

OFFICE OF HEALTH INSURANCE

Louisiana Department of Insurance
Commissioner of Insurance James J. Donelon



**Mandated Healthcare
Benefits Study
2005-2007**

LOUISIANA DEPARTMENT OF INSURANCE

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Mandated Healthcare Benefits Study (2005-07)

Authority

Under the authority of HCR 131 of the 2008 Regular Legislative Session, the Louisiana Department of Insurance reviewed the cost and effectiveness of health insurance mandates. (See attached Exhibit A)

The last such study was completed under the authority of Act 1133 of the 2001 Regular Session of the Louisiana Legislature (now codified as LRS 22:1047, previously codified as LRS 22:230.5), in which the Louisiana Department of Insurance was directed to conduct an actuarial cost analysis and submit a report to the House and Senate Insurance Committees prior to the commencement of the 2003 Regular Legislative Session. The Office of Health and the Life and Health Actuarial Services Section completed the associated report, effective February 28, 2003.

Executive Summary

HCR 131 directs the Louisiana Department of Insurance to:

1. Determine the cost of the current mandates both in terms of absolute dollars and as a percentage of health insurance premiums.
2. Compare Louisiana's statutory mandates with those of other states to determine which of them are statutorily mandated in these other states and which of them are strictly on a voluntary basis.
3. Determine the cost savings resulting from early disease diagnosis and treatment through certain statutorily prescribed mandates versus the cost of treating such diseases if early detection were not encouraged through the mandates.

In completing items (1) and (3), HMO and health indemnity companies with substantial health insurance premium revenue in Louisiana were surveyed over the three year period from 2005 through 2007, using a questionnaire designed to determine: (a) the procedural cost of the health insurance mandates, (b) the number of members serviced under the specific mandate and (c) the cost of treating the diseases which certain mandates attempted to diagnose early. Industry response, although not perfect, and not always fully utilized, provided representation from

companies with about 96% (\$7.2 billion of \$7.5 billion) of the aggregate Louisiana health insurance premium collected over the three year study period. However, problems with the data received forced us to limit the “mandate cost” to “disease cost” comparison study to the major cancers, namely: (a) breast, cervix and uterine, (b) prostate, (c) colon.

In completing item (2), we surveyed the states participating in the National Association of Insurance Commissioners (“NAIC”) and also obtained copies of two reports analyzing the costs associated with mandates in Texas and Maryland. Results received from the individual states were supplemented with a comprehensive review of all mandates from all states published by the NAIC. (NAIC’s Compendium of State Laws on Insurance Topics, II-HB-10 (3/06); II-HB-15 (8/06); II-HB-20 (5/07); II-HB-25 (2/08))

Louisiana’s current mandates can be found at R.S. 22:1021, et seq. (Attached hereto is Exhibit B, representing a chart of all Louisiana mandates and their legal citations.) We found that most states had the same or similar mandates as Louisiana. The most likely mandates being those which screen or detect cancer as well as treatment for such illnesses. In addition, well-baby care and mandates for the diagnosis and treatment of diabetes and metabolic disease formulas were also found in most states.

In comparing costs, Texas reports a cost of 4.40%, for a total of 20 mandates. Maryland reports a cost of 15.4% for group plans and 18.6% for individual plans for a total of 42 mandates. While Maine reports a cost of 8.30% for non-HMO plans and 8.03% for HMO plans of groups larger than 20 for a total of 26 mandates. The cost for an individual contract in Maine for non-HMO plans is 3.66% and 2.95% for HMO contracts for the same 26 mandates.

In summary, the study results are:

1. The aggregate cost of the mandates over the three year study period was determined to be about \$413 million, representing about 6% of premium revenue. In comparison, the 2003 study showed the mandates as costing 4.88%. (The actual dollar costs are not relevant because the cost comparisons of the two studies are not comparable due to differing premium basis.)
2. When the cost of the colorectal mandate (was not in effect in 2003) and the cost of the maternity and breast reconstruction mandates are removed (these are federal mandates) the 2008 mandate costs shrink to about \$283 million

and 4.20% of premium. The corresponding 2003 value is 2.79%. This latter value when rounded up is the popularly cited 3%. **So, in rounded terms, the cost of Louisiana state health insurance mandates as a percent of premium were 3% in 2003 and 4% in 2008.**

3. The total cancer diagnoses mandate cost was determined to be \$84 million, representing about 1.2% of premium revenue. The total cost of treating these cancers was found to be \$323 million, representing about 4.6% of premium. While it is clear that the pure cost of treating these diseases is more expensive than the pure cost of the diagnostic mandates, the nature of our study does not quantify the amount of savings resulting from early disease diagnosis through the mandates since some treatment is inevitable even if the cancer is discovered through the mandated diagnostic procedure. A pure cost savings analysis would require testing through medical trials rather than as a health insurance cost survey.
4. Louisiana's mandates were the same or similar to most states surveyed. The most common mandates being those intended to screen and/or treat cancer as well as well-baby care and mandates for the diagnosis and treatment of diabetes and metabolic disease formulas were also found in most states.
5. Costs comparisons with Texas, Maryland and Maine indicate that Louisiana has the lowest number of mandates at 17 and the lowest cost impact on premium at a total of 4%.

Study Methodology

The purpose of our study was to survey the cost of Louisiana's health insurance statutory mandates over the three year period from 2005 through 2007. A Questionnaire was sent to 31 companies that received Louisiana health insurance premium. We received 18 responses, 14 of which provided information in the correct format. We subsequently found the data from two of the companies to be lacking credibility. The 12 remaining companies received 96% of the Louisiana health insurance premium revenue over the three year study period. The respondent companies provided information from the following lines of business:

- (1) Group indemnity
- (2) Individual indemnity
- (3) Group HMO
- (4) Individual HMO
- (5) Blanket Group

The questionnaire that was sent to companies attempted to obtain the following information:

- (1) Claim costs incurred for the specific mandate.
- (2) Number of claim procedures undertaken for the specific mandate.
- (3) Claim costs incurred in treating the disease that the mandate was supposed to mitigate.
- (4) Number of claim procedures undertaken in treating the disease that the mandate was supposed to mitigate.

The questionnaire listed the CPT codes for each mandate and the CPT codes for the diseases surveyed. The surveyed companies used the CPT reference to provide the costs and number of services for the mandates and disease processes reviewed. The returned survey response CPT codes were totaled to obtain the aggregate cost and number of services for the specific mandates and disease process. From this information the following items were obtained or derived:

- (1) Aggregate three year claim cost of the mandate.
- (2) Aggregate number of services over the three year period for the mandate.
- (3) Claim cost per service for the mandate.
- (4) Cost of mandate as a percentage of premium.
- (5) Aggregate three year claim cost of the disease process that the mandate was supposed to mitigate.
- (6) Aggregate number of services over the three year period for the disease process that the mandate was supposed to mitigate.

- (7) Claim cost per service for the disease process that the mandate was supposed to mitigate.
- (8) Ratio of the “disease process cost to the mandate cost” for the disease process that the mandate was supposed to mitigate.

Statutory Mandates – Descriptions and Cost Review

The cost of the seventeen statutory mandates (15 state and 2 federal) to the Louisiana health insurance industry was surveyed over a three year study period (2005 through 2007). We received responses from 18 companies, 12 of which provided useable information, giving representation to 96% of the Louisiana health insurance premium revenue received over the study period. The results are presented in aggregate over the three year study period and include:

- (a) mandate costs
- (b) mandate cost as a percentage of premium revenue
- (c) number of mandated services
- (d) cost per mandated service

The results are detailed below and summarized in Table I.

The highlighted legal references are from the re-codified Louisiana Revised Statutes Title 22. (The former Title 22 references are cited in brackets.)

1026 (was 215.8) – Cleft lip and cleft palate treatment and correction, and for secondary conditions and treatment attributable to that primary condition. HMOs and limited benefit supplemental policies are exempt from this mandate.

Claim cost data was received from only five of the twelve companies, representing \$4.6 billion in premium revenue (total all companies \$7.2 billion).

The reported claim costs were about \$457,000, yielding a cost to premium percentage of about 0.01% (0.02% in the 2003 study). There were 304 services reported, for a cost per service of about \$1,500.

1027 (was 215.10) & 245 (was 2004.1) – Hearing impaired interpreter expenses performed by a qualified interpreter / transliterator when used by the insured in connection with covered medical treatment or diagnostic consultations. Limited benefit supplemental policies are exempt.

Claim cost data was received from three of the twelve companies, representing \$1.3 billion in premium revenue (total all companies \$7.2 billion).

The reported claim costs were about \$20,000 yielding a cost to premium percentage less than 0.01% (similar results were observed in the 2003 study). There were 13 services reported, for a cost per service of about \$1,500.

1028A (was 215.11A) – Annual Pap test and minimum mammography examination (one baseline mammogram for any woman age 35-39, one every 24 months for any woman age 40-49, one every 12 months for any woman age 50 or older). These benefits are not subject to any type of deductibles. Limited benefit supplemental policies are exempt from this mandate.

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$55.4 million, yielding a cost to premium percentage of about 0.77% (0.55% in the 2003 study). There were 693,650 services reported, for a cost per service of about \$80.

1028B (was 215.11B) – Prostate cancer detection including digital rectal examination and prostate-specific antigen testing for men over age 50 and as medically necessary for men over age 40. This benefit is not subject to any type of deductible. Limited benefit supplemental policies are exempt from this mandate.

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$5.4 million, yielding a cost to premium percentage of about 0.07% (0.10% in the 2003 study). There were a total of 329,295 services reported, for a cost per service of about \$20.

1029 (was 215.12) – Routine colorectal cancer screening tests, including: fecal occult blood test, flexible sigmoidoscopy, or colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. Limited benefit supplemental policies are exempt from this mandate.

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$25.3 million, yielding a cost to premium percentage of about 0.35%. (This mandate was not part of the 2003 study.) There were a total of 55,894 services reported, for a cost per service of about \$450.

1030 (was 215.14) – Immunizations for dependent children from birth to age 6, includes basic immunization series as defined by the state health officer and required for school entry. Benefits are payable under the same circumstances and conditions as are paid for all other diagnoses, treatments, illnesses, or accidents. HMOs and limited benefit supplemental policies are exempt.

Claim cost data was received from nine of the twelve companies, representing \$4.7 billion in premium revenue (total all companies \$7.2 billion).

The reported claim costs were about \$24.0 million, yielding a cost to premium percentage of about 0.51% (0.18% in the 2003 study). There were a total of 334,315 services reported, for a cost per service of about \$70.

1031 (was 215.15) – Attention deficit / hyperactivity disorder. Benefits are payable under the same circumstances and conditions as are paid for all other diagnoses, illnesses or accidents, up to \$600 for the initial diagnosis, \$50 per outpatient doctor visit, \$2,500 annual maximum, and \$10,000 lifetime maximum. HMOs and limited benefit supplemental policies are exempt.

Claim cost data was received from nine of the twelve companies, representing \$4.7 billion in premium revenue (total all companies \$7.2 billion).

The reported claim costs were about \$3.9 million, yielding a cost to premium percentage of about 0.08% (0.07% in the 2003 study). There were a total of 28,260 services reported, for a cost per service of about \$140.

1032 (was 215.16) – Bone mass measurement for diagnosis and treatment of osteoporosis for “qualified individuals”, i.e. estrogen-deficient women at clinical risk of osteoporosis, individuals receiving long-term steroid therapy, or individual

being monitored to assess the response to or efficacy of approved osteoporosis drug therapies. HMOs and limited benefit supplemental policies are exempt.

Claim cost data was limited; being received from nine of the twelve companies, representing \$4.7 billion in premium revenue (total all companies \$7.2 billion).

The reported claim costs were about \$3.7 million, yielding a cost to premium percentage of about 0.08% (0.06% in the 2003 study). There were a total of 22,802 services reported, for a cost per service of about \$160.

1034 (was 215.21) – Treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes. Coverage includes the equipment, supplies, outpatient self-management training and education, and medical nutrition therapy. One-time evaluation and training expenses are covered up to \$500. Expenses for additional medically necessary training due to significant change in symptoms or conditions are covered up to \$100 per year and a \$2,000 lifetime maximum. Benefits are subject to the same annual deductibles or coinsurance established for all other covered benefits. Limited benefit supplemental policies are exempt.

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$8.5 million, yielding a cost to premium percentage of about 0.12% (0.01% in the 2003 study). There were a total of 24,520 services reported, for a cost per service of about \$350.

1040 (was 228.7) – Anesthesia and associated hospital charges when the mental or physical condition of the insured requires dental treatment to be rendered in a hospital setting, except for treatment of TMJ. Limited benefit supplemental policies are exempt.

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$1.2 million, yielding a cost to premium percentage of about 0.02% (0.03% in the 2003 study). There were a total of 2,439 services reported, for a cost per service of about \$500.

1044 (was 230.4) – Coverage for treatment provided in accordance with a Phase II, III, or IV clinical trial for cancer and health-related services, subject to applicable deductible, coinsurance or copayment amounts. Limited benefit and Short-term policies are exempt.

Claim cost data was received from three of the twelve companies, representing \$2.5 billion in premium revenue (total all companies \$7.2 billion).

The reported claim costs were about \$1.1 million, yielding a cost to premium percentage of about 0.04%. (The 2003 study reported a negligible cost percentage.) There were a total of 103 services reported, for a cost per service of about \$11,000.

1043 (was 669) – Severe mental illnesses (does not include alcohol and substance abuse) includes: schizophrenia or schizoaffective disorder, bipolar disorder, pervasive development disorder or autism, panic disorder, obsessive-compulsive disorder, major depressive disorder, anorexia / bulimia, Asperger’s Syndrome, intermittent explosive disorder, post-traumatic stress disorder, psychosis NOS when diagnosed in a child under 17, Rett’s Disorder, and Tourette’s Disorder. Individually underwritten limited benefit and short-term policies are exempt from the requirements of this mandate.

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$98.5 million, yielding a cost to premium percentage of about 1.37% (1.15% in the 2003 study). There were a total of 177,799 services reported, for a cost per service of about \$550.

1065 (was 250.4) & 1077 (was 250.17) – Provides for coverage of maternity stays of at least 48 hours for vaginal deliveries and 96 hours for cesarean section (Required for group plans by federal law. State law includes individual plans.)

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$93.6 million, yielding a cost to premium percentage of about 1.30% (2.00% in the 2003 study). There were a total of 28,510 services reported, for a cost per service of about \$3,300.

1077 (was 250.17) – Provides that policies that cover mastectomies also cover reconstructive breast surgery following a mastectomy. (Federal law mandates this coverage.)

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$11.1 million, yielding a cost to premium percentage of about 0.15% (0.09% in the 2003 study). There were a total of 5,270 services reported, for a cost per service of about \$2,100.

999 (was 215.20) – Prohibits plans that cover treatment of cancer from excluding coverage for any drug prescribed for treatment of cancer on the grounds that the drug is not approved by the US FDA for a particular indication if that drug is recognized for treatment of the covered indication in a standard reference compendia or in substantially accepted peer-reviewed medical literature and; mandates coverage for all medically necessary services associated with administration of the drug.

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$78.5 million, yielding a cost to premium percentage of about 1.09% (0.62% in the 2003 study). There were a total of 10,525 services reported, for a cost per service of about \$7,500.

1038 (was 215.25) – Hearing aids for children under age 18, subject to approval by an audiologist.

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$78,000, yielding a cost to premium percentage of less than 0.01%. (This mandate was not part of the 2003 study.) There were a total of 67 services reported, for a cost per service of about \$1,200.

1035 (was 215.22) – Low protein food products for treatment of inherited metabolic diseases, if medically necessary and obtained from a source approved by the health insurance issuer. Maximum benefit: \$200 per month. Excludes individually underwritten association plans. (New mandate for basic medical/surgical expense, major medical group plans issued or renewed after 1/1/2002)

Claim cost data was received from all twelve companies (\$7.2 billion in premium).

The reported claim costs were about \$2.1 million, yielding a cost to premium percentage of about 0.03%. (The 2003 study reported a negligible cost percentage.) There were a total of 2,447 services reported, for a cost per service of about \$850.

TABLE I (COST OF MANDATES STUDY)

Reference	Mandate	Mandate Costs (millions) 2008	Mandate Costs (%Prem.) 2008	Mandate Costs (%Prem.) 2003	Services 2008	Cost per Service 2008
1026	Cleft Lip & Cleft Palate	\$0.5	0.01	0.02	304	\$1,500
1027 & 245	Hearing Impaired Interpreter	-	-	-	13	\$1,500
1028A	Breast & Cervix Cancer Tests	\$55.4	0.77	0.55	693,650	\$80
1028B	Prostate Tests	\$5.4	0.08	0.10	329,295	\$20
1029	Colorectal Tests	\$25.3	0.35	N/A	55,894	\$450
1030	Immunization	\$24.0	0.51	0.18	334,315	\$70
1031	ADD & ADHD	\$3.9	0.08	0.07	28,260	\$140
1032	Osteoporosis	\$3.7	0.08	0.06	22,802	\$160
1034	Diabetes	\$8.5	0.12	0.01	24,520	\$350
1040	Special Dental	\$1.2	0.02	0.03	2,439	\$500
1044	Cancer Clinical Trials	\$1.1	0.04	-	103	\$11,000
1043	Severe Mental Illness	\$98.5	1.37	1.15	177,799	\$550
1065 & 1077	Maternity Coverage	\$93.6	1.30	2.00	28,510	\$3,300
1077	Reconstructive Breast Surgery	\$11.1	0.15	0.09	5,270	\$2,100
999	Cancer Drugs	\$78.5	1.09	0.62	10,525	\$7,500
1038	Hearing Aids	-	-	N/A	67	\$1,200
1035	Food Allergies	\$2.1	0.03	-	2,447	\$850
Total		\$412.8	6.00	4.88	1,716,213	
Total *		\$282.8	4.20	2.79	1,626,539	

N/A – Means not reported in the 2003 study

Total * - Means Total less Colorectal, Maternity & Reconstructive Breast Mandates

Statutory Mandates & Disease Cost Comparisons

As part of the mandated benefit study, companies were surveyed to obtain treatment cost data for certain disease processes over the three year period under our study (2005 through 2007). These costs were then compared to the cost of the disease prevention mandates to evaluate any cost savings resulting from the mandates.

Only some of the resulting disease cost data was found to be reliable so the comparison was limited to the following processes and mandate references:

- (1) Breast, cervix and uterine cancer (1028A)
- (2) Prostate cancer (1028B)
- (3) Colon cancer (1029)

This study was a statistical survey of the health insurance costs of treating a disease in comparison with the health insurance cost of early disease diagnosis. Since it is not a medical study, it is not possible to definitively determine the cost savings from early cancer diagnosis. (Such a study would require the following of the disease process of a selected group of medical patients over a satisfactory time period.) For example, one limitation of our study is that some of the cancer treatment costs in our data were inevitable and thus early diagnosis mitigated the cancer costs, but did not eliminate them. Intuitively, there are medical costs savings from the earlier diagnosis of cancer but the amount of such savings cannot be quantified from our study. What is clear from the study is that the cost of treating cancer is expensive and does exceed the cost of the mandates. The results are summarized in Table II and detailed below.

Breast, cervix and uterine cancer (1028A) – The cost of the mandated breast, cervix and uterine cancer diagnostic test was compared to the cost of treating these diseases. Over the three year study period about \$184.4 million was spent treating these 24,870 cancer services for a cost per service of \$7,400, while about \$55.4 million was spent on the 693,650 mandated tests for a cost per service of about \$80. From this information, the “disease treatment to diagnosis cost” ratio was determined to be about 3.3.

Prostate cancer (1028B) - The cost of the mandated prostate cancer diagnostic test was compared to the cost of treating this disease. Over the three year study

period about \$55.1 million was spent treating these 14,269 cancer services for a cost per service of \$3,900, while about \$5.4 million was spent on the 329,295 mandated tests for a cost per service of about \$20. From this information, the “disease treatment to diagnosis cost” ratio was determined to be about 10.2.

Colon cancer (1029) - The cost of the colon cancer diagnostic test was compared to the cost of treating this disease. Over the three year study period about \$83.0 million was spent treating these 8,302 cancers for services for a cost per service of \$10,000, while about \$25.3 million was spent on the 55,894 mandated tests for a cost per service of about \$450. From this information, the “disease treatment to diagnosis cost” ratio was determined to be about 3.3.

TABLE II (MANDATES & DISEASE COST COMPARISON)

Ref.	Mandate	Claim Costs (MM)	Claim Services	Claim Cost per Service	Test Costs (MM)	Test Services	Approx. Test Cost per Service	Ratio Treatment to Cost
1028A	Breast & Cervix Cancer Tests	\$184.4	24,870	\$7,400	\$55.4	693,650	\$80	3.3
1028B	Prostate Cancer Tests	\$55.1	14,269	\$3,900	\$5.4	329,295	\$20	10.2
1029	Colorectal Cancer Tests	\$83.0	8,302	\$10,000	\$25.3	55,894	\$450	3.3
Total		\$322.5	47,441		\$86.1	1,078,839		3.7

MM – refers to millions of dollars.

Comparison of other states—General Discussion

A survey of all fifty states was initiated by contacting our NAIC partners. In conducting this survey, we discovered that many states have multiple methods of characterizing their mandates. As a result, we supplemented the responses received through the use of a compilation of state statutes provided by the NAIC. Our survey results are best reported through the use of charts detailing the different mandates and then indicating the states which have the same or similar statutory provisions as Louisiana. (See Attached Exhibit C) Finally, we also recommend that the reader consult the report from the Council for Affordable Health Insurance entitled “Health Insurance Mandates in the States 2008” accessible at www.cahi.org. While this report serves as valuable information on mandates and their potential cost, we must caution that this report has a broader interpretation of “mandates” than we utilized in this survey. It should be noted that all references to “mandates” in our survey refers to a service or treatment that must be contained in a health insurance policy. We did not include mandates that must be “offered” but do not have to be accepted by the purchaser of the health insurance policy. In addition, we were not able to locate information from other states on all Louisiana mandates; therefore, our comparison includes only those mandates where a comparison was noteworthy.

Exhibit C details the comparison of the fourteen Louisiana mandates found in other states. Most states have anywhere from 2 to 13 of the same mandates in their statutory scheme. Mandates for the screening and treatment of breast, cervix, colon and prostate cancer are most likely to be found in the states surveyed. We also noted that coverage for well-baby care was seen in most states. The one identifying factor with this mandate appears in the maximum age required under the mandate. We note that while most states require well-baby care up to the age of 6 years old. Some states, notably, Arkansas, California, Florida, New York and Oklahoma, require coverage up to the age of 16 or 18 years. Finally, mandates for the diagnosis and treatment of diabetes and payment for infant formula for metabolic disease were also found in most states.

Voluntary offering of mandates—Other states

HCR 131 requires a determination of whether any benefit mandated in Louisiana has been voluntarily offered in other states. We were only able to obtain this information from Maryland. They report 86% of the exempted companies

voluntarily provide the cost of their 42 mandates. The only mandate not covered by a majority of the exempted companies is their mandated benefit for in vitro fertilization. We note that of the mandates identical to Louisiana's mandates, the most likely to be voluntarily offered are those for cancer screening and treatment (almost all) and hospitalization and general anesthesia for dental procedures with children (most). (See attached Exhibit D)

Comparison of other state—Costs

An added benefit of this survey was the receipt of survey costs from three states who have conducted similar surveys. Both Texas and Maryland law require an assessment of the cost of mandates as a percentage of the individual state's premiums for the individual, group and state employee insurance markets. Maine has also conducted a cost analysis of its mandates impact on its individual and group markets.

The latest Texas report of costs was issued at the end of 2008 and includes information on data collected for the twelve month reporting period of October, 2005 through September, 2006. Texas currently has 20 mandated benefits which represents \$378.84 million or 4.40% of all claims paid. The average premium cost of including the 20 benefits was estimated at \$107.71 for individual coverage and \$271.10 for family coverage. (All data and information can be attributed to the "Texas Mandated Benefit Cost and Utilization Summary Report, October 2005 - September 2006 Reporting Period." See www.tdi.state.tx.us)

Maryland currently has 42 mandates in place. Maryland reports a total impact on premiums of all mandates at 15.4% for group plans, 15.8% for state employee plans, and 18.6% for individual plans. (All data and information can be attributed to the "Study of Mandated Health Insurance Services: A Comparative Evaluation," Maryland Healthcare Commission, January 1, 2008. See www.mhcc.maryland.gov)

In Maine, there are 26 mandates. Maine conducted a survey which examined the impact of these mandates on its non-HMO and HMO market. The survey examines the total premium costs by groups larger than 20, groups of 20 or fewer and individual contracts. The cost impact on groups larger than 20 in the non-HMO market is 8.30% and 8.03% in the HMO market. The cost impact on groups of 20 or fewer in the non-HMO market is 4.00% and 5.96% in the HMO market. The

cost impact on individual contracts in the non-HMO market is 3.66% and 2.95% in the HMO market. (All data and information can be attributed to the “Cumulative Impact of Mandates in Maine.” See www.maine.gov/pfr/legislative/index.htm)

Conclusion

The aggregate cost of Louisiana mandates over the past three years is about \$413 million, representing 6% of premium revenue. Excluding the cost of the two federal mandates, maternity and breast reconstruction, the 2008 mandate costs shrink to about \$283 million, representing 4.20% of premium.

The cost of actually treating the major cancers is more than the cost of screening and detecting them. However, it is not possible to quantify the absolute cost savings of early diagnosis from the information in our survey.

A comparison of Louisiana mandates to those in other states indicates that our mandates are the same or similar. The most common mandates are those intended to screen and/or treat cancer as well as well-baby care, treatment of diabetes and coverage for metabolic disease formulas.

Costs associated with mandates in Texas, Maine and Maryland are higher than Louisiana. Texas has 20 mandates at a cost of 4.40%. Maryland reports a total impact on premiums of all mandates at 15.4% for group plans, 15.8% for state employee plans, and 18.6% for individual plans. Maine has 26 mandates at a cost of 8.30% (non-HMO) and 8.03% (HMO) for groups larger than 20. The cost impact on groups of 20 or fewer is 4.00% (non-HMO) and 5.96% (HMO). For individual contracts, the cost impact is 3.66% (non-HMO) and 2.95% (HMO).

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Director of Life and Health Actuarial Services
Financial Solvency

Karen Reiners Winfrey, J.D.
Deputy Commissioner
Office of Health Insurance

March 26, 2009
Baton Rouge, Louisiana

EXHIBIT A

Regular Session, 2008

HOUSE CONCURRENT RESOLUTION NO. 131

BY REPRESENTATIVES ROY, ANDERS, FRANKLIN, KLECKLEY, LAFONTA,
MONICA, AND PEARSON

A CONCURRENT RESOLUTION

To urge and request the Department of Insurance to conduct a study on statutorily mandated health insurance benefits to determine what each such statutory mandate costs in terms of absolute dollars and as a percentage of total health insurance premiums.

WHEREAS, a statutory mandate is a law which requires a health insurer, health maintenance organization, or preferred provider organization to provide coverage for a certain health insurance benefit; and

WHEREAS, at present, there are approximately seventeen such mandates, covering such diverse services and medical conditions as screenings for breast, cervical, prostate, or colorectal cancer, bone mass measurement, immunizations, diabetes, cleft lip and cleft palate, certain clinical cancer trials, and certain severe mental illnesses; and

WHEREAS, the issue of mandating certain health insurance benefits remains a volatile one for the legislature, with the debate generally centering on consumer protection versus cost; and

WHEREAS, proponents argue that mandates are necessary to ensure adequate benefits for consumers and that, to the extent that they provide for early detection and treatment of illnesses, some of these mandates may decrease the ultimate cost of health care and health insurance; and

WHEREAS, opponents, however, contend that mandated benefits offset any consumer gains by raising the cost of health insurance, making it less affordable and ultimately increasing the number of the uninsured; and

WHEREAS, the last time that a comprehensive study on the cost of statutory mandates was conducted was 2003.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby urge and request the Department of Insurance to conduct a study on statutorily mandated health insurance benefits to determine what each such statutory mandate costs in terms of absolute dollars and as a percentage of total health insurance premiums.

BE IT FURTHER RESOLVED that such a study review and compare the statutory mandates of Louisiana with those of a select group of states to determine if they have similar mandates in their laws or if any benefit mandated in Louisiana has been voluntarily offered in those other states.

BE IT FURTHER RESOLVED that the Department of Insurance also survey the health insurance industry to identify any long-term cost savings associated with a preventive care mandate as opposed to the long-term cost of the disease if the mandate did not exist.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the commissioner of insurance.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

EXHIBIT B

STATUTES	BENEFITS	APPLICABILITY - TYPES OF HEALTH INSURANCE PLANS							Exceptions
		All Types of Health Ins Plans	Group Indemnity	Group HMO	Individual Indemnity	Individual HMO	Blanket Group	Self Insurance	
MANDATED BENEFITS									
LSA-R.S. 22:1024 B	Professional ambulance services, including air or surface transport, for newly born dependents and for the temporarily medically disabled mother of the ill newly born.		✓		✓		✓		Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1026	Cleft lip and cleft palate treatment and correction, and for secondary conditions and treatment attributable to that primary condition.		✓		✓		✓		Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1027 & 245	Hearing impaired interpreter expenses performed by a qualified interpreter / transcriber when used by the insured in connection with covered medical treatment or diagnostic consultations.	✓							Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1028 A	Annual Pap test and minimum mammography examination (one baseline mammogram for any woman age 35-39, one every 24 months for any woman age 40-49, one every 12 months for any woman age 50 or older). These benefits are not subject to any type of deductibles.	✓							High Deductible Plans as defined by Internal Revenue Code, Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1028 B	Prostate cancer detection including digital rectal examination and prostate-specific antigen testing for men over age 50 and as medically necessary for men over age 40. This benefit is not subject to any type of deductible.	✓							High Deductible Plans as defined by Internal Revenue Code, Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1029	Routine Colorectal Cancer Screening	✓							Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1030	Immunizations for dependent children from birth to age 6, includes basic immunization series as defined by the state health officer and required for school entry. Benefits are payable under the same circumstances and conditions as are paid for all other diagnoses, treatments, illnesses, or accidents. These benefits are not subject to any type of deductibles.		✓		✓		✓		Short-Term and Limited Benefit, Supplemental Plans

APPLICABILITY - TYPES OF HEALTH INSURANCE PLANS										
STATUTES	BENEFITS	All Types of Health Ins Plans								Exceptions
		Group Indemnity	Group HMO	Individual Indemnity	Individual HMO	Blanket Group	Self Insurance			
LSA-R.S. 22:1031	Attention deficit / hyperactivity disorder. Benefits are payable under the same circumstances and conditions as are paid for all other diagnoses, illnesses or accidents, up to \$600 for the initial diagnosis, \$50 per outpatient doctor visit, \$2,500 annual maximum, and \$10,000 lifetime maximum.	✓		✓		✓			✓	Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1032	Bone mass measurement for diagnosis and treatment of osteoporosis for "qualified individuals", i.e. estrogen-deficient women at clinical risk of osteoporosis, individual receiving long-term steroid therapy, or individual being monitored to assess the response to or effect of approved osteoporosis drug therapies.	✓		✓		✓			✓	Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1034	Treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes. Coverage includes the equipment, supplies, outpatient self-management training and education, and medical nutrition therapy. One-time evaluation and training expenses are covered up to \$500. Expenses for additional medically necessary training due to significant change in symptoms or conditions are covered up to \$100 per year and a \$2,000 lifetime maximum. Benefits are subject to the same annual deductibles or coinsurance established for all other covered benefits.	✓								Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1035 & 246	Low protein food products for treatment of inherited metabolic diseases, if medically necessary and obtained from a source approved by the health insurance issuer. Maximum benefit: \$200 per month.	✓								Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1038	Coverage for hearing aids for a child under age 18, if fitted and dispensed by a licensed audiologist or hearing aid specialist following medical clearance by a licensed physician and audiologist evaluation. Benefit payable may be limited to \$1,400 per hearing aid for each hearing-impaired ear every 36 months.	✓								Short-Term and Limited Benefit, Supplemental Plans

APPLICABILITY - TYPES OF HEALTH INSURANCE PLANS									
STATUTES	BENEFITS	All Types of Health Ins Plans							
		Group Indemnity	Group HMO	Individual Indemnity	Individual HMO	Blanket Group	Self Insurance	Exceptions	
LSA-R.S. 22:1040	Anesthesia and associated hospital charges when the mental or physical condition of the insured requires dental treatment to be rendered in a hospital setting, except for treatment of TMJ.	✓							Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1043	Severe mental illnesses, including schizophrenia or schizoaffective disorder, bipolar disorder, panic disorder, obsessive-compulsive disorder, major depressive disorder, anorexia / bulimia, intermittent explosive disorder, post-traumatic stress disorder, psychosis NOS when diagnosed in a child under 17, Rett's Disorder, and Tourette's Disorder. (HB 958 deletes pervasive developmental disorder or autism and Asperger's Disorder from the definition of Severe Mental Illness.)	✓	✓			✓	✓	Individually Underwritten Plans, Short-Term and Limited Benefit, Supplemental Plans	
LSA-R.S. 22:1044	Coverage for treatment provided in accordance with a Phase II, III, or IV clinical trial for cancer and health-related services, subject to applicable deductible, coinsurance or copayment amounts.	✓						Short-Term and Limited Benefit, Supplemental Plans	
LSA-R.S. 22:1049	Plans issued on or after 01/01/2009 must provide coverage of prosthetic devices and prosthetic services. The annual limit of benefits will be no less than fifty thousand dollars per limb. The co-payments, deductibles and coinsurance amounts for prosthetic devices and services, including repair and replacement of devices, shall not be more restrictive than those provided for other benefits within the plan.	✓						Short-Term and Limited Benefit, Supplemental Plans	
LSA-R.S. 22:1050	Plans issued on or after 01/01/2009 must provide coverage for the diagnosis and treatment of autism spectrum disorder in individuals less than seventeen years of age. Coverage shall not be subject to any limits on the number of visits. Coverage shall be subject to a maximum benefit of thirty-six thousand dollars per year and a lifetime maximum benefit of one hundred forty-four thousand dollars.		✓			✓	✓	Small Group Plans (2-50), Individually Underwritten Plans, Short-Term and Limited Benefit, Supplemental Plans	

STATUTES	BENEFITS	APPLICABILITY - TYPES OF HEALTH INSURANCE PLANS							Exceptions
		All Types of Health Ins Plans	Group Indemnity	Group HMO	Individual Indemnity	Individual HMO	Blanket Group	Self Insurance	
LSA-R.S. 22:976 A	Service charges for the Louisiana Health Plan (\$2.00 per day for hospital confinement and \$1.00 per day for admission to outpatient ambulatory surgical care facility), without regard to deductibles, coinsurance or copayments.	✓							Insolvent Insurers and the Office of Group Benefits
LSA-R.S. 22:999	Prohibits plans that cover treatment of cancer from excluding coverage for any drug prescribed for treatment of cancer on the grounds that the drug is not approved by the US FDA for a particular indication if that drug is recognized for treatment of the covered indication in a standard reference compendia or in substantially accepted peer-reviewed medical literature and; mandates coverage for all medically necessary services associated with administration of the drug.	✓							Short-Term and Limited Benefit, Supplemental Plans
OPTIONAL MANDATED BENEFITS									
LSA-R.S. 22:1025	A plan shall include as an option to be exercised by the policyholder covered benefits for the treatment of alcoholism and drug abuse.		✓	✓				✓	Individually Underwritten Plans, Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1042	A plan shall include as an option to be exercised by the policyholder covered benefits for speech and language pathology therapy, physical therapy, rehabilitative services and occupational therapy. (Act No. 151 - Eff. 08/15/2008) As an alternative to offering optional coverage, including these benefits as standard benefits in such policies and programs shall be sufficient to comply.		✓		✓			✓	Short-Term and Limited Benefit, Supplemental Plans
LSA-R.S. 22:1043 A(2)	A plan shall offer to the policyholder an optional provision in the policy or contract which states that benefits shall be payable for the treatment of mental disorders other than severe mental illness under the same circumstances and conditions as benefits are paid for all other diagnoses, illnesses, or accidents.		✓	✓				✓	Individually Underwritten Plans, Short-Term and Limited Benefit, Supplemental Plans
DEFINITIONS									

STATUTES	BENEFITS	APPLICABILITY - TYPES OF HEALTH INSURANCE PLANS						Exceptions
		All Types of Health Ins Plans	Group Indemnity	Group HMO	Individual Indemnity	Individual HMO	Blanket Group	
LSA-R.S. 22:1000 A(1)	Group Indemnity & Group HMO - Any policy covering more than one person, issued to an employer, one or more labor unions, trustees of a fund established by an employer or an association, or an association covering employees of member employers or individual members.							
LSA-R.S. 22:1000 A(2)	Individual Indemnity & Individual HMO - "Family Group" - Any policy covering any one person, with or without eligible family members, issued to the head of the family.							
LSA-R.S. 22:1000 A(3)	Blanket Group - Any policy covering special groups of persons, issued to a common carrier covering passengers, an employer covering employees defined by exceptional hazards, an institution of learning covering students or teachers, a volunteer fire department covering members, or a creditor covering debtors.							
LSA-R.S. 22:452	Self-Insurance Plan - Any contract, plan, trust, arrangement, or other agreement providing health coverage to employees or two or more employers, which is not fully insured but is authorized to conduct the business of self-insurance by the Louisiana Department of Insurance.							

EXHIBIT C

COMPARISON OF STATE MANDATED BENEFITS

STATES	Cleft Lip/ Cleft Palate	Hearing Impaired Interpreter/Aid Expenses	Annual Pap Test and Mammography	Prostate Cancer Detection	Routine Colorectal Cancer Screening	Hospitalization and General Anesthesia for Dental Procedures for Children
ALABAMA			√		√	
ALASKA		√	√	√		
ARIZONA		√	√		√	
ARKANSAS		√	√		√	√
CALIFORNIA			√	√	√	√
COLORADO	√		√	√		√
CONNECTICUT	√	√	√	√		√
DELAWARE		√	√	√	√	
DISTRICT OF COLUMBIA		√	√	√		
FLORIDA	√		√	√	√	√
GEORGIA			√	√	√	√
HAWAII			√	√		
IDAHO			√	√		
ILLINOIS			√	√	√	√
INDIANA	√		√	√		√
IOWA			√	√		√
KANSAS			√	√		√
KENTUCKY		√	√	√	√	√
LOUISIANA	√	√	√	√	√	√
MAINE			√	√		√
MARYLAND	√	√	√	√	√	√
MASSACHUSETTS	√		√	√		√
MICHIGAN			√	√		
MINNESOTA	√	√		√		
MISSISSIPPI		√	√	√	√	
MISSOURI			√	√	√	
MONTANA			√		√	
NEBRASKA			√			
NEVADA			√		√	√
NEW HAMPSHIRE			√			√
NEW JERSEY			√	√	√	
NEW MEXICO			√	√	√	
NEW YORK			√	√		
NORTH CAROLINA	√		√	√	√	√
NORTH DAKOTA			√	√		
OHIO			√			
OKLAHOMA		√	√	√		√
OREGON			√	√	√	
PENNSYLVANIA		√	√		√	
PUERTO RICO			√	√		
RHODE ISLAND			√	√		
SOUTH CAROLINA	√		√	√	√	
SOUTH DAKOTA			√	√		
TENNESSEE			√	√		
TEXAS	√		√	√	√	
UTAH				√	√	
VERMONT			√			
VIRGINIA	√			√	√	√
WASHINGTON				√		√
WEST VIRGINIA			√	√		
WISCONSIN			√			
WYOMING			√	√	√	

COMPARISON OF STATE MANDATED BENEFITS

STATES	Physical, Occupational, and Speech Therapy	Chemo/ Cancer Therapy Treatment	Osteoporosis	Metabolic Disease Formulas	Well Baby Care	Diabetes Equipment, Supplies & Training	Mental Health	Clinical Trials
ALABAMA					√		√	
ALASKA		√		√		√		
ARIZONA		√		√		√		
ARKANSAS		√			√	√	√	
CALIFORNIA		√	√	√	√	√	√	√
COLORADO	√			√	√	√	√	
CONNECTICUT				√	√	√	√	√
DELAWARE					√	√		√
DISTRICT OF COLUMBIA					√	√	√	
FLORIDA			√	√	√	√	√	
GEORGIA					√	√	√	√
HAWAII				√	√	√	√	
IDAHO								
ILLINOIS			√			√	√	
INDIANA	√			√	√	√		
IOWA	√				√	√		
KANSAS			√			√	√	
KENTUCKY		√		√	√	√	√	
LOUISIANA	√	√	√	√	√	√	√	√
MAINE		√		√	√	√	√	√
MARYLAND	√		√	√	√	√	√	√
MASSACHUSETTS				√		√	√	√
MICHIGAN					√	√		
MINNESOTA				√	√	√	√	√
MISSISSIPPI					√	√	√	
MISSOURI	√	√	√	√	√	√	√	
MONTANA	√	√		√	√	√	√	√
NEBRASKA					√	√	√	√
NEVADA				√		√	√	√
NEW HAMPSHIRE				√			√	
NEW JERSEY	√	√	√	√	√	√		√
NEW MEXICO		√		√	√	√		
NEW YORK				√	√	√	√	√
NORTH CAROLINA			√			√		√
NORTH DAKOTA	√			√	√		√	
OHIO					√		√	
OKLAHOMA	√				√	√	√	
OREGON				√		√	√	
PENNSYLVANIA		√		√	√	√	√	√
PUERTO RICO					√			
RHODE ISLAND					√	√	√	
SOUTH CAROLINA	√	√				√		√
SOUTH DAKOTA				√		√	√	
TENNESSEE		√		√		√	√	√
TEXAS	√			√	√	√	√	
UTAH		√		√	√	√	√	
VERMONT				√	√	√	√	√
VIRGINIA	√	√			√	√	√	√
WASHINGTON		√		√		√	√	
WEST VIRGINIA		√	√		√	√	√	√
WISCONSIN					√	√	√	√
WYOMING	√				√	√		

EXHIBIT D

VOLUNTARY COMPLIANCE IN THE SELF- INSURANCE MARKET

STATES	Cleft Lip Cleft Palate	Healing Impaired Interpreter/Aid Expenses	Annual Pap Test and Mammography	Prostate Cancer Detection	Routine Colorectal Cance Screening	Hospitalization and General Anesthesia for Dental Procedures for Children
LOUISIANA	✓	✓	✓	✓	✓	✓
MARYLAND	✓	✓	✓	✓	✓	✓
Compliance Rate MD Only	Almost All	Half	Almost All	Almost All	Almost All	Most



OFFICE OF HEALTH INSURANCE
LOUISIANA DEPARTMENT OF INSURANCE