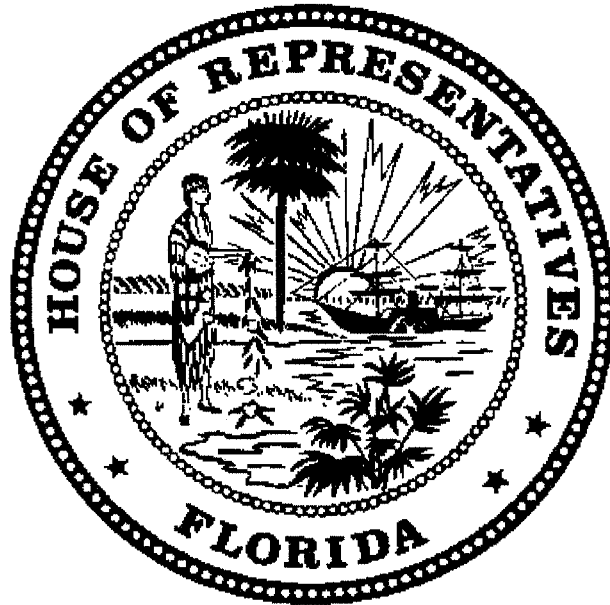

Health & Human Services Quality Subcommittee

Tuesday, November 15, 2011
9:00 AM – 11:30 AM
306 HOB

Dean Cannon
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Quality Subcommittee

Start Date and Time:	Tuesday, November 15, 2011 09:00 am
End Date and Time:	Tuesday, November 15, 2011 11:30 am
Location:	306 HOB
Duration:	2.50 hrs

Panel discussion on health insurance coverage mandates

Appearance forms can be found on myfloridahouse.gov. Please bring 2 copies of the form to the meeting and give them to the administrative assistant.

NOTICE FINALIZED on 11/08/2011 16:08 by Villar.Melissa

Section 624.215, F.S.

Select Year: 2011 Go

The 2011 Florida Statutes

Title XXXVII
INSURANCE

Chapter 624
INSURANCE CODE: ADMINISTRATION AND GENERAL PROVISIONS

View Entire Chapter

624.215 Proposals for legislation which mandates health benefit coverage; review by Legislature.—

(1) LEGISLATIVE INTENT.—The Legislature finds that there is an increasing number of proposals which mandate that certain health benefits be provided by insurers and health maintenance organizations as components of individual and group policies. The Legislature further finds that many of these benefits provide beneficial social and health consequences which may be in the public interest. However, the Legislature also recognizes that most mandated benefits contribute to the increasing cost of health insurance premiums. Therefore, it is the intent of the Legislature to conduct a systematic review of current and proposed mandated or mandatorily offered health coverages and to establish guidelines for such a review. This review will assist the Legislature in determining whether mandating a particular coverage is in the public interest.

(2) MANDATED HEALTH COVERAGE; REPORT TO AGENCY FOR HEALTH CARE ADMINISTRATION AND LEGISLATIVE COMMITTEES; GUIDELINES FOR ASSESSING IMPACT.—Every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, shall submit to the Agency for Health Care Administration and the legislative committees having jurisdiction a report which assesses the social and financial impacts of the proposed coverage. Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage, to the extent that information is available, shall include:

(a) To what extent is the treatment or service generally used by a significant portion of the population.

(b) To what extent is the insurance coverage generally available.

(c) If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.

(d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.

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

(f) The level of public demand for insurance coverage of the treatment or service.

(g) The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.

(h) To what extent will the coverage increase or decrease the cost of the treatment or service.

(i) To what extent will the coverage increase the appropriate uses of the treatment or service.

(j) To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.

(k) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

(l) The impact of this coverage on the total cost of health care.

History.—ss. 1, 2, ch. 87-188; s. 188, ch. 91-108; s. 4, ch. 91-429; s. 31, ch. 92-33.

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Florida Mandates

Florida Health Care Coverage Mandates

MANDATED OFFERINGS OF COVERAGE	
Benefit	**Florida Statute**
1. Alcoholism/Substance Abuse	s. 627.669, F.S.
2. Drug Abuse Treatment	s. 627.669, F.S.
3. Enteral Nutrition	s. 627.42395, F.S.
4. General Mental Health	s. 627.668, F.S.
5. Osteopathic Hospitals	s. 641.31(24), F.S.
MANDATED COVERAGE	
Service	**Florida Statute**
6. Ambulance Transportation and Services	s. 627.638, F.S.; s. 641.31(43), F.S.
7. Autism	s. 627.6686, F.S.; s. 641.31098, F.S.
8. Bone Marrow Transplant	s. 627.4236, F.S.
9. Breast Reconstruction	s. 627.6417, F.S.; s. 641.31(31), F.S.
10. Cleft Lip and Palate	s. 627.64193, F.S.; s. 627.66911, F.S.; s. 641.31(35), F.S.
11. Complex Dental Conditions	s. 627.419(7), F.S.; s. 627.65735, F.S.; s. 627.65755, F.S.; s. 641.31094, F.S.
12. Denial of Coverage- Breast Cancer	s. 627.6419, F.S.
13. Dental Anesthesia	s. 627.65755, F.S.; s. 641.31(34), F.S.
14. Diabetes Self-Management and Supplies	s. 627.6408, F.S.; s. 627.65745, F.S.; s. 641.31(26), F.S.
15. Emergency Room Service	s. 627.6472(8)(a), F.S.; s. 641.31(12), F.S.
16. Home Health Care	s. 627.6617, F.S.
17. Mammography Screening	s. 627.6418, F.S.; s. 627.6613, F.S.; s. 641.31095, F.S.
18. Mastectomy	s. 627.6417, F.S.; s. 641.31(32), F.S.; s. 627.6612, F.S.
19. Mastectomy Minimum Stay	s. 627.64171, F.S.; s. 627.66121, F.S.; s. 641.31(31), F.S.
20. Maternity Minimum Stay	s. 627.6406, F.S.; s. 641.31(18)(b), F.S.
21. Newborn Hearing Screening	s. 383.145(3)(j), F.S.
22. OB/GYN Annual Visit	s. 627.6472(18), F.S.; s. 641.51(11), F.S.
23. Osteoporosis Screening and Treatment	s. 627.6409, F.S.; s. 627.6691, F.S.; s. 641.31(27), F.S.
24. Pre-Existing Conditions	s. 627.6045, F.S.
25. PKU/Metabolic Screening	s. 383.14, F.S.
26. Rebates for Healthy Lifestyles	s. 627.65626, F.S.; s. 641.31(40), F.S.
27. Well Child Care	s. 627.6416, F.S.; s. 641.31(30), F.S.
Provider	**Florida Statute**
28. Certified Registered Nurse Anesthetist	s. 641.31(21), F.S.

Florida Health Care Coverage Mandates

29. Dermatologist	s. 627.6472(16), F.S.; s. 641.31(33), F.S.
30. Ophthalmologist	s. 641.31(20), F.S.; s. 641.51(12), F.S.
Covered Person	**Florida Statute**
31. Adopted Children	s. 627.6415, F.S.; s. 627.6578, F.S.; s. 641.31(17), F.S.
32. Continuation Dependent	s. 627.6041, F.S.; s. 627.6615, F.S.; s. 641.31(29), F.S.
33. Continuation Employee	s. 627.6692(5), F.S.; s. 641.3921, F.S.
34. Conversion to Non-Group Coverage	s. 627.6675, F.S.; s. 641.3921, F.S.
35. Dependent Student/Adult	s. 627.6562(1), F.S.; s. 641.31(41), F.S.
36. Disabled Dependent Adult	s. 627.6041, F.S.; s. 627.6615, F.S.; s. 641.31(29), F.S.
37. Newborn	s. 627.6406, F.S.; s. 627.641, F.S.; s. 641.31(9), F.S.
CONTINGENT MANDATED COVERAGE[1]	
Service	**Florida Statute**
38. Acupuncture	s. 627.6403, F.S.; s. 627.6618, F.S.
39. Ambulatory Surgery Center Services	s. 627.6056, F.S.; s. 627.6616, F.S.
40. Cancer Drugs	s. 627.4239, F.S.
41. Massage	s. 627.6407, F.S.; s. 627.6619, F.S.; s. 641.31(37), F.S.
42. Out-of-Hospital Services	s. 627.4232, F.S.
Provider	**Florida Statute**
43. Acupuncturist	s. 627.6403, F.S.; s. 627.6618, F.S.
44. Advanced Registered Nurse Practitioner	s. 627.6472(17), F.S.; s. 641.3923, F.S.
45. Birthing Center and Midwife	s. 627.6406, F.S.; s. 641.31(18), F.S.
46. Chiropractor	s. 627.419(4), F.S.
47. Continuing Care Retirement Facilities and ALFs	s. 641.31(25), F.S.
48. Dentist	s. 627.419(2), F.S.
49. Massage Therapist	s. 627.6407, F.S.
50. Nurse Midwife	s. 627.6406, F.S.; s. 627.6574, F.S.; s. 641.31(18), F.S.
51. Optometrist	s. 627.419(3), F.S.; s. 641.31(19), F.S.
52. Physician Assistant	s. 627.419(6), F.S.
53. Podiatrist	s. 627.419(3), F.S.
54. Registered First Nurse Assistant	s. 627.419(6), F.S.
Covered Person	**Florida Statute**
55. HIV Patient	s. 627.429(5)(a), F.S.

[1] Requires coverage of a service, condition, or provider *if* coverage is provided for a certain other service, condition, or provider. See, e.g., #40: If a policy covers cancer treatment, the policy must also cover prescribed drugs for the treatment of cancer.

Florida Health Care Coverage Mandates

MANDATED ELGIBILITY PROVISIONS FOR PROVIDER PARTICIPATION IN NETWORK	
Provider	**Florida Statute**
56. Marriage/Family Therapist	s. 627.6471(6), F.S.; s. 627.6472(15), F.S.
57. Professional Counselor	s. 627.6471(6), F.S.; s. 627.6472(15), F.S.
58. Psychiatric Nurse	s. 627.6471(6), F.S.; s. 627.6472(15), F.S.
59. Psychologist	s. 627.6471(6), F.S.; s. 627.6472(15), F.S.

PPACA Mandates -
State Group Plan

MERCER

As of February 25, 2011

Division of State Group Insurance

State of Florida

Estimating the annual financial impact of federal health reform for FY 2010-11 through FY 2014-15

STATE EMPLOYEES' GROUP HEALTH SELF-INSURED TRUST FUND

Appendix 2

Summary of Fiscal Impact to Forecast of Patient and Affordable Care Act (PPACA) through FY 2014-2015

Dollars in millions

Reform	Effective Date	Revenue (R) Expense (E)	Estimated Annual Fiscal Impact FY 2010-11 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2010-11 Total
1. Early retiree medical reinsurance (Illustrative, assumes application is approved and receipts are available through 2012. Estimates are based on full Mercer analysis done in 2010 at the time of the application.)	Jun 2010	R									
		E	-	-	-	-	(8.38)	(2.25)	(3.36)	(13.99)	(13.99)
		Net	-	-	-	-	(8.38)	(2.25)	(3.36)	(13.99)	(13.99)
2. No lifetime dollar maximum	Jan 2011	R									
		E	-	-	-	-	1.33	0.11	0.00	1.44	1.44
		Net	-	-	-	-	1.33	0.11	0.00	1.44	1.44
3. Restricted annual dollar limits	Jan 2011	R									
		E	-	-	-	-	0.00	0.00	0.00	0.00	0.00
		Net	-	-	-	-	0.00	0.00	0.00	0.00	0.00
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	R									
		E	-	-	-	-	0.28	0.08	0.45	0.81	0.81
		Net	-	-	-	-	0.28	0.08	0.45	0.81	0.81
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assume 3rd and 4th year are same as 2nd year)	Jan 2012	R									
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
6. Other pass-through fees include (Illustration assumes cumulative increase to 2014 and trended thereafter):		R									
Pharmaceutical industry fees	Jan 2011	E	-	-	-	-	-	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	Net	-	-	-	-	-	-	-	-	-
Health insurance industry fees	Jan 2014										
7. Extension of coverage for all adult children until age 26	Jan 2011	R									
		E	-	-	-	-	1.72	0.45	2.69	4.86	4.86
		Net	-	-	-	-	1.72	0.45	2.69	4.86	4.86
8. Eliminate all preexisting condition limitations	Jan 2014	R									
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
9. Free-choice vouchers	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
10. Shared responsibility "free rider surcharge"	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
11. Medicaid Expansion and migration into Exchange	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
12. Individual Mandate with federal subsidies	Jan 2014	R	-	-	-	-					
		E	-	-	-	-	-	-	-	-	
		Net	-	-	-	-	-	-	-	-	-
TOTAL		R	-	-	-	-	-	-	-	-	-
		E	0.00	0.00	0.00	0.00	(5.05)	(1.61)	(0.22)	(6.88)	(6.88)
		Net	0.00	0.00	0.00	0.00	(5.05)	(1.61)	(0.22)	(6.88)	(6.88)

- Exhibit assumes non-grandfathered status
- Exhibit based on available information and legislative guidance as of February 1, 2011
- Exhibit applies to the State Employees' Group Health Self-Insurance Trust Fund Estimating Conference Package updated December 2010
- "Net" is defined as Expense less Revenue
- The negative expense of $7.08M associated with Item #11, Medicaid Expansion, for Fiscal Year 2013-14 uses the assumption that there will be a $5.62M loss of revenue due to employees exiting the plan ($4.81M in employer contributions plus $0.81M in employee contributions) for the illustrated level of decreased enrollment in the plan, resulting in savings of $1.46M due to medical and pharmacy inflation. The negative expense of $14.73M associated with Item #11 for Fiscal Year 2014-15 uses the assumption that there will be a $11.41M loss of revenue due to employees exiting the plan ($9.75M in employer contributions plus $1.66M in employee contributions), resulting in savings of $3.32M.
- The expense of $138.08M associated with Item #12, the Individual Mandate, for Fiscal Year 2013-14 uses the assumption that increased trust fund revenues will be available to offset the current level of costs ($104.30M in employer contributions plus $5.31M in employee contributions) for the illustrated level of increased enrollment in the plan, with the deficit of $28.47M due to medical and pharmacy inflation. The expense of $287.21M associated with Item #12 for Fiscal Year 2014-15 uses the assumption that increased trust fund revenues will be available to offset the current level of costs ($211.72M in employer contributions plus $10.79M in employee contributions), resulting in a deficit of $64.70M.
- The total estimated impact of ERRP from July 2010 through December 2013 is from the DSGI December 2010 Fiscal Outlook and assumes the application is approved, however, funds may be exhausted prior to the December 2013 estimated program end date.

STATE EMPLOYEES' GROUP HEALTH SELF-INSURED TRUST FUND

Appendix 2

Summary of Fiscal Impact to Forecast of Patient and Affordable Care Act (PPACA) through FY 2014-2015

Dollars in millions

Reform	Effective Date	Revenue (R) Expense (E)	Estimated Annual Fiscal Impact FY 2011-12: July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2011-12 Total
1. Early retiree medical reinsurance (Illustrative, assumes application is approved and receipts are available through 2012. Estimates are based on full Mercer analysis done in 2010 at the time of the application.)	Jun 2010	R									
		E	(6.92)	(1.87)	(2.78)	(11.57)	(6.92)	(1.87)	(2.78)	(11.57)	(23.14)
		Net	(6.92)	(1.87)	(2.78)	(11.57)	(6.92)	(1.87)	(2.78)	(11.57)	(23.14)
2. No lifetime dollar maximum	Jan 2011	R									
		E	1.38	0.12	0.00	1.50	1.43	0.13	0.00	1.56	3.06
		Net	1.38	0.12	0.00	1.50	1.43	0.13	0.00	1.56	3.06
3. Restricted annual dollar limits	Jan 2011	R									
		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	R									
		E	0.28	0.09	0.45	0.82	0.30	0.10	0.48	0.88	1.70
		Net	0.28	0.09	0.45	0.82	0.30	0.10	0.48	0.88	1.70
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assume 3rd and 4th year are same as 2nd year)	Jan 2012	R									
		E	-	-	-	-	0.03	0.00	0.04	0.07	0.07
		Net	-	-	-	-	0.03	0.00	0.04	0.07	0.07
6. Other pass-through fees include (Illustration assumes cumulative increase to 2014 and trended thereafter):		R									
Pharmaceutical industry fees	Jan 2011	E	-	-	-	-	-	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	Net	-	-	-	-	-	-	-	-	-
Health insurance industry fees	Jan 2014										
7. Extension of coverage for all adult children until age 26	Jan 2011	R									
		E	1.80	0.46	2.69	4.95	1.87	0.48	2.91	5.26	10.21
		Net	1.80	0.46	2.69	4.95	1.87	0.48	2.91	5.26	10.21
8. Eliminate all preexisting condition limitations	Jan 2014	R									
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
9. Free-choice vouchers	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
10. Shared responsibility "free rider surcharge"	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
11. Medicaid Expansion and migration into Exchange	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
12. Individual Mandate with federal subsidies	Jan 2014	R									
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
TOTAL		R	-	-	-	-	-	-	-	-	-
		E	(3.46)	(1.20)	0.36	(4.30)	(3.29)	(1.16)	0.65	(3.80)	(8.10)
		Net	(3.46)	(1.20)	0.36	(4.30)	(3.29)	(1.16)	0.65	(3.80)	(8.10)

- Exhibit assumes non-grandfathered status
- Exhibit based on available information and legislative guidance as of February 1, 2011
- Exhibit applies to the State Employees' Group Health Self-Insurance Trust Fund Estimating Conference Package updated December 2010
- "Net" is defined as Expense less Revenue
- The negative expense of $7.08M associated with Item #11, Medicaid Expansion, for Fiscal Year 2013-14 uses the assumption that there will be a $5.62M loss of revenue due to employees exiting the plan ($4.81M in employer contributions plus $0.81M in employee contributions) for the illustrated level of decreased enrollment in the plan, resulting in savings of $1.46M due to medical and pharmacy inflation. The negative expense of $14.73M associated with Item #11 for Fiscal Year 2014-15 uses the assumption that there will be a $11.41M loss of revenue due to employees exiting the plan ($9.75M in employer contributions plus $1.66M in employee contributions), resulting in savings of $3.32M.
- The expense of $138.08M associated with Item #12, the Individual Mandate, for Fiscal Year 2013-14 uses the assumption that increased trust fund revenues will be available to offset the current level of costs ($104.30M in employer contributions plus $5.31M in employee contributions) for the illustrated level of increased enrollment in the plan, with the deficit of $28.47M due to medical and pharmacy inflation. The expense of $287.21M associated with Item #12 for Fiscal Year 2014-15 uses the assumption that increased trust fund revenues will be available to offset the current level of costs ($211.72M in employer contributions plus $10.79M in employee contributions), resulting in a deficit of $64.70M.
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Dollars in millions

Reform	Effective Date	Revenue (R) Expense (E)	Estimated Annual Fiscal Impact FY 2012-13 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2012-13 Total
1. Early retiree medical reinsurance	Jun 2010	R									
(Illustrative, assumes application is approved and receipts are available through 2012. Estimates are based on full Mercer analysis done in 2010 at the time of the application.)		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2. No lifetime dollar maximum	Jan 2011	R									
		E	1.49	0.13	0.00	1.62	1.54	0.15	0.00	1.69	3.31
		Net	1.49	0.13	0.00	1.62	1.54	0.15	0.00	1.69	3.31
3. Restricted annual dollar limits	Jan 2011	R									
		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	R									
		E	0.30	0.11	0.48	0.89	0.32	0.10	0.53	0.95	1.84
		Net	0.30	0.11	0.48	0.89	0.32	0.10	0.53	0.95	1.84
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assume 3rd and 4th year are same as 2nd year)	Jan 2012	R									
		E	0.03	0.00	0.04	0.07	0.06	0.00	0.08	0.14	0.21
		Net	0.03	0.00	0.04	0.07	0.06	0.00	0.08	0.14	0.21
6. Other pass-through fees include (Illustration assumes cumulative increase to 2014 and trended thereafter):		R									
Pharmaceutical industry fees	Jan 2011	E	-	-	-	-	-	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	Net	-	-	-	-	-	-	-	-	-
Health insurance industry fees	Jan 2014										
7. Extension of coverage for all adult children until age 26	Jan 2011	R									
		E	1.94	0.50	2.90	5.34	2.01	0.52	3.15	5.68	11.02
		Net	1.94	0.50	2.90	5.34	2.01	0.52	3.15	5.68	11.02
8. Eliminate all preexisting condition limitations	Jan 2014	R									
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
9. Free-choice vouchers	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
10. Shared responsibility "free rider surcharge"	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
11. Medicaid Expansion and migration into Exchange	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
12. Individual Mandate with federal subsidies	Jan 2014	R									
		E	-	-	-	-	-	-	-	-	-
		Net	-	-	-	-	-	-	-	-	-
TOTAL		**R**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
		E	**3.76**	**0.74**	**3.42**	**7.92**	**3.93**	**0.77**	**3.76**	**8.46**	**16.38**
		Net	**3.76**	**0.74**	**3.42**	**7.92**	**3.93**	**0.77**	**3.76**	**8.46**	**16.38**

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- Exhibit based on available information and legislative guidance as of February 1, 2011
- Exhibit applies to the State Employees' Group Health Self-Insurance Trust Fund Estimating Conference Package updated December 2010
- "Net" is defined as Expense less Revenue
- The negative expense of $7.08M associated with Item #11, Medicaid Expansion, for Fiscal Year 2013-14 uses the assumption that there will be a $5.62M loss of revenue due to employees exiting the plan ($4.81M in employer contributions plus $0.81M in employee contributions) for the illustrated level of decreased enrollment in the plan, resulting in savings of $1.46M due to medical and pharmacy inflation. The negative expense of $14.73M associated with Item #11 for Fiscal Year 2014-15 uses the assumption that there will be a $11.41M loss of revenue due to employees exiting the plan ($9.75M in employer contributions plus $1.66M in employee contributions), resulting in savings of $3.32M.
- The expense of $138.08M associated with Item #12, the Individual Mandate, for Fiscal Year 2013-14 uses the assumption that increased trust fund revenues will be available to offset the current level of costs ($104.30M in employer contributions plus $5.31M in employee contributions) for the illustrated level of increased enrollment in the plan, with the deficit of $28.47M due to medical and pharmacy inflation. The expense of $287.21M associated with Item #12 for Fiscal Year 2014-15 uses the assumption that increased trust fund revenues will be available to offset the current level of costs ($211.72M in employer contributions plus $10.79M in employee contributions), resulting in a deficit of $64.70M.
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STATE EMPLOYEES' GROUP HEALTH SELF-INSURED TRUST FUND

Appendix 2

Summary of Fiscal Impact to Forecast of Patient and Affordable Care Act (PPACA) through FY 2014-2015

Dollars in millions

Reform	Effective Date	Revenue (R) Expense (E)	Estimated Annual Fiscal Impact FY 2013-14 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2013-14 Total
1. Early retiree medical reinsurance (Illustrative, assumes application is approved and receipts are available through 2012. Estimates are based on full Mercer analysis done in 2010 at the time of the application.)	Jun 2010	R									
		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2. No lifetime dollar maximum	Jan 2011	R									
		E	1.61	0.14	0.00	1.75	1.68	0.14	0.00	1.82	3.57
		Net	1.61	0.14	0.00	1.75	1.68	0.14	0.00	1.82	3.57
3. Restricted annual dollar limits	Jan 2011	R									
		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	R									
		E	0.33	0.11	0.52	0.96	0.34	0.11	0.57	1.02	1.98
		Net	0.33	0.11	0.52	0.96	0.34	0.11	0.57	1.02	1.98
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assume 3rd and 4th year are same as 2nd year)	Jan 2012	R									
		E	0.06	0.00	0.08	0.14	0.06	0.00	0.08	0.14	0.28
		Net	0.06	0.00	0.08	0.14	0.06	0.00	0.08	0.14	0.28
6. Other pass-through fees include (Illustration assumes cumulative increase to 2014 and trended thereafter):		R									
Pharmaceutical industry fees	Jan 2011	E	-	-	-	-	7.25	1.87	11.29	20.41	20.41
2.3% excise tax on medical devices	Jan 2013	Net	-	-	-	-	7.25	1.87	11.29	20.41	20.41
Health insurance industry fees	Jan 2014										
7. Extension of coverage for all adult children until age 26	Jan 2011	R									
		E	2.09	0.54	3.14	5.77	2.09	0.64	3.40	6.13	11.90
		Net	2.09	0.54	3.14	5.77	2.09	0.64	3.40	6.13	11.90
8. Eliminate all preexisting condition limitations	Jan 2014	R									
		E	-	-	-	-	0.69	0.21	1.13	2.03	2.03
		Net	-	-	-	-	0.69	0.21	1.13	2.03	2.03
9. Free-choice vouchers	Jan 2014	R	-	-	-	-	0.00	0.00	0.00	0.00	0.00
		E	-	-	-	-	0.00	0.00	0.00	0.00	0.00
		Net	-	-	-	-	0.00	0.00	0.00	0.00	0.00
10. Shared responsibility "free rider surcharge"	Jan 2014	R	-	-	-	-	0.00	0.00	0.00	0.00	0.00
		E	-	-	-	-	0.00	0.00	0.00	0.00	0.00
		Net	-	-	-	-	0.00	0.00	0.00	0.00	0.00
11. Medicaid Expansion and migration into Exchange	Jan 2014	R	-	-	-	-	(1.98)	(0.60)	(3.04)	(5.62)	(5.62)
		E	-	-	-	-	(2.50)	(0.75)	(3.83)	(7.08)	(7.08)
		Net	-	-	-	-	(0.52)	(0.15)	(0.79)	(1.46)	(1.46)
12. Individual Mandate with federal subsidies	Jan 2014	R					38.61	11.54	59.46	109.61	109.61
		E	-	-	-	-	48.64	14.53	74.91	138.08	138.08
		Net	-	-	-	-	10.03	2.99	15.45	28.47	28.47
TOTAL		**R**	**-**	**-**	**-**	**-**	**36.63**	**10.94**	**56.42**	**103.99**	**103.99**
		E	**4.09**	**0.79**	**3.74**	**8.62**	**58.25**	**16.75**	**87.55**	**162.55**	**171.17**
		Net	**4.09**	**0.79**	**3.74**	**8.62**	**21.62**	**5.81**	**31.13**	**58.56**	**67.18**

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- The negative expense of $7.08M associated with Item #11, Medicaid Expansion, for Fiscal Year 2013-14 uses the assumption that there will be a $5.62M loss of revenue due to employees exiting the plan ($4.81M in employer contributions plus $0.81M in employee contributions) for the illustrated level of decreased enrollment in the plan, resulting in savings of $1.46M due to medical and pharmacy inflation. The negative expense of $14.73M associated with Item #11 for Fiscal Year 2014-15 uses the assumption that there will be a $11.41M loss of revenue due to employees exiting the plan ($9.75M in employer contributions plus $1.66M in employee contributions), resulting in savings of $3.32M.
- The expense of $138.08M associated with Item #12, the Individual Mandate, for Fiscal Year 2013-14 uses the assumption that increased trust fund revenues will be available to offset the current level of costs ($104.30M in employer contributions plus $5.31M in employee contributions) for the illustrated level of increased enrollment in the plan, with the deficit of $28.47M due to medical and pharmacy inflation. The expense of $287.21M associated with Item #12 for Fiscal Year 2014-15 uses the assumption that increased trust fund revenues will be available to offset the current level of costs ($211.72M in employer contributions plus $10.79M in employee contributions), resulting in a deficit of $64.70M.
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STATE EMPLOYEES' GROUP HEALTH SELF-INSURED TRUST FUND

Appendix 2

Summary of Fiscal Impact to Forecast of Patient and Affordable Care Act (PPACA) through FY 2014-2015

Dollars in millions

Reform	Effective Date	Revenue (R) Expense (E)	Estimated Annual Fiscal Impact FY 2014-15: July-December Medical	July-December Drugs	July-December HMO	July-December Total	January-June Medical	January-June Drugs	January-June HMO	January-June Total	FY 2014-15 Total	FY 2010-11 through FY 2014-15 GRAND TOTAL
1. Early retiree medical reinsurance (Illustrative, assumes application is approved and receipts are available through 2012. Estimates are based on full Mercer analysis done in 2010 at the time of the application.)	Jun 2010	R										
		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(37.13)
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(37.13)
2. No lifetime dollar maximum	Jan 2011	R										
		E	1.74	0.15	0.00	1.89	1.81	0.16	0.00	1.97	3.86	15.24
		Net	1.74	0.15	0.00	1.89	1.81	0.16	0.00	1.97	3.86	15.24
3. Restricted annual dollar limits	Jan 2011	R										
		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	R										
		E	0.35	0.12	0.57	1.04	0.37	0.12	0.60	1.09	2.13	8.46
		Net	0.35	0.12	0.57	1.04	0.37	0.12	0.60	1.09	2.13	8.46
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assume 3rd and 4th year are same as 2nd year)	Jan 2012	R										
		E	0.06	0.00	0.08	0.14	0.06	0.00	0.08	0.14	0.28	0.84
		Net	0.06	0.00	0.08	0.14	0.06	0.00	0.08	0.14	0.28	0.84
6. Other pass-through fees include (Illustration assumes cumulative increase to 2014 and trended thereafter):		R										
Pharmaceutical industry fees	Jan 2011	E	7.38	1.90	11.49	20.77	7.83	2.02	12.20	22.05	42.82	63.23
2.3% excise tax on medical devices	Jan 2013	Net	7.38	1.90	11.49	20.77	7.83	2.02	12.20	22.05	42.82	63.23
Health insurance industry fees	Jan 2014											
7. Extension of coverage for all adult children until age 26	Jan 2011	R										
		E	2.22	0.59	3.42	6.23	2.36	0.63	3.64	6.63	12.86	50.85
		Net	2.22	0.59	3.42	6.23	2.36	0.63	3.64	6.63	12.86	50.85
8. Eliminate all preexisting condition limitations	Jan 2014	R										
		E	0.71	0.22	1.16	2.09	0.75	0.23	1.23	2.21	4.30	6.33
		Net	0.71	0.22	1.16	2.09	0.75	0.23	1.23	2.21	4.30	6.33
9. Free-choice vouchers	Jan 2014	R	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
10. Shared responsibility "free rider surcharge"	Jan 2014	R	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		E	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		Net	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11. Medicaid Expansion and migration into Exchange	Jan 2014	R	(1.98)	(0.60)	(3.04)	(5.62)	(2.04)	(0.62)	(3.13)	(5.79)	(11.41)	(17.03)
		E	(2.50)	(0.75)	(3.83)	(7.08)	(2.70)	(0.81)	(4.14)	(7.65)	(14.73)	(21.81)
		Net	(0.52)	(0.15)	(0.79)	(1.46)	(0.66)	(0.19)	(1.01)	(1.86)	(3.32)	(4.78)
12. Individual Mandate with federal subsidies	Jan 2014	R	38.61	11.54	59.46	109.61	39.77	11.89	61.24	112.90	222.51	332.12
		E	48.64	14.53	74.91	138.08	52.54	15.69	80.90	149.13	287.21	425.29
		Net	10.03	2.99	15.45	28.47	12.77	3.80	19.66	36.23	64.70	93.17
TOTAL		R	36.63	10.94	56.42	103.99	37.73	11.27	58.11	107.11	211.10	315.09
		E	58.60	16.76	87.80	163.16	63.02	18.04	94.51	175.57	338.73	511.30
		Net	21.97	5.82	31.38	59.17	25.29	6.77	36.40	68.46	127.63	196.21

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Council for Affordable
Health Insurance Memo

The Council for Affordable Health Insurance's

POLICY TRENDS

A CAHI Web Memo | October 2010

Trends in State Mandated Benefits, 2010

Since the early 1990s, the Council for Affordable Health Insurance (CAHI) has tracked state-mandate legislation in all 50 states and Washington, DC. For purposes of our mandate report counting, we include Washington, DC, as a "state" although technically it is not. Although there was only a handful of state mandates in the 1960s, CAHI's most recent report, "Health Insurance Mandates in the States, 2010," has identified 2,156 nationwide.

Since CAHI closely monitors mandate legislation, we see mandate "trends" developing long before many others. The purpose of this short report is to periodically identify some of those trends, i.e., which mandates are growing in popularity among state legislators and in which states.

What Is a Mandate? A mandated benefit is a law that requires a health insurance policy or health plan to cover (or offer to cover) specific providers, procedures, benefits or people. Mandated benefits make health insurance more comprehensive, but they also make it more expensive. The vast majority of mandates come from state legislatures, though the federal government has been increasingly willing to impose mandates.

How Much Do Mandates Cost? Every special interest group claims its specific therapy improves care AND saves money but often it is not true. Actuaries have repeatedly warned that virtually all mandates *increase* the cost of coverage by increasing utilization over time (which is often referred to as frequency of use). Why is this so? Mandates require insurers to pay for care that consumers previously funded out of their own pockets, if they purchased it at all. Insurers have to pay more claims and as a result raise premiums to cover those costs. Experience demonstrates that when health insurance costs increase, more people drop or decline coverage.

CAHI's team of independent member and non-member actuaries has estimated that (depending on the state, number of mandates, and type of policy) mandates can boost the cost of a policy between 10 and 50 percent. A full state-by-state tabulation of those mandates, plus an actuarial estimate of each mandate's impact on the cost of a health insurance policy, is available in CAHI's "Health Insurance Mandates in the States, 2010" (www.cahi.org). The cost estimates come from a working group of actuaries and not CAHI staff.

Increasingly Popular Mandates. Some mandates appear in only a few states; others have passed in virtually every state. That's because some mandate legislation "catches on." That is, one or two states pass it, legislators in other states hear about it — often through a special interest group pushing the legislation in numerous states — and they introduce a version of the legislation in their own state. Such mandates gain a momentum that can be hard to stop, regardless of what they might do to the cost of health insurance.

Mandates in the States 2004-2010

Year*	Amount
2004	1,823
2005	1,825
2006	1,843
2007	1,901
2008	1,961
2009	2,133
2010	2,156

** CAHI has tracked state mandates since 1992, however our first report compiling the data nationwide was published in 2004.*

Source: Council for Affordable Health Insurance, October 2010

Emerging Mandates. Several mandates are growing in popularity, and we expect to see much more legislative activity on them in the near future. For example:

- *Autism:* Autism and treatment for its various complications is becoming one of the most discussed mandates. Autism is a brain disorder that affects three areas of development: communication, social interaction, and creative or imaginative play. In the past, autism has fallen under the broader category of mental health, but one of the latest state legislative trends is to pass a standalone autism mandate separate from mental health benefit mandates. Thus far, 25 states have passed autism mandates, but the number of bills introduced has grown each year. With advances in the diagnosis (including a new rapid test to screen for

autism) and treatment, autism mandates will likely remain high on legislative priority lists.

- *Diabetes:* A study published in November 2009 by the University of Chicago concluded that the number of Americans with diabetes will nearly double in the next 25 years, and the costs of treating them will triple. Despite the fact that insurers already cover the disease, 38 states have passed a diabetic self-management mandate and 47 states have mandated coverage for diabetic supplies. Because of the the prevalence of the disease, politicians will be tempted to consider new and expanded diabetes-related mandates.

- *Screening Mandates:* It is a firmly held belief by many policymakers that all preventive care saves both lives and money. Recent developments reported in the *Journal of the American Medical Association* and elsewhere have called these beliefs into question. Some screening tests can lead to a high number of false positives, leading to expensive and unnecessary treatments. Some conditions—including less risky cancers—may be better left untreated because the cure is worse for the patient than the disease. In the states, cancer screening mandates include colorectal cancer screening (34); cervical cancer screening (31); mammography screenings (50); ovarian cancer screening (7); and prostate cancer screening (36).

Trends in Mandated Benefit Studies. Legislators often receive conflicting information on the cost of mandates. While *individually* most mandates cost very little as a percentage of premium (with many mandates costing less than one percent of premium), when all mandated benefits are combined together on a health insurance policy, the costs can be very high. Therefore, it is vital legislators understand these costs before voting on any new mandate. There are now at least 30 states that require a mandate's cost to be assessed before it is implemented.

Trends in State "Mandate-Lite" Policies. A few states are getting the message: mandates make health insurance more expensive. There are at least 10 states that allow individuals to purchase a policy with fewer mandates. Plans can be tailored to the individual's needs and financial situation.

Conclusion. The introduction of state-mandated benefit legislation is slowing down. Rather than seeing some 100 mandates enacted each year, we are seeing about half of that number enacted nationwide. That reduction implies that some state legislators are finally getting the message: mandates increase the cost of health insurance, forcing some people to remain, or become, uninsured. Unfortunately, Congress is going the opposite direction. After having taken a decades-long position that states should regulate health insurance, Congress increasingly wants to micromanage insurance benefits.

As we have said before, "mandated benefits make health insurance more comprehensive, but they also make it more expensive." Policymakers need to understand their decisions impact the affordability of health insurance, and can lead to an increase in the number of people who forgo coverage.

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Policy Trends can be found exclusively online at www.cahi.org.

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