninsured in 1997, up from 4.6 million in 1996. These individuals are responsible for the majority of uncompensated health care expenses, which are passed on to other payers, often in the form of increased taxes and higher hospital charges for insured patients. In 1993, uncompensated hospital costs in Texas totaled 2.91 billion dollars; in 1996, those costs had increased by 23 percent, for a total of $3.59 billion.[30] Opponents of mandated benefits have argued that elimination of mandates would enable more employers to purchase coverage for their uninsured employees, thus reducing the number of uninsured Texans. However, anecdotal information suggests there may be little relationship between a state's uninsured rate and the number or cost of mandated benefits. For example, one study found that mandated benefits in Maryland account for as much as 21 percent of premium.[31] Yet Maryland has a relatively low uninsured rate of 13.4 percent, which is below the national average of 17.7 percent.

In an effort to address the lack of insurance among small employers, many state legislatures enacted laws allowing small employers to purchase "bare-bones" coverage which excludes state mandated benefits. However, availability of this less-expensive health insurance option has experienced only modest success. Addressing the problems of the uninsured population has proven to be a difficult task, partly because the issues contributing to their insurance status are complex. To better understand why small employer reforms have not been more successful and to develop future programs that will more effectively meet the needs of the uninsured, it is necessary to consider the specific characteristics of this large group of uninsured citizens.

Characteristics of the Uninsured Population – National Data

Most of the information on the uninsured and insured population is obtained from the annual Current Population Survey (CPS) conducted by the U.S. Census Bureau. The March CPS survey includes a detailed set of questions on both private and public health insurance. While the survey covers only a very small number of US citizens, each state has a representative sample size to assure accuracy for that state's population. In its most recent report, which covers calendar year 1997, the U.S. Census Bureau reports that the following individuals are most likely to be uninsured:

- Young adults between the ages of 18-24
- Persons of Hispanic origin
- Individuals with lower levels of education
- Part-time workers
- Persons not born in the United States

[30] "Texas Hospitals Utilization and Financial Trends, 1993-1996",Texas Department of Health, Bureau of State Health Data and Policy Analysis, 1998.

[31] Blue Cross, Blue Shield of Maryland, "Presentation to the Commission on Mandated Health Insurance Benefits", Governor's Commission on Health Care Policy and Financing, October 19, 1988.

Some additional highlights from the CPS report provide more details on who is uninsured. Unless otherwise noted, the data provided are national statistics:

- Approximately 16.1 percent of the US population were without health insurance coverage during 1997. Texas tied with Arizona for the highest percentage of uninsured citizens, with 24.5 percent of the state population (4,836,000 citizens) reported as uninsured.

- The highest uninsured rate was among people of Hispanic origin:

Race/Ethnicity	Percent Uninsured
White	15.0%
Non-Hispanic White	12.0%
Black	21.5%
Asian/Pacific Islander	20.7%
Hispanic	34.2%

- Foreign-born citizens are much more likely to be uninsured than people born in the United States:

Citizenship	Percent Uninsured
Native citizen	28.1%
Foreign-born citizen	51.7%
Naturalized citizen	34.8%
Not a citizen	56.3%

- Despite Medicaid availability for eligible individuals, the poor (family income at poverty level) and near poor (family income between 100 and 125% of poverty level) are still more likely to be uninsured. About one half (49.2%) of poor full-time workers were uninsured in 1997, down from 52.2 percent in 1996. Among the near poor, 30.8 percent were uninsured.

Employment and income greatly influence who is insured and uninsured. The 1997 CPS survey shows that 85% of the uninsured lived in families headed by employed workers. However, a comparison of uninsured and insured workers shows considerable differences in the type of industry, size of firm, work hours and income. Understanding these variances in work status is critical to developing effective insurance reforms that will address the specific needs of the uninsured population.

Because only limited data on the 1998 CPS survey results are available at this time, the 1997 CPS survey was used to obtain the following detailed information on employment factors which characterize the uninsured population. [32]

Work Status
Most of the uninsured are employed or live in families with an employed family head, but for a variety of reasons insurance is either not available from the employer or unaffordable.

[32] Employee Benefit Research Institute, "Source of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey," EBRI Issue Brief Number 192, December 1997.

- 59.5% of uninsured lived in families where the family head worked full-time for a full year
- 25.5% of the uninsured lived in families where the family head worked part-time
- 15.5% of the uninsured lived in families with unemployed family head

Firm Size

A majority of uninsured workers are employed at firms with less than 50 employees. However, a considerable number of employees at large firms are also uninsured. While small employers often do not offer insurance for a variety of reasons, most *large* employers do. Many of these firms, however, have eligibility criteria that exclude certain employees from enrolling in the health plan. For example, though exact statistics are not known, studies suggest that most uninsured workers at large firms are classified as temporary or "part-time" and cannot participate in the firm's health insurance plan. A national survey of employer sponsored health benefits reports that only 47 percent of firms offer health insurance to part-time employees, and only eight percent will insure temporary employees. [33] Other employees may not be eligible due to requirements that they be employed for a minimum time period (3-12 months).[34]

Additional facts from the 1997 CPS Survey:

- 48% of uninsured workers (11.2 million people) were either self-employed or worked in private sector firms with fewer than 25 employees; however, five million uninsured employees worked in firms with 500 or more employees

- 33% of employees in firms with less than 10 employees were uninsured and 28% of employees in firms with 10-24 employees were uninsured.

- 11.9% of employees in firms with 1,000 employees were uninsured

[33] *Health Benefits in 1997*. KPMG Peat Marwick, June 1997, Pg. 17.
[34] *Employer-Sponsored Health Insurance*. National Center for Health Statistics, DHHS Publication No. (PHS)98-1017, December 1997.

Type of Industry
Uninsured rates vary considerably by industry category. In most cases, there is a strong relationship between industry type and employee income, both of which largely influence whether insurance is available to employees. Businesses with a high percentage of low-paying, temporary, part-time or seasonal jobs are less likely to provide insurance. As a result, certain industries have a disproportionate number of low-income workers, and a correspondingly high number of uninsured employees. States with a large number of such jobs experience a higher than average number of uninsured citizens. Again, using the 1997 CPS survey, the following information is available:

- The majority of uninsured people list their primary employment as retail, manufacturing or professional services, or are self-employed:

Table 5-1
Uninsured Workers Ages 18-64 by Industry Type

Industry Type	Number of Uninsured Workers	% of Uninsured Working Population
Retail	5.4 Million	23.3%
Manufacturing	2.7 Million	11.6%
Professional Services	2.2 Million	9.5%
Construction	2 Million	8.7%
Business/Repair Srvcs.	1.8 Million	7.7%
Government	1.2 Million	5.1%
Personal Services	1.2 Million	5.1%
Transportation, Communications, Utilities	1.0 Million	4.1%
Agriculture	0.9 Million	4.0%
Wholesale	0.6 Million	2.7%
Finance, Insurance and Real Estate	0.6 Million	2.7%
Entertainment	0.5 Million	2.0%
Mining	0.1 Million	0.3%
Self-Employed	3.0 Million	13.3%
Total	**23.3 Million**	**100%**
Source: Employee Benefit Research Institute estimate of the March 1997 Current Population Survey		

- Some industries have a much higher rate of uninsured employees than others. As the table below shows, individuals are most likely to be uninsured if they work in agriculture (39% of workers are uninsured), construction (31.3% of workers are uninsured), or retail trade (26.3% of workers are uninsured).

Table 5-2
Uninsured Workers By Type of Industry

Industry	Percentage of Uninsured Workers within Industry
Industry Average	**17.5%**
Agriculture	39.0%
Personal Services	33.1%
Construction	31.3%
Retail	26.3%
Business & Repair Services	25.0%
Self-Employed	24.2%
Entertainment	23.3%
Wholesale	14.7%
Transportation	13.4%
Manufacturing	12.8%
Professional Services	11.8%
Mining	10.2%
Finance, Insurance, Real Estate	8.7%
Government	6.3%
Source: Employee Benefit Research Institute estimates of the March 1997 Current Population Survey	

The Uninsured in Texas – How Texas Compares with Other States

While national data provides valuable information that is necessary for the development of federal policies and in identifying trends in health care costs and benefits, state level information is critical to the development of policy decisions that address the specific needs of a state's uninsured population. Because Texas has an unusually high rate of uninsured citizens compared to the national rate, policymakers need to be aware of population characteristics that most influence the uninsured and how Texas differs from national trends.

Unfortunately, most of the published data provides very little state-level analysis. However, the Employee Benefits Research Institute has separately analyzed CPS survey results on a state-by-state basis and has published some of that data. Based on their most recent report, the following information provides a closer look at the uninsured Texas population.[35]

- Texas workers were less likely to have employment based health insurance than citizens in other states. The Texas rate of employment-based health insurance coverage for workers between the ages of 18 and 65 was 66.5% compared to the national average of 72.3%.

- Consistent with national trends, larger firms were more likely than small firms to provide health insurance. Of those Texas workers employed by firms with 1,000 or more employees, 67.5% had coverage in their own name, compared to only 21.2 % of workers in firms with less than 10 employees.

[35] McDonnell, Ken, "Sources of Health Insurance and Characteristics of the Uninsured, West South Central States, 1996". *Facts from EBRI*, Employee Benefits Research Institute, July 1998.

- A total of 74.3% of full-time workers had employment-based insurance compared to 50% of part time workers. Twenty-one percent of all full-time workers were uninsured, compared to 32.8% of all part-time workers.

- Texas workers in personal services and agriculture industries had the highest uninsured rates; 57.3% of personal services employees and 47.6% of agriculture workers were uninsured. Government workers had the lowest uninsured rate at 7.9%, followed by employees of mining companies (10.2%).

- Thirty-seven percent of children living in families with incomes between 100 and 149 percent of poverty were uninsured compared to 7.3% of children in families with incomes of 400% or more.

Using additional information provided by EBRI, further analysis has been developed on how the uninsured population in Texas compares with other states. Table 5-3 summarizes data comparing five states with relatively high uninsured rates (Texas, Arizona, California, Florida, New York) with five states that report low uninsured rates (Illinois, Maryland, Ohio, Pennsylvania and Virginia). A review of this data reveals several obvious patterns that are consistent with national trends, indicating significance differences between the populations of states with high rates of uninsured citizens and states with low rates.

- In every case, the five states with high uninsured rates have a significantly greater percentage of non-citizens than states with low uninsured rates. The percentage of noncitizens in states with low rates ranged from only 1.2% up to 6.3% compared to ranges of 10.7% to 18.2% in states with high uninsured populations. Texas' rate, at 9 percent, is more than seven times higher than both Ohio's and Pennsylvania's.

- With only one exception (California) the median household income was higher in every state with low uninsured rates than in states with high uninsured rates. States with high numbers of uninsured citizens also had lower income levels than the national average of $35,287.

Table 5–3
Population Characteristics of States with High and Low Rates of Uninsured Citizens

	Total Population	% of Uninsured Citizens	% of Non-Citizens	Median Household Income	% of Population with Employment Based Insurance	% of Full-Time Workers w/Insurance	% of Part-Time Workers with Insurance	% of Workers who are Union Members
National	234 Million	17.7%	6.7%	$35,287	64%	Not available	Not available	14.5%
States with Relatively High Rate of Uninsured Individuals								
Texas	17.4 Million	26.7%	9.0%	$33,029	57.4%	74.3%	50.0%	6.6%
Arizona	4.2 Million	27.7%	11.2%	$31,706	52.4%	67.4%	46.2%	5.9%
California	28.9 Million	22.3%	18.2%	$38,457	55.9%	73.4%	47.3%	16.5%
Florida	11.8 Million	22.9%	10.7%	$30,632	56.4%	71.8%	49.6%	7.5%
New York	16.2 Million	19.1%	13.4%	$34,707	61.1%	78.3%	65.3%	26.8%
States with a Relatively Low Rate of Uninsured Individuals								
Illinois	10.5 Million	12.5%	6.3%	$39,375	71.5%	85.9%	68.8%	20.0%
Maryland	4.5 Million	12.9%	6.0%	$43,123	70.8%	82.4%	66.7%	14.8%
Ohio	9.8 Million	7.5%	1.2%	$35,022	71.6%	85.5%	76.3%	19.5%
Pennsylvania	10.2 Million	11.1%	1.7%	$35,221	72.4%	87.1%	64.3%	17.7%
Virginia	5.7 Million	14.0%	4.1%	$38,252	67.0%	81.9%	68.5%	6.8%

Sources: Employee Benefit Research Institute estimates of the March 1997 Current Population Survey; the U. S. Census Bureau; the U.S. Bureau of Labor Statistics

- States with high rates of uninsureds had a lower percentage of both part-time and full-time workers with insurance. In some cases, the difference was more than 15 percent in comparison with states with low uninsured populations.

- With a few exceptions, states with low uninsured rates also had higher percentages of union member employees than states with high uninsured rates. For example, Texas reports that 6.6% of workers who belong to a union compared to rates that were more than twice as high in Illinois (20%), Ohio (19.5%), Pennsylvania (17.7%) and Maryland (14.8%).

Because the majority of uninsured citizens are either employed or are dependents of employed workers, analysis of specific employment characteristics is critical. Using additional information provided by the Employee Benefit Research Institute, Table 5-4 compares employment characteristics of Texas, California and Illinois employees. These states were selected for a number of reasons. All three states have populations that are large enough to provide statistically valid sample sizes for state-level CPS data. Both Texas and California also have high uninsured rates and share similar demographic characteristics. Illinois has a relatively low uninsured rate (12.5%), allowing for a useful analysis of the links between employment and prevalence of insurance coverage and how those factors differ among the three states.

All three states report striking similarities, but also some interesting differences. Retail employees represent the highest percentage of uninsured workers (22.5%, 21.4%, and 22.0%) in all three states, followed by manufacturing employees in California (15.5%) and Illinois (12.1%). In Texas however, self-employed individuals hold second place with 13.5 percent of the uninsured; construction workers are the third largest segment of the uninsured workers at 10.4 percent.

Table 5-4
Employment and Uninsured Rates for Workers Age 18-64 By Industry Type and State: Texas, California, Illinois

Column A : Employment Rate *– the total percentage of workers age 18-64 by industry (i.e., in Texas, 15.2 percent of all workers are employed in government jobs)*

Column B: Uninsured Rate *– the total percentage of the uninsured working population by industry (i.e., in Texas, government employees represent 4.7 percent of uninsured workers)*

Industry	Texas		California		Illinois	
	A	B	A	B	A	B
Government	15.2%	4.7%	13.9%	5.2	13.3	0.0
Agriculture	2.0	3.9	3.2	6.4	1.0	2.0
Mining	1.5	0.6	0.3	0	0.1	0.0
Construction	5.9	10.4	3.8	5.7	5.5	7.2
Manufacturing	12.7	8.2	15.8	15.5	17.0	12.1
Transportation/Utilities/ Communication	5.6	4.5	4.8	4.0	7.0	0.0
Wholesale	3.6	2.9	3.4	3.2	2.8	2.0
Retail	15.3	22.5	14.7	21.4	12.9	22.0
Finance/Insur/Real Estate	4.7	2.6	5.0	3.4	6.7	3.6
Business/Repair Services	6.1	7.8	6.2	7.0	6.0	11.0
Personal Services	2.7	6.2	3.4	5.3	2.0	5.0
Entertainment/Recreation	1.5	2.2	1.7	2.1	1.6	4.8
Professional Services	13.5	9.7	12.6	8.3	15.0	10.3
Self-Employed	9.5	13.5	10.9	12.5	8.5	9.5

From a different perspective, comparisons can be made of the relative probability that an employee will be uninsured if he/she works for a particular industry. Table 5-5 shows the percentage of uninsured workers within each industry category. Nationally, employees are most likely to be uninsured if they work in agriculture, personal services or construction. Though Texas rates are considerably higher than the national average, the same three categories have the highest uninsured rates though in a different order. Texas employees are most likely to be uninsured if they work in personal service industries (57.3% of workers are uninsured), agriculture (47.6% are uninsured) or construction (44.3% are uninsured). Interestingly, in Illinois, workers in the entertainment industry have the highest uninsured rate; 37.7 percent of all entertainment workers have no coverage.

Table 5-5
Uninsured Workers Age 18-64 by Type of Industry Texas, Illinois, California

Industry	National	Texas	Illinois	California
Agriculture	39.0	47.6%	23.5	45.5
Personal Services	33.1	57.3	31.0	35.0
Construction	31.3	44.3	16.2	33.7
Retail	26.3	37.3	21.2	32.9
Business & Repair Services	25.0	32.3	22.6	25.3
Self-Employed	24.2	36.2	13.9	25.9
Entertainment	23.4	39.4	37.7	27.6
Wholesale	14.7	20.5	8.5	21.6
Transportation	13.4	20.7	7.6	18.8
Manufacturing	12.8	16.3	8.8	22.2
Professional Services	11.8	18.2	8.5	14.8
Mining	10.2	10.2	0.0	5.7
Finance/Insurance/Real Estate	8.7	14.1	6.5	15.2
Government	6.3	7.9	5.5	8.5

This data raises some interesting questions about Texas' and California's high uninsured rate compared Illinois' low uninsured rate. While one might expect uninsured rates within industry types to be comparable across state lines, this data indicates significant differences. For example, in Illinois, only 23.5 percent of agriculture workers are uninsured compared to 47.6 percent in Texas and 45.5 in California. Only 16.2 percent of construction workers in Illinois are uninsured, compared to 44.3 percent in Texas. In California, the rate is more than 10 percent lower than in Texas (33.7 percent compared to 44.3 percent). In fact, with only three exceptions, Texas consistently shows a higher rate of uninsured employees than California. In four of those categories – personal services, construction, self-employed, entertainment – the Texas uninsured rate is at least ten percent higher than in California.

These comparisons suggest that more information may be needed to determine why Texas employees are less likely to have insurance than those employed in the same occupation in other states. Do Texas employers simply not offer coverage and, if so, why don't they? Or do they require employees to pay more of the cost of insurance, resulting in fewer employees accepting coverage? Are the differences due to lower wages paid to workers in Texas, and if so, why? This information must be determined in order to develop truly effective insurance reforms that address the specific reasons why Texas employees have no health coverage.

Declining Health Insurance – Are Mandates A Factor?

One of the more frequent arguments raised against mandated benefits suggests that states with relatively high numbers of mandated benefits will have more uninsured citizens since those states' employers are less likely to offer coverage due to the increased costs associated with mandates. However, a study of the effects of state regulations on premium did not find evidence that premiums were higher in states with a large number of mandates than in states with few mandated benefits.[36] A separate study further concluded that self-insuring was no more likely in states with many mandates than in states with fewer mandates.[37] Neither of these studies, however, compared uninsured rates based on the prevalence of mandated benefits within various states.

To determine whether there is evidence of any direct relationship between mandated benefits and the uninsured rate, Table 5-6 provides state comparisons of uninsured rates and the prevalence of mandated benefits. While there are some states with both a high number of mandates and high uninsured rates, there is no consistent pattern that suggests an obvious connection between mandated benefits and a state's uninsured population. States with a high uninsured rate have a varying number of mandated benefits ranging from 16 to 27. Likewise, states with low uninsured rates have between 11 and 29 mandated benefits. For example, Texas has a high uninsured rate of 26.7 % and a total of 20 mandated benefits, which is slightly higher than the average of 18. In comparison, Minnesota has an uninsured rate of 11.3%, but has a total of 29 mandated benefits. Wisconsin has the lowest uninsured rate of all states, at 9.5%, but has 19 mandated benefits. And while some states with low uninsured rates had a relatively low number of mandated benefits (New Hampshire, Michigan and North Dakota), some states with high uninsured rates also had relatively low number of mandates (Louisiana, Arizona).

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[36] Jensen, G., K. Cotter and M. Morrisey, "State Insurance Regulations and Employers' Decisions to Self-Insure," Journal of Risk and Insurance, June 1995, pp. 185-213.

[37] Garfinkel, S., "Self-insuring employee health benefits," Medical Care Research and Review; Vol. 52, 1995; pp. 475-491.

From another perspective, state uninsured rates were compared in those states with the lowest number of mandated benefits and those with the highest number of mandated benefits (Table 5-6). States with the lowest number have uninsured rates ranging from 14.0% up to 18.6%, most of which are slightly better than the national average of 17.7%. However, states with the highest number of mandates have much greater variance in uninsured rates. In fact, both Maryland and Maine have the highest number of mandates of any state at 30 and 29, respectively, but both have low uninsured rates of only 12.9% and 14.0%. These data do not indicate any distinct link between the prevalence of mandated benefits and uninsured citizens. However, this illustration does not entirely dismiss the idea that mandated benefit costs are a factor that, when combined with other costs, contributes to an employer's or individual's decision to not purchase insurance. It does, however, raise questions as to the relative significance of mandated benefits. If mandates do, in fact, considerably increase the cost of health insurance, then it would follow that states with the most mandates would have the highest insurance costs and, thus, the highest uninsured population. However, that is not the case. Obviously there are other factors that impact health insurance costs and employers' health insurance purchasing decisions.

Table 5 – 6
Comparison of Relationship Between Uninsured Rates and Number of Mandated Benefits by State

A. States w/High Uninsured Rates	Uninsured Rate	# of Mandates*
Arizona	27.7%	16
Texas	26.7	20
Arkansas	24.9	19
New Mexico	24.7	19
Louisiana	23.3	15
Florida	22.9	27
B. States w/Low Uninsured Rates		
Wisconsin	9.5%	19
New Hampshire	10.9	11
Michigan	10.1	14
Pennsylvania	11.1	23
South Dakota	11.1	15
Minnesota	11.3	29
North Dakota	11.3	14
C. States w/the Fewest Mandates		
Idaho	18.6%	6
Delaware	14.8	8
Wyoming	15.2	8
Kentucky	17.6	8
Vermont	12.4	9
Alabama	14.9	10
D. States w/the Most Mandates		
Maryland	12.9%	30
Minnesota	11.3	29
Florida	22.9	27
California	22.3	25
Connecticut	12.5	25
Virginia	14.0	23
*Source: Blue Cross and Blue Shield Association		

Though the relative importance of specific factors responsible for the growing number of uninsured may not be clear, there is no question that the problem is becoming increasingly serious. The percentage of uninsured Americans has been growing since at least 1987. Nationally, the percentage of uninsureds has grown from 14.8 percent in 1987 to 16.1 percent in 1997 for a total of 43.4 million uninsured citizens. Some studies have suggested that a decline in employment based health insurance coverage is largely responsible for the increase in the uninsured population. In 1987, 69.2 percent of Americans had insurance through an employer, but the number slowly dropped in subsequent years, reaching a low of 63.5 percent in 1993. In recent years, the trend has reversed, however, with 64 percent of individuals insured under an employment based policy in 1996.

Statistics show that a decline in public sources of health insurance is at least partly responsible for the increased number of uninsureds. Welfare reform has limited benefits for some low-income citizens, resulting in fewer people receiving Medicaid. In 1993, 12.7 percent of the population received insurance benefits under Medicaid but by 1997, the number dropped to 10.8 percent. Many of the individuals who left the Medicaid program are now employed in low paying jobs that do not provide health insurance benefits, leaving these people and often their families uninsured. Government programs providing benefits for military employees under CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program for the Department of Veteran Affairs) have also reduced the number of enrollees, down from 3.8% of the population in 1994 to 2.0% in 1996.

Much of the increase in the number of people without insurance is attributed to uninsured children. In 1995, 13.8 percent of children were uninsured compared with 14.8 percent in 1996. During this same one-year period, the number of adults who were uninsured actually decreased from 19 percent to 18.9 percent. Anecdotal data suggests that the increased number of uninsured children may be at least partly due to recent changes in welfare that have resulted in fewer children enrolling in Medicaid, even though they are eligible for coverage.[38] Others likely lost coverage as employers discontinued contributions towards dependent coverage, forcing lower income employees to drop coverage due to their inability to afford the premium costs.

Researchers suggest a variety of factors share the blame for increasing numbers of uninsured. Recent studies provide the most sophisticated analyses and the most specific information to date. A review of the decline in employment-based health insurance found that declines in family income and structural changes in the economy – such as the movement from manufacturing to the service industries – were responsible for 35 percent of the loss of employment–based insurance.[39] Size of the employer's firm also played a strong role. Approximately 18 percent of the decline in insurance was related to shifts in workers moving from large firms to small firms. Other factors include the increasing use of part-time workers (seven percent of the decline in coverage) and decreased unionization (six percent).

Policies Without Mandated Benefits – Small Employer Insurance Reforms

Since 1989, more than 40 states – including Texas – have passed health insurance reforms designed to make health insurance more accessible and attractive to small businesses. Though the definition of a small business varies, Texas and most other states define small employers as those with no more than 50 employees, which is consistent with the federal definition used in the Health Insurance Portability and Accountability Act (HIPAA). These employers were targeted for reform since the majority of all uninsured workers are either self-employed or work in small firms.

Unfortunately, the reforms have generally met with limited success and have expanded coverage by only a modest amount. In a study sponsored by the Henry J. Kaiser Foundation, small group market reforms were reviewed to determine their impact on the uninsured.[40] Reform efforts were classified into three categories:

> **Bare Bones Policies**: These laws allow insurers to sell plans that are exempt from most state mandated benefit laws and, in some cases, premium taxes, thus allowing small firms to purchase insurance at a lower price;
>
> **Premium Regulations**: Impose limits on premium increases and/or establish community rating requirements that are intended to narrow the differences in premiums for small groups so that costs are more affordable.
>
> **Standards for Underwriting and Contracting Practices**: Includes marketing and underwriting criteria that are designed to make coverage more attractive and more widely

[38] Fronstin, Paul, p. 5.
[39] Acs, Gregory. "Explaining Trends in Health Insurance Coverage Between 1988 and 1991." *Inquiry,* Volume 32, Spring 1995, pp. 102-110.
[40] Jensen, Gail and Michael Morrisey, "State Reforms of Small Group Health Insurance" and "Small Employers and Health Insurance". The Henry J. Kaiser Foundation, September 1997.

available to small employers. Includes such provisions as guaranteed issue, guaranteed renewability, and limits on pre-existing condition restrictions.

The researchers found that approximately 11% of small business insurance purchases in 1995 were attributed to reforms, resulting in an increase of about nine percent of workers who would not otherwise have coverage. Future increases are not expected as reforms have reached their potential to expand coverage. The study concluded that small employer reforms have had a limited effect because they fail to address affordability of coverage. When controlling for other factors that affect health insurance costs (such as deductibles and coinsurance requirements), the average price of health insurance for small firms was unaffected by insurance reforms.

Using information collected under a separate survey, the Kaiser Foundation also looked at reasons why small employers do not offer health insurance. Employers reported that cost was the most significant reason, but not the only one. As the table below indicates, employers also report the firms' profits are too uncertain, health insurance is not a high priority among workers, and administrative burdens are too much trouble.

Table 5-7
Six Most Common Reasons Small Firms Give For Not Offering Health Insurance, 1995

Premiums too high	83%
Premium increases uncertain	75%
Business profits too uncertain	75%
Workers prefer higher wages	61%
Employees have coverage under spouse's or parent's policy	60%
Administrative hassle	60%
Source: 1995 Wayne State University Survey of Employer Sponsored Health Benefits in Small Firms	

A separate study of the effect of "bare-bones" regulations found similarly disappointing participation results. In a review of 16 states that allow the sale of limited benefit policies to small employers, employers and employees overwhelmingly selected plans with standard, comprehensive benefits over the less-expensive plans with limited benefits.[41] The study found that waivers of state mandated benefits appealed to a limited number of employers and suggested that additional insurance market reforms are required to make health insurance more widely available and affordable. Other researchers also concluded that bare bones policies have been unpopular and fail to adequately reduce the cost of insurance. Reductions in premium costs were determined to be mostly due to increased deductible and copayment requirements and reductions in hospital benefits. The exclusion of mandated benefits was found to have little if any effect on premiums.[42]

An extensive review of 11 different demonstration projects established under the Robert Wood Johnson Foundation's Health Care for the Uninsured also looked at projects designed to make insurance more affordable for small firms. The study found that even with premium reductions of 25 to 50 percent below market rates, most projects had enrolled fewer than 10 percent of the

[41] "No Sale: The Failure of Barebones Insurance". Families USA Foundation, July, 1993.
[42] Hilts, Philip J., "Bare Bones Health Insurance Found to Attract Few Buyers," *New York Times*, July 23, 1993.

uninsured small businesses after two years of operation.[43] The study suggests that if employers are to continue as the primary source of health insurance, policymakers must address the fundamental problems regarding the small-group market. Some suggested approaches are:

(1) Aggressive marketing and education efforts aimed at small firms should be used to make the working uninsured and their employers aware of affordable products and how to purchase them.
(2) Development of government subsidies to help low-income workers and their families obtain coverage at an affordable rate.
(3) Establishment of programs to provide affordable individual coverage for those not covered by an employer-sponsored plan, including part-time, temporary, and seasonal workers.

Texas' Small Employer Market Experience

Small employer health insurance reforms passed by the Texas Legislature in 1993 and amended in 1995 resulted in the adoption of two standard group policy forms that exclude many of the mandated benefits required under large group policies. Insurers are required to make these policies available to any small employer, but they may also continue to sell the same full-coverage policies that include all the mandated benefits. Benefits offered under the two standard plans are comparable in many ways, but there are also some notable differences. Both the Basic and Catastrophic plans must provide:

- Physician/provider services for treatment of illness or injury;
- Hospital benefits
- Anesthesia
- Outpatient Services
- X-Ray and Laboratory Services
- Maternity Benefits
- Limited coverage of durable medical equipment, physical therapy, skilled nursing care, home health care

The Basic Plan also offers a preventive care benefit rider that includes coverage for well-child care, immunizations and annual check ups. Both plans offer coverage for alcohol/drug abuse, mental health care, and prescription drugs for an additional premium.
The Catastrophic Plan also provides increased levels of benefits for durable medical equipment, physical therapy, skilled nursing facility and home health care, and covers hospice care and certain organ and tissue transplants.

The most significant differences between the two plans are requirements for deductibles, co-insurance payments, and limits on out-of-pocket expenses to consumers. The Catastrophic plan requires relatively high deductibles of $2,500-$5,000 and annual out-of-pocket limits of between $5,000 and $10,000. In comparison, the Basic plan requires an annual deductible of only $500 and $3,000 annual out-of-pocket limit. These features are significant since they reflect at least a $2,000 difference in the amount of health care expenses that insureds are personally responsible for. While high deductibles and coinsurance requirements translate into considerably lower premium costs for employers, such plans are often unappealing to employees, particularly low-income workers.

[43] Helms, David W., Anne K. Gauthier, and Daniel M. Campion, "Mending the Flaws in the Small-Group Market," *Health Affairs*, Vol. 11, No. 2, Summer 1992, pp. 7-27.

In addition to requiring insurers to offer the two standard benefit plans to small employers, several other provisions were included in the Small Employer Health Insurance Availability Act. The Act established safeguards for health benefit plans sold to small employers and created several options for employees who want to keep coverage when they leave a job. Insurers are required to accept all groups without consideration of health conditions. Waiting periods that exclude coverage of pre-existing health conditions are now limited to no longer than one year, and employees may receive "credit" for the time he or she had coverage under a previous job. Insurers are also required to offer coverage for dependents, although the employee is usually responsible for paying the additional premium cost. Premium rate increases are limited and all rates must fit within two broad pricing bands.

Despite predictions that some of these added provisions (particularly guaranteed issue) would do more harm than good by increasing premiums and reducing the number of small employers with health insurance, statistics indicate that the Texas reforms are working. Since 1993, the number of small employers with health insurance has more than doubled from 36,952 to 83,437 (Table 5-8) in 1997, which represents about 28 percent of the 296,694 Texas employers with less than 50 employees as of September 1996. However, anecdotal data suggests that reforms other than the availability of alternative plans that exclude mandated benefits are largely responsible for the large increase in the number of insured small employers. Plan enrollment statistics show that the majority of employers have elected to provide the same comprehensive benefit plans sold to large employees rather than purchase the Basic or Catastrophic plans. Less than eight percent of employers chose the standard plans that exclude most of the mandated benefits in 1993 and 1994, and the percentage dropped to under seven percent in 1995 and 1996.

Table 5-8
Texas Small Employer Health Plan Enrollment – 1993-1997

	1993	1994	1995	1996	1997
Total Number of Small Employers w/Health Plans	36,952	50,144	63,698	74,164	83,437
Total Number/Percentage of Small Employers w/Standard Plans That Exclude Most Mandated Benefits	2,803 7.58%	3,855 7.68%	4,279 6.7%	5,046 6.8%	5,092 6.10%
Total Number/Percentage of Small Employers w/Full Coverage Plans That Include Mandated Benefits	34,149 92.4%	46,289 92.3%	59,419 93.2%	69,118 93.1%	78,345 93.8%

While there is no statistical explanation for the surprisingly low enrollment in the standard Basic and Catastrophic plans, some researchers have found that employers and consumers are generally uninterested in limited benefit plans except as a last resort. Employers who purchase insurance in order to remain competitive with other businesses must provide benefits that are relatively comparable in order to attract and retain employees. Limited information collected from insurers by TDI indicates that the rates charged for the standard plans are considerably lower, which would suggest that the level of benefits also plays a significant role in an employer's health insurance decisions.

Subsidy Programs For the Uninsured

To date, most of the state insurance reform programs have focused on uninsured children, small employer groups, and low-income workers. Statistics show that most uninsured individuals fall into at least one of these categories so it makes sense that reform efforts would address the needs of these specific populations.

Texas' legislative reforms have primarily focused on uninsured children and small employer reforms. The Texas Healthy Kids Corporation was established by the 75th Legislature and has just begun enrolling children in limited areas of Texas. Because this is a new program, no data is available on the number of children the program will reach, but experience in other states has shown this program to be very successful in providing coverage for children whose parents can afford the relatively inexpensive premium. As discussed above, Texas' small employer reforms have been somewhat successful based on the increased number of employers providing coverage. However, there are still many small employers who do not offer insurance for a variety of reasons, but primarily because of cost.

A number of states have developed insurance programs specifically for low-income individuals and families that do not qualify for Medicaid but cannot afford or do not have access to any other type of insurance. Some states have directed their efforts toward Medicaid expansion coverage for low-income pregnant women and children while others have developed broader approaches that generally involve subsidized insurance programs. Although the success of these programs has varied significantly, there are a number of common "lessons learned" that run throughout.

While there is no direct correlation between any of these insurance programs and mandated benefits, the relationship between premium costs and insurance participation is a common factor that affects all insurance plans regardless of what benefits are included. Mandated benefits have been targeted as contributing to the uninsured population in Texas, and both employer and insurance groups have recommended that limiting future mandates or allowing employers to purchase policies without mandates would increase the number of Texans with insurance. However, the experience of other states' programs suggest that considerable cost reductions are necessary in order to significantly increase the number of people with insurance. Whether or not these cost reductions can be accomplished through the elimination of mandates is certainly debatable. However, before considering such proposals, it is worth noting the experience from other states.

In a review of state insurance subsidy programs, researchers reviewed data from Hawaii, Minnesota and Washington to determine how many eligible people actually enrolled in the program and the relationship to income.[44] Although the three programs differ in significant ways, all three offer health insurance on a sliding scale basis to uninsured residents. Premium subsidies were primarily directed towards families and individuals under 200 percent of poverty level; subsidies either ended or decreased significantly at 200 percent. Plan benefits and premium costs varied among the three programs, but all provided comprehensive health insurance coverage.

Despite the differences among the state populations and the plan costs, the plans' participation rates relative to income were strikingly similar. The results showed that when premiums are one percent of income, a majority (57 percent) of the eligible uninsured would participate. At three percent of income, 35 percent of the uninsured would join. When premium costs increase to five percent of income, only 18 percent would participate. Using a hypothetical family of two at 200 percent of poverty (about $21,000), the researchers found that the average cost of health insurance under these programs would represent about 14 percent of the family's total income, or $2,940 (which is considerably lower than the national average cost of approximately $5,000 for employment based coverage). If a state program subsidized as much as half the cost (seven

[44] Ku, Leighton and Teresa A. Coughlin, "The Use of Sliding Scale Premiums in Subsidized Insurance Programs". The Urban Institute, March 1997.

percent), the family would still need to pay about $1,470. The study concluded that at this level, less than 10 percent of the families eligible for the subsidy would participate.

This data is significant because it illustrates how "affordability" varies considerably by income. While the programs above were aimed at encouraging individuals to purchase insurance as opposed to employers, any effort in Texas that is intended to attract the uninsured must adequately address the problem of affordability as it applies to those individuals in order to be successful. While small decreases in insurance costs may result in a small number of people purchasing insurance, research indicates that substantial cost decreases or premium subsidy programs will be necessary to significantly impact the uninsured population.

This data is particularly useful since many of the questions about the affordability of insurance hinge on determining a specific cost that an individual or family is willing or able to pay for coverage. These studies suggest that looking at cost as a percentage of total income is a more effective way of determining what is or is not affordable.

Conclusion

Comprehensive health insurance coverage is essential to guarantee that individuals have access to necessary medical care in a timely and cost-effective manner. Rising numbers of uninsured individuals has become both a national and statewide public policy concern. This is particularly true in Texas, where nearly five million people are uninsured. While a number of initiatives have been tried in various states in order to improve affordability and accessibility of health insurance, many of these programs have failed because they did not adequately consider the economic and social characteristics of the uninsured. Although mandated benefits do contribute to the cost of health insurance, studies have shown that significant improvements in the number of people with insurance will require major policy changes that result in either premium subsidy programs or significant reductions in the insurance benefits provided under group policies. Small group health insurance reforms have been successful in increasing the number of small employers with coverage, but the total number of uninsured Texas has continued to rise. Thus, while piece meal approaches have not been particularly effective in improving the overall rate of insurance in Texas or in other states, some programs have been more successful than others and provide encouragement for states attempting to develop their own programs. To achieve substantial improvements in the number of Texans with insurance, however, will require targeted policy interventions that realistically address the specific needs of this complex population.

CHAPTER SIX
MANDATED BENEFIT EVALUATION LAWS

In 1979, John Larson, Ph.D., conducted one of the first comprehensive studies of mandated benefits and health insurance costs. Conducted at the request of the Virginia Bureau of Insurance, the Larson report concluded that mandated benefit legislation had been disjointed and failed to address the underlying problems in the health care system.[45] Larson found that …"the health insurance mechanism has clear limits as an instrument for remedying many of the very real problems with the health care delivery system…" and concluded that an in-depth analysis of each mandated coverage proposal is necessary. Larson went on to say that while reviewing the possible negative effects of mandated benefits is not intended to preclude further consideration of such proposals, these unintended consequences should be anticipated.

In his final recommendations, Larson suggested that all future mandated benefits proposed by the Virginia Legislature be subject to a rigorous review process to determine the necessity of the mandate and its potential impact on insurance costs. Within 10 years, more than a dozen states had established mandated benefit evaluation procedures as a requirement for consideration of any new mandated benefit legislative proposals. The success of such programs has varied considerably, however, largely due to a lack of data and unrealistic review criteria.

Experience of the Texas Mandated Benefit Review Panel

The Texas Mandated Benefit Review Panel was established by the Legislature in 1993 for the purpose of reviewing both existing and newly proposed mandated benefits in Texas. The panel's enabling legislation, Article 21.52D, TIC, specified that the Commissioner of Insurance appoint to the panel three senior researchers, two of whom were required to be experts in health research or biostatistics and serve on the faculty of a Texas university.

The panel encountered numerous problems throughout its four-year tenure. Finding qualified candidates who met the statutory criteria and who were willing to commit the time required to conduct a study of this magnitude was difficult and resulted in a one year delay before the appointments were finalized. The panel's initial meetings focused on the role of mandated benefits and the concept of using mandates as a policy for promoting public health goals for the state. While the panel did not reach any conclusion regarding these issues, the members agreed that development of a detailed statewide health care strategy that addresses the role of health insurance in relation to public policy goals would perhaps provide some answers about the appropriate role of government mandates in health insurance.

Before actually beginning the review process, the panel first developed a uniform methodology based on objective, scientific principles. The first step in the review process was determination of whether a mandate is defined in a way that enough information is available for assessing the cost impact. The panel agreed that mandated benefits that are too broad or general in nature are impossible to review due to the many factors that would affect the availability and reliability of data. For example, mandates that cover general populations of people, such as newborns with birth defects, encompass so many different medical services and types of treatments that it is impossible to calculate an average cost. While some information is available on specific congenital problems, such as heart defects or low birth weight, the conditions are too numerous to

[45] Larson, John G., Ph.D., *Mandated Health Insurance Coverage – A Study of Review Mechanisms,* Report to the Bureau of Insurance, State of Virginia, 1979.

be categorized into a single study. Too many factors are unknown. However, mandates that are specific as to the type of illness or type of service provided (such as TMJ or mammography screening) are generally good candidates for review.

The panel then established standard criteria for reviewing the efficacy, cost, cost effectiveness and medical necessity of each benefit. Because the panel was not given any funding for research studies or contracting for data, they relied solely on published studies and the limited data provided by insurers at the request of TDI. Much of the information needed was not available and the panel reported that this severely limited their ability to perform any type of meaningful cost analysis.

After establishing a process for reviewing mandated benefits and identifying the type of information that would be required, the panel members determined that the review criteria was generally unrealistic given the amount of time available (approximately one year for all existing mandates and 30 days for newly proposed legislation) and the level of detailed data analysis that would be required. The panel eventually chose one mandated benefit for a demonstration review in an effort to illustrate to legislators both the usefulness and the complexity of such an analysis. Mammography was chosen in large part because of the availability of statistics regarding the efficacy, cost and effectiveness of mammography.

During the 1995 and 1997 legislative sessions, the Mandated Benefit Review Panel was also required to review legislative proposals that included new mandated benefit requirements. During its initial session, six proposed mandates were referred to the panel. Under statutory guidelines, the panel was given 30 days to conduct its evaluation and issue a report summarizing its findings. Of the six bills referred to the panel, only three were reviewed. The panel recommended amending two of the bills and passage of the third as it was submitted. In all three cases, the legislation was passed as recommended by the panel.

The remaining three bills were returned to the Legislature without a review. As the panel explained in its report, these bills were quite lengthy and comprehensive and would require an extensive amount of research and analysis that could not be accomplished with the allotted 30 days. In at least one case, the panel questioned whether the referred legislation was actually a "mandated benefit" and should have been referred for review. Unfortunately, the panel's inability to respond to one of the proposals was particularly disturbing to the legislator who authored the bill. Other legislators were also both confused and concerned with the process. In most cases, legislators did not even realize that the mandated benefit legislation was subject to this review process until late in the session when timing was critical.

Recognizing these legitimate concerns, in February 1997 the panel issued a report that discussed these problems and included suggestions that the panel hoped would be used to improve the review process during the 75th Legislative Session. However, the recommendations were never implemented and the panel's enabling legislation was repealed. However the following summary of the panel's suggestions provides information that may useful in considering the establishment of a similar evaluation process in the future.

Recommendation One: Timeliness of Legislative Referrals

Although Article 21.52D, TIC, did not specify that a legislative proposal must be referred to the panel for review within a specific time frame, it did require that the panel be given 30 days within which to conduct the review once the referral was made. Under the best of circumstances, this 30 day deadline was difficult to meet, particularly if numerous proposals are referred at once. Both legislators and panel members felt pressure from unreasonable time constraints, particularly when

bills were referred relatively late during the session. The panel suggested that all legislative proposals subject to this review be referred to the panel within 5 calendar days after the bill is referred to committee. This would ensure that the Panel be allowed the full 30 days to conduct its review without endangering the legislation's chance for passage due to time constraints. The panel also suggested that other members, including the chairs of the House Insurance Committee and Senate Economic Development Committee, be allowed to refer legislative proposals to the panel for review rather than limiting that authority to the Speaker or Lieutenant Governor. The panel also suggested that the panel should be allowed to decline to review a proposal if the members agree that they cannot conduct an adequate review as required by statute within the time frame allowed (30 days). This would alleviate conflicts between panel members and Legislators who need an opinion from the panel in order for their bill to progress. In addition, this provision would also address any future questions that might arise concerning the legality or constitutionality of bills that were not appropriately reviewed by the panel as required by law.

Recommendation Two: Realistic Review Criteria and Funding

The panel was particularly concerned that the level of review required by the statute could not be reasonably conducted within a 30-day period. In designating the membership of the review panel (three senior researchers, two of whom must be experts in health research or biostatistics and must serve on the faculty of a university in Texas), the panel believed that the Legislature desired a scientifically oriented review that is unbiased, based on accepted scientific standards, and conducted by qualified, objective individuals. At the same time, however, it is obvious that individuals with such qualifications already have many professional demands. Under the best of conditions (i.e., where data is readily available and meets the criteria for review), thirty days is a relatively short time frame in which to conduct such a rigorous research-based review of new legislative proposals, particularly given the voluntary nature of the panel members. Most likely, the panel will be reviewing numerous proposals at once, further reducing the amount of time that can be spent on any single proposal.

In addition to reviewing new legislative mandates, the panel was also directed to review all existing mandates using the same rigorous research criteria as applies to new proposals. As pointed out earlier, the panel did not believe that most of the existing mandates could be adequately reviewed given that most of the data needed to evaluate cost and cost effectiveness is not available as it applies to past experience, is not currently collected by insurers or regulators, and cannot be obtained without substantial effort and expense. For these reasons, the panel agreed that it is impossible to conduct a review of all existing mandates using the review criteria described in the statute.

After reviewing other states' mandated benefit review procedures, the panel found that the most successful states provided funding and broader review criteria that allow for flexibility. In addition, reviews of new mandate proposals are conducted outside the legislative session (prior to being introduced) and, therefore, allow for a longer review period. For these reasons the panel offered the following suggestions:

A) Because the panel was not funded or staffed to conduct a rigorous scientific investigation, the panel suggested that it should be required to provide its' **professional opinion** as to the necessity of the proposed legislation. Language stating that the summary must include "...research evidencing the medical efficacy of the health care service; and the manner in which similar mandated benefit provisions enacted in other states have affected health care and health insurance costs in those states" implied that the panel members should actually conduct the research studies and make a decision based on their findings. Since such a comprehensive study

could not be completed within 30 days, the panel suggested that the panel should instead be directed to conduct a review of current literature and relevant studies and, based on their analysis of this information and their own professional experience, provide the Legislature with their professional opinion as to whether or not the mandate should be adopted, or adopted with revisions. Further, the statute should provide that, if the panel is unable to reach a decision because adequate information is not available, the panel should issue a statement to that effect in lieu of a recommendation.

B) If the Legislature determines that a more rigorous scientific approach is required, the panel should be provided with funding and additional time that would allow the members to contract with professional librarians, students, medical experts and/or professional consultants to assist them in compiling and reviewing literature and conducting metanalysis of the proposed mandated benefit. In cases where information is not readily available but could be developed or collected over time, the ability to contract for some of the required work and the extended time in which to conduct the study would allow the Panel to conduct a more rigorous review.

Recommendation Three: Standard Review Procedures

During both the 74th and 75th Legislative Sessions, there was some confusion among both Legislators and panel members as to how this review panel was intended to function. In many cases, legislators were not even aware of the requirement that new mandates be submitted to the panel for review. As a result, most legislation was referred to the panel relatively late in the session, causing concern among both legislators who were anxious for a decision from the panel and panel members who were under pressure to issue hurried decisions. If a panel is to operate effectively in the future, realistic operating guidelines that clearly outline the process and interaction between legislators and panel members should be established and clearly communicated to each legislator at the beginning of each session of the Legislature.

Other States' Evaluation Requirements

In the early 1980's, the National Association of Insurance Commissioners (NAIC) received a proposal from an insurance industry committee that recommended states should adopt evaluation procedures for reviewing all mandated health insurance benefits.
That proposal was eventually adopted by numerous states, but in varying forms. Some states required reviews of all current mandates as well as all legislative proposals requiring new mandates. Other states required that only future proposals be reviewed.

Of the few states that have collected mandated benefit cost information, all report that the data is limited and imperfect. No state has been able to develop and implement a system that measures all of the factors affecting cost. For example, none of the studies reviewed in this report have been able to determine the savings that may be a result of the elimination or reduction of future, more costly services due to mandates for certain services. Though a number of reports mention this problem, none have been able to address it. These questions and others raised in various studies point out the limitations in determining the true costs associated with mandated benefits.

While the legislative directives for reviewing mandates vary widely from state to state, the more detailed statutes follow the same basic review criteria with varying degrees of success. Funding provisions, or the lack thereof, and time constraints placed on researchers conducting the reviews are two recurring factors affecting the quality of benefit reviews. Two states (Hawaii and Maine) have performed in-depth scientific studies, but only on certain mandates. Virginia has also

performed some comprehensive reviews, but was generally unable to provide reliable cost information. Pennsylvania also used the same basic review criteria as Hawaii, Maine and Virginia, but relied mostly on public testimony and documentation provided by proponents and opponents of specific mandates. Although the requirements vary somewhat, the review criteria (shown below) used by these four states (Hawaii, Maine, Pennsylvania, and Virginia) is basically the same. The methodology used to implement these criteria, however, differs drastically.

Standard Review Criteria for Evaluating Mandated Benefits in Other States

Social Impact

a. The extent to which the treatment or service is generally utilized by a significant portion of the population.

b. The extent to which insurance coverage for the treatment or service is already available.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

e. The level of public demand for the treatment or service.

f. The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.

g. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

Financial Impact

a. The extent to which the proposed insurance coverage would increase or decrease premiums or the cost of services over the next five years.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

f. The impact of coverage on the total cost of health care.

Medical Efficacy

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

b. If the legislation seeks to mandate coverage of an additional class of practitioners:

1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.

2) The methods of the appropriate professional organization that assure clinical proficiency.

Effects of Balancing the Social, Financial and Medical Efficacy Considerations

a. The extent to which the benefit addresses a medical or broader social need and whether it is consistent with the role of health insurance.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

Cost Effectiveness Analysis As a Review Criteria

Cost effectiveness analysis (CEA) has become a popular tool among researchers and policy makers faces with difficult decisions regarding health care spending and priorities for services. Numerous states – including Texas[46] – have required a cost effectiveness study of all newly proposed health insurance mandates before the proposals may be considered by the Legislature. Insurers and employers support cost effectiveness studies as an objective, science-based approach to evaluating the relative value of specific mandated health insurance benefits. Researchers and academicians point out that CEA, when done correctly, provides a more rational approach to determining what benefits are the most effective.

Despite widespread agreement regarding the usefulness of CEA, for a variety of reasons, CEA has not been effectively used as a basis for health care decisions making. Concerns over methodological inconsistencies and conflicting study results have proven particularly troublesome. When the state of Oregon attempted to determine which health benefits would be covered by Medicaid based on the cost effectiveness of different treatment-condition pairs, problems with the CEA technique and applicability were in part responsible for the failure of this project.

Numerous studies point out problems with the science of CEA. One review of numerous CEAs found a lack of adherence to basic analytical principles and a wide variation in sources of data and quality of information on costs and effectiveness.[47] Lack of methodological standards and inconsistencies in study results has created confusion and disagreement among various groups who rely on such reports. For example, when the National Cancer Institute compared various cost-effectiveness studies of mammography screening, they found wide discrepancies in the findings and conclusions.[48] The study findings varied significantly; one study found that mammography would save more than it cost while a separate study found the cost was nearly $84,000 per-life-year saved. Other studies fell somewhere in between.

In some cases, conflicting CEA results may be attributed to the group sponsoring the review. At the request of the US Agency for Health Care Policy Research, a group of prominent researchers conducted a review of the outcomes and effectiveness research activities being conducted by

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[46] Article 21.52D, Texas Insurance Code; subsequently abolished under House Bill 2180, Acts of the 75th Texas Legislature

[47] Udvarhelyi,S., G.A. Colditz, A. Rai, A.M. Epstein, "Cost Effectiveness and Cost-Benefit Analyses in the Medical Literature: Are the Methods Being Used Correctly?" *Ann. Internal Medicine* 116:238-44, 1992.

[48] Brown, M.L., and Fintor, L. "Cost-Effectiveness of Breast Cancer Screening: Preliminary Results of a Systematic Review of the Literatures." *Breast Cancer Res. Treatment* 25:113-118, 1993.

pharmaceutical companies, insurers, managed care organizations, health information technology companies and other private-sector groups. [49] The focus of the study was to determine whether government participation in this research area should be decreased since many private entities are conducting similar studies. The studies subject to the review focused on effectiveness of certain health care treatments on health outcomes and included cost effectiveness.

While the researchers fully supported the concept and usefulness of outcomes and effectiveness research, the authors cautioned that studies conducted by private business are generally being used in a focused way to promote business goals and other organizational objectives, particularly in the pharmaceutical, insurance, and managed care industries.[50] When evaluating such research, the study cautions that care must be taken to consider the diversity in motivations and variations in approaches. Because health care organizations, employers, payers and providers tend to pursue research that is directly relevant to their own concerns the researchers found that continued government involvement in such research is necessary to fill in important gaps.

U.S. Panel on Cost-Effectiveness in Health and Medicine

In response to growing concerns with the validity of CEA, the U.S. Public Health Service appointed a blue ribbon panel of 13 scientists and scholars with expertise in CEA. [51] The panel was charged with three tasks:

- Assess the current state-of-the-science of CEA methodology;
- Make recommendations for the conduct of CEAs that improve CEAs' quality, comparability, and utility for making decisions about the allocation of public resources; and
- Identify unresolved methodological issues and issue recommendations as to research priorities for the field.

In its report, the panel identified two basic types of methodological problems that limit the relevance and usefulness of CEAs. First, inadequate study designs or lack of documentation sometimes produce unreliable results. Secondly, differences in critical aspect of their approach make it difficult to compare even the best well-designed CEAs. The panel further identified the following specific methodological problems:[52]

- *The CEA does not define the perspective of the analysis; different CEAs use different perspectives which are not comparable*.
  The perspective of a CEA – whether it be that of society as a whole, the perspective of an insurer or managed care organization, a pharmaceutical company, or some other party – determines what costs and effects should be included. Differing perspectives are determined by the group conducting the study and result in widely different study results. The broadest perspective that encompasses the most costs and effects is that of society as a whole; from this perspective, all costs are relevant. Analyses done from an insurer's or payer's

[49] Mendelson, Daniel N., Clifford S. Goodman, Roy Ahn, Robert J. Rubin, "Outcomes and Effectiveness Research in the Private Sector," *Health Affairs* 17(5): 75-90, 1998
[50] Ibid, pg. 76.
[51] U.S. Public Health Service, *Cost Effectiveness in Health and Medicine – Project Summary from the report of The Panel on Cost-Effectiveness in Health and Medicine*. U.S. Government Printing Office, 1996.
[52] Ibid, pp. 6-10.

perspective are narrower and include very different costs. A CEA done from a payer's perspective will not be comparable to a CEA done from a societal perspective.

- *The CEA's data on effectiveness are inadequate or difficult to evaluate*
  The validity of a CEA relies on both the quality of the data and the ability of outside parties to evaluate the quality of the data. CEA analysts frequently combine data from several sources and integrate the information into a single analysis, but fail to provide information that allows the reader to judge the quality of the data.

- *The CEA's data on costs are inadequate or not generalizable*
  Adequate documentation is frequently absent for types of resource use that are important in analyzing a CEA. Some CEAs use inappropriate expenses, or fail to include all relevant costs.

- *CEAs are not reported in standardized ways*
  For most CEAs, there is little information with respect to the quality of a study or its comparability with other, similar analyses. Frequently the reader is left to guess about important components of the study. The lack of guidelines for reporting CEAs and problems in evaluating such studies has resulted in an uneven, questionable quality.

To address these and other concerns, the Panel issued a series of recommendations for the conduct of CEAs to improve their quality, comparability, and usefulness in making informed health policy decisions. The recommendations focus specifically on the requirements of people who use CEAs as a basis for making informed decisions. When studies are conducted using the Panel's recommended Reference Case analysis, comparisons of the cost-effectiveness of varying health interventions can be made in a meaningful way. Because many of the panel's recommendations deal with very technical aspects and methodological issues, this report does not include a full summary of the Panel's recommendations. Following is an abbreviated list of some of the more general recommendations that address overall issues of CEA relevancy. For a complete discussion of the panel's findings, please refer to the final report, Cost-Effectiveness in Health and Medicine.[53]

[53] Gold, M.R., J. E. Siegel, L.B. Russell, and M.D. Weinstein, eds. *Cost-Effectiveness in Health and Medicine.* New York: Oxford University Press, 1996.

Panel Recommendations:

- *A reference case analysis should be based on the societal perspective*
  Two reasons the panel gave for recommending this perspective are: 1) the societal perspective represents the public interest and is compatible with the view that decision that affect people with differing interest are most likely to be fair if they are made by those who do not stand to gain from them; and 2) because the societal perspective does not represent any particular individual or institutional viewpoint, it by necessity includes all costs and health effects associated with an intervention.
- *Evaluation of effectiveness should incorporate both benefits and harms of alternative interventions.*
  To conduct an analysis from the societal perspective, all benefits and harms must be included or the result will be an erroneously favorable cost-effectiveness ratio.
- *Incorporation of morbidity and mortality consequences into a single measure should be accomplished using Quality-Adjusted Life Years (QALY).*
  Although many CEAs look at years of life gained to measure the effectiveness of certain interventions, such studies fail to account for improvements in health-related quality of life. Issues such as reduced pain or increased mobility would not be included in a CEA that looks only at survival rates. For this reason, the panel recommends that Quality-Adjusted Life Years be combined with survival data for a more accurate outcome measurement.

Usefulness of Cost-Effectiveness Analysis in Determining Health Benefits

In its concluding remarks, the panel on Cost Effectiveness in Health and Medicine reiterates the value of CEA and acknowledges that compliance with the somewhat stringent requirements may provide a challenge in some cases. The Panel admits that some aspects of methodology remain unresolved due to a lack of consensus among the members. Future research and improved data collection capabilities will likely improve the accuracy of CEAs and provide more relevant information for decision making. But the Panel cautions that no single analytical tool – including CEA – can replace the political or social implications that must be considered when making health care policy decisions. However, when used in conjunction with other information, a cost-effectiveness analysis allows a more reasoned assessment of the options.

As pointed out by Robert H. Brook of UCLA, "we already ration care in this country on the basis of access, insurance and knowledge. I'd rather try to do it on the basis of scientific evidence." Cost effectiveness studies provide an opportunity to review objective, science-based information on the cost of specific medical interventions.

Physicians, consumers, pharmaceutical companies, insurers and employers provide convincing but conflicting arguments for and against mandatory health insurance benefits. In an effort to more objectively evaluate the merits of such proposals, many legislators and policymakers have required cost effectiveness studies of legislation proposing new mandated benefits. Most states have, however, found such studies to be of limited value in making policy decisions.

While virtually everyone agrees that cost-effectiveness is a necessary and useful measure, different groups have varying perspectives as to how to measure cost effectiveness. This is particularly true when trying to attach a price value to a person's life or quality of health. When the state of Oregon attempted to limit inclusion of Medicaid services based on cost-effectiveness, the proposed plan received such overwhelming criticism that the initial proposal was withdrawn

and substantially revised using factors other than cost-effectiveness.[54] In general, the public felt that availability of health services should not be based solely on issues of cost or cost-effectiveness, even when those services are being provided at taxpayers' expense.

Many of the most widely accepted medical interventions – particularly preventive medical services – often do not reap the expected cost savings. In a review of widely utilized preventive health services, the Office of Technology Assessment reported that only three were truly cost effective, i.e., the services yielded more cost savings than expenses: prenatal care for poor women, tests in newborns for some congenital disorders, and childhood immunizations. [55] The study found that, in general, preventing disease is more expensive than treating it. For example, it is cheaper to provide $100,000 worth of treatment for a single individual than to provide $100 screenings for 1,500 individuals.

Similar results were found in a highly regarded, comprehensive study of cost benefit estimates conducted by the Harvard University School of Public Health. [56] The Harvard study looked at 587 "life-saving interventions" that reduce the probability of premature death, including medical care, injury prevention, and pollution control. After reviewing 1200 separate cost-effectiveness studies, the researchers found 229 that met the established selection criteria.

The study found that, in general, medical interventions are much more cost effective than either injury prevention or environmental controls. However, when looking at cost-effectiveness alone, few medical services meet the traditional definition of "cost effectiveness." Cancer screening in particular was found to be extremely costly. The study shows that the median cost for a life-year saved by all cancer screening programs to avert cancer death is about $750,000. Certain cancer-screening tests are more cost effective than others. Cervical cancer screening for women age 20 and older costs $224,000 per life year saved, but only $11,000 when limited to women age 60 and older. Mammography screening costs $810 per-life-year-saved for women age 50, but increases to $190,000 for women age 40-49. In general, however, screening for cancer costs more than the treatment.

Many medical treatments that are known to be medically effective are generally not cost effective when considering life-years saved. Because of disagreements over how to measure the value of an individual's life, or the added value from improved quality of life, most studies measure cost-effectiveness in terms of life-years saved. Under these circumstances, a very limited number of medical interventions are truly cost-effective. But these studies also show that, clearly, some medical services are less costly than others. John Graham, one of the authors of the Harvard study, states "our analysis shows a lot of what is done in medicine is quite effective and reasonable in cost compared to other ways we invest money." For comparison, the following chart provides a list of some of the medical interventions and the associated cost-per-life-year saved included in the Harvard report.

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[54] Brown, L.D., "The National Politics of Oregon's Rationing Plan," *Health Affairs* 10(2):29-51, 1991.
[55] Leutwyler, Kristin, "The Price of Prevention." *Scientific American* 124-129, April 1995.
[56] Tengs, Tammy O., Miriam E. Adams, Joseph S. Pliskin, Dana G. Safran, Joanna E. Siegel, Milton C. Weinstein, John D. Graham, "Five Hundred Life Saving Interventions and Their Cost Effectiveness," *Risk Analysis*, Vol 15, No. 3, 1995.

MEDICAL INTERVENTIONS AND RELATIVE COST EFFECTIVENESS

Medical Intervention	Cost/life-year saved
Bone marrow transplant and high chemotherapy for breast cancer	$130,000
Postsurgical chemotherapy for women w/breast cancer age 60	$22,000
Childhood immunizations (includes all immunizations)	$0 or less
Screening blood donors for HIV	$14,000
Screening donated blood for HIV w/an additional FDA test	$880,000
Low cholesterol diet for men age 20 and 180 mg/dL	$360,000
Hypertension screening for asymptomatic men age 40	$23,000
Hypertension screening for asymptomatic women age 40	$36,000
Influenza vaccination for all people	$140
Influenza vaccination for high risk people	$570
Sickle cell screening for African-American newborns	$240
Sickle cell screening for non-African-American high risk newborns	$110,000
Financial incentive of $100 to seek prenatal care - low risk women	$0 or less
Prenatal care for pregnant women	$0 – $2,100
Home dialysis for end-stage renal disease	$22,000
Kidney transplant for end-stage renal disease	$17,000
Bone marrow transplant for acute nonlymphocytic leukemia	$20,000
Heart transplant for patients age 50 w/terminal heart disease	$100,000
Heart transplant for patients 55 or younger w/favorable prognosis	$3,600
Detoxification for heroin addicts	$0 or less
Methadone maintenance for heroin addicts	$0 or less
Coronary care unit for emergency patients w/acute chest pain	$250,000
Intensive care for patients with multiple trauma	$26,000
Neonatal intensive care for low birth weight infants	$270,000
PKU Screening in newborns	$0 or less
Smoking cessation advice for women age 35-39	$2,900
Smoking cessation advice for men age 35-39	$1,400
Smoking cessation advice for people who smoke more than one pack per day	$9,800

The Harvard study did not make any recommendations or conclusions regarding the use of cost-effectiveness studies. However, researchers generally agree that factors other than cost must be considered when determining health care benefits. Quality of life is a key factor that is difficult to measure. For example, pollution controls are extremely expensive and save very few lives. The median cost for toxin control was $28 million per-life-year-saved compared to $19,000 for medical interventions and $48,000 for injury reduction requirements. Few would disagree that the quality of air and its effect on our quality of life necessitates government regulation, which translates into costs. But the relative value of such controls is subject to great debate. The study's most expensive cost intervention requires emission controls of carcinogenic chloroform at pulp mills at a cost of $99.4 billion for each life-year saved. [57] The value of such requirements is questionable when cost is the only factor considered. Clearly improved quality of life is also a desirable outcome.

In some cases, the cost-effectiveness of medical services/benefits varies depending on the health of the individual receiving care, which only adds to the complexity of determining whether an intervention is cost effective. For example, the Harvard Study reports a wide difference in the costs-per-life-year-saved of beta-blocker treatment following myocardial infarction, depending on the overall health of the individual receiving the medication:

Beta blockers for MI survivors with no angina or hypertension: $360
Beta blockers for high-risk MI survivors: $3,000
Beta blockers for low-risk MI survivors: $17,000

[57] Though the actual controls cost only $30.3 million annually, at this rate it would take more than 33,000 years to avoid one single fatal case of cancer, which calculates into a cost of $99.4 billion.

Cost effectiveness of blood pressure screening also varies considerably based on the age and health condition of the individual, and is never truly "cost effective;" screening for high blood pressure generally costs more than actually treating heart attacks and strokes.[58] According to the OTA review, the cost of adding one healthy year of life due to blood pressure screening varies from $10,000 to $50,000 depending on the age and sex of the individual.

Based on cost-effectiveness alone, many of the most widely used health care interventions would never be included in a typical insurance policy. Even when services are proven to be overwhelmingly cost-effective, there is no guarantee insurers will include such services. Childhood immunizations are one of the few benefits which are proven to save more money than they cost, yet many insurers continued to exclude such benefits from health insurance plans until the Texas Legislature mandated coverage of immunizations beginning in 1998.[59]

The Oregon Medicaid experiment's failed attempt to limit services on the basis of cost effectiveness is an example of the practical problems associated with making health care decisions based primarily on cost. When health officials in Oregon ranked the cost effectiveness of 695 medical conditions and related treatments, funding was allocated for only the top 565 services. Public outcry regarding the unfairness of the methodology resulted in withdrawal of the list. The Oregon Health Services Commission subsequently adopted a process which ranked services based on 13 different factors, including cost-effectiveness.

[58] Ibid, pg. 124.
[59] Senate Bill 172, Acts of the 74th Texas Legislature, 1997

CHAPTER SEVEN
CONCLUSIONS AND LEGISLATIVE ALTERNATIVES

As residents of the state that holds the undesirable title of the highest percentage of uninsured citizens, Texans understandably share a growing interest in improving access to affordable health care and health insurance. Unfortunately, in a well meaning effort to provide quick relief, health care and health insurance reform efforts sometimes fail to adequately evaluate the population demographics and the relationship between rising health care costs and rising *insurance* costs. Development of an insurance plan that is affordable and adequate must take into consideration both the health needs and income levels of the people for whom the plan is intended. Families earning less than $20,000 a year cannot afford the same premium payment as those earning $30,000 or $50,000, and individuals with chronic health conditions may not need the same health services as those who are healthy. Successful insurance reform will most likely require several well-designed programs that appeal to individuals with diverse needs and incomes.

Data collected as part of this study indicate that claims costs for those mandated benefits for which information is generally available are relatively small. However, it is also true that each incremental cost – no matter how small – may price some individuals out of the insurance market entirely. Ironically, while mandated benefits are intended to improve and expand access to certain insurance benefits, the added cost may actually have the opposite effect of making insurance unobtainable for some people. At the same time, while the elimination of certain mandated benefits may result in lower premium costs, the exclusion of specific coverages may also force some people with insurance to turn to public health care programs for treatment not covered by their health insurance plans. Many good arguments have been raised regarding the benefits of allowing employers to purchase only the benefits they want. However, the theory of risk-sharing on which insurance is based only works if the risk is spread among a large number of people. If the only people purchasing specific benefits are those who intend to use them, the cost will definitely be unaffordable.

Public policy decisions regarding mandated benefits and health insurance benefits in general must be considered in conjunction with public goals regarding health care affordability and accessibility. Because so many other factors affect health insurance premium costs, reform efforts directed solely towards mandated benefits will have a limited effect on improving accessability and affordability of health insurance. However, even incremental cost decreases may enable some employers to purchase health care for their employees. While it is not the purpose of this report to suggest that the Legislature should or should not take certain steps regarding mandated benefits, TDI has been asked to include suggestions describing possible alternatives for legislative consideration. The following discussion should not be interpreted as TDI recommendations, but is intended to simply present options that the Legislature may wish to consider in its deliberations.

A. Implement a review process for all newly proposed mandated benefits

Although the original Mandated Benefit Review Panel established in Texas was abolished, the concept of an independent review process for newly introduced mandated benefit proposals holds great appeal for employers and insurers. A similar review process could be re-established in Texas with several substantial changes in how the panel functions. As described earlier in this report, certain factors are critical to the success of such a process, including:

- Adequate funding that enables the group to contract with outside parties as necessary;
- Realistic review criteria and time requirements for the review process;

- Diversity of panel members with backgrounds that cover both the medical and economic aspects of health care and health care funding;
- A well-informed Legislature that understands the review process and time constraints that might affect the advancement of proposed legislation.

Members of the Legislature should be aware that cost information may be very limited or unavailable entirely. Depending on the intent of the Legislature, the process may include or exclude participation of outside parties, such as providers, insurers, employers, or others who support or oppose the proposed benefit under review.

B. Require TDI to collect detailed claims and premium cost information on mandated benefits.

If it is the desire of the Legislature to obtain mandated benefit cost information on a regular basis, insurers should be required to report annual claims and premium costs for specific benefits to the Texas Department of Insurance. To assure standard reporting criteria among all insurers, data should be collected according to guidelines established by TDI . Insurers writing more than $25,000,000 in annual group accident and health insurance premiums represent more than 80 percent of the insurance business in Texas and should be able to collect basic claims information at a relatively small cost. Companies writing less than $25,000,000 in health insurance coverage may be exempt from reporting requireiments.

At least one state – Virginia – already requires insurers to report claims experience and premium costs for specific mandated benefits, indicating that companies can provide the information if required to do so. Texas has also had favorable experience collecting limited claims data from large insurers, though premium cost information has not been widely available. However, if insurers are notified in advance that they will be expected to provide such data, most companies should be able to collect and segregate the necessary information in a way that allows them to report the required data.

C. Expand the availability of small-employer health insurance Basic and Catstrophic Plans to large employers in Texas.

Allowing employers with more than 50 employees to purchase the standard Basic and Catastrophic plans now available only to small employers may encourage some large employers who currently offer no insurance to provide coverage for their employees. In 1996, more than 5,000 Texas employers chose to purchase either the Basic or Catastrophic insurance plans. Though information is not available on how many of these employers previously had no insurance, we do know that the total number of small employers with insurance has increased considerably as a result of all small group health insurance reforms. Extending this opportunity to large employers may further increase the number of employers offering health insurance.

However, the possibility also exists that some employers who now offer comprehensive benefits that include all mandates would choose to drop that coverage in favor of the less expensive standard plans. The result may be that some people lose certain benefits that are important to their personal health care needs. This is particularly true of low income workers who may not be able to afford the considerably higher deductibles and co-payments required under the Catastrophic plan. To limit such adverse financial consequences, the Legislature may want to consider requiring insurers to offer employees the option of purchasing lower deductible and coinsurance requirements for an additional premium. By requiring the employee to pay the increased expense, employers' costs would not be affected. This option may increase the appeal of these plans to both employees and employers.

To monitor the impact of these plans on employees and the large employer market, the Legislature may want to direct TDI to collect data on the number of employers and employees insured under both the Catastrophic and Basic plans; the number of employers purchasing coverage for the first time; and the number of employers who replaced existing insurance plans with the standard plans. Premium information, claims costs and utilization data may also be useful in analyzing the succes of these plans.

D. Impose automatic "sunset" dates on newly adopted mandated benefit provisions; benefits would be subject to review after a certain date and would be continued or abolished based on continuing need, utilization, claims and premium cost experience.

While some have suggested that a moratorium be placed on all new mandated benefits, many individuals find such action too restrictive and unrealistic given the constantly changing technological advances in medicine. As an alternative, the Legislature may wish to attach "sunset" provisions to newly adopted mandated benefit legislation that would require a periodic review of the costs and continuing need for such insurance provisions. Insurers could be required to collect and report annual cost and utilization data for each benefit. At the appropriate time, the Legislature or some other entity selected by the Legislature would review the available information as well as other relevant data to determine whether continuation of the mandated benefit is in the public interest. While this provision would not prevent the adoption of new benefits, it would establish a continuing review process to determine whether benefits should continue to be mandated as written, changed to a mandated offer, amended or abolished completely.

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APPENDIX A

SUMMARY OF TEXAS MANDATED BENEFITS, OFFERINGS AND COVERAGES

ACCIDENT & HEALTH INSURANCE
TEXAS MANDATED BENEFITS/OFFERS/COVERAGES
January 1, 1998

Mandated Benefits

ALZHEIMER'S DISEASE, BIOLOGICAL BRAIN DISEASE AND SERIOUS MENTAL ILLNESS - Section 3.3826(a)(2)(A) & (B), Subchapter Y, Texas Administrative Code	No long term care policy may exclude or limit coverage for covered services on the basis of a diagnosis of Alzheimer's disease or biologically-based brain disease/serious mental illness.	Applicable to any individual or group long term care, home health or nursing home policy.
CHEMICAL DEPENDENCY - Article 3.51-9, Texas Insurance Code; Sections 3.8001 - 3.8022 Subchapter HH, Texas Administrative Code	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. The series of treatments must be in accordance with the standards adopted under 28 TAC §§3.8001 - 3.8022.	Applicable to any group policy providing basic hospital, surgical or major medical expense benefits.
COMPLICATIONS OF PREGNANCY - Section 21.405, Subchapter E, Texas Administrative Code	Benefits for complications of pregnancy must be provided on the same basis as for other illnesses.	Applicable to any individual or group policy including major medical, hospital/medical/surgical, hospital indemnity, and disability coverages.
DIABETES - Article 21.53G, Texas Insurance Code	Medical or surgical expense polices which provide benefits for treatment of diabetes and associated conditions must provide coverage to each qualified insured for diabetes equipment, diabetes supplies and diabetes self-management training programs.	Applicable to any individual, group, blanket or franchise insurance policies that provide benefits for medical or surgical expenses. Not applicable to small employer health benefit plans.
EMERGENCY CARE - Article 3.70-3C, Section 5, Texas Insurance Code	Reimbursement for the following emergency care services must be at the preferred provider level of benefits, if an insured cannot reasonably reach a preferred provider: (a) any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital which is necessary to determine whether a medical emergency condition exists; (b) necessary emergency care services including treatment and stabilization of an emergency medical condition; and (c) services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition.	Applicable to any insurance policy that contains preferred provider benefits.

Mandated Benefits - Cont.

GOVERNMENT HOSPITAL COVERAGE - Section 3.3040(d), Subchapter S, Texas Administrative Code	Policies providing hospital confinement indemnity coverage may not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.	Applicable to any individual policy providing hospital indemnity coverage.
IMMUNIZATIONS - Article 21.53F, Texas Insurance Code	Policies that provide benefits for a family member of the insured shall provide coverage for each covered child from birth through the date the child is six years old for (1) immunization against diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; and varicella; and (2) any other immunization that is required by law for the child. Immunizations may not be subject to a deductible, copayment or coinsurance requirement.	Applicable to any individual, group, blanket or franchise insurance policies that provides benefits for medical or surgical expenses. Not applicable to small employer health benefit plans.
MAMMOGRAPHY - Article 3.70-2(H), Texas Insurance Code	Annual screening by low-dose mammography for females 35 years old or older must be provided on the same basis as other radiological examinations.	Applicable to any individual or group policy.
MASTECTOMY • Minimum Length of Stay following Mastectomy or Lymph Node Dissection - Article 21.52G, Texas Insurance Code	Policies that provide benefits for the treatment of breast cancer must include coverage for inpatient care for an enrollee for a minimum of (a) 48 hours following a mastectomy and (b) 24 hours following a lymph node dissection for the treatment of breast cancer. A plan is not required to provide the minimum hours of coverage of inpatient care required if the enrollee and the enrollee's attending physician determine that a shorter period of inpatient care is appropriate.	Applicable to an individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to small employer health benefit plans.
• Reconstructive Surgery Incident to a Mastectomy - Article 21.53D, Texas Insurance Code	Policies that provide coverage for mastectomy must provide coverage for breast reconstruction. The coverage may be subject to the same deductible or copayment applicable to mastectomy.	Applicable to an individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses, including cancer policies. Not applicable to small employer health benefit plans.
MATERNITY (Minimum Stay following Birth of a Child) - Article 21.53F, Texas Insurance Code	Policies providing maternity benefits, including benefits for childbirth, must include coverage for inpatient care for a mother and her newborn child in a health care facility for a minimum of (a) 48 hours following uncomplicated vaginal delivery, and (b) 96 hours following uncomplicated C-section. Policies that provides in-home postdelivery care are not required to provide the minimum number of hours unless the inpatient care is determined to be medically necessary by the attending physician or is requested by the mother.	Applies to individual, group, blanket of franchise insurance policies that provide benefits for medical or surgical expenses.
MENTAL/NERVOUS DISORDERS WITH DEMONSTRABLE ORGANIC DISEASE - Section 3.3057(d), Exhibit A, Subchapter S, Texas Administrative Code	No individual policy may exclude mental, emotional or functional nervous disorders <u>with</u> demonstrable organic disease. Exclusion of mental/nervous disorders <u>without</u> demonstrable organic disease would be permitted in certain designated policies (not including disability income).	Applicable to any individual policy (primarily major medical, hospital indemnity and hospital/medical/ surgical coverages.
ORAL CONTRACEPTIVES - Section 21.404, Subchapter E, Texas Administrative Code	Benefits for oral contraceptives must be provided when ALL other prescription drugs are provided.	Applicable to any individual or group policy providing coverage for prescription drugs.
OSTEOPOROSIS, DETECTION AND PREVENTION - Article 21.53C, Texas Insurance Code	Policies that provide benefits for medical or surgical expenses incurred as a result of an accident or sickness must provide to qualified individuals coverage for medically accepted bone mass measurement to determine a person's risk of osteoporosis and fractures associated with osteoporosis.	Applicable to any group contract that provides benefits for medical or surgical expenses.

Mandated Benefits - Cont. PHENYLKETONURIA (PKU) - Article 3.79, Texas Insurance Code	Policies that provide benefits for prescription drugs must include formulas for treatment of PKU or other heritable diseases.	Applicable to any group policy which provides coverage for prescription drugs.
PROSTATE TESTING - Articles 21.53F and 3.50-4, Sec. 18D, Texas Insurance Code	• Policies 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 at least 50 years of age and asymptomatic; or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor - Article 21.53F.	Applies to an individual, group, blanket, or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to small employer health benefit plans. Applies to any health benefit plan offered under the Texas Public School Employees Group Insurance Act.
	• A health benefit plan offered under the Texas Public School Employees Group Insurance Act must provide coverage for prostate specific antigen test for each male who is at least 50 years of age or at least 40 years of age with a family history of prostate cancer or other risk factor for medically accepted prostate specified antigen test - Article 3.50-4, Sec. 18D.	
SERIOUS MENTAL ILLNESS - Articles 3.51-14, 3.50-2, 3.50-3 & 3.51-5A, Texas Insurance Code	• A group health benefit plan (a) must provide coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (b) may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and (c) must include the same amount limits, deductibles, and coinsurance factors for serious mental illness as for physical illness - Article 3.51-14.	Applies to any group health benefit plan that provides benefits for medical or surgical expenses. Applicable to the specific governmental employee benefit plans referenced.
	• Benefits for serious mental illness must be provided as extensive as any other physical illness. ♦ Texas State Employees Uniform Group Insurance Benefits Act - Article 3.50-2, Section 5(j)(2) ♦ Texas State College and University Employees Uniform Insurance Benefits Act - Article 3.50-3, Section 4C(2) ♦ Local Governments - Article 3.51-5A(a)(2)	
	NOTE: The definition of serious mental illness is not identical in all of the cited articles.	

Mandated Benefits - Cont.		
TELEMEDICINE - Article 21.53F, Texas Insurance Code	Policies may not exclude a service from coverage solely because the service is provided through telemedicine and not provided through a face-to-face consultation. Benefits for a service provided through telemedicine may be made subject to a deductible, copayment, or coinsurance requirement; however, the deductible, copayment, or coinsurance may not exceed that required by the plan for the same service provided through a face-to-face consultation.	Applies to an individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to small employer health benefit plans.
TEMPOROMANDIBULAR JOINT (TMJ) - Article 21.53A, Texas Insurance Code	Benefits for TMJ must be provided when benefits for other medically necessary diagnostic or surgical treatment of skeletal joints are provided.	Applicable to a group health benefit plan that provides benefits for medical or surgical expenses. Not applicable to small employer health benefit plans.
TRANSPLANT DONOR COVERAGE - Section 3.3040(h), Subchapter S, Texas Administrative Code	A policy providing a specific benefit for the recipient in a transplant operation shall also provide reimbursement of any medical expense of a live donor to the extent that the benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.	Applicable to any individual policy providing for transplant coverage.

Mandated Benefit Offers

ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE - Section 3.3040(g), Subchapter S, Texas Administrative Code	When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all eligible insureds under such coverage.	Applicable to any individual policy providing accidental death and dismemberment coverage.
HOME HEALTH - Article 3.70-3B, Texas Insurance Code	Unless rejected in writing by the group policyholder or negotiated for lesser benefits, benefits must provide services for skilled nursing; physical, occupational, speech, or respiratory therapy; home health aide; medical equipment and medical supplies other than drugs and medicines. Benefits must include at least 60 visits in any calendar year or in any continuous period of 12 months for each person covered under the policy.	Applicable to group policies (primarily major medical and hospital/medical/ surgical coverages).
IN-VITRO FERTILIZATION - Article 3.51-6, Section 3A, Texas Insurance Code	Unless rejected in writing by the group policyholder, benefits for in-vitro fertilization must be provided to the same extent as benefits provided for other pregnancy-related procedures subject to certain requirements.	Applicable to any group policy providing coverage on an expense incurred basis (primarily major medical and hospital/medical/ surgical coverages).
MATERNITY BENEFITS - Section 21.404(6), Subchapter E, Texas Administrative Code	No insurer may refuse to offer maternity coverage in an individual coverage if comparable family coverages would offer maternity coverage.	Applicable to any individual policy (primarily major medical and hospital/medical/surgical coverages).
MENTAL HEALTH - Article 3.70-2(F), Texas Insurance Code	The insurer must offer and the group policyholder shall have the right to reject benefits of mental or emotional illness.	Applicable to any group accident and sickness policy (primarily major medical and hospital/medical/ surgical coverages).

Mandated Benefit Offers - Cont.		
SERIOUS MENTAL ILLNESS - Article 3.51-14, Texas Insurance Code	Small employer carriers must offer to small employers coverage for serious mental illness that complies with the following: (a) 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) the coverage 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) the coverage must include the same amount limits, deductibles, and coinsurance factors for serious mental illness as for physical illness.	Applicable to small employer health benefit plans.
SPEECH AND HEARING - Article 3.70-2(G), Texas Insurance Code	Unless rejected by the group policyholder or an alternative level of benefits is negotiated, benefits must be provided for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally.	Applicable to any group policy providing coverage on an expense incurred basis (primarily major medical and hospital/medical/ surgical coverages).

Mandated Coverages

CHEMICAL DEPENDENCY TREATMENT FACILITY - Article 3.51-9, Texas Insurance Code	Treatment of chemical dependency in a chemical dependency treatment facility must be covered as favorable as any other physical illness and must be provided on the same basis as treatment in a hospital.	Applicable to group policies (primarily major medical and hospital/medical/surgical coverages).
CONTINUATION		
• CONTINUATION FOR CERTAIN DEPENDENTS - Article 3.51-6, Section 3B, Texas Insurance Code	Continuation of coverage for certain dependents is required for a period of three years upon termination of coverage due to divorce from or retirement or death of the insured member.	Applicable to any expense incurred group policy (primarily major medical and hospital/medical/surgical coverages).
• CONTINUATION OF COVERAGE DURING LABOR DISPUTE - Article 3.51-8, Texas Insurance Code	Continuation of coverage is required for a period of six months after cessation of work.	Applicable to any group policy resulting in all or a portion of premiums being paid though a collective bargaining agreement - could include any coverages.
• CONTINUATION OF COVERAGE UPON DIVORCE - Section 21.407, Subchapter E, Texas Administrative Code	In individual policies, if a person loses coverage due to a change in marital status, that person shall be issued a policy which the insurer is then issuing which most nearly approximates the coverage in effect prior to the change in marital status. The policy will be issued without evidence of insurability and will have the same effective date and expiration date as the prior policy.	Applicable to any individual policy.
• CONTINUATION OF SPOUSE UPON DEATH OR AGE LIMIT OR OTHER OCCURRENCE - Sections 3.3052(b) & 3.3050(1), Subchapter S, Texas Administrative Code	In the event of the insured's death, the spouse of the insured, if covered, shall become the insured in any guaranteed renewable, noncancellable, or limited guarantee of renewability individual policy. In policies covering both the insured and spouse, the age of the younger spouse will be used for fulfilling the age or duration requirements in guaranteed renewable, noncancellable, or limited guarantee of renewability policies.	Applicable to any individual policy issued on a guaranteed renewable, noncancellable, or limited guarantee of renewability basis.

Mandated Coverages - Cont.		
• CONTINUATION/ CONVERSION - Article 3.51-6, 1(d)(3), Texas Insurance Code and Subchapter F, Texas Administrative Code	Group policies delivered, issued for delivery or renewed on or after January 1, 1998, must provide continuation of coverage for a period of 6 months upon termination of coverage for any reason, except termination due to gross misconduct. Carriers may offer conversion coverage which complies with minimum benefit standards for conversion policies. Through renewal on or after January 1, 1998, group policies must provide, at the insured's option, a conversion privilege or a continuation of coverage for a period of 6 months upon termination of coverage for any reason, except termination due to gross misconduct.	Applicable to any expense incurred group policy (primarily major medical and hospital/medical/surgical coverages).
CRISIS STABILIZATION UNIT & RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS - Article 3.72, Texas Insurance Code	A policy providing benefits for treatment of mental or emotional illness or disorder when confined in a hospital must include benefits for treatment in a crisis stabilization unit or residential treatment center for children and adolescents. For purposes of determining policy benefits and benefit maximums, each two days of treatment in the facility will be considered equal to one day of treatment in a hospital or inpatient program.	Applicable to any group policy providing inpatient mental illness coverages (primarily major medical and hospital/medical/surgical coverages).
DEPENDENTS		
• ADOPTED CHILDREN - Articles 3.51-6, Section 3D, 3.70-2(K), 26.21A and 26.84(b), Texas Insurance Code	Policies providing coverage for the immediate family or children of an insured may not exclude or limit coverage for an adopted child. A child is considered to be a child of the insured, if the insured is a party in a suit in which the adoption of the child by the insured is sought. Natural or adopted children of the insured may not be excluded from coverage based on residency with or financial responsibility of the group member or insured. Natural or adopted children of the spouse of the insured may not be excluded from coverage based on financial responsibility, but are required to reside with the group member or person insured.	Applicable to any individual or group accident or sickness policy.
• CERTAIN GRANDCHILDREN - Articles 3.51-6, Section 3E, 3.70-2(L) & 3.70-2(M), Texas Insurance Code	Policies that provide coverage for dependents must provide coverage for grandchildren if such grandchildren are dependents for federal income tax purposes.	Applicable to any individual or group policy providing coverage for hospital, surgical or medical expense coverage.

Mandated Coverages - Cont.		
• CERTAIN STUDENTS - Article 21.24-2, Texas Insurance Code	Policies that condition dependent coverage (for a child 21 years of age or older) on the child's being a full-time student at an educational institution shall provide the coverage for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student. Coverage will continue until the 10th day of instruction of the subsequent academic term; on which date the plan may terminate coverage of the child if the child does not return to full-time status before that date.	Applies to a group, blanket or franchise health benefit plan that provides benefits for medical or surgical expenses. Not applicable to small employer health benefit plans.
• MEDICAL SUPPORT FOR CHILDREN - Articles 3.96-1 thru 3.96-10, Texas Insurance Code and Sections 21.2001-21.2011, Subchapter K, Texas Administrative Code	Policies that provide coverage for dependents must provide coverage for a child who must be provided medical support under an order issued under Section 1.01, Subchapter A, Chapter 231 of the Family Code.	Applicable to any expense incurred individual or group policy that provides benefits for medical or surgical expenses.
• MEDICAL SUPPORT FOR CHILDREN - Article 3.70-2(M)(1), Texas Insurance Code	Policies that provide coverage for dependent children of a group member or a person insured under the policy must provide coverage for a child for whom the group member or insured must provide medical support under an order issued under Section 14.061, Family Code, or enforceable by a court in this state.	Applicable to any individual and group accident or sickness policy.
• MENTALLY/PHYSICALLY HANDICAPPED CHILDREN - Article 3.70-2(C), Texas Insurance Code; Section 3.3052(g), Subchapter S, Texas Administrative Code	Continuation of coverage upon attainment of the limiting age is required for a child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the insured for support and maintenance.	Applicable to any individual or group policy providing for dependent coverage.
• NEWBORN CHILDREN - Articles 3.70-2(E), 26.21(n) and 26.84(a), Texas Insurance Code; Sections 3.3401-3.3403, Subchapter U, Texas Administrative Code	Policies that provide maternity coverage or dependent coverage must provide automatic coverage to a newborn child for congenital defects or abnormalities for the initial 31 days. Coverage must be continued beyond the 31 days if notification of the birth is given and any required premium paid within the 31-day period.	Applicable to any individual or group policy providing accident and sickness coverage including major medical, hospital/medical/ surgical, and maternity.
EXTENSION OF BENEFITS		
• UPON TERMINATION BY INSURER (INDIVIDUAL COVERAGE) - Section 3.3052(e), Subchapter S, Texas Administrative Code	An extension of benefits is required upon termination of any individual policy by the insurer. Termination shall be without prejudice to any continuous loss which commenced while the policy was in force; however, may be based on the continuous total disability of the insured and limited to the duration of the policy benefit period, payment of the maximum benefit, or a period of not less than three months.	Applicable to any individual policy.
• FOR TOTALLY DISABLED PERSONS (GROUP COVERAGE) - Article 3.51-6A, Texas Insurance Code	An extension of benefits is required upon termination of policy for totally disabled persons. In policies providing benefits for loss of time from work or specific indemnity during hospital confinement, benefits payable for that disability or confinement are not affected by the termination. In policies providing hospital or medical expense coverages, the extension must be provided at least for the period of the disability or 90 days, whichever is less.	Applicable to any group policy (primarily major medical, hospital/ medical/surgical, disability income, hospital indemnity, accident medical expense coverages).
• UPON ACCEPTANCE OF PREMIUM (INDIVIDUAL COVERAGE) - Section 3.3052(c), Subchapter S, Texas Administrative Code	If an insurer accepts a premium for coverage extending beyond the date, age or event specified for termination of an insured family member, then coverage as to such person shall continue during the period for which an identifiable premium was accepted (unless due to a misstatement of age).	Applicable to any individual policy.

Mandated Coverages - Cont.		
• PREGNANCY BENEFITS (INDIVIDUAL COVERAGE) - Section 3.3052(d), Subchapter S, Texas Administrative Code	In the event of cancellation by the insurer or refusal to renew by the insurer of a policy providing pregnancy benefits, an extension of benefits is required for any pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy continued in force.	Applicable to any individual policy providing pregnancy benefits.
HIV, AIDS, OR HIV-RELATED ILLNESSES - Articles 3.51-6, Section 3C; 3.51-6D; 3.50-2, Section 5(j)(1); 3.50-3, Section 4C(1); and 3.51-5A(a)(1), Texas Insurance Code; Section 3.3057(d), Exhibit A, Subchapter S, Texas Administrative Code	A policy may not exclude or deny coverage, and cancellation is prohibited for HIV, AIDS, or HIV-Related illness.	Applicable to any individual or group policy (primarily major medical and hospital/medical/surgical coverages).
PODIATRIST CERTIFICATION - Article 21.52A, Texas Insurance Code	A policy providing disability income benefits may not deny payment of those benefits when the disability is certified by a licensed podiatrist and the sickness or injury may be treated by the podiatrist under the scope of his license.	Applicable to individual or group policies providing benefit for disability.
PRACTITIONERS - Articles 21.52, 21.52A, 3.70-2(B), 3.70-2(H), 3.70-3C, Texas Insurance Code	Certain practitioners are required to be recognized when benefits are scheduled in the policy for which services can be performed within scope of licenses.	Applicable to any group, individual, blanket, or franchise policy.
PREEXISTING CONDITIONS		
• INDIVIDUAL COVERAGE - Article 3.70-1(H), Texas Insurance Code	An individual health carrier must waive or reduce the preexisting condition time period as follows: (a) The preexisting condition time period shall be waived for an individual who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date not more than 63 days before the effective date of the individual coverage provided the most recent creditable coverage was under a group health plan, governmental plan or church plan. (b) If there has been more than a 63 day break between coverage, the preexisting time period of an individual health benefit plan shall be reduced by the time the individual was covered under creditable coverage during the 18 months preceding the effective date of coverage under the individual coverage provided the most recent creditable coverage was under a group health plan, governmental plan or church plan.	Applies to individual hospital, medical or surgical coverages.
• LONG TERM CARE COVERAGE - Section 3.3824 (c), Subchapter Y, Texas Administrative Code	Replacing company shall waive any time periods applicable to preexisting conditions and probationary periods to the extent such time periods have been satisfied under the policy being replaced.	Applicable to individual or group long term care policies.
• MEDICARE SUPPLEMENT INSURANCE - Article 3.74, Section (8), Texas Insurance Code; Section 3.3306(1)(A), Texas Administrative Code	Replacing company shall waive any time periods applicable to preexisting condition waiting periods, elimination periods, and probationary periods to the extent such time was spent under the original policy.	Applicable to individual or group medicare supplement policies.
• REPLACEMENT AND DISCONTINUANCE OF GROUP AND GROUP TYPE ACCIDENT AND HEALTH INSURANCE - Article 3.51-6A, Texas Insurance Code	Benefits must be provided for preexisting conditions upon replacement of the master policy, but may provide the lesser of the benefits of the prior plan, or the benefits of the succeeding carrier's plan determined without application of the preexisting conditions limitation.	Applicable to any group policy (primarily major medical and hospital/medical/surgical coverages).

Mandated Coverages - Cont.		
• SMALL and LARGE EMPLOYER COVERAGE - Articles 26.49 (e) and (f) and 26.90(e) and (f), Texas Insurance Code	A small or large small employer carrier must waive or reduce the preexisting condition time period as follows: (a) The preexisting condition time period shall be waived for an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the large or small employer health benefit plan. (b) If there has been more than a 63 day break between coverage, the preexisting condition time period of a large or small employer health benefit plan shall be reduced by the time the individual was covered under creditable coverage during the 12 months preceding the effective date of coverage under the large or small employer health benefit plan.	Applicable to large or small employer health benefit plans.
PSYCHIATRIC DAY TREATMENT FACILITY - Article 3.70-2(F), Texas Insurance Code	A policy providing benefits for treatment of mental illness in a hospital must include benefits for treatment in a psychiatric day treatment facility. Determination of policy benefits and benefit maximums will consider each full day of treatment in a psychiatric day treatment facility equal to one-half day of treatment in a hospital or in-patient program. On rejection of mandated benefits the insurer shall offer and the policyholder can select an alternate level of benefits, but any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in hospital facilities.	Applicable to any group policy providing mental illness coverage (primarily major medical, hospital/medical/surgical coverage).
PUBLIC INSTITUTIONS - Articles 3.70-2(D), 3.42B, Texas Insurance Code	Policies may not exclude benefits when services are provided by tax supported institutions for which charges are made.	Applicable to any group or individual policy.

APPENDIX B

SELF-FUNDED EMPLOYERS' COMMENTS TO TDI SURVEY QUESTIONS

Following is a listing of comments received by self-funded employers in response to questions included in the TDI survey. Comments are not edited for content but have been corrected for spelling and typographical errors.

Question: Do you believe mandates are necessary to guarantee individuals access to certain types of health insurance benefits?

Without mandates, because of "cost" there is no doubt that certain diseases/procedures would not be covered.

The problem is – where do you draw the line on mandates? Payers can choose coverage –rich or poor or in between - according to what they can afford. Mandates will result in higher cost and more uninsured.

Most employers genuinely want to take care of their employees – employees are our best assets.

Yes as long as we have state and federal bureaucracies that do not exhibit sufficient control to operate efficiently and prevent fraud and unscrupulous providers.

We cover all state mandates except, starting this year, we limit $25,000 drug and mental benefits.

I don't feel employers should be able to avoid mandates through self-insurance arrangements. Self-insurance should be used to tailor a plan to a company and control administrative costs.

Some health conditions should be my option to cover.

Many of the mandated coverages would be eliminated; for example, chemical dependency and mental illness.

Generally the supply/demand process will take care of things.

Insurance benefits should provide financial protection in the event of significant medical expense; insurance should not be used as a reimbursement mechanism for "selected" medical expenses.

Yes because there are certain types of health benefits that are covered by one company but not another company.

Benefits are rewards or enticements provided by employers to attract and retain employees; thus they are not (nor should any part of them become) entitlements, which is what all levels of government are attempting to do. What we offer and what we want or can afford to offer should be totally the employer's option! It's like saying "if you come to the wedding the gift must be worth $150."

The variation of mandates from one state to another causes enormous problems for multi-state employers – that is one of the single greatest cost multipliers of all. States should stay out of the health insurance arena.

It isn't about access, but who will pay for it.

Certain basic benefits should be mandated. However, group health insurance should be for the sudden, unforeseen, not a maintenance program where every "hang nail claim" is covered causing excessive utilization coupled with upward spiraling costs.

To keep good employees, health needs must be met. ON the above mentioned mandates they were in our plan design prior to many of the laws requiring – i.e., oral contraceptives, newborns, handicapped, chiropractors.

Yes, but I don't agree on all the coverages mandated. Mandates should only cover life-threatening conditions.

I believe most companies want to take care of their employees and it is the handfull who don't that seem to cause the problems.

I believe that alcohol and drug mandates encourage abuse of the system.

I do not consider myself qualified to answer as I do not perceive all circumstances.

If costs of providing health insurance benefits continue to rise due to mandates, neither the employers nor the employees will be able to pay for health insurance benefits. Many small companies simply cannot afford the expense.

Mandated benefits do not influence our decision to self-insure – it was the administrative costs and flexible plan design that influenced us.

Consumer/market demand should produce policies that cover such benefits.

Yes I would not cover certain items, such as Viagra, if the Supreme Court had not made the latest ruling regarding reproduction.

The State of Texas has on at least two occasions passed the costs of mandated coverages to school districts because of a cost savings to the state (workers comp and unemployment comp), and continues to cover state employees in both of these areas; along with covering 100% of their health insurance.

Mandated health care is a complicated issue, far too complicated to address in this format.

24 hours post-birth is unreasonable; 48 hours is much more reasonable.

Many times mandates respond to certain political agenda rather than demonstrated need. Most larger employers provide for necessary care under their plans but do not want to be told what they can and can't do. Multi-state employers cannot stand the administrative cost of compliance with multiple mandates from different states.

If mandates are driving the cost of medical insurance so high, then less people can afford coverage – the laws are self-defeating.

Mandates have a direct relationship to premium and cost. Excessive mandates will make insurance rates excessive for the underserved.

I think its imperative to mandate preventative care – this will reduce expenditures (if utilized) in the long-run. I also believe that psychiatric (as opposed to psychological) should be covered fully so that employees and families can remain productive in society.

Yes, however they are overused.

Unfortunately we live in a society where costs will exclude certain coverages unless mandated.

Cost is minimal if required in all states. Mandates generally only make all carriers do what the quality carriers normally provide.

Health insurance is a voluntary benefit for employees. Each employee group is different. In our environment, we have a good number of employees making $6-8 an hour. Mandated coverages – that for most will not be used – price these benefits out of reach for many of these people. Without the mandate, a plan can be structures that provides basis and catastrophic healthcare coverage at a more reasonable cost.

The cost of health insurance is becoming so expensive; mandates are driving this up. In principal I agree with the concept, but practically how can business be forced to continue footing the bill? Health providers need to make certain services available at a more reasonable cost.

Each employer should be able to develop a plan design that meets the health needs of their workforce in a cost-effective way; without the burden of unfunded legislative mandates.

I think state mandates should continue and that self-funded plans should be subject to all state mandates.

Our plan has always allowed the doctor to make the decisions.

In some cases yes, to ensure coverage of otherwise uninsurable individuals.

Only after negotiating and consulting with insurers and employers and mandates should only be a last resort and for extreme situations – not political.

I believe the ones benefiting are the practitioners who raise the fees immediately upon the passing of a mandate. Therefore, actually reducing access for those without health insurance.

State mandates are problematic for multi-state employers, but are not a bad idea in general.

QUESTION: What changes would need to occur in order for you to re-enter the commercial market?

Traditional insurance costs have not been competitive against our self-insured cost over the last 7 years. The mandate issue is not a big issue with us.

Over-legislating can be worse than under regulating or over-legislating. We must get away from the notion that every small claim is to be mandated for coverage. It is too expensive.

Current economic conditions of the company makes self-insured status more desirable.

Can't afford to, but would like to have the option of paying a premium and knowing what my annual cost is going to be.

Increases in premiums realistically equated to loss ratios.

Increases need to be tied to experience.

Most large companies are self-insured (I guess) so albeit the smaller guys who are big enough and can least afford it are stuck with fully insured plans and mandates.

Our group is too small to safely self-insure. If we could join with other small groups it would be beneficial. We've been able to offer more and better benefits as a self-insured group than when we had a conventional fully insured plan.

We choose to not enter the commercial market due to our company being a multi-state employer.

50 states plus the federal government – all being involved in – runs the cost up; one multi-state company may have 5 – 10 - 25+ different riders in their commercial plans just to please all the state legislators.

Need consistency across states.

Rules and regulations should be national to reduce interstate interpretation problems.

We actually self-insured not only for financial reasons, but also because it allows us to design a plan that is more beneficial to our employees than most commercial plans. We provide extremely low deductible ($100) and co-pays (90/10) at a cost to the company that a commercial plan cannot compete with.

HMO Providers must share utilization data.

We are committed to a direct purchasing arrangement with our providers. It allows us to amend plans as needed and provides better benefits more effectively. It allows us to work with providers.