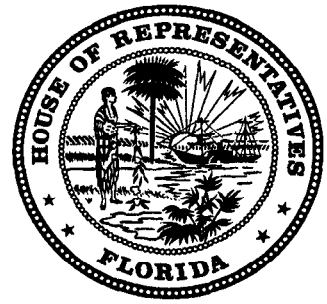
Managing Mandated Health Benefits:

Policy Options for Consideration



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EXECUTIVE SUMMARY

INTRODUCTION

State laws frequently require private health insurance policies and health maintenance organization (HMO) contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are referred to as "mandated [health] benefits."

Recognizing that "most mandated benefits contribute to the increasing cost of health insurance premiums," while acknowledging the social and health benefits of many of these mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits. At that point, the Legislature had approved 16 mandated benefits. In the thirteen years since, the Legislature has approved an additional 35 mandated benefits. With 51 mandated health benefits, Florida now has one of the nation's most extensive set of coverage requirements. The lone procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandate benefit prior to consideration--has been largely ignored. Staff could confirm only four instances since 1987 in which the required study was completed for a mandated benefit.

The primary purpose of this report is to present legislators with policy options for considering proposed mandated health benefits legislation and managing the cumulative impact of mandated benefits. Before presenting these options, this report discusses the health care coverage status of Floridians and health benefit and premium costs nationally, mandated benefits in Florida, and legislative mechanisms used in Florida and other states to manage mandated benefits. This report does not examine the merits of any particular mandated benefit or mandated benefits generally.

KEY FINDINGS

#1: By some measures, Florida has more mandated benefits than nearly every other state (p.7-9)

#2: An estimated 33 percent of all Floridians are covered under health plans subject to mandated benefits. These Floridians are covered under a private insurer or HMO plan, other than a basic or standard small employer group plan. The remaining 67 percent of all Floridians are unaffected by mandated benefits, because they are either uninsured or covered under plans not subject to these mandates (p.10-13).

#3: It is not always apparent in statute which health plans are subject to which state-mandated health benefits (p.12).

#4: Floridians covered under health plans not subject to mandated benefits nonetheless appear to enjoy benefits generally comparable to many of those mandated for private insurer and HMO plans. However, unlike benefits mandated for private insurer and HMO plans, benefits included in these other sources of coverage either are funded by the general public or funded voluntarily by those securing the coverage (p.14 and Appendix 3)

#5: Unlike in several other states, the cost of mandated benefits in Florida has not been calculated (p.16-18).

#6: The statutorily-prescribed process for legislative consideration of proposed mandated health benefits legislation is largely ignored. Only four impact reports could be confirmed (p.23-24).

#7: Special requirements can be found in the state constitution, statutes, legislative rules, and policy statements of several standing committees specific to legislative consideration of certain types of legislation (p.24-26).

#8: Twenty states have special statutory provisions for managing mandated benefits legislation (p.27-33).

#9: In Florida, small employers purchasing health care coverage overwhelmingly select plans other than basic and standard small employer group plans authorized by the Legislature as alternatives to more comprehensive plans (p.11-12, 21).

#10: Basic and standard small employer group plans include more of the mandated benefits generally applicable to insurer and HMO plans than appear to be required by law. They include approximately 80 percent of the mandated benefits applicable to private insurer group plans and HMO plans. As presently constituted, these small employer plans may not be functioning as the alternative intended by the Legislature (p.12).

POLICY OPTIONS

A. Retain the Current Process

The Legislature could maintain the current process for considering proposed mandated health benefits. At the same time, it could insist on submission of the statutorily-required impact analysis before considering a proposed mandated benefit. The Legislature could adopt the existing statutorily-required process as a legislative rule or the Insurance Committee could adopt it as a statement of committee policy.

B. Define "Mandated Health Benefits"

Several states define "mandated health benefits." The Legislature could define this term to facilitate identification of mandated benefits for regulatory purposes and cost studies.

C. Establish One Location in Florida Statutes for All Mandated Benefits and Clearly Delineate Which Mandated Benefits Apply to Which Health Plans

Like it has done for specialty license plates under the Transportation Code, the Legislature could consolidate all mandated benefits into a separate part of the Insurance Code, instead of dispersing them throughout several different parts of two chapters. The Legislature also could reconcile inconsistencies in existing law or resolve interpretative differences that may exist. Finally, the Legislature could review the benefits included in the basic and standard small employer group plans.

D. Determine the Cost and Public Benefit of Existing Mandated Health Benefits

The Legislature could commission a study to quantify the cost and resulting public benefit of health mandates. The total cost could be stated as a percentage of total claims costs or overall premium. This study would produce a baseline cost for use by policy makers.

E. Establish a New Process for Considering Proposed Mandated Health Benefits

The Legislature could create a new process for considering proposed mandated health benefits. The following options could be adopted in statute, by legislative rule, by committee policy, or by a combination of all three. The process could:

1. require all proposed mandated benefits to undergo evaluation by a review entity prior to legislative “consideration”;
2. direct a review entity using statutory criteria to prepare an impact analysis for all proposed mandated benefits prior to legislative “consideration”;

3. require proponents of a proposed mandated benefit to submit an application and pay a fee to defray the costs of conducting an impact analysis (similar to the statutory process for considering specialty license plate proposals);
4. require proponents to submit data necessary to complete an impact analysis;
5. require insurers and HMOs to submit data necessary to complete an impact analysis;
6. specify the way in which the review process is activated (e.g., at the request of the legislative presiding officers, committee chair, individual legislators); or,
7. specify a time frame within which an impact analysis must be requested and completed.

F. Designate or Create a Review Entity

The Legislature could designate or create a review entity with a variety of responsibilities. The entity could be a state agency; a multi-agency review panel; a consensus estimating conference; an independent non-governmental board; or a private sector actuarial firm. The entity could develop an official list of mandated benefits; calculate the cost of existing mandates; monitor the cumulative costs of mandates as new ones are adopted; conduct cost-benefit analyses of proposed mandates; establish an "affordability cap" for mandated benefits included in health plans; or issue recommendations to the Legislature for managing the impact of mandates--to repeal existing or suggest new mandated benefits.

G. Manage the Impact of Mandated Health Benefits and Needed Coverages

The Legislature could decide to legislate limits on mandated benefits, both existing and proposed, and require coverages where appropriate. The Legislature could:

1. preserve some or all existing mandates (could be based on cost-benefit review);
2. convert some or all existing mandates into mandatory offers;
3. repeal mandates (outright or sunset), perhaps according to a schedule;
4. sunset new mandated benefits (could be based on cost-benefit review);
5. repeal (outright or sunset) mandated benefits exceeding an individual affordability cap;
6. repeal (outright or sunset) certain mandates if an overall affordability cap is exceeded;
7. require insurers and HMOs to comply with mandates only if Medicaid and Medicare provides a comparable benefit;
8. limit new mandated benefits to the state health plan for a trial period; or,
9. authorize insurers and HMOs to offer "employer choice" plans with different benefit packages, from a minimal benefit plan option to limits on mandated benefits in plans based not on the number of mandated benefits but on their cost. Other packages could include plans including fewer or less costly mandated benefits in exchange for different utilization provisions, or alternative deductible or co-payment requirements.

I. INTRODUCTION

State laws frequently require private health insurance policies and health maintenance organization (HMO) contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are referred to as "mandated [health] benefits."

Recognizing that "most mandated benefits contribute to the cost of health insurance premiums," yet acknowledging the social and health benefits of many of these mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits. At that point in time, the Legislature had approved 16 mandated benefits. In the thirteen years since, the Legislature has approved an additional 35 mandated benefits. With a total of 51 mandated health benefits applicable either to private insurer or HMO health plans, Florida now has one of the nation's most extensive set of coverage requirements. The lone procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandated benefit prior to consideration--has been largely ignored. Staff could confirm only four instances since 1987 in which the required study was completed for a mandated benefit.

These mandated benefits affect plans covering an estimated 33 percent of *all* Floridians and 40 percent of *insured* Floridians. The nearly one-half of all Floridians who either are uninsured or covered under Medicare or Medicaid are not affected. Plans provided by self-funded employers also are similarly unaffected.

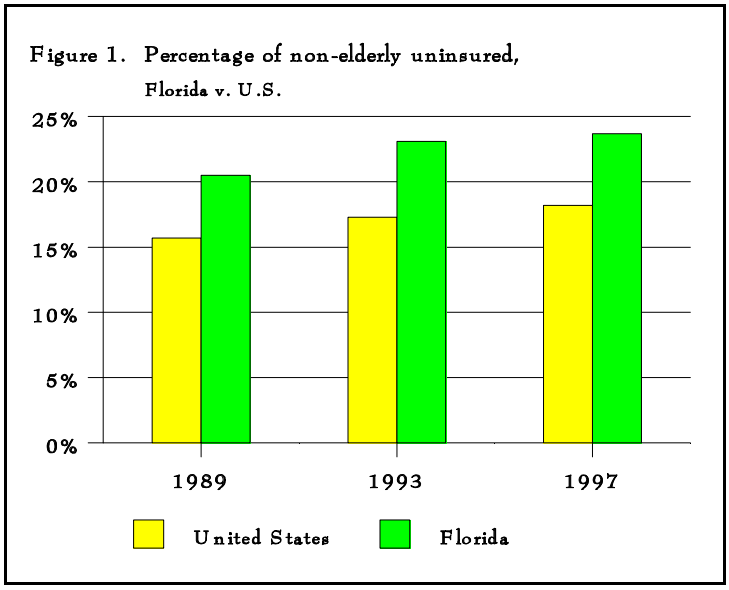
The primary purpose of this report is to present legislators with policy options for considering proposed mandated health benefits legislation and managing the cumulative impact of mandated benefits. Before presenting these options, this report discusses the health care coverage status of Floridians and health benefit and premium costs nationally, mandated benefits in Florida, and legislative mechanisms used in Florida and other states to manage mandated benefits. The report does not evaluate the merits of any particular mandated benefit or mandated benefits generally.

In preparing this report, staff encountered numerous data challenges. In many instances, data was either nonexistent, compiled in a way that made its use difficult, not Florida-specific, or of questionable accuracy. This report nonetheless included data recognizing these limitations.

II. HEALTH CARE COVERAGE STATUS AND COSTS

A. Coverage Status of Floridians

In 1998, 12.5 million Floridians, or 83 percent of *all* Floridians, had some form of private or public health care coverage. The remaining 2.5 million Floridians, or 17 percent of *all* Floridians, were uninsured.[1] Nearly a quarter of *non-elderly* Floridians were uninsured. As shown in Figure 1, the percentage of *non-elderly* uninsured Floridians exceeded the national average by 30 percent in 1997 (essentially unchanged since 1989). The increasing percentage of non-elderly uninsured in Florida has occurred during a time of declining unemployment rates.



Source: Employee Benefit Research Institute

According to the 1998 Health Confidence Survey sponsored by the Employee Benefit Research Institute (EBRI), 48 percent of the uninsured nationwide cite cost as the primary reason for being uninsured. Costs would have to be "cut in half" to entice one-third of these respondents back into the marketplace.[2]

B. Health Benefit and Premium Costs

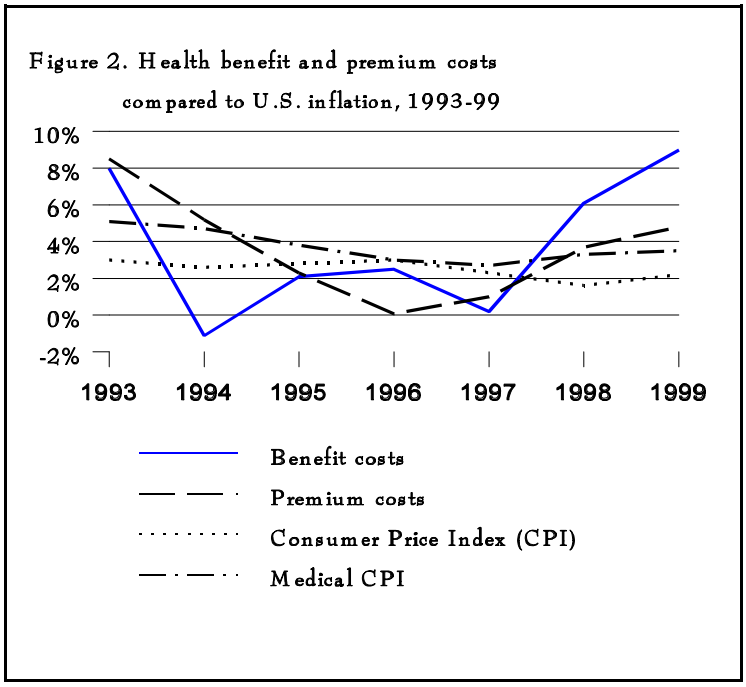
Nationally, total health benefit costs have risen quite dramatically since 1997, after several years of relatively modest fluctuations in overall costs. As shown in Figure 2, health benefit costs

[1]U.S. Census Bureau. (1999). *Health insurance coverage status and type of coverage by state -- all persons: 1997 to 1998* (Table HI-4). Washington, DC: Author.

[2]Employee Benefit Research Institute. (1998). *1998 Health Confidence Survey*, at 8. [Study underwritten by the American Association of Retired Persons, BlueCross BlueShield, AT&T, and the American Hospital Association, among others.]

recently experienced a "sudden jump in the health benefit cost trend--from half as fast as the medical component of the Consumer Price Index (CPI) [in 1997] to twice as fast [in 1999]."[3]

Since 1997, the medical CPI has jumped from 2.7 percent to 3.5 percent, after a steady decline from 5.1 percent to 2.7 percent between 1993 and 1997.[4] Some point to these figures as evidence of the beginning of a trend towards a more pronounced acceleration of health care costs.[5] However, the medical CPI has remained relatively stable since 1993, despite wide fluctuations in health benefits costs. A report prepared by the Robert Wood Johnson Foundation for the Institute of the Future released in November 1998, predicted average health care spending would increase an average of 6.4 percent annually through 2010.[6]



Source: Costs: Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 1998 at 8; Premiums: Kaiser/HRET Employer-Sponsored Health Benefits, 1999 Survey at 14; (includes KMPG Survey of Employer-Sponsored Health Benefits, 1988, 1993, 1996, 1998); CPI and medical CPI: U. S. Department of Labor, Bureau of Labor Statistics

On a national basis, the size of annual premium increases declined from 1989, before bottoming out in 1996. A 1997 study found health insurance premium increases [on a national level had] "decelerated greatly."[7] Annual premium increases for employer-

[3]William M. Mercer Companies, LLC. (1998). *Mercer/Foster Higgins national survey of employer-sponsored health plans*, at 4.

[4]U.S. Department of Labor, Bureau of Labor Statistics. (1999). Retrieved from the World Wide Web: http://stats.bls.gov/cpihome.htm

[5]Reasons cited for the most recent cost increases include double-digit increases in drug costs, additional mandated coverages, new treatments, the end of the exodus from indemnity plans to HMOs, pressures on HMOs to surrender more control over care, and consolidation in the HMO industry.

[6]Woodward, K.L. (1999). Analysts see 10-year stability in health care costs. *Business First -- Columbus, 15* (40), 46.

[7]Jensen, G.A., et. al. (1997). The new dominance of managed care insurance trends in the 1990s, at 134.

sponsored health insurance . . . declined from over 18 percent in 1989 to 2.3 percent in 1995.[8] As the study noted:

> "premium increases were below the rate of general inflation. Indeed, average premium increases were only two-thirds of the inflation rate; in real terms, health insurance premiums actually fell."[9]

Since 1996, premium increases have again grown larger. A recent survey conducted by The Kaiser Family Foundation found "(p)remiums for employer-sponsored health coverage [for all health plan types had] increased 4.8 percent from the Spring of 1998 to the Spring of 1999."[10] Employers with self-funded health plans reported cost increases that were just under one-half that of employers that obtained coverage from an insurer--3.7 percent compared to 5.8 percent. BlueCross BlueShield sees insurance premiums rising "as much as 10 percent annually for at least the next three years."[11] Additionally, a U.S. Chamber of Commerce survey of 251 small businesses nationwide found health care premiums had increased an average of 19 percent in 1998.[12] Some observers suggest the larger premium increases could be due to the historic pattern of profitability and pricing known as the "underwriting cycle."[13]

To illustrate the changing cost impact on purchasers of health plans in Florida, the Department of Insurance reviewed the approved rate increases for five of the largest insurers and HMOs. For large group HMO plans, the average rate increase approved by the Department of Insurance was 8.6 percent in 1999, up from 6.2 percent in 1998. For indemnity insurers, the average for 1999 was 3.6 percent, up from 1.3 percent in 1998.

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[8]Id. at 128-29.

[9]Id. at 134.

[10]The Kaiser Family Foundation and Health Research and Educational Trust. (1999). *Employer health benefits, 1999 annual survey*, at 3.

[11]Blues chief sees continuing surge in health premiums. (1999, April 12). *Indianapolis Business Journal, 20* (4) at 29A.

[12]U.S. Chamber of Commerce. (1999). *Small business health care survey, executive summary*, at 4.

[13]The Kaiser Family Foundation and Health Research and Educational Trust. (1999). *Employer health benefits, 1999 annual survey*, at 13. "The underwriting cycle is the historic pattern of profitability and pricing, where insurers during times of profitability compete for market share by under-pricing their products. Eventually, most insurers experience financial losses, and then try to restore their profitability by raising premiums."

III. MANDATED HEALTH BENEFITS

A. What Are "Mandated Health Benefits"?

The Legislature has not defined the phrase "mandated [health] benefits." For purposes of this report, a "mandated [health] benefit" is a statutory requirement imposed upon a private insurer or HMO health plan to cover a specific condition, disease, or illness; a particular type of health care treatment or service; a particular person; or a particular health care provider.[14] Mandatory offers of coverage for which insurers may charge additional premium are also included within the meaning of the term. Not included for purposes of this report, although perhaps qualifying as a mandated benefit in the literal sense of the word, are the minimum standards of coverage specified in statute.[15]

B. Inventory of Mandated Health Benefits[16]

Preparing an inventory of mandated health benefits is a subjective process. Two people examining the same set of statutory requirements could reach different conclusions about the total number of mandated benefits, depending on the definitions used and where the line separating related mandates is drawn. Maternity care is an example of the challenge. Maternity care could be considered one mandate encompassing minimum hospital stays and postdelivery care for the

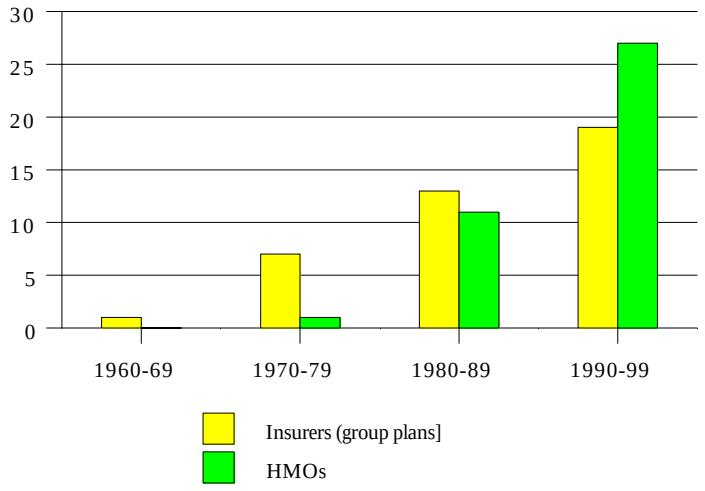
[14]The National Association of Insurance Commissioners includes as a mandated benefit requirements that certain persons be covered; certain illnesses or procedures be covered; and care by certain providers be reimbursed if a covered expense. National Association of Insurance Commissioners. (1999, September). *Compendium of State Laws on Insurance Topics*.

[15]The Department of Insurance, acting at the direction of the Legislature, has established minimum standards for benefits for a number of coverage categories. Categories include: basic hospital, medical, and surgical expense insurance, hospital confinement indemnity insurance, and major medical expense insurance. [See *The Insurance Industry*, Arthur Andersen, 1991, p. 70: Major medical expense complements basic hospital and surgical expense insurance. It provides benefits in cases where substantial expenses are incurred within a reasonably short period of time. Major medical policies generally have extremely high limits, in some cases in excess of $250,000.] Policy forms are also regulated under state law. Under Florida law, policies must indicate the cost of coverage, effective dates, duration of coverage, and time frames for paying claims. Insurers must also include an outline of coverage.

[16]A mandate applicable only to the small employer group market is not included in the inventory of mandated health benefits. These include continuity of care (Florida COBRA), hospice care, and emergency care outside the geographic area. Also not included are mandates relating to policy issuance or renewal for reasons other than the existence of some condition or continuity of treatment or provider. Among these are guaranteed renewability and portability of coverage requirements. Similarly, mandates applicable only to exclusive provider organizations (EPOs) are not included in the total, although they are noted in Appendix 1.

mother and newborn, or it could be counted as two separate mandates--one for minimum stays and one for postdelivery care.

Figure 3. Number of mandated benefits applied by decade since 1960



In preparing this report, staff identified 51 mandated health benefits applicable either to private insurer or HMO plans as of December 31, 1999. Of the 51 mandated benefits, 40 apply to either private individual or group policies provided by insurers. Individual policies are subject to 34 and group policies to 39. HMOs must comply with 39 mandated benefits. Appendix 1 of this report contains a summary description of each mandated health benefit identified for this report.

In a separate count, BlueCross BlueShield Association placed the number of mandates in Florida statutes at 44--the second highest in the nation, compared to an average of 25 among all states.[17] By that measure, Florida ranked among the states having the greatest number of mandated benefits.

Figure 3 shows the pace of growth in the application of new mandates to insurers and HMOs from the first mandated benefit approved in the 1960s through 1999, for the 51 mandated benefits. For insurers, the number of new mandated benefits has increased steadily over time; for HMOs, mandated benefits have been added more rapidly, with more than two-thirds applied since 1990. Appendix 2 identifies the year in which the Legislature first applied each mandated benefit to insurers and HMOs.

Table 1 groups states according to the number of statutorily-mandated benefits.

[17]BlueCross BlueShield Association. (1998). *State legislative health care and insurance issues: 1998 survey of plans*.

Table 1. Number of mandated health benefits among the states		
Number of mandates	Number of states	States
Fewer than 10	0	None
10-19	8	AL (12), DE (13), HI, ID (10), IA, VT, WV, WY (13)
20-29	30	AK, AZ, CO, GA, IL, IN, KS, KY, LA, MI, MS, MO, MT, NE, NH, NV, NJ, NM, ND, OH, OK, OR, PA, RI, SC, SD, TN, UT, WA, WI
30-39	9	AR, CA, CT, ME, MA, NY, NC, TX, VA
40 +	3	FL (44), MD (47), MN (40)

Source: Compiled using data from BlueCross BlueShield Association, December 1998.

According to a study commissioned by the Health Insurance Association of America, "[t]he number of state mandates increased at least 25-fold between 1970 and 1996."[18] Benefits most commonly mandated by states include breast reconstruction, mammography screening, minimum maternity stays, care for newborns, and treatment for alcoholism. Table 2 contains a sampling of several mandated benefits in Florida and their popularity among the states.

Table 2. Extent to which certain mandated benefits for private insurer and HMO plans in Florida are required in other states			
Mandated benefit	States with mandate	Mandated benefit	States with mandate
Breast reconstruction	50	Well-child care	29
Minimum maternity stays	50	Adopted children	25
Newborns	49	TMJ disorders	17
Mammography screening	48	Osteopaths	14
Chiropractors	42	Acupuncturists	7
Diabetic supplies	32	Dental anesthesia	5
Nurse midwives	31	Massage	2

Source: Compiled using data from BlueCross BlueShield, December 1998

[18]Jensen, G.A. & Morrisey, M.A. (1999, January). *Mandated benefit laws and employer-sponsored health insurance*, at 1.

C. Applicability of Mandated Health Benefits to Health Plans

An estimated 33 percent of *all* Floridians are covered under health plans subject to mandated health benefits. These Floridians are covered under a private insurer or HMO plan.[19] The other 67 percent are unaffected by mandated health benefits because they either are uninsured or covered under plans not subject to these mandates. Among *insured* Floridians, 40 percent are in plans subject to mandated health benefits.

Table 3. Applicability of mandated benefits to various health plans[20]

Health plans	Percentage		Mandates Applicable?
	Insured Floridians	*All* Floridians	
Insurer/HMO	40%	33%	Yes, with exceptions
Self-Funded ERISA* Employer	26%	21%	No
Medicare	22%	18%	No
Medicaid	12%	10%	No
No health plan/uninsured	N/A	17%	No

*Federal Employee Retirement Income Security Act of 1974

1. Insurer and Health Maintenance Organization Health Plans

Most private health plans provided by insurers and HMOs are subject to mandated health benefits.

Private insurer and HMO health plans are offered on an individual and group basis. An individual plan is a single policy covering one person or one family. For 1998, individual plans

[19]Whether or not federally-qualified HMOs are subject to mandated health benefits is apparently an unanswered question in the minds of some. According to Jensen, "the majority of HMO subscribers are in federally-qualified plans." See Jensen, *Benefit laws*, *supra* note 18, at 1.

[20]Sources of data: 1. Medicare: HMO database, Florida Department of Insurance; and federal Health Care Financing Administration data. 2. Medicaid: Agency for Health Care Administration, State of Florida. 3. Self-funded employer plans: derived percentages by applying national average rate calculated by the EBRI. 4. Insurer/HMO: HMO from Department of Insurance HMO database; insurer share is the remainder after deducting all others from total insured population. Note: These figures are based on 1998 data. They should be considered only as a general guide. In many cases, specific data was not available, requiring the use of extrapolations.

accounted for less than 10 percent of total earned premium (when including premium from "all other health plans" in total premium earned).

Group plans are by far the most common, accounting for over 70 percent of earned premium for calendar year 1998 (when including premium from "all other health plans" in total premium). A group plan is a single policy covering more than one person or entity. Group plans are typically sponsored by employers, associations, or other organizations, and are classified as small or large group depending on the number of individuals covered. The Florida Health Care Access Act[21] treats small employer groups as employers with 1 to 50 employees. As of December 31, 1998, over 1.7 million Floridians (employees and their dependents), representing approximately 21 percent of Floridians covered under a plan provided by a private insurer or HMO, or self-funded employer, were covered under a small employer group plan. This includes nearly 950,000 employees, or roughly one-half, of an estimated 1.8 million small business employees in Florida.[22]

Under the Florida Employee Health Care Access Act, the Legislature established the "basic" and "standard" small employer group plans and exempted them from mandated coverages not expressly made applicable in law to these two plan types.[23] For the period ending December 31, 1998, these two plan types accounted for only $139 million in earned premium or just over 8 percent of the more than $1.7 billion in premium earned for all small employer group plans, according to figures provided by the Department of Insurance. In terms of covered lives, the Department of Insurance enrollment report for the period ending December 31, 1998, showed an enrollment for basic and standard plans of approximately 163,000 compared to a total small employer group enrollment of approximately 1.7 million,[24] meaning that just under 10 percent of those insured under a small employer group plan were enrolled in a basic or standard plan.[25] However, this is up markedly from 1995, when these two plan types accounted for just over 5 percent of lives covered by a small employer group plan. According to the Department of Insurance small employer enrollment report for the period ending June 30, 1999, the number

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[21]§ 627.6699, FLA. STAT., (1999).

[22]"Small employer" for purposes of the number of people *employed* is the number of people employed by firms with 1 to 49 employees as of March 30, 1999. [Source: Florida Department of Labor and Employment Security, Office of Labor Market Statistics, "Employment and wages covered by unemployment compensation, first quarter, 1999, size of firm, private ownerships."] For purposes of the number of employees *insured*, it includes firms with 1 to 50 employees as of December 31, 1998. [Source: Florida Department of Insurance, "Florida Employee Health Care Access Act enrollment report, December 31, 1998."] Although drawn from two different sources, and despite the slightly different time periods, the comparison should be useful for general illustration.

[23]See § 627.6699(15)(a), FLA. STAT., (1999). The Legislature authorized these plan types in 1992.

[24]Similar enrollment data is not maintained for large group and HMO plans.

covered under a basic or standard plan had nearly doubled in the six months since the December 31, 1998, report for a total of 276,000 covered lives.

It is not always clear, however, which mandated benefits apply to insurer and HMO plans, and further, which apply to individual, or small or large group, policies. The statutes can be inconsistent and confusing. For instance, the statute may refer to "an insurer" but then in describing those covered refer to "subscriber," a term associated with HMOs. In another, that related to the cancer drugs mandate, the statute states that an "insurer" may not exclude coverage, but in another section states that this section may not be interpreted to "affect the determination as to whether particular dosages . . . are covered under [a] health maintenance organization contract."[26] Finally, although small employer health benefit plans include plans offered by both insurers and HMOs, most of the references to mandated benefits applicable to basic and standard small employer group plans reference only the comparable mandated benefit applicable to *insurers* and not *HMOs*. As a result, staff found that:

> of the 39 mandated benefits for insurer group plans generally, 24 expressly apply to the basic and standard small employer group insurer plans. Yet, these basic and standard plans actually include 31 of the 39 benefits mandated for insurer plans. That is because they include 7 additional benefits that are not statutorily-mandated; and,

>of the 39 mandated benefits for HMO plans generally, staff found only 7 expressly apply to the basic and standard HMO plans for small employers. The Department of Insurance interprets the mandated benefits referenced in the Act as also applying to basic and standard plans issued by HMOs. As a result, the Department of Insurance finds an additional 17 mandated benefits applicable to these HMO small employer plans. Also included in these HMO plans, although not statutorily-mandated, are another 7 benefits for a total of 31.

2. Employer Self-Funded ERISA Plans

Rather than purchasing a health care plan from an insurer or HMO, employers may self-fund their health plans and make claims payments using their own resources. Insurers or HMOs frequently administer these plans under a contract with the employer. Since the federal Employee Retirement Income Security Act of 1974 (ERISA)[27] generally preempts state regulation and

[26] § 627.4239, Fla. Stat., (1999).

[27] 29 U.S.C. § 1001, et. seq.

premium taxation of self-funded health plans,[28] these self-funded ERISA plans are not subject to mandated health benefits.

Employers self-fund using any number of plan options. Large employers tend to self-fund health benefits plans to a much greater extent than small employers.

Nationally, surveys indicate that anywhere between 30 and 60 percent of employees receive health insurance coverage under a self-funded ERISA plan.[29] In 1997, using the U.S. General Accounting Office methodology from a previous analysis, the EBRI estimated that 39 percent of individuals, including employees, were covered under a self-funded ERISA plan in 1995. No similar figure is available for Florida: neither the Department of Insurance nor the Agency for Health Care Administration knows the number of employers with a self-funded ERISA health benefits plan or the number of Floridians covered under a self-funded ERISA plan.[30]

3. Medicare and Medicaid

Medicare and Medicaid are the primary sources of health care coverage for nearly a quarter of *all* Floridians and one-third of *insured* Floridians. These plans are not subject to the mandated health benefits applicable to private health plans provided by insurers and HMOs.

The Medicare program is a federal program covering individuals 65 years of age or older and individuals under 65 determined by the Social Security Administration to be disabled. Medicare offers the "original" Medicare indemnity-type plan and Medicare+Choice, a managed care alternative. The Florida Medicaid program provides health services to certain economically disadvantaged families and other aged, blind, or disabled low income individuals. An entitlement program, Medicaid is funded principally by the federal and state government.

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[28]U.S. General Accounting Office. (1996, August 19). *Health insurance regulation costs* [GAO/HEHS-96-161], at 4.

[29]Employee Benefit Research Institute. (1997, December). *Estimates of the percentage of employers offering self-funded ERISA health benefit plans and the number of participants in these plans* (EBRI Notes), at 6. [This percentage is up from 33 percent in 1989.] See also, U.S. Department of Labor, Bureau of Labor Statistics. (1996). *Employee benefits in medium and large private establishments*, 1991, 1993, and 1995; and U.S. Department of Labor, Bureau of Labor Statistics. (1994). *Employee benefits in small private establishments*. [The Bureau of Labor Statistics estimated the number of full-time employees in self-funded plans for small employers (1994), and for medium and large employers (1995) at 31 and 47 percent, respectively.] See also, Jensen, G.A., New dominance, *supra* note 7, at 128 [Researchers concluded 46 percent of employees nationally were in self-funded plans in 1995.]

[30]Since the percentage of Floridians employed by firms of fewer than 100 employees and more than 500 employees is roughly equal to the national average, it would be reasonable to assume that Floridians participate in self-funded ERISA plans at about the national average.

D. General Availability of Benefits Required of Insurer and HMO Health Plans

Although mandated health benefits apply only to private insurer and HMO health plans, Floridians are in many instances receiving comparable benefits either under an exempt self-funded ERISA plan, or through Medicaid or Medicare. However, these plans are funded quite differently. These plans either are paid for by the general public, as in the case of Medicaid and Medicare, or funded voluntarily by those with the freedom to design a plan with benefits they are willing to purchase, such as an employer with a self-funded plan. Insurer and HMO plans subject to mandated benefits are paid for by those securing the coverage, regardless of whether or not they want to purchase all of the mandated benefits.

Appendix 3 of this report shows in a general and simplified manner the extent to which these plans not subject to mandated health benefits nonetheless appear to provide generally comparable coverages.[31]

Eleven of the 25 largest private sector employers in Florida which self-fund their health benefits plans indicated they include a benefit generally comparable to many of the mandated benefits. Of the 28 insurer mandates compared by these employers, employers had generally comparable coverages for 26. Of the 30 HMO mandates compared by these employers, employers had generally comparable coverages for 27. This finding is consistent with a U.S. General Accounting Office report citing several studies indicating that "[s]elf-funded health plans typically offer many of the benefits commonly mandated by states for fully insured health plans."[32]

Medicaid and Medicare program recipients have available to them benefits generally comparable to those mandated for private insurer and HMO plans. Of the 39 mandates applicable to private insurer group plans and HMO plans, Medicaid provided a generally comparable benefit for 34. In the case of Medicare, 31 of the 39 mandated benefits for insurer group plans either were covered or not applicable in the Medicare context; 35 of the 39 HMO plan mandates likewise either were covered or not applicable.[33]

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[31]The actual terms of the coverage may vary. Staff did not analyze the details of the specific coverages or compare deductibles or co-payments, or determine the extent to which the coverages meet the letter of the benefit mandated on insurers and HMOs operating in the private market place. This information should therefore be considered only as a starting point in any comparison of benefits among the different sources of coverage.

[32]U.S. General Accounting Office. *Health regulation costs*, *supra* note 28, at 15.

[33]For example, mandates related to children services are not included for purposes of the comparison.

E. The Cost of Mandated Health Benefits

1. The General Cost Impact of Mandated Benefits

The Legislature has recognized in legislative intent that "most mandates contribute to the increasing cost of health insurance premiums."[34] Insurers and HMOs contend benefits mandated benefits increase costs by: 1) increasing utilization of health care services (e.g., more visits, generally more costs) and possibly causing overutilization (e.g., insureds visit both a chiropractor and an orthopedic physician); 2) giving providers of certain benefits pricing leverage since insurers and HMOs must purchase these benefits once mandated; and 3) by requiring insurers and HMOs to include an additional benefit they might not offer otherwise.

By stating that "most" mandates increase costs, that same legislative intent recognizes that some mandates may not increase premium costs. These could be of at least two types: one, a preventative care mandate, such as mammogram screening or well-child care, which may avoid the need to provide more costly services in the future; and two, a mandated treatment or provider substituting for a more expensive alternative (e.g., nurse-midwife for obstetrician) that insurers or HMOs may be unwilling to offer in the absence of a mandate for any number of reasons such as the fear of legal liability.

Certain mandated benefits may not necessarily reduce premium costs but may reduce the costs borne by the general public, resulting in an "offset effect" by "reduc[ing] the need for future utilization of more expensive resources."[35] According to one researcher, if an insurance policy or HMO contract does not cover a particular treatment or condition, then the general public may end up funding the service since "society is unwilling to commit to refuse charity care to those who become ill without insurance."[36]

2. Considerations in Calculating the Cost of Mandates

> "While in theory it may sound simple to determine [the cost of mandated health benefits], the reality is that much of the data needed for an accurate assessment is either unavailable or can only be developed at considerable cost to insurers."[37]

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[34] § 624.215(1), FLA. STAT., (1999).

[35] Gruber, J. (1993). State-mandated benefits and employer-provided health insurance, at 437.

[36] Id. at 437.

[37] Texas Department of Insurance. (1998, December). *Mandated health benefits* (Report to the Texas Legislature), at 4.

Cost determinations are complicated by a lack of reported data, difficulty in calculating costs avoided, and failure to account for the cost of mandated benefits which would today be provided in the absence of a specific mandate. Further, which "cost" is the most useful cost--the full cost or the "marginal" or incremental additional cost to implement the mandated benefit? Neither the Department of Insurance nor the Agency for Health Care Administration collects information to calculate the total estimated costs of existing mandated health benefits. Insurers report total claims and claims costs, but do not submit claims data specific to each mandate. Likewise, HMOs do not submit this information. Consequently, claims costs, premium impacts, the relative cost of individual mandates, and the percentage of claims accounted for by mandated benefits cannot be determined based on information currently submitted.

Individual mandates vary in cost and so do the cumulative costs. The number of mandated benefits is less a factor than the particular mandates enacted. Certain mandated benefits are more expensive than others. For example, insurers consider obstetrical care and mental health care mandates to be expensive; mammograms, on the other hand, are thought to be less than 1 percent of premium costs.[38]

3. Mandated Benefits Cost Studies in Florida and Other States

a. Florida

Staff was unable to identify any comprehensive study of the cumulative cost of mandated health benefits in Florida. The cost of mandated benefits in Florida apparently has not been calculated.

Staff contacted several insurers and HMOs and found none routinely track the costs of mandated benefits on an ongoing basis. However, they all indicated they could calculate the claims costs associated with most, if not all, of these required benefits. Those contacted suggested they do not routinely track the cost of mandated benefits unless there is a particular reason from a business standpoint to segregate out these costs. Since the benefits must be provided regardless of the cost, insurers and HMOs instead focus on responding to the mandate in the most cost-effective manner possible. Some do periodically study the cost of particular mandates. Despite the lack of readily-available comprehensive cost data, insurers can cite examples of how mandates have increased their costs and ultimately the premiums paid by employers and individuals for health care coverage.

For example, one HMO provided an example of the way in which mandated benefits increased utilization and, presumably, premium costs. The requirement that HMOs provide direct

[38]U.S. General Accounting Office. *Health regulation costs, supra* note 28, at 12-13.

access to dermatologists increased dermatological visits for this HMO from 50,000 in 1996, the year prior to the mandate, to over 90,000 for the year ending July 1, 1999. This 85 percent increase in the number of visits occurred during a period when their HMO enrollment increased 29 percent.

Another example cited by an insurer is for the chiropractor mandate. For a recent 12-month period for one insurer, the number of chiropractor visits recorded by this insurer was over 70,000 with over 1 million services rendered.

b. Other states

Several states, most notably Virginia, require insurers and HMOs to submit detailed utilization and cost data. That data is then used to calculate the cost impact of the different mandates. It is a laborious task, according to several of the insurers with whom staff spoke. Florida does not collect the data now required in Virginia.

Studies have been conducted in several states to identify the percentage of claims attributed to mandated benefits. Nearly all of these studies calculate the full cost of the benefit, rather than the marginal cost. A 1996 U.S. General Accounting Office report on claims costs in six states cited studies as far back as 1988, revealing claims costs ranging from 5.4 percent in Iowa to 22 percent in Maryland.[39] Recent studies in several states, for example, Virginia and Maryland, provide a more current cost impact. In considering cost data, it is important to remember that states have different mandated benefits and costs will vary accordingly.

In Virginia, a state with extensive cost reporting requirements for insurers and HMOs, the average claim cost per group certificate for the 1997 reporting period was $263, accounting for 16.62 percent of total claims costs.[40] The premium impact on group certificates for family coverage was 29.17 percent of overall average premium on a full cost (as opposed to marginal cost) basis.[41] The 1998 BlueCross BlueShield report showed Virginia had 33 mandated benefits.

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[39]Id. at 11-12.

[40]Commonwealth of Virginia, State Corporation Commission. (1999). *Report of the State Corporation Commission on the financial impact of mandated health insurance benefits and providers pursuant to section 38.2-3419.1 of the Code of Virginia: 1997 reporting period* (House Document No. 6), at ii.

[41]Id. at 17.

In Maryland, mandates were priced on a full cost and marginal cost basis.[42] On a full cost basis, the estimated annual cost per policy for a group insurance policy was $604. The marginal cost came in at $148. This represents 15.4 percent and 3.8 percent of the average premium per policy. Maryland has 47 mandated benefits according to the 1998 BlueCross BlueShield report.

Maine calculates the cost impact of proposed mandated health benefits and also determines the cumulative costs of mandated benefits. As part of a December 22, 1999, report, the Maine Bureau of Insurance estimated the cumulative premium impact of 19 currently mandated benefits on group policies covering more than 20 employees to be 7.54 percent for fee-for-service plans, and 7.12 percent for managed care plans.[43] For comparison purposes, the 1998 BlueCross BlueShield report showing Florida with 44 mandated benefits shows Maine with 31.

In Hawaii, the State Auditor evaluates the marginal cost of proposed mandated benefits but does not assign specific dollar amounts. The cumulative costs of existing mandated benefits is not determined.

4. Cost Implications

a. The uninsured population

According to the EBRI, "the current cost of health insurance appears to be the primary reason (survey) respondents are uninsured."[44] A Heritage Foundation study of sixteen states which were "[according to the Foundation] most aggressive in passing laws designed to increase access to health insurance for their uninsured citizens" found that in 1996, "all 16 states experienced an average annual growth in their uninsured populations *eight times* that of the other 34."[45] The study

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[42]William M. Mercer, Inc. (1998, December 15). *Mandated health insurance services evaluation*, at Exhibit 1. The "marginal" cost "equals the full cost of the benefit minus the value of the services that would be covered in the absence of the mandate."

[43]State of Maine, Bureau of Insurance, (1999, December 22). *A Report to the Joint Standing Committee on Banking and Insurance of the 119th Maine Legislature: review and evaluation of proposed LD 1158*, at 19.

[44]Employee Benefit Research Institute. (1999 October 5). *The 1999 health confidence survey: summary of findings*, at 5.

[45]Schriver, M. & Arnett, G. (1998). *Uninsured rates rise dramatically in states with strictest health insurance regulations* (Backgrounder No.1211), at 1. [States studied are states passing small-employer market reforms between 1990-94 and individual market reforms including guaranteed issue and rate restrictions by early 1995.]

noted that all of the states had about the same one-year average growth rate in 1990. Mandated benefits were but one of six regulatory policies adopted in these states.[46]

A 1988 study found the "number of mandated benefits was a strong and statistically significant cause of lack of health insurance."[47] The authors of that study estimated that in 1986 mandates accounted for 25 percent of the uninsured nationwide and, in Florida, 18 percent.[48] A recent study found the number of mandates "decreased the probability of having any private insurance. . . . imply[ing] that between one-fifth and one-quarter of the uninsured problem can be attributable to mandates."[49]

However, according to a 1998 report to the Texas Legislature:

> "There does not appear to be any correlation between premium costs and uninsured rates, or between prevalence of mandated benefits and uninsured rates (i.e., *states with a high number of mandated benefits do not have higher uninsured rates than states with a low number of mandates*)."[50]

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[46]Other regulatory policies included guaranteed issue, guaranteed renewability, restriction of pre-existing condition exclusions, portability requirements, and imposition of community rating.

[47]National Center for Policy Analysis. (1988). *Freedom of choice in health insurance* (Policy Report No. 134), at 20.

[48]Id. at 20.

[49]Sloan, F.A. & Conover, C.J. (1998, Fall) Effects of state reforms on health insurance coverage of adults. *Inquiry*, 35, 280-293, at 288.

[50]Texas Department of Insurance, *Mandated health benefits*, *supra* note 37 at 4 (emphasis added).

This appears to be the case when focusing on specific states. For example, contrast Hawaii with Alabama. Hawaii has 18 mandates, but an uninsured rate of 8.9 percent; Alabama has 12 mandates, but 18 percent uninsured. However, Table 4 shows that when states are grouped according to the number of mandated benefits enacted and their uninsured rates are averaged, a correlation does seem to exist, except for those states with 40 or more mandated benefits.

Table 4. Comparison of mandated benefits to the percentage uninsured, averaged for all states

Number of mandated benefits	Average percentage of uninsured
< 10	13.4%
10-19	15.6%
20-29	16.8%
30-39	19.5%
40 +	16.3%

Sources: 1. Compiled from data prepared by BlueCross BlueShield Association. (1998). *Survey of plans, supra*, note 17.
2. Employee Benefit Research Institute. (1998). *Sources of health insurance and characteristics of the uninsured: analysis of the March 1998 current population survey* (EBRI Issue Brief, 1998), at 14.

That a state has a large number of mandated benefits and a large percentage of uninsured or vice-versa cannot necessarily be attributed to the existence of mandated benefits since there are a number of states with a large number of mandated benefits that have a small percentage of uninsured. Any number of variables could influence the uninsured rate; for example, the state could have a publicly-funded program of health care for those without insurance.

b. Small employers

One study concludes that "[w]ages, other health benefits, or non-health benefits will be reduced to pay for the new coverage."[51] However, the study seems to discount the value of health insurance coverage to employees relative to the other elements of a job benefits package. According to the National Center for Policy Analysis, "requiring employers to provide health insurance . . . is simply a disguised attempt to force workers to take health insurance rather than

[51]Jensen, *Benefit Laws, supra* note 18, at 9. Another recent study conducted by two professors at Baylor University in Waco, Texas claims that "where mandates have been studied, the evidence is overwhelming that the increased cost of insurance is passed on to workers through decreased wages . . . and/or through loss of jobs." The authors cite two studies as the basis for this contention. *See* Seward, J.A. & Henderson, J.W. (1999, January). *Report on the cost of health insurance mandates*, at 27

wages."[52] Further, that as mandated benefits increase insurance costs, employers will choose not to insure their employees. Ten percent of the respondents in a survey conducted by the U.S. Chamber of Commerce cited premium increases as the reason they discontinued offering health insurance to employees.[53]

Another study, in referring to this phenomenon as the "displacement effect," concluded that "mandate[d] [benefits] do not significantly affect the propensity of [small] firms to offer health insurance."[54] The author of this study contends that higher insurance costs [without regard to mandated benefits] for small businesses may explain why so many do not offer coverage. The author found the difference between the amount paid in claims and the premium collected to be eight times that for a firm of fewer than 5 employees than it is for a firm of over 1,000 employees.[55]

In Florida, the Department of Insurance data presented on page 9 of this report shows that small employers purchasing coverage overwhelmingly opt for coverage other than the basic or standard coverages despite the fact these are subject to fewer of the mandated benefits. However, the percentage of lives covered under a basic or standard benefit plan for small employers nearly doubled from 1995 to 1998. And, in just the first six months of 1999, the number of lives covered under a basic or standard policy jumped from 162,000 to 276,000.

c. Self-funding of health benefit plans by employers

Employers may choose to self-fund their health benefits plan to control costs, among other reasons.

One study found that "most mandated benefits had a positive but statistically insignificant effect on the likelihood of conversion."[56] "(W)hen considered in isolation, mandates were not a significant factor. Premium tax considerations together with mandates, however, were important in

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[52]National Center for Policy Analysis. (1997). *State health care briefing book, problem no. 2: rising number of uninsured*, at 2.

[53]U.S. Chamber of Commerce. (1999). *Small business health care survey, executive summary*, at 1.

[54]Gruber, J. (1993). State-mandated benefits, *supra* note 35 at 455. Gruber's conclusion prompts him to suggest a study to determine "why there is so much interest in such an apparently . . . unimportant issue."

[55]Id. at 459.

[56]Jensen, *Benefit laws*, *supra* note 18, at 15.

driving the self-insurance movement of the early 1980's. . . ," according to the study's author.[57] (Employers that self-insure do not pay premium taxes to the state and are not subject to the financial solvency requirements under either ERISA or state law.) Given that firms choosing to self-insure provided benefits similar to private insurer and HMO plans, the author concluded that "while mandates constraints may have been important to some firms, they were unimportant for most firms in deciding whether to self-insure."[58] Another team of researchers arrived at a similar conclusion: ". . . past state policies related to mandated benefits have not driven firms to self-insure in order to escape the cost of providing these benefits."[59]

Employers self-fund for many reasons, including greater cost control, different tax treatment, and ability for multi-state employers to structure a uniform benefits plan. Staff contacted several of the largest employers in Florida to find out their reasons for self-funding their health benefits plans. The primary reasons cited were lower administrative costs, greater control over premium charges (increases were too high and unpredictable), and greater control over plan design. Freedom from mandated health benefits, while not selected as the single most important reason for self-insuring, could be included within others that were, especially "greater control over plan design." One very large employer indicated mandated benefits are "occasionally a concern." However, according to this employer, they self-fund "to ensure [their] premiums are representative of the actual cost [claims] for [their] employers and retirees." The other reason cited is to have a "consistent national plan design," rather than 50 different ones (i.e., one for each state).

d. Employer control of plan costs

Mandated benefits may make it more difficult for employers to control health plan costs by not being able to select the coverages they want; legislators and agency regulators, in effect, purchase plans for them.[60] Insureds may be forced to purchase coverages they do not need or their employees do not want, and forego those they do need.[61]

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[57]Jensen, G.A., Cotter, K.D., & Morrisey, M.A. (1995). State insurance regulation and employers' decisions to self-insure. *The Journal of Risk and Insurance*, 62 (2), at 208.

[58]Id. at 209.

[59]Acs, G., Long, S.H., Marquis, M.S., & Short, P.F. (1996, Summer). Self-insured employer health plans: prevalence, profile, provisions, and premiums. *Health Affairs*, 15 (2).

[60]The Heritage Foundation. (1999). *Rising costs, reduced access: how regulation harms health consumers and the uninsured* (Backgrounder No. 1307), at 3.

[61]Argument raised by the Council for Affordable Health Insurance.

IV. LEGISLATIVE APPROACHES FOR MANDATED HEALTH BENEFITS LEGISLATION

A. Special Statutory Requirements for Legislation Proposing A New Mandated Health Benefit in Florida

In 1987, the Legislature called for a "systematic review of current and proposed mandated or mandatorily-offered health coverages" and established guidelines to be used to conduct the review. Since that time, proponents seeking to require a private insurer or HMO to provide a particular coverage have been required under Florida law to prepare a report assessing the social and financial impacts of the proposed mandate.[62] The law specifies twelve criteria that proponents must address in the impact analysis. These include an assessment of the extent to which:

> the treatment or service is used by a significant portion of the population;
> the insurance coverage is generally available;
> any general lack of availability of coverage causes persons to forego necessary treatment;
> any general lack of availability of coverage results in unreasonable financial hardship;
> there is public demand for the treatment or service;
> the coverage is included in collective bargaining negotiations;
> cost increase or decrease result from the treatment or service;
> coverage will increase the appropriate uses of the treatment or service;
> the coverage will be a substitute for a more expensive treatment or service;
> the coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders; and,
> the coverage will impact the total cost of health care.[63]

Proponents must submit the report to the Agency for Health Care Administration and the relevant legislative committees. Although the Legislature has enacted approximately 35 mandated benefits enacted since 1987, staff could only identify four reports submitted for mandated health benefits enacted since that time.[64]

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[62] § 624.215(1), FLA. STAT., (1999).

[63] § 624.215(2), FLA. STAT., (1999).

[64] According to the Agency for Health Care Administration, reports were only received for two mandates [Letter received via e-mail from Sandy Berger with the agency to Bobbye Iseminger, staff to the Committee on Insurance, dated August 9, 1999]. One (autism) did not become law; the other (bone marrow transplant donors) became law in 1999. Committee staff could uncover only three additional instance where a study had been submitted since 1987 for a mandate ultimately enacted by the Legislature. A review of staff bill analyses for mandates enacted between 1987 and

The law does not expressly provide for any independent determination of the cost of proposed mandates other than that normally undertaken by the Legislature in consideration of bills generally.

B. Other Legislation With Special Requirements in Florida

Special requirements for considering certain types of legislation or other legislative business exist in the state constitution, statutes, and legislative rules. Some standing committees have their own set of formal policies for handling certain types of legislation.

Special constitutional or statutory requirements are encountered when proposing changes in the state retirement system; creation of a public records exemption or specialty license plate, and approval of a local bill or local government mandate. The Legislature uses an estimating conference to consider fiscal impacts on the state employees group health plan. Both the Senate and the House of Representatives adopt rules, jointly and separately, defining the process for considering certain types of legislation--for example, legislation affecting appropriations--or conducting other legislative business. These examples offer parallels the Legislature may examine in considering approaches for proposed mandated benefits legislation.

1. Local Government Mandates

In 1990, Florida voters approved a constitutional amendment to limit legislative enactment of local government mandates, i.e. laws which require local governments to expend funds or which reduce revenues available to local governments. That constitutional amendment requires a covered mandates proposal to "fulfill an important state interest" and be approved by two-thirds of the membership in each house. Certain mandates are not covered under the amendment.

2. Florida Retirement System

If the Legislature proposes any benefit increase to members of the Florida Retirement System, the state constitution requires an actuarial valuation and appropriate funding before the benefit increase may be provided.[65]

1999 uncovered a reference to two of the three--that for mammograms and for newborn adopted children in 1988 (CS/HB 481; June 30, 1989). Staff located a copy of a study for birthing centers in 1989, although the bill analysis made no reference to it.

[65] §14, Art. X, Fla. Const.

3. Open Government/Public Records and Public Meetings

The "Open Government Sunset Review Act of 1995" requires the Legislature to consider certain criteria before enacting future exemptions. The Act also provides for a review of all existing exemptions. The Legislature must find existing or proposed exemptions serve an "identifiable public purpose" and be "sufficiently compelling." Exemptions must be reviewed by the Legislature before their scheduled repeal. This policy applies to both existing and proposed exemptions. The Act provides for the automatic repeal of any exemption five years after enactment unless subsequently reenacted by the Legislature.

Public records exemptions must be presented in a separate, stand-alone bill. They generally cannot be created as a part of another general bill, although multiple exemptions could be proposed in a single bill.

4. Local Bills

The state constitution makes a distinction between general laws and special laws ("local" laws). It also spells out procedures specific to the enactment of special laws. The Constitution also sets out special procedural requirements and substantive limitations for local bills. Local bills can only pertain to certain delineated subject matter. Furthermore, unless the bill provides for a ratifying referendum, notice of intent to enact such a bill must be advertised in a newspaper or posted at the courthouse.[66] Notice must include a description of the substance of the proposal. House Rules prohibit a committee from reporting a local bill out of committee if the substance of the bill could be enacted by the local governing body. The House Community Affairs Committee has an official policy requiring local bills to have had a public hearing locally and be approved by the legislative delegation before these bills can be agendaed for committee consideration.

5. Specialty License Plates

The Legislature requires organizations seeking a new specialty license plate to satisfy a number of preconditions. They must submit an application to the Department of Highway Safety and Motor Vehicles (DHSMV) for review. The application fee could be as high as $60,000. In addition, they must submit a survey performed by a firm approved by the DHSMV indicating intent on the part of at least 15,000 motor vehicle owners to buy the plate. Approved specialty license plates are consolidated in a single section of Florida Statutes.

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[66] § 11.02, Fla. Stat., (1999).

6. Sunrise Act

The "Sunrise Act"[67] sets out certain factors the Legislature must consider in deciding whether or not to regulate a profession or occupation. Proponents are required to submit certain information to the state agency which would have jurisdiction over the regulation. The amount of information is quite voluminous. The agency must then provide the Legislature with information as to the effect of the proposed legislation.

7. Consensus Estimating Conferences

The Legislature has established ten different estimating or forecasting conferences, each designed to develop official information for use by state policymakers and administrators in making state planning and budgeting decisions. Perhaps the most well-known is the Revenue Estimating Conference. Other conferences include economic, education, criminal justice, and social services. Relevant to this report, the Economic Estimating Conference evaluates the state group health insurance plan and considers various fiscal impacts on the plan.

8. Reviser's Bills

The House of Representatives has adopted rules establishing special procedures for reviser's bills.

9. Lobbyist Registration and Reporting

The Senate and House of Representatives have adopted joint rules through concurrent resolution to regulate lobbyist activities.

[67] § 11.62, Fla. Stat., (1999),

B. Legislative Requirements in Other States for Mandated Benefits Legislation

State legislatures clearly have been struggling to find ways to manage the plethora of proposed legislation requiring insurers and HMOs to provide a particular health benefit. In the first six months of 1999, according to the National Conference of State Legislatures, 15 states have considered bills to study mandated benefits or to create a body to review mandates.[68] The year prior, in 1998, "legislators approved [sixteen] bills in [eleven states] . . .to study the effects of health insurance mandates."[69] In comparison, 42 states enacted 134 laws mandating benefits (created new mandate or revised existing mandate) in 1997."[70] In 1998, legislators nationwide introduced approximately 215 mandates bills, 94 of which were enacted, according to the NCSL.[71] In New Jersey, Governor Whitman established a task force through executive order to develop guidelines for reviewing health mandated benefits.[72]

Table 5. State approaches to mandated health benefits

Approach	Yes	No
1. Requirement for a cost-benefit analysis or fiscal impact statement for proposed mandated benefits (not routine fiscal impact statement done for all bills)	18	30
2. Agency or special body to review, evaluate, or price mandated benefits on an *ongoing permanent* basis	11	37
3. Statutory restrictions on enactment of new or continuation of existing mandated benefits	2	46
None of the above	28	20

Source: Survey conducted by staff of the Committee on Insurance, Florida House of Representatives (1999).

To determine how states generally handle mandated benefits legislation, committee staff surveyed all 50 states. All but the California and West Virginia Legislatures responded. The results are presented in Table 5. Twenty-eight states[73] apparently do not treat mandated benefits

[68]National Conference of State Legislatures. (1999). *Mandated benefits* (Issue Brief No. 070231), at 7.

[69]Id. at 4.

[70]Id. at 3.

[71]Id. at 3-4.

[72]Executive Order No. 92, State of New Jersey, March 12, 1999

[73]Alabama, Alaska, Arkansas, Connecticut, Delaware, Idaho, Illinois, Indiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Texas, Utah, Vermont, Wyoming.

bills any differently than any other type of legislation--there is no special mechanism or process, no review panel, no special conditions placed on enactment, and no required fiscal impact determinations (other than might otherwise be required of any legislation). By far, the most common response of states has been to call for an impact analysis to assess the financial impact, social impact, and/or medical efficacy of the proposal.

1. Impact Analysis

The most common response among states to mandated benefits has been to provide for the preparation of a special impact analysis.[74] This is true in 18 states. As shown in Table 6, Florida is one of these states.

a. Is an impact analysis required to be submitted in these states?

In 14 of these states, a report must be submitted. However, in four other states,[75] the report is prepared only *if requested* by some specified individual or body.[76] For example, Hawaii has a "sunrise act" applicable to mandated health benefits. Before the Legislature can consider a proposed mandated benefit, the Legislature must approve a concurrent resolution requesting the State Auditor to prepare an impact analysis.[77]

Table 6. States providing for an impact analysis specific to mandated health benefits

Arizona	Kentucky	Pennsylvania
Colorado	Louisiana	South Carolina
Florida	Maine	Tennessee
Georgia	Maryland	Virginia
Hawaii	Mississippi	Washington
Kansas	Oregon	Wisconsin

Source: Survey conducted by staff of the Committee on Insurance, Florida House of Representatives (1999).

[74]This is as opposed to routine fiscal impact analyses prepared for legislation generally. Also, not included are impact analyses required only to determine the cost of a mandate under a state or local governmental health insurance program or limited to local governments pursuant to a restriction on the enactment of local government mandates.

[75]Hawaii, Kentucky, Louisiana, and Pennsylvania.

[76]Louisiana has a special twist to its law: a report is required *unless* the committee decides otherwise. LA. REV. STAT. ANN. § 603.1A. (West 1999).

[77]HA. REV. STAT. §23-51 (1998)

b. Who is responsible for conducting the analysis and when must it be submitted?

States typically require either a designated state agency or special review panel to conduct the review. In Maine, the review panel may contract with a private actuarial firm to complete the analysis. However, seven states,[78] including Florida, direct the proponents or sponsor of a mandates proposal to complete the analysis. One state, Pennsylvania, permits both proponents *and* opponents to submit information. Two states, Louisiana and Tennessee, direct fiscal committee staff to conduct the review.[79]

c. When must the analysis be completed?

State policy runs the gamut in specifying when an impact analysis must be submitted. Time frames can include the following:

> at the time the proposal is filed (e.g., Oregon);
> within 30 days after analysis is requested (e.g., South Carolina);
> 90 days prior to session (e.g., Washington);
> timely manner (e.g., Maine); or,
> before being heard or before final passage by committee (e.g., Kentucky).

Florida law is silent on the timing of the submission.

d. What type of analysis is conducted?

For the most part, states call for a similar impact analysis. All include a financial component. Fourteen, including Florida, must include an analysis of the social impact of the proposal. Seven require the analysis to consider the medical efficacy of the mandate as well.

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[78]Arizona, Colorado, Florida, Kansas, Mississippi, Oregon, and Washington.

[79]In 1999, the Oklahoma Legislature repealed a 1998 enactment requiring its fiscal review committee to prepare an impact analysis for health mandates bills. [1999 Okla. Sess. Law Serv. Ch. 397 § 47 (West)] Fiscal staff found the hard data needed to determine the costs of mandated benefits difficult to obtain: "[w]hen SB 12 passed [in 1998], no one realized the virtual impossibility of gathering hard data . . . on the cost of mandates. . . . National figures, studies done by other states, etc. were used as health plans in [Oklahoma] did not gather the relevant data in almost all instances. . . .We were not even able to discover how many PSA prostrate screenings had been performed in [Oklahoma] during any time period. . . . Although this should have been coded the same in all provider locations, no health plan could provide the data."

e. What criteria are used in the analysis?

Virtually all states include a laundry list of specific criteria to examine in conducting the analysis. Some are more elaborate than others. Georgia, Oklahoma, and South Carolina, for example, pose just five questions; Colorado, twelve; and Maine, thirty. Examples include the following:

> cumulative impact of mandated benefits on total health care costs;
> increase or decrease the cost of the treatment or service;
> increase or decrease the cost of health care and health insurance premiums;
> increase or decrease the administrative costs of insurers;
> ability of employers to purchase policies meeting employee needs;
> public demand for the treatment or service or for insurance coverage for the treatment or service;
> alternatives to meeting an identified need;
> current availability of particular coverage to general population;
> substitute for more expensive treatment or service;
> unreasonable financial hardship on persons needing treatment if coverage not generally available;
> employers shifting to self-insured plans;
> benefit offered by employers with self-insured plans;
> methods to manage costs and use of proposed mandate;
> use of treatment or service by a significant portion of population;
> treatment recognized by medical community as effective and efficacious;
> contribution of benefit to quality of patient care and health status of population;
> proportion of population with such coverage;
> documentation of medical need;
> affordability of health insurance; or,
> inclusion in collective bargaining agreements.

Florida law, with twelve, includes most of these criteria.

f. What is the effect on legislative consideration of proposed mandates?

Only five states[80] directly attempt to limit the prerogative of the legislature to act on mandates legislation based on whether or not an impact analysis has been submitted. Maine is the

[80]Hawaii, Kansas, Kentucky, Maine, Mississippi

most direct: "a proposed mandate may not be enacted into law unless [the] review and evaluation . . . has been completed."[81]

2. Permanent Review Body

Only 11[82] of the 48 states responding reported having either an ongoing permanent body charged with reviewing proposed mandated health benefits or a state agency specifically charged with reviewing proposed mandated benefits.

Virginia and Maryland have established standing commissions specifically for the purpose of reviewing and evaluating mandated benefits.[83] In Pennsylvania, the Health Care Cost Containment Council is required to convene a Mandated Benefits Review Panel consisting of four senior researchers to develop independently certified documentation for proposed mandates.[84]

The remaining states designate a state agency such as the Department of Insurance to review a proposed mandate if requested by either the appropriate legislative committee or, in some states, by the Governor's office. In Georgia, the Clerk of the House and the Secretary of the Senate must deliver any health insurance mandates bills to the Insurance Commissioner for a fiscal review within five days after first reading.

In Maryland, the General Assembly established an independent commission--the Health Care Access and Cost Commission (HCACC)--charged with assessing the "social, medical, and financial impacts of a proposed mandated health insurance service."[85] The HCACC calculates the cost of each proposed mandated benefit and the cumulative cost of all existing mandated benefits to compare these costs to statutory "affordability" caps.

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[81]MAINE REV. STAT. ANN. § 2752.2 (West 1998)

[82]Colorado, Georgia, Hawaii, Kentucky, Maine, Maryland, Pennsylvania, South Carolina, Virginia, Washington, and Wisconsin. Texas is not included among this group. Texas had a special review panel--the Texas Mandated Benefit Review Panel--but dismantled it in 1997 after only a four year existence. According to a report of the Texas Department of Insurance, the panel encountered significant problems, including unrealistic time frames for reviewing proposed mandates, inadequate data, lack of clarity as to how the panel should function, and legislator unawareness of the requirement that the panel review proposed mandates.

[83]See VA. CODE ANN. § 9-297 (1999); MD. [Insurance] CODE ANN. §§ 15-1501 and 15-1502.

[84]PA. STAT. ANN. TIT. 35, §449.9 (Purdon 1999).

[85]MD. [Insurance] CODE ANN. § 19-1502 (1997 Volume and 1998 Supp.).

In 1999, the Colorado Legislature created the Health Care Task Force. The Task Force is a committee of legislators scheduled to meet primarily between legislative sessions. Among other assignments, the Task Force is required to study the "social and financial costs and benefits of mandated health care coverage."[86]

Other states have considered, but not yet enacted, legislation to create a special panel to review mandated benefits. In 1999, the Missouri Legislature considered, but did not enact, legislation to create an advisory commission on mandates, and legislation to create a mandated benefits commission. Tennessee did likewise during the 1997-98 session. However, several state legislatures, Texas for one, have enacted legislation creating a temporary committee to study the costs and benefits of proposed mandated benefits. Missouri, likewise, approved legislation for a one-time study of mandated benefits.

3. Restrictions on Enactment

Staff identified two states with distinct limitations on legislative approval of mandated benefits legislation: Maryland and Oregon.[87]

Maryland, at least in the small group market, is the only state staff could identify that has attempted to limit the cumulative cost of all mandated benefits to a specific dollar amount. In Maryland, insurance carriers can only sell one insurance product to small employers--the product developed by the HCACC. In 1993, the Maryland General Assembly enacted an "affordability" cap on mandates costs for the small group plan. The cap is set at 12 percent of the average wage in the state. If the HCACC finds the cumulative cost of approved mandates exceeds this amount, the HCACC must adjust the level of benefits or cost sharing arrangements under the plan so the cap is not exceeded in the future.[88]

In 1999, the Maryland General Assembly considered a similar approach for the large group market by requiring a comparison of mandates costs to the average annual wage in Maryland and to health insurance premiums.[89] However, an actual cap was not imposed and benefits adjustments were not provided for. Instead, the calculations are used as the basis for triggering

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[86]Colo. Rev. Stat. §26-15-107 (1999).

[87]The Iowa Legislature has enacted a presumed exclusion of mandated benefits. Mandated benefits are not to be included in a basic benefits policy unless the Commissioner of Insurance finds that inclusion is cost-effective based on an actuarial review and that inclusion "is in the best interests of affordable health care coverage." This presumption applies only to individual coverage and small group plans (25 or fewer group members under Iowa law).

[88]William M. Mercer, Inc. (1998). *Mandated health insurance services evaluation*, at 2.

[89]Md. [Insurance] Code Ann. §§ 15-1501 and 15-1502, (1999).

further review by the HCACC. If the HCACC finds the full cost of mandated benefits exceeds 2.2 percent of the average wage in the state, then it must evaluate the social, medical, and financial impacts of each existing mandated benefit and report its findings to the General Assembly. The General Assembly can then use this information to decide whether or not to enact proposed mandates or repeal existing mandates.

The Oregon Legislature appears to be the only state which sunsets mandated benefits. Since 1985, Oregon law has provided for the automatic repeal of mandated benefits statutes six years from the effective date of the particular mandate.[90] According to Oregon legislative staff, several mandates have expired under this law.

[90] OR. REV. STAT. § 743.700 (1997)

V. POLICY OPTIONS

A. Retain the Current Process

The Legislature could maintain the current process for considering proposed mandated health benefits. At the same time, it could insist on submission of the statutorily-required impact analysis before considering a proposed mandated benefit. The Legislature could adopt the existing statutorily-required process as a legislative rule or the Insurance Committee could adopt it as a statement of committee policy.

B. Define "Mandated Health Benefits"

Several states define "mandated health benefits." The Legislature could define this term to facilitate identification of mandated benefits for regulatory purposes and cost studies.

C. Establish One Location in Florida Statutes for All Mandated Benefits and Clearly Delineate Which Mandated Benefits Apply to Which Health Plans

Like it has done for specialty license plates under the Transportation Code, the Legislature could consolidate all mandated benefits into a separate part of the Insurance Code, instead of dispersing them throughout several different parts of two chapters. The Legislature also could reconcile inconsistencies in existing law or resolve interpretative differences that may exist. Finally, the Legislature could review the benefits included in the basic and standard small employer group plans.

D. Determine the Cost and Public Benefit of Existing Mandated Health Benefits

The Legislature could commission a study to quantify the cost and resulting public benefit of health mandates. The total cost could be stated as a percentage of total claims costs or overall premium. This study would produce a baseline cost for use by policy makers.

E. Establish a New Process for Considering Proposed Mandated Health Benefits

The Legislature could create a new process for considering proposed mandated health benefits. The following options could be adopted in statute, by legislative rule, by committee policy, or by a combination of all three. The process could:

1. require all proposed mandated benefits to undergo evaluation by a review entity prior to legislative “consideration”;

2. direct a review entity using statutory criteria to prepare an impact analysis for all proposed mandated benefits prior to legislative “consideration”;
3. require proponents of a proposed mandated benefit to submit an application and pay a fee to defray the costs of conducting an impact analysis (similar to the statutory process for considering specialty license plate proposals);
4. require proponents to submit data necessary to complete an impact analysis;
5. require insurers and HMOs to submit data necessary to complete an impact analysis;
6. specify the way in which the review process is activated (e.g., at the request of the legislative presiding officers, committee chair, individual legislators); or,
7. specify a time frame within which an impact analysis must be requested and completed.

F. Designate or Create a Review Entity

The Legislature could designate or create a review entity with a variety of responsibilities. The entity could be a state agency; a multi-agency review panel; a consensus estimating conference; an independent non-governmental board; or a private sector actuarial firm. The entity could develop an official list of mandated benefits; calculate the cost of existing mandates; monitor the cumulative costs of mandates as new ones are adopted; conduct cost-benefit analyses of proposed mandates; establish an "affordability cap” for mandated benefits included in health plans; or issue recommendations to the Legislature for managing the impact of mandates--to repeal existing or suggest new mandated benefits.

G. Manage the Impact of Mandated Health Benefits and Needed Coverages

The Legislature could decide to legislate limits on mandated benefits, both existing and proposed, and require coverages where appropriate. The Legislature could:

1. preserve some or all existing mandates (could be based on cost-benefit review);
2. convert some or all existing mandates into mandatory offers;
3. repeal mandates (outright or sunset), perhaps according to a schedule;
4. sunset new mandated benefits (could be based on cost-benefit review);
5. repeal (outright or sunset) mandated benefits exceeding an individual affordability cap;
6. repeal (outright or sunset) certain mandates if an overall affordability cap is exceeded;
7. require insurers and HMOs to comply with mandates only if Medicaid and Medicare provides a comparable benefit;
8. limit new mandated benefits to the state health plan for a trial period; or,
9. authorize insurers and HMOs to offer "employer choice" plans with different benefit packages, from a minimal benefit plan option to limits on mandated benefits in plans based not on the number of mandated benefits but on their cost. Other packages could include plans including fewer or less costly mandated benefits in exchange for different utilization provisions, or alternative deductible or co-payment requirements.

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APPENDICES

Appendix 1. Inventory of Mandated Health Benefits
(January 2000)

#	Mandated Benefit	Summary Description of Mandated Benefit
1.	Acupuncturists	Provides that any individual or group health insurance policy that provides coverage for acupuncture shall also cover the services of an acupuncturists certified pursuant to chapter 457 under the same conditions that apply to services of a licensed physician. (627.6403; 627.6618; 627.6699, Florida Statutes)
2.	Ambulatory surgical centers	Provides that no individual or group health insurance policy providing coverage on an expense-incurred basis, or individual or group service or indemnity-type contract issued by a non-profit corporation, or self-insured group health benefit plan, shall be issued unless coverage provided for any service performed in an ambulatory surgical center, as defined in s. 395.002, is provided, if such service would have been covered as an eligible inpatient service. (627.6056; 627.6616; 627.6699, Florida Statutes)
3.	Birthing centers	Provides that any policy of health insurance or HMO contract that provides coverage for maternity care must also cover the services of birth centers licensed under ss. 383.30-383.335. (627.6406(1); 627.6574(1); 627.6699; 641.31(18)(a), Florida Statutes)
4.	Bone marrow transplants	Provides that an insurer or HMO may not exclude coverage for bone marrow transplants recommended by referring and treating physicians under a policy exclusion for experimental, clinical investigative, educational or similar procedures if the particular use of the transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to 627.4236(3) which outlines the rules specifying the bone marrow transplant procedure. (627.4236 (2), Florida Statutes)
5.	Bone marrow transplants: donors	Bone marrow procedures covered by any insurance policy or HMO contract, as outlined in 627.4236(2), must include costs associated with the donor-patient to the same extent and limitations as costs associated with the insured, except that reasonable costs of searching for the donor may be limited to immediate family members and the National Bone Marrow Donor Program. (627.4236(2), Florida Statutes)
6.	Breast cancer	Provides that an insurer or HMO may not exclude or deny health coverage based solely upon a diagnosed predisposition to, or a family history of, breast cancer, unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer. Coverage also may not be denied nor canceled solely due to breast cancer if the insured has been free from breast cancer for more than 2 years before request for coverage. (627.6419 (1), (2) and (3), Florida Statutes)
7.	Cancer: certain drug therapies	Provides that an insurer may not exclude coverage in any individual or group insurance policy which is issued, amended, delivered or renewed in this state which covers the treatment of cancer for any drug prescribed on the grounds that the drug is not approved by the United States Food and Drug Administration for a particular indication if the drug is recognized for treatment in a standard reference compendium or recommended in the medical literature. This also includes administration of the drug. (627.4239(2), Florida Statutes)

#	Mandated Benefit	Summary Description of Mandated Benefit
8.	Children: foster and adopted	Provides that any individual or group health insurance policy providing coverage for a family member must provide that benefits applicable to children of the certificateholder or subscriber also apply to an adopted child and foster child at the moment of placement. HMO contracts must provide coverage for an adopted child. Chapter 641 does not address foster children (627.6415; 627.6578; 627.6699 (adopted only); 641.31(17) , Florida Statutes)
9.	Children: handicapped children services	Provides that a hospital or medical expense policy, group health insurance policy, an HMO contract, or health care services plan that is issued or delivered in this state provide coverage as long as the child continues to be (1) incapable of self-sustaining employment because of mental retardation or physical handicap, and (2) chiefly dependent on member or employee for support and maintenance. (627.6041; 627.6615; 627.6699; 641.31(29), Florida Statutes)
10.	Children: newborn	Provides that any health insurance policy, group health insurance policy or HMO contract providing coverage for a family member of the certificateholder or subscriber must provide coverage for newborns from time of birth. (627.641; 627.6575; 627.6699; 641.31(9), Florida Statutes)
11.	Children: well child care	Provides that all health insurance policies or an HMO contract covering a family member of the insured, certificate holder, or subscriber, must provide coverage for child health supervision services, which includes periodic visits (history, physical exam, development assessment, and immunizations and laboratory tests). This meets the standards set out in the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. (627.6416; 627.6579; 627.6699; 641.31(30)(b)1., Florida Statutes)
12.	Chiropractors	Provides that insurance policies, health care services plans and contracts providing for the payment of expenses and/or procedures will be construed to include payment to a chiropractic physician who provides benefits or procedures within the scope of his or her license. (627.419 (4); 627.6699, Florida Statutes)
13.	Cleft lip/palate	Provides that any health insurance policy or HMO contract that covers a child under the age of 18 must provide coverage for treatment of cleft lip and cleft palate for the child. The coverage must include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating physician or surgeon, or in the case of an HMO, the primary care physician or the physician to whom the child was referred deems it to be medically necessary and consequent to treatment of the cleft lip or cleft palate. (627.64193; 627.66911; 627.6699; 641.31(35), Florida Statutes)
14.	Continuity of provider	Provides that when a contract between an organization and a treating provider is terminated for any reason other than for cause, each party shall allow subscribers for whom treatment was active, to continue coverage through completion of the treatment, if medically necessary, until the subscriber picks another provider, or during the open enrollment period offered by the organization, not to exceed 6 months or through postpartum care, if pregnant. (641.51(7), Florida Statutes)

#	Mandated Benefit	Summary Description of Mandated Benefit
15.	Conversion to non-group	Provides that a group insurance policy or HMO contract shall provide that an employee, member, subscriber, or covered dependant, as applicable, whose insurance has been terminated for any reason (other than non-payment) shall be entitled to a policy or certificate of health insurance. (627.6675; 641.3921; 641.3922, Florida Statutes)
16.	Dental care: out-of-network	Provides that any employer, group, or organization that pays or contributes to the premium of a group health insurance plan or dental plan or dental service plan corporation which provides dental coverage only upon the condition that services be rendered by an exclusive list of dentists or group of dentists shall also provide an alternative to allow the insured a free choice of dentist. (627.6577, Florida Statutes)
17.	Dentists	Provides that any health insurance policy, health care services plan, or other contract providing for the payment of surgical procedures which are specified in the policy or contract or are performed in an accredited hospital and in consultation with a licensed physician will be construed to include payment to a dentist who provides benefits or procedures within the scope of his or her license. (627.419(2); 627.6699; Florida Statutes)
18.	Dental procedures: general anesthesia and hospitalization	Provides that any individual health insurance policy, group policy, or HMO contract which provides coverage for general anesthesia and hospitalization services to a covered person shall not preclude such coverage in assuring the safe delivery of necessary dental care provided to covered person who is under 8 years old and is determined by a licensed dentist and the child's physician to require necessary dental treatment in a hospital or ambulatory surgical center due to the complex nature of the procedure or has one or more medical conditions that would create significant or undue medical risk to the patient, if procedure is not performed in a hospital or ambulatory surgical center. This does not cover diagnosis or treatment of dental disease. (627.4295; 627.65755; 641.31(34), Florida Statutes)
19.	Dependent coverage	Provides that if an insurer offers (group) coverage that insures dependent children of the policyholder or certificate holder, the policy must cover the dependent child at least until the end of the calendar year in which the child reaches 25 if the child is dependent upon the policyholder or certificate holder for support or the child is living in the household or the child is a full-time or part-time student. (627.6562; 627.6699(5)(h), Florida Statutes)
20.	Dermatologists: access	Provides that an exclusive provider organization and an HMO which offers dermatological services shall provide direct access for office visits and minor procedures and testing, to a dermatologist who is under contract with the exclusive provider organization or HMO. Also provides for five office visits to a dermatologist within a 12 month period without authorization or referral. (627.6472(16); 641.31(33), Florida Statutes)

#	Mandated Benefit	Summary Description of Mandated Benefit
21.	Diabetes treatment	Provides that any health insurance policy, group health insurance policy, or HMO contract provide coverage for all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the patient's treating physician, or in the case of an HMO, the patient's primary care physician or the physician to whom the patient is referred who specializes in treating diabetes, certifies that the equipment, supplies or services, are necessary. (627.6408; 627.65745; 641.31(26)(a), Florida Statutes)
22.	Emergency room screening: coverage for non-emergencies	Under 627.6472, EPOs are prohibited from restricting payment for covered services if the services are for symptoms requiring emergency care or urgent care, and it is not reasonable to obtain the services through a network provider. Provides that each HMO contract, certificate, or member handbook shall state that emergency services and care shall be provided to subscribers in emergency situations without prior approval from provider. As defined in s. 641.47, a determination shall be made as to whether an emergency situation exists or not. The HMO shall compensate the provider for the screening, examination and evaluation in this determination. If a determination is made that an emergency medical situation does not exist, payment for services rendered subsequent to that determination is governed by the contract under which the subscriber is covered. (627.6472; 641.31(12); 641.513(3)(a), Florida Statutes)
23.	Enteral feeding formulas/ treatment of PKU	Provides that any individual or group health insurance policy to be delivered or issued for delivery in the state shall make available, for an appropriate additional premium, coverage for prescription and non-prescription enteral formulas (nutrient and food supplements) for home use which are prescribed by a physician as medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism or for malabsorption originating from congenital or acquired during the neonatal period. The nutrient and food supplements must be prescribed by a physician, but may be over-the-counter, non-prescription products. The coverage for inherited diseases of amino acids and organic acids must include food products modified to be low-protein; the amount of such coverage may not exceed $2,500 a year for any insured individual through the age of 24 years. The coverage described in this section must be made available regardless of any preexisting condition. (627.42395, Florida Statutes)
24.	Extension of benefits	Provides that an individual insurance policy, a group insurance policy, or an HMO contract must provide for continuation of policy benefits in connection with the total disability of a certificate holder for at least 12 months under "major medical" type of coverage. Terms specific to extension of maternity expense coverage is included for both insurers and HMOs. Terms for dental are included for group insurance policies but not for group HMO contracts. (Similar to provisions for individual policies, but limited to coverage terminated before eligibility for Medicare or Medicaid benefits (627.646; 627.667; 641.3111, Florida Statutes)
25.	HIV exclusion	Provides that a group health insurance policy or an HMO contract shall contain an exclusion or limitation of coverage for HIV or AIDS, with some exception and not exclude coverage of a member or subscriber because of a positive test result for exposure to the HIV infection or a specific sickness or medical condition derived from such infection, except as provided in a preexisting condition clause. (627.411(1)(f); 627.429(5); 627.6699(6)(d); 641.3007(5), Florida Statutes)

#	Mandated Benefit	Summary Description of Mandated Benefit
26.	Home health care services	Provides that any group health insurance policy providing coverage on an expense-incurred basis shall provide coverage for home health care by a home health care agency licensed under part IV of chapter 400. Such coverage may be limited to home health care under a health plan prescribed by a licensed physician and performed by a registered graduate nurse, a licensed practical nurse, a physical therapist, a speech therapist, an occupational therapist, or a home health aide. (627.6617, Florida Statutes)
27.	Mammogram coverage	Provides that an accident or health insurance policy, a group health insurance policy, or HMO contract issued, amended, delivered or renewed in this state, must provide coverage for the following: (a) baseline mammogram for any woman who is 35, but younger than 40; (b) a mammogram every two years for any woman 40 or older, but younger than 50, or more frequently if physician recommends; (c) a mammogram every year for a woman 50 or older; and (d) one or more mammograms a year, based on physician's recommendation for any woman who is at risk for breast cancer (has family history of breast cancer, has history or biopsy-proven benign breast disease, has mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before age 30). (627.6418; 627.6613; 627.6699; 641.31095, Florida Statutes)
28.	Massage	Provides that any policy of health insurance or HMO contract that provides coverage for massage shall also cover the services of the persons licensed to practice massage pursuant to chapter 480, where the massage as defined in chapter 480, has been prescribed by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, as being medically necessary and the prescription specifies the number of treatments. (627.6407; 627.6619; 641.31(37), Florida Statutes)
29.	Mastectomy: length of stay	Provides that any individual or group accident or health insurance policy that is issued, amended, delivered or renewed in this state, or any HMO contract, which provides coverage for breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient. (627.64171; 627.66121(1); 627.6699; 641.31(31)(a), Florida Statutes)
30.	Mastectomy: out-patient	Provides that any individual or group accident or health insurance plan or any HMO contract that provides coverage for mastectomies, must also provide coverage for outpatient postsurgical follow up care in keeping with prevailing medical standards by a licensed health care professional qualified to provide postsurgical mastectomy care. (627.64171; 627.66121 (2); 627.6699; 641.31, Florida Statutes)
31.	Mastectomy: surgical procedures and devices	Provides that any health insurance plan, group policy, or HMO contract that provides coverage for mastectomies must provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy. Breast reconstructive surgery must be in a manner chosen by the treating physician under contract with the HMO, consistent with prevailing medical standards, and in consultation with the patient. Under the group or health insurance plan, an additional premium may be charged for this coverage. (627.6417(1); 627.6612(1); 627.6699; 641.31(32), Florida Statutes)

#	Mandated Benefit	Summary Description of Mandated Benefit
32.	Maternity care: length of stay	Provides that any health insurance policy, group health insurance policy or HMO contract providing maternity or newborn coverage cannot limit length of stay to any time period less than that determined to be medically necessary. (627.6406(2); 627.6574(2); 627.6699; 641.31(18)(b), Florida Statutes)
33.	Maternity care: nurse-midwives /midwives	Provides that any health insurance, group policy of health insurance or HMO contract that provides maternity benefits must also cover nurse-midwives and midwives licensed pursuant to chapter 467. (627.6406(1); 627.6574(1); 627.6699; 641.31(18)(a), Florida Statutes)
34.	Maternity care: post-delivery	Provides that any policy of health insurance or any HMO contract that provides coverage, benefits, or services for maternity or newborn care must provide coverage for postdelivery care for a mother and her newborn infant. The postdelivery care must include a postpartum assessment and newborn assessment. The services must include physical assessment of the newborn and mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards. (627.6406(4); 627.6699; 641.31(18)(d), Florida Statutes)
35.	Mental and nervous disorders: services and providers	Provides that every insurer, HMO, and nonprofit hospital and medical service plan corporation transacting group health insurance or prepaid health care in this state shall make available to the policyholder, for an additional premium, benefits or level of benefits specified in s. 627.668(2) for the necessary care and treatment of mental and nervous disorders (which can be in-patient, outpatient, or partial hospitalization). The applicant has the right to select any alternative benefits or level of benefits, as long as they are not less than the benefits outlined in s. 627.668(2)(a), (b) or (c). As outlined in s. 627.668(2)(b), services may be provided by a licensed physician, a psychologist licensed pursuant to chapter 490, a mental health counselor licensed pursuant to chapter 491, a marriage and family therapist licensed pursuant to chapter 491, and a clinical social worker licensed pursuant to chapter 491. (627.668; 627.6699, Florida Statutes)
36.	Nurse anesthetist	Provides that HMO contracts which provide anesthesia coverage, benefits, or services shall offer to the subscriber, if requested and available, the services of a licensed certified registered nurse anesthetist. (641.31(21), Florida Statutes)
37.	OB/GYN: access	Provides that an EPO and HMO shall allow, without prior authorization, a female subscriber to visit a contracted OB/GYN for one annual visit and for medically necessary follow up care detected at that visit. (627.6472(18); 641.51(10), Florida Statutes)
38.	Ophthalmolo-gists	Provides that, notwithstanding any other provisions of law, HMO policies or contracts which provide coverage, benefits, or services which are performed by physicians who are ophthalmologists, licensed pursuant to chapter 458 or 459, shall offer to the subscriber the services of an ophthalmologist. (641.31(20), Florida Statutes)
39.	Optometrists	Provides that, notwithstanding any other provision of law, HMO policies or contracts or any health insurance policy, services plan, or contract, which provides coverage, benefits, or services as described in s. 463.002(5), shall offer to the subscriber the services of an optometrist licensed pursuant to chapter 463. (627.419(3); 627.6699; 641.31(19), Florida Statutes)

#	Mandated Benefit	Summary Description of Mandated Benefit
40.	Osteopathic hospitals	Provides that each HMO that provides for inpatient and outpatient services by allopathic hospitals shall provide as an option for the subscriber similar inpatient and outpatient services by an osteopathic hospital when the services are available in the HMO service area. As a condition of providing osteopathic inpatient and outpatient services through an osteopathic hospital that does not have a written contract with an HMO, the HMO may require the subscriber or any other person receiving these services to release the HMO from any liability concerning malpractice as a result of these services. (627.6699; 641.31(24), Florida Statutes)
41.	Osteoporosis screening	Provides that any health insurance policy, group health insurance policy, or HMO contract that covers a resident of this state and that is issued, amended, delivered or renewed in this state after October 1, 1996, must provide coverage for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including individuals with a family history of osteoporosis. These sections do not apply to specified accident, specified disease, hospital-indemnity, Medicare supplement, or long-term-care policies or to the state employee health insurance program. (627.6409; 627.6691; 641.31(27), Florida Statutes)
42.	Out-of-hospital services	Provides that no health insurance policy which provides coverage on a medical, hospital, or surgical expense-incurred basis shall be delivered or issued for delivery in this state unless coverage is provided for treatment performed outside a hospital for any accident or illness as defined in the policy, provided that such treatment would be covered on an inpatient basis and is provided by a health care provider whose services would be covered under the policy if the treatment was performed in a hospital and provided the treatment of the accident or illness is medically necessary. (627.4232, Florida Statutes)
43.	Podiatrists	Provides that, notwithstanding any other provision of law, when any health insurance policy, health care service plan, or other contract provides for the payment for procedures specified in the policy or contract which are within the scope of a podiatrist's professional license, such policy shall be construed to include payment to a podiatrist who performs such procedures. The payments shall be made in accordance with the coverage now provided for medical and surgical benefits. (627.419(3); 627.6699, Florida Statutes)

#	Mandated Benefit	Summary Description of Mandated Benefit
44.	Preexisting conditions	Provides that in individual health insurance policies, preexisting condition provisions may not exclude coverage after 24 months have passed following the individual's effective date of coverage, and may relate only to: 1) conditions that had manifested themselves during the 24-month period; or 2) a pregnancy existing on the effective date of coverage. (627.6045(1)(2), Florida Statutes). Insurers and HMOs offering group coverage may impose a preexisting condition exclusion only if: 1) the exclusion relates to a physical or mental condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date; 2) such exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date; and 3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (see 627.6561(5) and 641.31071(5) et. seq., Florida Statutes) as of the enrollment date. (627.6561(1)(2), Florida Statutes) However, group insurers and HMOs may not impose any preexisting condition exclusion in the case of: 1) Newborns covered under creditable coverage within 30 days of birth; 2) adoptees covered under creditable coverage before the last day of the adoption; or 3) pregnancy. (627.6561(4); 641.31071(2)(4), Florida Statutes) Follow-up care for breast cancer (627.64172; 627.66122; 627.6699; 641.31096, Florida Statutes)
45.	*PCP: Chiropractor	Provides that if services are offered through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or 459, and chapters 460 and 461 is designated for each subscriber upon request. Chiropractors are licensed under Chapter 460. (641.19(13)(e), Florida Statutes)
46.	*PCP: OB/GYN	Provides that if services are offered through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or 459, and chapters 460 and 461 is designated for each subscriber upon request. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the HMO's provider network. (641.19(13)(e), Florida Statutes)
47.	*PCP: Osteopath	Provides that if services are offered through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or 459, and chapters 460 and 461 is designated for each subscriber upon request. Osteopathic physicians are licensed under Chapter 459. (641.19(13)(e), Florida Statutes)
48.	PCP: Podiatrist	Provides that if services are offered through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or 459, and chapters 460 and 461 is designated for each subscriber upon request. Podiatrists are licensed under Chapter 461. (641.19(13)(e), Florida Statutes)

#	Mandated Benefit	Summary Description of Mandated Benefit
49.	Psycho-therapeutic services	Under an individual policy issued by insurer or an EPO contract, if psychotherapeutic services are covered by a policy issued by the insurer, the insurer shall provide eligibility requirements for all groups of health care providers licensed under chapter 458, 459, 490 or 491, which include psychotherapy in their scope of practice. Also included are persons certified as advanced registered nurse practitioners in psychiatric mental health under s. 464.012. The insurer may not discriminate against a health care provider by excluding such practitioner from its provider network solely on the basis of the practitioner's license. (627.6471(6); 627.6472(15), Florida Statutes)
50.	Substance abuse	Provides that insurers, HMOs, and nonprofit health care services plans transacting group health insurance or providing prepaid health care in this state shall make available benefits for the necessary care and treatment of substance abuse impaired persons, if the applicant for the coverage selected any alternative benefits or level of benefits as may be offered by the plan, which would be in-patient or out-patient benefits. The benefits shall be applicable only if the treatment is provided by, or under the supervision of, or prescribed by, a licensed physician or licensed psychologist and if services are provided in a program accredited by the Joint Commission on Accreditation of Hospitals or approved by the state. (627.669, Florida Statutes, which originally offered coverage for alcoholism, then was amended to include drug dependency)
51.	TMJ	Provides that any health insurance policy, group health insurance policy, or HMO contract which provides coverage for any diagnostic or surgical procedure involving bones or joints of the skeleton shall not discriminate against coverage for similar diagnostic or surgical procedure involving bones or joints of the jaw and facial region, if such procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury. This does not cover care or treatment of the teeth or gums, intraoral prosthetic devices, or cosmetic surgery. (627.419(7); 627.65735; 641.31094, Florida Statutes)

*PCP = Primary care provider

Note: State mandated benefits applicable only to small employer group plans are not included in this table.

Appendix 2. Year in Which Mandated Health Benefits Were Applied to Insurers and/or HMOs

#	Benefit Mandate	Individual	Group	HMO
1.	Acupuncturists	1987	1987	--
2.	Ambulatory surgical centers	1982	1982	--
3.	Birthing centers	1989	1989	1989
4.	Bone marrow transplants	1992	1992	1992
5.	Bone marrow transplants: donors	1999	1999	1999
6.	Breast cancer	1992	1992	1992
7.	Cancer: certain drug therapies	1995	1995	--
8.	Children: foster and adopted	1985	1985	1988
9.	Children: handicapped children services	1970	1970	1997
10.	Children: newborn	1972	1974	1984
11.	Children: well child care	1986	1986	1997
12.	Chiropractors	1986	1986	--
13.	Cleft lip/palate	1998	1998	1998
14.	Continuity of provider	--	--	1999
15.	Conversion to non-group	--	1978	1985
16.	Dental care: out-of-network	--	1984	--
17.	Dentists	1969	1969	--
18.	Dental procedures: general anesthesia and hospitalization	1998	1998	1998
19.	Dependent coverage	--	1992	--
20.	Dermatologists: access	*	*	1997
21.	Diabetes treatment	1995	1995	1996
22.	Emergency room screening: coverage for non-emergencies	*	*	1996
23.	Enteral feeding formulas/ treatment of PKU	1995	1995	--
24.	Extension of benefits	1978	1975	1991

#	Benefit Mandate	Individual	Group	HMO
25.	HIV exclusion	1988	1988	1988
26.	Home health care services	--	1987	--
27.	Mammogram coverage	1988	1988	1995
28.	Massage	1992	1992	1999
29.	Mastectomy: length of stay	1997	1997	1997
30.	Mastectomy: out-patient	1997	1997	1997
31.	Mastectomy: surgical procedures and devices	1987	1987	1997
32.	Maternity care: length of stay	1996	1996	1996
33.	Maternity care: nurse-midwives /midwives	1983	1983	1989
34.	Maternity care: post-delivery	1996	1996	1996
35.	Mental and nervous disorders: services and providers	--	1976	1998
36.	Nurse anesthetist	--	--	1989
37.	OB/GYN: access	--	*	1999
38.	Ophthalmologists	--	--	1989
39.	Optometrists	1972	1972	1989
40.	Osteopathic hospitals	--	--	1991
41.	Osteoporosis screening	1996	1996	1996
42.	Out-of-hospital services	1984	1984	--
43.	Podiatrists	1990	1990	--
44.	Preexisting conditions	1996	1992	1997
45.	**PCP: Chiropractor	--	--	1988
46.	**PCP: OB/GYN	--	--	1995
47.	**PCP: Osteopath	--	--	1996
48.	**PCP: Podiatrist	--	--	1988
49.	Psychotherapeutic services	1996	--	--
50.	Substance abuse	--	1979	1979

#	Benefit Mandate	Individual	Group	HMO
51.	TMJ	1996	1996	1996

*Applies to Exclusive Provider Organization (EPO) only and, therefore, not counted as a mandate on insurers generally.
**PCP = Primary care provider

Note: State mandated benefits applicable only to small employer group plans are not included in this table.

Appendix 3. Benefits Mandated For Private Insurer and HMO Health Plans and Availability of Generally Comparable Benefits Under Other Health Plans

Benefit		Mandated on Insurer and HMO Health Plans?					Generally Comparable Benefit Available?		
		Insurer Health Plans			HMO Health Plans		Other Health Plans		
		Individual	Group: Small Employer (Basic / Standard plans)	Group: Large or Other Small	Small Employer (Basic / Standard plans)	Large or Other Small	Employer Self-funded ERISA Plans[1]	Medicaid	Medicare
1.	Acupuncturists	Yes	Yes	Yes	No*	No	No	No	No
2.	Ambulatory surgical centers	Yes	Yes	Yes	No*	No	Yes	Yes	Yes, certain surgical procedures in approved ambulatory centers
3.	Birthing centers	Yes	Yes	Yes	No*	Yes	Yes	Yes	Yes, only Medicare approved centers
4.	Bone marrow transplants	Yes	No, ltd. cov. std. plan	Yes	No, ltd. cov. std. plan	Yes	Yes	Yes	Yes
5.	Bone marrow transplants/donor	Yes	No**	Yes	No**	Yes	Yes	No	Yes
6.	Breast cancer	Yes	No	Yes	No	Yes	...	Yes	Yes
7.	Cancer: drug therapies	Yes	No	Yes	No	...	Yes	Yes	No
8.	Children: adopted and foster	Yes	Yes	Yes	No*	Yes, for adopted; no for foster	Yes	Yes	N/A
9.	Children: services for handicapped	Yes	Yes	Yes	No*	Yes	Yes	Yes	N/A
10.	Children: newborn	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A
11.	Children: well care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A
12.	Chiropractors	Yes	Yes	Yes	No*	No	...	Yes	Yes

Benefit		Mandated on Insurer and HMO Health Plans?					Generally Comparable Benefit Available?		
		Insurer Health Plans			HMO Health Plans		Other Health Plans		
		Individual	Group: Small Employer (Basic / Standard plans)	Group: Large or Other Small	Small Employer (Basic / Standard plans)	Large or Other Small	Employer Self-funded ERISA Plans[1]	Medicaid	Medicare
13.	Cleft lip/palate	Yes, <18 years old	Yes	Yes	No*	Yes, <18 years old	Yes	Yes	N/A
14.	Continuity of provider	No	No	No	No	Yes	Yes	Yes	N/A
15.	Conversion to non-group	N/A	No**	Yes	No**	Yes	...	N/A	N/A
16.	Dental care: out-of-network	No	No	Yes	No	No	Generally yes	Yes, participating dentists	No, dental services generally not covered
17.	Dentists	Yes	Yes	Yes	No*	No	...	...	...
18.	Dental procedures: general anesthesia and hospitalization	Yes	No	Yes	No	Yes	Generally yes	Yes	No, dental not covered
19.	Dependent coverage	No	Yes	Yes	Yes	No	Yes	Yes, for those <18; sliding scale based on income	No
20.	Dermatologists: access	No	No	No, except EPOs***	No	Yes	Yes	Yes, but Medipass must go through primary care physician	Yes, if medically necessary; pays 80% of 100% approved
21.	Diabetes treatment	Yes	Yes	Yes	Yes	Yes	Yes	Yes, but certain equipment limited to those < 21	Yes, but no medications

Benefit		Mandated on Insurer and HMO Health Plans?					Generally Comparable Benefit Available?		
		Insurer Health Plans			HMO Health Plans		Other Health Plans		
		Individual	Group: Small Employer (Basic / Standard plans)	Group: Large or Other Small	Small Employer (Basic / Standard plans)	Large or Other Small	Employer Self-funded ERISA Plans[1]	Medicaid	Medicare
22.	Emergency room screening/coverage for non-emergencies	No	No	No, except EPOs***	No	Yes	Yes	Yes	Yes, when urgent and at participating hospitals
23.	Enteral feeding formulas/treatment of PKU	Yes, additional premium	No	Yes, additional premium	No	No	No clear consensus	Yes, but some limited to those < 21	N/A. Supplies covered when in feeding tube
24.	Extension of benefits	Yes	...	Yes	...	Yes	...	Yes	Yes
25.	HIV exclusion	Yes	Yes	Yes	No**	Yes	Generally yes	Yes	Yes
26.	Home health care services	No	No**	Yes	No**	No	Yes	Yes, subject to certain requirements	Yes
27.	Mammogram coverage	Yes	Yes	Yes	No*	Yes	Yes	Yes	Yes
28.	Massage	Yes	No	Yes	No	Yes	Generally no	No, except for AIDS waiver	No
29.	Mastectomy: length of stay	Yes	Yes	Yes	No*	Yes	Yes	Yes, subject to retrospective review	Yes
30.	Mastectomy: out-patient	Yes	Yes	Yes	No*	Yes	...	Yes	Yes
31.	Mastectomy: surgical procedures and devices	Yes	Yes	Yes	No*	Yes	Yes	Yes, for prosthesis; surgery subject to review	Yes, devices at 80% of 100% approved; surgery on case-by-case basis

Benefit		Mandated on Insurer and HMO Health Plans?					Generally Comparable Benefit Available?		
		Insurer Health Plans			HMO Health Plans		Other Health Plans		
		Individual	Group						
			Small Employer (Basic / Standard plans)	Large or Other Small	Small Employer (Basic / Standard plans)	Large or Other Small	Employer Self-funded ERISA Plans[1]	Medicaid	Medicare
32.	Maternity care: length of stay	Yes	Yes	Yes	No*	Yes	Yes	Yes	Yes
33.	Maternity care: nurse-midwives/midwives	Yes	Yes	Yes	No*	Yes	Yes	Yes	Yes
34.	Maternity care: post-delivery	Yes	Yes	Yes	No*	Yes	...	Yes	Yes
35.	Mental/nervous disorders: services and providers	No	Yes	Yes, additional premium	Yes	Yes, additional premium	Yes	Yes, subject to certain service limits	Yes, inpatient and outpatient w/ limitations
36.	Nurse anesthetist	No	No	No	No	Yes	...	Yes	Yes
37.	OB/GYN: access	N/A	No	No, except EPOs***	No	Yes	Yes	Yes	Yes. Medicare + Choice provides routine/preventative women's health services as a basic benefit
38.	Ophthalmologists	No	No**	No	No**	Yes	Yes	Yes	Yes, for eye disease or injury
39.	Optometrists	Yes	Yes	Yes	No*	Yes	...	Yes	No
40.	Osteopathic hospitals	No	Yes	No	Yes	Yes	Yes	Yes	No, unless a "participating hospital"

Benefit		Mandated on Insurer and HMO Health Plans?					Generally Comparable Benefit Available?		
		Insurer Health Plans			HMO Health Plans		Other Health Plans		
		Individual	Group				Employer Self-funded ERISA Plans[1]	Medicaid	Medicare
			Small Employer (Basic / Standard plans)	Large or Other Small	Small Employer (Basic / Standard plans)	Large or Other Small			
41.	Osteoporosis screening	Yes	No	Yes	No	Yes	Yes	Yes	Yes, bone mass measurement for at-risk only
42.	Out-of-hospital services	Yes	No**	Yes	No**	No	Yes	Yes, full ambulatory	Yes
43.	Podiatrists	Yes	Yes	Yes	No*	No	...	Yes	Yes
44.	Preexisting condition	Yes	Yes	Yes	Yes	Yes		Yes, preexisting condition does not preclude from Medicaid	Yes, preexisting condition does not preclude from Medicare
45.	****PCP: Chiropractor	N/A	N/A	N/A	No	Yes	Generally no	No	Yes
46.	****PCP: OB/GYN	N/A	N/A	N/A	No**	Yes	Generally yes	Yes	Yes
47.	****PCP: Osteopath	N/A	N/A	N/A		Yes	...	Yes	Yes
48.	****PCP: Podiatrist	N/A	N/A	N/A	No**	Yes	Generally no	No	Yes

Benefit		Mandated on Insurer and HMO Health Plans?					Generally Comparable Benefit Available?		
		Insurer Health Plans			HMO Health Plans		Other Health Plans		
		Individual	Group: Small Employer (Basic / Standard plans)	Group: Large or Other Small	Small Employer (Basic / Standard plans)	Large or Other Small	Employer Self-funded ERISA Plans[1]	Medicaid	Medicare
49.	Psychotherapeutic services	Yes	No	No, except EPOs***	No	No	Yes	Yes; Medicaid physician and community health services provide comprehensive therapy coverages; psychologist and social work services only covered through a community mental health center	N/A. However, Medicare covers psychiatrist services with special limits
50.	Substance abuse	No	No	Yes, additional premium	No	Yes, additional premium	Yes	Yes	Yes
51.	TMJ	Yes	No**	Yes	No**	Yes	Yes	Yes	Yes

*Included in plan based on DOI's interpretation that they are required by law.
**Included in basic and standard small employer group plans, but not a statutorily-mandated benefit.
***EPOs = Exclusive Provider Organizations
****PCP = Primary care provider
...Benefit not included in list for purposes of comparison

Note: State mandated benefits applicable only to small employer group plans are not included in this table.

1. Based on information from eleven of the largest private employers in Florida. A response of "yes" indicates that virtually all apparently offer a benefit which is similar or identical to the mandated benefit. A response of "generally yes" or "generally no" means there was a much narrower majority offering or not offering an identical or similar benefit.