HEALTH INSURANCE MANDATES IN THE STATES

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A State-by-State Breakdown of Health Insurance Mandates and Their Costs

A health insurance "mandate" is a requirement that an insurance company or health plan cover (or offer coverage for) common — but sometimes not so common — health care providers, benefits and patient populations. They include:

- Providers such as chiropractors and podiatrists, but also social workers and massage therapists.
- Benefits such as mammograms, well-child care and even drug and alcohol abuse treatment, but also acupuncture and hair prostheses (wigs).
- And populations such as adopted and non-custodial children.

For almost every health care product or service, there is someone who wants insurance to cover it so that those who sell the products and services get more business and those who use the products and services don't have to pay out of pocket for them.

The Impact of Mandates. While mandates make health insurance more comprehensive, they also make it more expensive because mandates require insurers to pay for care consumers previously funded out of their own pockets. Based on our analysis presented in this paper, mandated benefits currently increase the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state. Mandating benefits is like saying to someone in the market for a new car, if you can't afford a Lexus loaded with options, you have to walk. Having that Lexus would be nice, as would having a health insurance policy that covers everything one might want. But drivers with less money can find many other affordable options; whereas when the price of health insurance soars, few other options exist.

According to the 1999 study "Mandated Benefit Laws and Employer Sponsored Health Insurance," by economists Gail Jensen and Michael Morrisey for the Health Insurance Association of America (HIAA), as many as one in four individuals who are without coverage are uninsured because of the cost of state health insurance mandates.

Why Is the Number of Mandates Growing? Elected representatives find it difficult to oppose any legislation that promises enhanced care to potentially motivated voters. The sponsors of mandates know this fact of political life. As a result, government interference in and control of the health care system is steadily increasing. So too is the cost of health insurance.

By the late 1960s, state legislatures had passed only a handful of mandated benefits; today, the Council for Affordable Health Insurance (CAHI) has identified more than 1,800 mandated benefits and providers. More are on their way. In January 2004 alone, CAHI followed the introduction of 295 new mandates in states across the country. This number only increased as the legislative sessions progressed.

How do state legislators justify their actions? One way is to deny a mandate is a mandate. For example, legislators may claim that requiring health insurance to cover a type of provider — such as a chiropractor, podiatrist, midwife or naturopath — is not a mandate because they aren't requiring a particular therapy. But if insurance is required to cover the provider, it must pay for the service provided. There is no essential difference in requiring insurance to cover a chiropractor (a provider) or chiropractic care (the therapy).

Another way legislators justify their support is to assert the new mandate will cost little or nothing. Indeed, legislators and a mandate's supporters usually claim that mandating a new provider or benefit will *save money*. But with more than 1,800 mandates in force, we have overwhelming evidence: mandates virtually always cost money rather than save it.

CAHI's Mandated Benefits and Providers Chart. The Council for Affordable Health Insurance tracks the introduction and passage of health insurance mandates in every state. The information is broken down on a state-by-state basis into three categories: benefits, providers and covered populations. Boxes with a "Y" indicate that the state has passed that particular mandate. Totals for each state and mandate are also included. Thus anyone can easily determine how many mandates and which ones each state has passed.

Mandates and Standard Coverage. Please note that the health care community would consider some of the mandates listed in the chart to be the typical and appropriate standard of care and/or treatment, and therefore would likely be included in many standard health insurance policies. The purpose of this chart is to tabulate the number of benefits mandated by the states and assess their impact on the cost of insurance — not to make judgments about which mandates should or should not be included in a health insurance policy.

Assessing the Cost of Mandates. In addition listing the state mandated benefits, this chart provides a cost assessment of each one. CAHI's Actuarial Working Group on State Mandated Benefits analyzed company data and their experience and provided cost-range estimates — less than 1%, 1-3%, 3-5% and 5-10% — if the mandate were added to a comprehensive family policy that did not include the coverage. However, mandate legislation differs from bill to bill and from state to state. For example, one state may require insurance to cover a limited number of chiropractor visits per year, while another state may require chiropractors to be covered equally with medical doctors. The second will have a greater impact on the cost of a health insurance policy than the first. It would be impossible to make a detailed assessment of the cost of each state's mandates without evaluating each piece of legislation (more than 1,800 of them). Thus, the estimated cost level indicated in the chart is considered typical but may not apply to all variations of that mandate. Further, the additional cost of a mandate depends on the benefits of the policy to which it is attached. Example: A mental health mandate costs nothing if it is already covered but can be very costly if added to a policy that doesn't cover it.

It is also important to note that mandated benefits may only apply to certain kinds of coverage. For example, a mandated benefit may exempt individual or small group coverage or may only apply to insurance companies that are domiciled in the state. As a result, some kinds of coverage are disproportionately affected and become less attractive to buyers (who now seek out alternatives to these high-cost plans). Finally, states may pass a mandate in one legislative session only to come back in a later session and either expand or reduce the original bill's scope.

A Caution about Comparisons and Cost Estimates. Because mandates can drive up the cost of health insurance, it would be easy to assume that the states with the most mandates would also have the highest premiums. While that may be true in some states, it is not necessarily so. Some mandates have a much greater impact on the cost of health insurance than others. For example, mental health parity mandates, which require insurers to cover mental health care at the same levels as physical health care, have a much greater impact on the cost of premiums than would mandates for inexpensive procedures which few people need.

Warning: It may be tempting to think that since a particular mandate doesn't add much to the cost of a health insurance policy, there is no reason for legislators to oppose it. The result of this reasoning is that many states have 40, 50 or more mandates. Although one mandate may only increase the cost of a policy by 1%, 40 such mandates will price many people out of the market. It is the accumulated impact of dozens of mandates that makes health insurance inaccessible to people. Where health insurance may have been affordable, adding additional benefits to a comprehensive policy will price some people out of the health insurance market.

The Rest of the Story. The mandates enumerated here don't tell the whole story. States have other ways of adversely affecting the cost of health insurance. For example, several states have adopted legislation that requires health insurers to accept anyone who applies, regardless of their health status, known as "guaranteed issue." Or they limit insurers' ability to price a policy to accurately reflect the risk an applicant brings to the pool, known as "community rating" or "modified community rating." Both guaranteed issue and community rating can have a devastating impact on the price of health insurance, especially as younger and healthier people cancel their coverage, leaving the pool smaller and sicker.

Thus, in the aggregate, mandates drive up the cost of health insurance. But determining the impact in a particular state requires careful analysis of each piece of mandate legislation, as well as other regulations that have been promulgated.

For more information on government mandates, guaranteed issue and community rating, please visit CAHI's website at www.cahi.org.

	Total	Est. Cost	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD
BENEFITS																							
Alcoholism	45	1% to 3%	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y	Y	Y	Y
Alzheimer's	2	<1%																					Y
Ambulatory Surgery	12	1% to 3%			Y	Y						Y	Y	Y						Y	Y		
Ambulance	8	<1%							Y			Y									Y		
Autism	5	<1%									Y		Y					Y		Y			
Birthing Centers/Midwives	6	<1%						Y				Y											
Blood Lead Poisoning	6	<1%					Y				Y											Y	
Blood Products	1	<1%																					Y
Bone Marrow Transplants	10	<1%										Y	Y							Y		Y	
Bone Mass Measurement	13	<1%					Y						Y				Y		Y	Y			Y
Breast Reconstruction	48	<1%	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
Cancer Pain Medications	1	<1%																					
Cervical Cancer Screening	26	<1%	Y				Y		Y	Y	Y		Y				Y				Y	Y	
Chemotherapy	3	<1%																					
Chlamydia	3	<1%											Y										Y
Cleft Palate	12	<1%						Y				Y				Y		Y			Y		Y
Clinical Trials	19	<1%				Y	Y		Y		Y		Y								Y	Y	Y
Colorectal Cancer Screening	21	<1%		Y					Y	Y	Y		Y				Y	Y					Y
Contraceptives	29	1% to 3%				Y	Y	Y	Y		Y		Y	Y	Y	Y	Y			Y		Y	Y
Congenital Bleeding Disorders	2	<1%																					
Dental Anesthesia	27	<1%					Y	Y	Y			Y	Y		Y		Y	Y	Y	Y	Y		Y
Diabetes Self-Management	22	<1%	Y			Y	Y	Y				Y	Y	Y	Y		Y	Y	Y	Y			Y
Diabetic Supplies	47	<1%	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Drug Abuse Treatment	35	<1%	Y	Y	Y		Y		Y	Y	Y	Y		Y			Y		Y		Y		Y
Emergency Services	46	<1%			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hair Prostheses	7	<1%							Y													Y	Y
Hearing Aid	9	<1%							Y											Y	Y		Y
Home Health Care	19	<1%				Y	Y	Y	Y			Y								Y		Y	Y
Hospice Care	11	<1%			Y			Y						Y						Y			Y
In Vitro Fertilization	15	3% to 5%			Y		Y		Y					Y			Y				Y	Y	Y
Kidney Disease	1	<1%																					
Long Term Care	3	1% to 3%								Y													
Lyme Disease	3	<1%							Y														
Mammogram	50	<1%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mastectomy	24	<1%			Y		Y		Y			Y	Y				Y		Y	Y		Y	
Mastectomy Stay	24	<1%			Y		Y		Y			Y	Y				Y		Y				Y
Maternity	21	1% to 3%			Y		Y	Y	Y				Y	Y					Y			Y	Y
Maternity Stay	50	<1%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mental Health General	40	1% to 3%		Y	Y		Y	Y	Y	Y		Y	Y	Y			Y		Y	Y	Y	Y	Y
Mental Health Parity	42	5% to 10%		Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Minimum Hysterectomy Stay	1	<1%																					
Minimum Testicular Cancer Stays	1	<1%																					Y
Morbid Obesity Treatment	4	1% to 3%											Y					Y					Y
Neurodevelopment Therapy	1	<1%																					
Newborn Hearing Screening	13	<1%										Y						Y				Y	Y
Newborn Sickle-cell Testing	2	<1%																					
Off-Label Drug Use	37	<1%		Y	Y	Y	Y		Y		Y	Y	Y				Y	Y	Y		Y	Y	Y
Orthotics/Prothetics	10	<1%					Y	Y	Y			Y						Y					Y
Ostomy Related Supplies	1	<1%							Y														
Other Infertility Services	8	<1%					Y										Y						
PKU/Formula	33	<1%	Y		Y	Y	Y	Y	Y			Y		Y				Y		Y	Y	Y	Y
Port-wine Stain Elimination	2	<1%																					
Prescription Drugs	3	5% to 10%																					
Prostate Screening	34	<1%	Y		Y		Y	Y	Y	Y	Y		Y				Y	Y	Y		Y	Y	Y
Rehabilitation Services	7	1% to 3%							Y								Y				Y	Y	
Second Surgical Opinion	11	<1%					Y					Y						Y					Y
TMJ Disorders	19	<1%			Y							Y	Y				Y			Y			Y
Well-Child Care	31	1% to 3%			Y		Y	Y	Y	Y		Y	Y	Y	Y				Y		Y	Y	Y
Wilm's Tumor	1	<1%																					

Legend: Y - Mandated; (shaded) - Not Mandated

ME	MI	MN	MO	MS	MT	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	VT	WA	WI	WV	WY
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
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										Y																			

	Total	Est. Cost	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD
PROVIDERS																							
Acupuncturists	11	1% to 3%					Y					Y											
Chiropodist	3	<1%																					
Chiropractors	47	1% to 3%	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y
Dentists	36	3% to 5%	Y	Y	Y	Y	Y	Y	Y			Y			Y			Y	Y		Y	Y	
Denturists	2	<1%																					
Dieticians	4	<1%																					
First Nurse Assistant	4	<1%										Y	Y							Y			
Lay Midwives	3	<1%																					
Licensed Health Professional	11	<1%			Y												Y	Y					Y
Marriage Therapists	11	<1%							Y			Y											
Massage Therapists	4	<1%										Y											Y
Naturopaths	4	<1%	Y																				
Nurse Anesthetists	20	<1%		Y	Y	Y		Y										Y	Y			Y	Y
Nurse Midwives	32	<1%	Y			Y	Y	Y	Y		Y	Y									Y	Y	Y
Nurse Practitioners	30	<1%	Y			Y	Y	Y	Y		Y				Y				Y				Y
Nurses	11	<1%						Y						Y	Y								
Occupational Therapists	13	1% to 3%	Y			Y	Y		Y			Y									Y		Y
Opticians	3	1% to 3%																					
Optometrists	44	1% to 3%	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y
Oral Surgeons	7	<1%										Y					Y	Y	Y				
Osteopaths	24	1% to 3%	Y		Y			Y				Y					Y	Y	Y	Y			Y
Pain Management Specialist	2	1% to 3%							Y										Y				
Pastoral Counselors	2	<1%																					
Pharmacists	4	<1%		Y															Y				
Physical Therapists	17	1% to 3%	Y						Y										Y		Y		Y
Physician Assistants	17	<1%	Y	Y							Y	Y			Y				Y	Y			Y
Podiatrists	35	<1%		Y	Y	Y	Y				Y	Y					Y	Y	Y	Y	Y	Y	Y
Professional Counselors	16	<1%			Y		Y					Y					Y					Y	
Psychiatric Nurse	17	<1%					Y	Y	Y			Y										Y	Y
Psychologists	44	1% to 3%	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y			Y	Y	Y	Y	Y	Y	Y
Public or Other Facilities	25	<1%			Y	Y	Y		Y			Y				Y		Y			Y		Y
Social Workers	28	1% to 3%	Y				Y	Y	Y			Y					Y		Y		Y	Y	Y
Speech or Hearing Therapists	18	<1%			Y		Y														Y	Y	
COVERED PERSONS																							
Adopted Children	42	<1%	Y		Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y			Y	Y
Continuation/Dependents	44	<1%			Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y
Continuation/Employees	44	<1%			Y		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Conversion to Non-Group	42	1% to 3%			Y	Y	Y	Y		Y		Y	Y		Y	Y	Y	Y	Y	Y	Y		Y
Dependent Students	10	<1%							Y			Y	Y								Y		
Handicapped Dependents	39	1% to 3%			Y	Y	Y		Y			Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Newborns	51	1% to 3%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Custodial Children	10	<1%							Y														
Total	1818		24	18	37	28	48	35	50	16	23	50	38	22	22	13	37	35	37	33	39	40	58

Legend: Y - Mandated; [shaded] - Not Mandated

ME	MI	MN	MO	MS	MT	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	VT	WA	WI	WV	WY
Y					Y						Y	Y				Y		Y				Y		Y		Y			
										Y														Y		Y			
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y			Y		Y
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Y		Y	Y	Y	Y	Y	Y		Y		Y	Y				Y	Y	Y		Y	Y	Y	Y			Y	Y	Y	Y
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Y	Y	Y		Y	Y	Y	Y		Y			Y	Y			Y			Y	Y	Y	Y	Y	Y					Y
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Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
Y	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Y					Y	Y													Y	Y		Y					
	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Y		Y			Y		Y				Y					Y					Y		Y						Y
45	25	60	39	27	39	45	33	27	34	39	43	47	43	25	35	31	37	40	28	28	38	51	36	54	23	48	29	35	31

ADDITIONAL MANDATES

Although not yet prevalent nationwide, CAHI is also monitoring activity related to the following additional mandates —

GA	Ovarian Cancer Screening	1	<1%
IA	Anti-psychotic Drugs	1	<1%
MN	Anti-psychotic Drugs Ovarian Cancer Screening	2	<1% <1%
WI	AIDS Vaccines	1	<1%
CA	Domestic Partners	1	<1%
	Mandates in all states (from above chart)	**1818**	
	Total	**1824**	

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Health Insurance

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For additional information please contact Tom Gardner, Director of Communications, at 703/836-6200 or by email at tgardner@cahi.org

EXHIBIT 1

Survey for 2004 Total Mandate Costs – Required Pursuant to IN Code 27-1-3-30

Indiana Dept. of Insurance/Benefit Mandate Task Force

Company Name:____________________ __________________________ NAIC Number ___________

Address____

Contact Name for this Form_______________________________Phone__________ Date_________

The Indiana DOI needs for you to furnish the following information for costs for each of the mandates listed below for calendar year 2004. The primary need is to determine the total cost of the listed mandated benefits, but it would be very helpful if you could also furnish the **marginal cost** of each benefit, which is the total cost minus the estimated cost that would have been covered in the absence of the mandate.

Please return this survey to: Keith Powell, IDOI, 311 W. Washington St. #300, Indpls.,IN 46204

Cost items	Mandate	Description
1. benefit cost (total $ or $/person/2004)______ 2. admin cost (same units as 1) _______ 3. total cost (1. plus 2.) _______ 4. total cost as % of premium _______ 5. price (% premium or $/person/2004)_______ 6. marginal cost as % of premium _______	**Autism/PDD:** 27-8-14.2	Must provide coverage for everything in physician's treatment plan for condition.
1. benefit cost (total $ or $/person/2004)______ 2. admin cost (same units as 1) _______ 3. total cost (1. plus 2.) _______ 4. total cost as % of premium _______ 5. price (% premium or $/person/2004)_______ 6. marginal cost as % of premium _______	**Colorectal Cancer Screening:** 27-8-5-16 27-8-14.8 27-13-7-17	Must provide coverage for exams and lab tests for any non-symptomatic insured 50+ or <50 if at high risk.
1. benefit cost (total $ or $/person/2004)______ 2. admin cost (same units as 1) _______ 3. total cost (1. plus 2.) ______ 4. total cost as % of premium ______ 5. price (% premium or $/person/2004)_______ 6. marginal cost as % of premium _______	**Dental Anesthesia:** 27-8-5-27 27-13-7-15	Must include coverage for anesthesia and hospital charges for dental care for a child or disabled individual if required.
1. benefit cost (total $ or $/person/2004)______ 2. admin cost (same units as 1) _______ 3. total cost (1. plus 2.) _______ 4. total cost as % of premium _______ 5. price (% premium or $/person/2004)_______ 6, marginal cost as % of premium _______	**Diabetes:** 27-8-14.5 27-8-5-16.5	If diabetes is covered, must provide coverage for necessary supplies, equipment, and self-management training.
1. benefit cost (total $ or /person/2004)_______ 2. admin cost (same units as 1) _______ 3. total cost (1. plus 2.) _______ 4. total cost as % of premium _______ 5. price (% premium or $/person/2004)_______ 6, marginal cost as % of premium _______	**Emergency Services Treatment:** 27-13-36-9	(For HMOs) Must provide payment for emergency services provided in out-of-service area facility.

1. benefit cost (total $ or /person/2004)_______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium _______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Inherited Metabolic Disorder:
27-8-24.1
27-13-7-18

Must provide coverage for medical foods necessary and prescribed by a physician to treat the disorder.

1. benefit cost(total $ or$/person/2004) _____
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium ______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Mammography:
27-8-14.6
27-13-7-15.3
27-8-5-16.5

Must offer screening for breast cancer as a base-line between ages 35-39, and annually at 40+. If <40 and at high risk, then annual screenings. Any additional mammograms or ultrasounds as medically necessary if prescribed by a physician.

1. benefit cost (total $ or $/person/2004)______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium _______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Maternity (Minimum Benefits):
27-8-24

If maternity is covered, must provide minimum hospital stay for mother and newborn.

1. benefit cost (total $ or$/person/2004)_____
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium _______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Mental Health Parity:
27-8-15.6
27-13-7-14.8
27-8-5-16.5

If mental health coverage is provided, treatment limitations or financial requirements may be imposed unless the same ones apply for other medical/surgical treatments.

1. benefit cost (total $ or $/person/2004)_____
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium _______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Morbid Obesity:
27-8-14.1
27-13-7-14.5
27-8-5-16.5

Must provide coverage for surgical treatment of morbid obesity as defined in the statute.

1. benefit cost (total $ or $/person/2004)______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium _______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Mail Order RX:
27-8-31.2-5

If prescription drugs are covered and access through mail order or the Internet is available, the insurer cannot require an insured to use those processes.

1. benefit cost (total $ or $/person/2004)______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium ______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium ______

Newborn Coverage:
27-8-5.6
27-8-5-16.5

Allows an individual or family policy to cover a newborn from the moment of birth to day 31, including cleft palate and abnormalities.

1. benefit cost (total $ or $/person/2004)______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium _______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Newborn Testing:
16-41-17

Requires certain tests be performed on newborns to find certain health conditions.

1. benefit cost (total $ or $/person/2004)______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium ______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

RX Drugs Access to Off-formulary:
27-8-38-1

(For HMOs)
Must provide non-formulary drugs/devices that are medically necessary without penalty or additional cost-sharing.

1. benefit cost (total $ or $/person/2004)______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium ______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

RX Drugs Off-label:
27-8-20
27-8-5-16.5

Must include coverage for drugs or biologic used in cancer chemotherapy that may not be FDA approved for that particular type of cancer.

1. benefit cost (total $ or $/person/2004______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium _______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Prostate Cancer Screening:
27-8-14.7
27-13-7-16
27-8-5-16.5

Must provide (if employer based) or must offer (if individual) coverage for annual test if 50+ or if < 50 and at high risk per ACS guidelines.

1. benefit cost (total $ or $/person/2004)______
2. admin cost (same units as 1) _______
3. total cost (1. plus 2.) _______
4. total cost as % of premium _______
5. price (% premium or $/person/2004)_______
6. marginal cost as % of premium _______

Substance Abuse:
27-8-5-15.6
27-13-7-14.8

If the policy includes coverage for substance abuse and/or chemical dependency in the treatment of mental illness, coverage shall be offered without limitations or financial requirements unless similarly imposed on other medical/surgical conditions.

Report on the Cost of Benefit Mandates in Indiana in 2004
To the Legislative Council
From the Mandated Benefits Task Force on 3/9/06

Background
This report provides the Task Force's response to the following requirement in IC 27-1-3-30:

(m)The task force shall annually determine the full cost of all existing mandated benefits in Indiana as a percentage of:
(1) Indiana's average annual wage; and
(2) health coverage premiums.
(n) In making the annual determination under subsection (m), the task force shall consider the full cost of existing mandated benefits under:
(1) a typical group and individual:
(A) accident and sickness insurance policy; and
(B) health maintenance organization contract;
In Indiana; and
(2) the state employee health plans provided for in IC 5-10-8-7(b) and IC 5-10-8-7(c).

In order to develop this cost determination, the Task Force created a Survey (Exhibit 1) for Indiana health insurers. All Indiana health insurers were mailed a Survey and asked to complete it; 55 insurers responded with usable data.

Scope of Study
There are more than 40 Indiana statutorily required health insurance provisions. However, because IC 27-1-3-30 (m) & (n) cited above refers to "mandated benefits", the Task Force focused on the 17 provisions it considered to be mandated *benefits* (Exhibit 2) excluding from the study provisions that were either administrative or procedural in nature (e.g. internal and external grievance procedures) or federal mandated benefits.

Survey Analysis and Limitations .

The Department of Insurance actuary, Keith Powell, analyzed the insurers' Survey responses. The Task Force and Mr. Powell found that the Survey provided some very general conclusions, but the accuracy of these conclusions was limited by some problems with Survey responses as well as some inherent assumptions in the Survey itself.

The insurer response rate to the Survey was somewhat low in terms of overall number of insurers responding, but did include most insurers writing the larger percentage of coverage in the marketplace. 385 insurers were sent Surveys, but 219 of those insurers responded that they did not write health insurance policies in Indiana. Fifty-five insurers sent Survey responses with useful data, and 111 insurers did not respond to the Survey. Many insurers that did answer it did not provide all of the information requested. We did receive varying degrees of response from insurers writing approximately $5.2 billion of the total $6.0 billion of Accident & Health insurance in Indiana in 2004; however, the vast majority did not respond in full.

More importantly, the accuracy of the data in the responses received seems somewhat limited for the reasons set out below.

1. The majority of companies that explained to Mr. Powell their methodology for obtaining the total mandated benefit cost said they assigned diagnosis (ICD) or procedure (CPT) codes to each mandate to extract claims payments from their 2004 claims files. However, because often a significant portion of the claims payments under these codes would not be required by the mandated benefit itself, this process most probably resulted in an inflated cost of the mandate.

2. The marginal cost estimates (total cost of the mandated benefit minus the estimated cost that would have been covered in the absence of the mandate) that were reported seemed speculative, although they may have been more accurate than the total benefit costs. As Mr. Powell observed, when a company that knows what benefits it provided before the Indiana mandate, knows what it does in other states, knows it does for self-funded plans, etc., says that the marginal cost is zero, that is far less speculative than a claims person trying to map the maternity mandate using diagnosis and procedure codes, which are extremely unlikely to capture the nuances of the actual mandate.
3. The majority of companies that explained to Mr. Powell how they determined administrative costs said they used an allocation of some or all of overall overhead based on the claim dollars paid. Companies used different methods of allocation. Some large, multi-state insurers reported their administrative expenses as very small or zero; small Indiana insurers may have a different experience.
4. The insurers' responses may include claims payments for self-funded groups that are not required to provide Indiana state mandated benefits. These self-insured groups' claims payments should have been excluded from the Survey, but excluding such claims from insurers' data presents added complexity to an already complex query.
5. The findings below are estimates based on partial responses from some insurers, using very general assumptions about the percent of the insurers' market premium that had responded compared to the total market premium.

Only 23 insurers provided usable marginal cost data in their Survey responses. However, the marginal cost of the mandated benefits is a better measure than the total cost. The statute requires a report with the full cost of the mandates. However, as mentioned above under number 2, the marginal cost (total cost of the mandated benefits minus the estimated cost that would have been covered in the absence of the mandate) may be less speculative than the total cost. In addition, the marginal cost is a much better measure of the true cost of a mandated benefit, since it is the real measure of the additional cost to insurers (and their insureds) of a mandated benefit. For example if breast cancer screenings are mandated from age 40 on, but insurers had already voluntarily covered breast cancer screenings from age 50 on, then the marginal cost, which is the cost of screenings from ages 40-50, is a much better measure of the cost of the benefit mandate than the total cost of screenings from age 40 on

This Survey did not look at the benefits provided by mandated benefits. Business, social, economic, and medical efficacy implications vary quite widely from one mandate to another (e.g., based on incidence of the disease, utilization statistics, and consequences of not obtaining services) but certainly should be accounted for in determining the overall value of a mandated benefit.

Indiana's 2004 average annual wage was computed by the Indiana Chamber of Commerce, and is based on the total number of individuals employed. However, this overall average wage may not accurately reflect the average wage of persons with health insurance (as opposed to persons with coverage in self-funded employer health plans) in Indiana. Typically, larger employers offer higher wages, and larger employers also tend to self-fund their health benefit plans. Consequently, we would expect the average wage (denominator) for insured persons to be somewhat lower, and thus the cost of mandates as a percentage of the wage to be somewhat higher, if the numerator and denominator were based on the same populations.

The estimated number of insured persons in 2004 in Indiana, 2,090,287 (which number is used in the calculation of total cost per average annual wage) was the number of covered lives as of 12/31/04 determined by the Indiana Comprehensive Health Insurance Association (ICHIA). Some of these covered lives would be children or unemployed spouses, so attributing the average annual wage to each one is not accurate; however, the number of children and unemployed spouses in this total number is not known.

The amount of Indiana health premium in 2004, estimated from the National Association of Insurance Commissioners (NAIC) reported Accident & Health premium, was 6 billion dollars. However, ICHIA shows the amount of health premium in Indiana in 2004 to be almost 4 billion dollars. The NAIC value was used

to extrapolate from reported insurer Survey responses to an estimated total insurer response. Both the NAIC value and the ICHIA value were used to compare the total costs of mandated benefits to total premium.

Survey Findings

The insurers who responded with total costs that were fixed dollar amounts, or that could be converted with simple adjustments to fixed dollar amounts, showed a total cost (both benefits and administrative cost) of $140 million in calendar year 2004. For insurers not providing total cost data, costs were estimated by extrapolation based on National Association of Insurance Commissioners (NAIC) reported Accident & Health premium, and those estimates raised the total costs to $240 million in calendar year 2004. If the marginal costs as reported by insurers who furnished such numbers apply to the experience of all insurers, then the marginal costs reduce from $240 million to $90 million, or about 3/8 of reported gross costs.

The estimated total mandated benefit cost per person in 2004 is the full cost of all existing mandated benefits in Indiana in 2004 (240 million dollars) divided by the number of insureds (2.09 million), which equals $114.82 total mandated benefit cost per insured in 2004. The total mandated benefit cost per insured ($114.82) divided by the average annual Indiana wage in 2004 ($34,098) results in the total mandated benefit cost per insured in 2004 being 0.34% of Indiana's average annual wage. The estimated marginal mandated benefit cost per insured in 2004 would be 0.13% of Indiana's average annual wage.

The estimated total mandated benefit cost in Indiana in 2004 (240 million dollars) divided by the total Indiana health coverage premium ($6 billion based on NAIC data) shows that the total mandated benefit cost is 4% of health coverage premiums. If the total Indiana health premium determined by ICHIA of $4 billion is used instead, the total mandated benefit cost in 2004 is 6% of health coverage premiums. The estimated marginal mandated benefit cost in Indiana in 2004 is 1.5% – 2.25% of health coverage premiums. The Task Force wishes to restate that the validity of the data set out above is questionable because of the limited and incomplete responses received.

Proposal for Future Reports

The Task Force's observations and recommendations are offered with an important caveat: our group, along with Mr. Powell, Department of Insurance actuary, found that while the Survey provided some very general conclusions, the accuracy of these conclusions was limited by some problems with survey responses as well as by some inherent assumptions in the Survey itself.

The Task Force and the Department of Insurance have learned much from this effort to estimate the total cost of existing mandated benefits in Indiana for the calendar year 2004. The survey findings, although based on estimated values that incorporate many assumptions, indicate that the total cost of mandated benefits in Indiana appears to be a small percentage of the total premium or of the average annual wage. The Task Force makes the following recommendations, based upon the survey limitations set out above, the great amount of work required of participating insurers, and the lack of any requirement for all insurers to participate in the survey. It is recommended that the law cited above be revised to either:

1) make reporting of data a requirement of insurers under specified methodologies and definitions established by the Department of Insurance; or

2) eliminate the requirement for the Task Force to annually determine and report on the full cost of all existing mandated benefits.

It is the conclusion of the Task Force that, as evidenced by this report, the voluntary reporting by insurers using their own methodologies creates a significant lack of consistent, all inclusive data. Considering the

great deal of time and effort needed to complete this report by the Department of Insurance and those insurers willing to report, the Task Force believes that mandated reporting by insurers using consistent, prescribed methodologies is the only reliable manner to assure usable future reports. The Task Force does recognize that the establishment of reporting requirements with prescribed methodologies will increase the cost of the reporting for both the Department of Insurance and insurers. However, without mandated reporting with prescribed methodologies by insurers, the Task Force believes that future reporting by insurers is likely to include fewer responses than reported in this survey.

The alternative recommendation is to eliminate the requirement for the Task Force to annually determine and report on the full cost of all existing mandated benefits. The Council for Affordable Health Insurance currently provides some mandated benefits cost estimates for Indiana (Exhibit 3). Continued annual work by this Task Force on total mandated benefit cost may not materially add to this information, even if our law is changed to mandated insurer reporting with prescribed methodologies.

Further, the Task Force recommends that future efforts of the Task Force be directed to concentrate only on the study of the total cost and the marginal cost of specific mandates proposed by the Indiana legislature in summer study sessions, bills presented during legislative sessions, or other such venues. The Task Force considers it unlikely that the reported relationships between mandated benefit costs, total premium, and annual average wage will change significantly over the next few years. Thus, a focused study of a specific proposed mandated benefit and its marginal costs could produce valuable information and guidance needed by legislators and the governor prior to determining whether a specific mandated health coverage would benefit Indiana consumers.

Respectfully Submitted: The Mandated Benefits Task Force

EXHIBIT 2 - INDIANA BENEFIT MANDATES

Statute/Regulation	Effective Date	Benefit	Apply to Individual	Apply to Small Group & Employer Assoc	Apply to Large Group & Employer Assoc	Apply to Out-of-State Non-Emp Assoc or Trusts	Summary
27-8-14.2	Issued, renewed, delivered, or entered into after 6/30/01	Autism and other pervasive developmental disorders	Yes, must offer	Yes	Yes	Yes if policy is issued in IN	Must provide coverage for everything in physician's treatment plan even if policy doesn't normally cover
27-8-14.8 27-13-7-17 27-8-5-16.5	Issued, delivered, amended, renewed after 6/30/00 Issued or renewed after 6/30/02	Colorectal Cancer Screening	No	Yes	Yes	Yes if policy and/or cert is issued in IN	Must provide coverage for colorectal cancer exams and lab tests for cancer for any nonsymptomatic insured for insureds 50+ or less than 50 and at high risk. May not require additional annual deductible or coinsurance that is greater than that set for similar benefits
27-8-5-27 27-13-7-15	Issued or renewed after 7/1/99	Dental Anesthesia	No	Yes	Yes	Yes if policy is issued in IN	Must include coverage for anesthesia and hospital charges for dental anesthesia for dental care if a child or disabled individual's mental or physician condition requires dental treatment to be rendered in hospital or ambulatory outpatient surgical center.
27-8-14.5 includes HMOs 27-8-5-16.5	Issued or renewed after 12/31/97 Issued or renewed after 6/30/02	Diabetes treatment, supplies, equipment	Yes	Yes	Yes	Yes if policy and/or cert is issued in IN	If cover diabetes, must provide coverage for medically necessary treatment, supplies and equipment and self-management training - - subject to general provisions of the plan
27-13-36-9 HMOs only	Issued or renewed on or after 7/1/98	Emergency Services Treatment	Yes	Yes	Yes	Yes, if policy is issued in IN	(For HMOs) Must provide payment for emergency services provided in out-of service area facility
27-8-24.1 27-13-7-18	Issued , delivered, amended, renewed after 12/31/03	Inherited Metabolic Disorder - PKU	No	Yes	Yes	Yes if policy is issued in IN	Must provide coverage for medical food that is medically necessary and prescribed by the individual's treating physician for the treatment of the inherited metabolic disease. May not be subject to the dollar limits, coinsurance or deductibles that are less favorable than dollar limits, coinsurance or deductibles that apply for coverage for prescription drugs OR physical illness generally if prescription drugs are not covered.
27-8-31.2-5	Issued or renewed after 6/30/03	Mail Order RX	Yes	Yes	Yes	Yes, if policy is issued in IN	If prescription drugs are covered and accessible through mail order or Internet, the insurer cannot require an insured to use those processes
27-8-14-6 27-13-7-15.3 27-8-5-16.5	Issued, delivered, or renewed after 6/30/99	Mammography	No	Yes	Yes	Yes if policy and/or cert is issued in IN	Must provide (or offer to provide) coverage for breast cancer *screening* mammography. 35-39=1 baseline before 40. 40+=1 *screening* annually; additional mammo and ultrasound if physician determines medically necessary. If under 40 and at high risk=1 *screening* annually; additional mammo and ultrasound if physician determines medically necessary. See stature for payment level requirements.

EXHIBIT 2 - INDIANA BENEFIT MANDATES

Statute/Regulation	Effective Date	Benefit	Apply to Individual	Apply to Small Group & Employer Assoc	Apply to Large Group & Employer Assoc	Apply to Out-of-State Non-Emp Assoc or Trusts	Summary
27-8-24 includes HMOs, Mother's & Newborns Act - Federal	Issued, delivered, executed or renewed on or after 7/1/96	Maternity Benefits-minimum benefits if maternity coverage provided	y	Yes	Yes	Yes if policy and/or cert is issued in IN (under Newborns & Mothers)	If provide maternity benefits must provide minimum benefits to mother and newborn that cover minimum length stay at hospital. *Mother's and Newborn Act applies to self-funded employer plans.*

EXHIBIT 2 - INDIANA BENEFIT MANDATES

Statute/Regulation	Effective Date	Benefit	Apply to Individual	Apply to Small Group & Employer Assoc	Apply to Large Group & Employer Assoc	Apply to Out-of-State Non-Emp Assoc or Trusts	Summary
27-8-5-15.6 27-13-7-14.8 27-8-5-16.5	Issued, entered into, renewed after 12/31/99	Mental Health Parity	y	n	Yes	Yes if policy and/or cert is issued in IN	If MH benefits are offered -- no treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed for other medical or surgical conditions. *(ERISA plans of employers with more than 51 employees must meet federal party law - check with Dept. of Labor)*
27-8-14.1 27-13-7-14.5 27-8-5-16.5	Issued, delivered, entered into or renewed after 6/30/00 Issued or renewed after 6/30/02	Morbid Obesity-Surgical procedures for treatment	No	Must offer to policy holder - not at certificate holder's level	Must offer to policy holder - not at certificate holder's level (State plan must	Yes if policy and/or cert is issued in IN	Must provide coverage for surgical treatment of morbid obesity (defined in stature) if morbidly obese for 5 years and treating unsuccessfully with physician for at lease 18 months continuous months.
27-8-5-5.6 27-8-5-16.5 NO for HMOs	Issued or renewed after 6/30/97	Newborn Coverage (including cleft palate)	Yes unless pregnancy pre-existed issuance of policy	Yes	Yes	Yes if policy and/or cert is issued in IN	Provides that the insurance benefits applicable for individuals or family members also be payable with respect to a newly born child of the insured, certificate holder, or subscriber from the moment of birth to day 31. Includes cleft palate & abnormalities.
16-41-17	1993	Newborn Testing	?	Yes	Yes	Yes if policy is issued in IN	Certain tests required to be performed on newborns.
27-13.38	Issued, delivered, renewed after 1/1/99	Prescription Drugs-Access to off-formulary	Yes, if HMO	Yes, if HMO	Yes, if HMO	Yes if HMO & policy is issued in IN	HMO must provide expeditious process for obtaining, w/out penalty or additional cost-sharing, specific, medically necessary & appropriate non-formulary drugs/devices w/out prior approval
27-8-20 includes HMOs 27-8-5-16.5	Policies or contracts effective after 6/30/93 Issued or renewed after 6/30/02	Prescription Drugs-Off-Label Use of Certain Drugs if Rx coverage provided	Yes	Yes	Yes	Yes if policy and/or cert is issued in IN	Applies to drugs or biologics used in anticancer chemotherapeutic regimens; may not exclude coverage of a covered drug for a particular indication on the grounds that the drug has not been approved by the FDA for the particular indication.
27-8-14.7 27-13-7-16 27-8-5-16.5	Issued, delivered, amended, renewed after 6/30/99 Issued, renewed after 6/30/02	Prostate Cancer Screening	No	Yes (non-employer must offer)	Yes (non-employer must offer)	Yes if policy and/or cert is issued in IN	Must provide (or offer to provide) coverage for prostate screening. <50=1 test annually for high-risk according to American Cancer Society guidelines; 50+=1 test annually. See stature offer payment level requirements.
27-8-5-15.6 27-13-7-14.8	Issued, delivered, amended, or renewed after 6/30/03	Substance Abuse/Chemical Dependency Treatment	Yes *Read Summary carefully*	Yes *Read Summary carefully*	Yes *Read Summary carefully*	Yes if policy is issued in IN *Read Summary carefully*	If policy provides for coverage of services for the treatment of SA and CD when the services are required in the treatment of a mental illness, the insurer shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or financial requirements are not imposed on coverage of services for other medical or surgical conditions. POLICYHOLDER CAN CHOOSE TO HAVE COVERAGE WITHOUT LIMITATIONS.