

**COST OF STATE AND FEDERALLY MANDATED
HEALTH BENEFITS**

Report to the Tennessee General Assembly

Prepared by the Fiscal Review Committee Staff

June 29, 2011

Introduction:

Pursuant to Tennessee Code Annotated § 3-2-111 (c), the following is a report on the costs of state and federally mandated health benefits placed upon insurance issuers in Tennessee since 1990 and the impact of mandated health benefits on the premiums for health insurance coverage in Tennessee, especially on employees of companies with fewer than fifty employees. To complete this report, information was collected from Louisiana, Maryland, Massachusetts, Texas, and Virginia, as well as information from Blue Cross Blue Shield of Tennessee and the Council of Affordable Health Insurance. Each mandate was compared to mandates in other states that have conducted detailed cost studies on the mandate's impact to the cost of insurance and premiums. Information from studies conducted by Blue Cross Blue Shield of Tennessee and the Council of Affordable Health provided an impact more specific to Tennessee in some cases.

While the majority of the health mandated benefits result in cost increases that range from less than one percent to three percent, reports have found that some mandates can result in increases of as much as ten percent. The actual implementation of most single health benefit mandates have not been shown to result in significant increases in the monthly or annual cost of health insurance or premiums. Some are estimated to be as little of an increase of \$.25 or less per month, or \$3.00 annually. The accumulation of several health benefit mandates, on the other hand, can result in significant increases to the actual cost of health insurance and premiums.

Health Benefit Mandates and Potential Cost Impact

Newly born children, Tenn. Code Ann. §56-7-2301

Requires any insurer to offer newborns automatic coverage as long as application and premium are furnished within 31 days of birth.

According to the Council for Affordable Health Insurance (CAHI)¹, the estimated cost of a newborn being included under a parent's individual insurance policy for 31 days if the policy

¹ Information is included in the "Health Insurance Mandates in the States 2010" report by the Council for Affordable Health Insurance (CAHI). Cost estimates are based on CAHI's independent Actuarial Working Group on

already provides coverage for dependents is an increase of one to three percent of the total cost. According to a 2004 report by Blue Cross Blue Shield of Tennessee², the actual annual privately insured cost in the state was \$15,902, 537.

Dependent children, Tenn. Code Ann. §§ 56-7-2302 and 56-7-2347

Requires coverage through the age of 24 of dependent children who are unmarried and dependent on the insured for support and maintenance. Law also requires coverage not to terminate for a dependent child who is incapable of self-sustaining employment by reason of intellectual or developmental disability. Coverage must also be provided to adopted children under the age of 18 at the time of placement with no denial. Requires policies to provide benefits for minor children who are by court order in the custody of a guardian under any policy or plan issued to or on behalf of the guardian. Requires coverage for non-charitable hospitalization claims.

Louisiana reported total costs in 2008³ to be less than one percent of premiums for dependent coverage. That same year, Maryland⁴ reported dependent coverage mandates were less than one percent of health insurance premiums. According to the 2008 and 2010 CAHI reports the estimated cost to health insurance for the dependent children mandate in Tennessee is less than one percent of total costs which is similar to most states. CAHI also reports that costs for foster children and adopted children are also less than one percent, respectively.

The federal Affordable Care Act of 2010 requires continuation of coverage through age 26 for dependents. This mandate went into effect in 2010, but there is not currently data on the actual fiscal impact of the extension.

Mandated Benefits analysis of company data and experience which provides cost-range estimates for a mandate being added to a policy that did not include the coverage.

² Blue Cross Blue Shield of Tennessee (BCBST) published the “Effects of Government Mandated Benefits on Health Care Costs” in September 2004 which was a white paper detail on higher health care costs from well-intentioned laws.

³ The Louisiana Department of Insurance, Office of Health Insurance, published “Mandated Healthcare Benefits Study, 2005 – 2007,” to provide an analysis of the impact of statutorily mandated health benefits on premium costs in Louisiana and to compare the mandates to other states. The study included three years of claims data from insurance providers.

⁴ The Maryland Health Care Commission (MHCC) is required to conduct an evaluation of existing mandated services every four years. Since 1999, the MHCC has contracted with Mercer to perform the annual analysis of current mandates.

Continuation of terminated group coverage, Tenn. Code Ann. §56-7-2312

Authorizes the continuance of coverage under a group policy that has been terminated for any reason, except discontinuance of the group policy in its entirety, for the remainder of the month in which the policy was terminated and three additional policy months if the enrollee was covered for a full three months prior to the termination. Continuation of coverage is dependent on the payment in advance to the employer of the full group premium, including any portion of the premium usually paid by the person's former employer on or before the beginning of each month's coverage.

Any increase in costs to claims and premiums associated with this benefit appears to be minimal. Since there is no change in coverage and the cost of the premiums during the extension shift to the enrollee from the employer, any increase in premiums will be borne by the enrollee. There was not a significant increase in the cost of claims. According to the BCBST 2004 report, the annual privately insured cost in Tennessee as a result of the Congressional Omnibus Budget Reconciliation Act (COBRA) of 1985 (26 CFR Part 54) was \$8,136,182 due in part to the increased usage of coverage. If the mandated extension of coverage results in increased usage by the enrollee, there will be increase claims costs that can shift to the group plan as a whole. According to the CAHI 2010 report, the continuation of employee coverage accounts for less than one percent of health insurance costs. Reports in Louisiana (2008) and Maryland (2008) indicated a one percent increase in the cost of health insurance premiums.

Converted policies, Tenn. Code Ann. §§ 56-7-2313 through 2322

Group health plan contracts are required to include conversion privileges in certain instances when people are leaving group health plans sold by an insurance company. When group coverage ends (if a person leaves a job, gets divorced from an insured worker, or if the employer stops offering health benefits), the person has the right to buy a non-group health insurance policy from the former group insurer.

Forty-one states total have some type of requirement regarding the conversion of policies to non-group policies. According to the 2008 and 2010 CAHI reports on mandated coverage, the average estimated costs for these conversion requirements range from one to three percent. It is estimated that costs in Tennessee for these benefits averages two percent of the total cost.

Texas has similar conversion requirements as Tennessee. A report on the cost of mandated health insurance in Texas (2000)⁵ indicated an increase in health insurance costs of

⁵ The 2000 "Cost Impact Study of Mandated Benefits in Texas, Reports #1 and #2" were the summary of a study performed by Milliman and Robertson, Inc. to evaluate the impact of premium rates and assist the Texas

three percent for increased usage of insurance benefits during the conversion period. Similar to the continuation of terminated group health coverage, if the mandated conversion of coverage results in increased usage by the enrollee, there will be claims costs that shift to between the group plan and the individual plan that will impact the premiums of all enrollees.

Eligibility for Medicaid, Tenn. Code Ann. §56-7-2348

Prohibits insurance providers from considering the availability or eligibility for coverage or calculating payments under their plans for eligible enrollees, subscribers, policyholders, or certificate holders based on one's eligibility status for Medicaid.

Of the studies that were researched for this report, substantial data was not found to determine a specific cost estimate for this mandate. If the enrollee population of a plan is substantially changed, then the co-payments and total health costs of the insurance plan and enrollees will increase. Based on other benefit mandates regarding required coverage of certain individuals included in the CAHI 2008 and 2010 reports, it is assumed that costs would increase by one percent, or less.

Patients' right to truth, Tenn. Code Ann. §56-7-2349

Prohibits any health insurer from restricting medical personnel in any way from informing patients of alternative medical care, treatments, programs, or pharmaceuticals that may be available to the enrollee or participant, regardless of whether covered by the plan or not.

Of the studies that were researched for this report, substantial data was not found to determine a specific cost estimate for this mandate. If the enrollee services provided by a plan are substantially changed where the average service costs are increase, then the co-payments and total health costs of the insurance plan and enrollees will increase. Based on other benefit mandates which increased available treatments included in the CAHI 2008 and 2010 reports, it is assumed that costs would increase by one to three percent.

Maternity benefits, Tenn. Code Ann. §56-7-2350

Minimum standards of coverage for maternity benefits offered by insurers as determined by permanent rules promulgated by the Departments of Finance and Administration and

Department of Insurance and the Joint Interim Committee on Health Benefit Mandates in its study of mandated benefits.

Commerce and Insurance. These rules include minimum stays and services. The state rules are in compliance with federal requirements pursuant to the federal Newborns' and Mother's Health Protection Act of 1996 which includes coverage for a minimum specified amount of time for the patient to remain in the hospital following the delivery of a baby (one to two days for vaginal delivery and three to four days for cesarean delivery).

Louisiana reported \$93.6 million in total costs in 2008, or 1.30 percent of premiums. That same year, Maryland reported hospitalization and minimum stay mandates for childbirth were less than one percent of health insurance premiums. That is consistent with the 2000 report from Texas indicating maternity benefits costing 0.2 to 0.3 percent of plan premiums. According to a 2008 report on the estimated annual spending on mandated benefits in Massachusetts for 2004 through 2005⁶, the total per maternity stay, including minimum maternity stay, was \$402,071 or 3.73 percent of the premiums.

The 2004 BCBST reported annual privately insured cost in Tennessee for the length of stay mandate to be \$18,121,496 and the mandate requiring pregnancy being recognized as an illness to cost \$258,878,508. According to the 2008 and 2010 CAHI reports the estimated cost to health insurance for the minimum stay mandate is less than one percent of total costs which is similar to most states.

Coverage for off-label uses of approved drugs, Tenn. Code Ann. §56-7-2352

Requires insurers to provide coverage to the same extent as any other drug coverage for off-label drug use as long as it has not been banned by the Federal Drug Administration (FDA) and is deemed medically necessary.

Louisiana reported \$78.5 million in total costs in 2008, or 1.09 percent of premiums. That same year, Maryland reported the cost of off-label use of drugs ranged from less than one percent of health insurance premiums to less than two percent. This is similar to the cost in Tennessee as reported by CAHI in 2010. CAHI estimates that costs in Tennessee are less than one percent of total health insurance costs which is average compared to the 35 other states that have a similar mandate.

⁶ In 2008, Compass Health Analytics, Inc. conducted the study "State-Mandated Health Insurance Benefits and Health Insurance Costs in Massachusetts" for the Division of Health Care Finance and Policy which estimated the costs and efficacy of services covered by existing benefit mandate laws in Massachusetts as of 2006. This study was used to publish the "Comprehensive Review of Mandated Benefits in Massachusetts" as required by the Massachusetts Health Reform legislation (Chapter 58 of 2006).

Coverage of dental procedures performed on minors in hospitals, Tenn. Code Ann. §56-7-2353

Requires insurers to provide coverage for any inpatient or outpatient hospital expenses for dental procedures on children eight years of age or younger including anesthesia.

Louisiana reported \$1.2 million in total costs in 2008, or 0.02 percent of premiums. That same year, Maryland reported the cost of anesthesia for dental patients in hospital settings was less than one percent of health insurance premiums. This is similar to the cost in Tennessee as reported by CAHI in 2010. CAHI estimates that costs in Tennessee are less than one percent of total health insurance costs which is average compared to the 30 other states that have a similar mandate.

Early detection of prostate cancer, Tenn. Code Ann. §56-7-2354

Requires insurance companies to provide coverage for testing for prostate cancer in men over 50 years of age and under 50 years of age if the tests are medically necessary and recommended by a physician.

Louisiana reported \$5.4 million in total costs in 2008, or 0.08 percent of premiums. That same year, Maryland reported that approximately 95 percent of claims were covered without the mandate resulting in a cost of less than one percent of health insurance premiums. That is consistent with the 2000 report from Texas indicating benefits costing 0.1 percent of plan premiums.

The 2004 BCBST reported annual privately insured cost in Tennessee for prostate screenings were \$23,299,066. According to the 2008 and 2010 CAHI reports the estimated cost to health insurance for the evaluation of the growth of malignant prostate glandular cells is less than one percent of total costs which is similar to 35 other states.

Coverage of emergency services, Tenn. Code Ann. §56-7-2355

Requires insurance companies to provide coverage for emergency medical treatment where an enrollee (prudent layperson) believes a serious impairment or dysfunction might occur if such treatment is not received. Coverage is subject to applicable copayments, coinsurance, and deductibles which are not necessarily the same as other treatment. This mandate was also required pursuant to the federal Emergency Medical Treatment and Active Labor Act of 1986.

The 2004 BCBST reported annual privately insured cost in Tennessee for emergency ambulance and prudent layperson mandates were \$141,643,527. According to the 2010 CAHI report the estimated cost to health insurance for emergency room services in less than one percent of total costs which is similar to 45 other states.

Coverage for mental health services, Tenn. Code Ann. § 56-7-2601

Requires insurance companies to provide coverage for mental health benefits at the same level as health benefits if the application of the mandate to a group health plan does not result in an increase in the cost under the plan of more than one percent. The mandate does not apply to group health plans issued to small employers with two to twenty-five employees. Requires the offering of coverage for alcohol and drug abuse when treatment is rendered in a community mental health center up to 30 visits. The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that provides participants who already have benefits under mental health and substance use disorder (MH/SUD) coverage parity with benefits limitations under their medical/surgical coverage.

Louisiana reported \$98.5 million in total costs in 2008, or 1.37 percent of premiums for severe mental illness. That same year, Maryland reported costs ranging from 0.4 to 0.8 percent of health insurance premiums for mental illness coverage including alcohol and drug abuse. That is consistent with the 2000 report from Texas indicating benefits costing 1.6 percent of plan premiums for severe mental illness and 0.4 percent for chemical dependency. According to a 2008 report on the estimated annual spending on mandated benefits in Massachusetts for 2004 through 2005, the average total per mental health unit, including all alcohol and drug abuse treatment and severe mental illness treatment, was \$238,576 or 2.21 percent of the premiums.

The 2004 BCBST reported annual privately insured cost in Tennessee for mental health parity mandates changing coverage limits to service rather than dollars were \$9,245,661. According to the 2010 CAHI report the estimated cost to health insurance for general mental health services to be one to two percent of total costs and five to ten percent of costs associated with mental health parity.

Early detection of colorectal cancer, Tenn. Code Ann. §56-7-2363

Requires health insurers to provide coverage for colorectal cancer examinations and laboratory test. Prohibits any annual deductible and coinsurance for this benefit from being greater than those established for all other similar benefits within the policy or contract of insurance.

Louisiana reported \$25.3 million in total costs in 2008, or 0.35 percent of premiums for colorectal tests. That same year, Maryland reported that approximately 87 percent of claims were covered without the mandate resulting in a cost of less than one percent of health insurance premiums. According to the 2008 and 2010 CAHI reports, the estimated cost to health insurance in Tennessee for evaluation of the colon, rectum, appendix, and anus to be less than one percent of total costs.

Medication counseling, Tenn. Code Ann. §56-7-2364

Requires insurance providers to offer medication counseling sessions by a pharmacist to enrollees who are prescribed and use six or more types of medication.

Of the studies that were researched for this report, substantial data was not found to determine a specific cost estimate for this mandate. If plan enrollees choose to participate in the counseling sessions, then the co-payments and total health costs of the insurance plan and enrollees will increase. Based on other benefit mandates that provide additional services, it is assumed that costs would increase by one to three percent, or less.

Health insurance coverage related to clinical trials, Tenn. Code Ann §56-7-2365

Requires health benefit plans to provide coverage for all routine patient care costs related to a clinical trial to enrollees diagnosed with cancer who are accepted into a clinical trial that a patient's doctor has determined could have a meaningful potential benefit to the enrollee.

Louisiana reported \$1.1 million in total costs in 2008, or 0.04 percent of premiums for clinical trial coverage. That same year, Maryland reported that approximately 76 percent of claims were covered under some conditions without the mandate resulting in a cost of between 0.1 and 0.3 percent of health insurance premiums. According to a 2008 report on the estimated annual spending on mandated benefits in Massachusetts for 2004 through 2005, the average total cost was \$2.9 million or 0.03 percent of the total premiums.

According to the 2010 CAHI report, the estimated cost to health insurance in Tennessee for clinical trials regarding cancer treatment to be less than one percent of total costs which is the average for 28 other states with some type of clinical trial coverage mandate.

Autism spectrum disorders, Tenn. Code Ann. §56-7-2367

Requires health insurance policies that cover neurological disorders to provide equal benefits and coverage for autism spectrum disorders in anyone under the age of 12.

According to a 2008 study⁷, costs in Virginia for autism spectrum disorders range from \$780 to \$74,880 depending on the type of treatment and the frequency in which the treatment is provided. The report included the results of a survey of Virginia health insurance companies which indicated the median monthly premium estimate for providing the coverage as a standard benefit would be \$4.88, with estimates ranging from \$0.14 to \$6.67, and for providing the

⁷ The Joint Legislative Audit and Review Commission of the Virginia General Assembly published an "Evaluation of House Bill 83: Mandated Coverage of Autism Spectrum Disorders" in September of 2008 which included costs for speech therapy, physical and occupational therapy, sensory integration, activities of daily living therapies, manual therapy, applied behavior analysis based therapy, and other therapies including aquatics, exercise, or dance.

coverage as an option would be \$18.67, with estimates ranging from \$13.33 to \$23.00. The coverage is estimated to result in an increase in premiums of two percent⁸.

The estimate of two percent is consistent with the estimate provided by the 2010 CAHI report which indicates that of the 25 states mandating evaluation and treatment services, the costs range from one to three percent of total costs. Tennessee is estimated to fit within that range with an average increase of approximately two percent.

Mammogram, Tenn. Code Ann. §56-7-2502

Requires health insurance coverage for mammography screening and evaluation when recommended by a physician. Also required by the federal Screening Mammography Act of 1999.

Maryland reported that approximately 96 percent of claims were covered under some conditions without the mandate resulting in a cost of 0.1 percent of health insurance premiums. That is consistent with the 2000 report from Texas indicating benefits costing 0.5 percent of plan premiums for mammograms. According to a 2008 report on the estimated annual spending on mandated benefits in Massachusetts for 2004 through 2005, the average total cost was \$41.3 million or 0.038 percent of the total premiums.

The 2004 BCBST reported annual privately insured cost in Tennessee for annual screening coverage was \$30,695,595. According to the 2010 CAHI report, the estimated cost to health insurance for screenings is less than one percent of the total in Tennessee.

Reconstructive breast surgery, Tenn. Code Ann. §56-7-2507

Requires health insurers to provide for reconstructive breast surgery within 5 years of a mastectomy for both the diseased and healthy breast. There is no requirement that the initial surgery be covered by the current insurer. Insurers that provide coverage for mastectomies must allow a patient to remain in the hospital for a minimum specified amount of time under the federal Women's Health and Cancer Rights Act of 1998.

Louisiana reported \$11.1 million in total costs in 2008, or 0.15 percent of premiums for reconstructive breast surgery. That same year, Maryland reported that approximately 98 percent of claims were covered under some conditions without the mandate resulting in a cost of 0.1 percent or less of health insurance premiums. That is consistent with the 2000 report from Texas

⁸ The survey only had responses from nine companies. There were two companies that responded that to offer the coverage as an option would increase monthly premiums by over \$600. These companies were considered outliers and were not included in the Virginia estimate.

indicating benefits costing 0.1 percent of plan premiums for reconstructive breast surgery for mastectomy.

The 2004 BCBST reported annual privately insured cost in Tennessee for breast reconstruction for mastectomy was \$2,958,612. According to the 2008 and 2010 CAHI reports, the estimated cost to health insurance for mastectomy coverage was less than one percent and the minimum stay requirement also accounted for less than one percent of total costs.

Bone density testing, Tenn. Code Ann. §56-7-2506

Requires an offering of coverage for bone density testing if recommended by a physician for diagnosis and treatment of osteoporosis.

Louisiana reported \$3.7 million in total costs in 2008, or 0.08 percent of premiums for osteoporosis coverage. That same year, Maryland reported that approximately 80 percent of claims were covered under some conditions without the mandate resulting in a cost of less than one percent of health insurance premiums.

The 2004 BCBST reported annual privately insured cost in Tennessee for coverage of bone mass measurement and other services related to osteoporosis was \$13,683,578. According to the 2010 CAHI report, the estimated cost to health insurance for bone mass measurements was less than one percent of total costs in Tennessee.

Phenylketonuria (PKU), Tenn. Code Ann. §56-7-2505

Requires health insurers to provide coverage for the medical and nutritional treatment of PKU.

According to the 2010 CAHI report, the PKU mandates provide for evaluation, education, treatment, and supplies like formula or special foods. There are 16 other states that provide this mandate and the average estimated increase is less than one percent of total cost. Tennessee is estimated to fall within the average of less than one percent. None of the state reports that we found included estimated costs for this mandate.

Small Business Impact

According to the United States Small Business Association (SBA), there are approximately 128,000 establishments statewide with fewer than 50 employees⁹. Of those establishments, approximately 75,000 have fewer than 5 employees, 24,800 establishments have between 5 and 9 employees, 16,900 have between 10 and 19 employees, and 11,300 have between 20 and 49 employees. According to the Bureau of Labor Statistics, approximately 74 percent of private workers in the states of Alabama, Kentucky, Mississippi, and Tennessee have access to health benefits. It is assumed that approximately 94,700 small businesses statewide provide some type of health benefits for their employees.

According to a 2010 report by the Kaiser Family Foundation¹⁰, firms that have a greater number of employees are more likely to offer health benefits. Fifty-nine percent of firms with three to nine employees offered benefits where 92 percent of firms with 25 to 49 employees responded to offering benefits. Premium costs vary depending on types of plans offered and the employers contribution to annual premiums. The following charts provide the cost of the premiums and the breakdown between employer and worker contributions in 2010.

Breakdown of the average annual firm and worker premium contributions and total premiums for covered workers for single and family coverage by plan type:

Type of Plan	Coverage	Employer Contribution	Worker Contribution	Total
HMO	Single	\$4,102	\$1,028	\$5,130
	Family	\$9,768	\$4,357	\$14,125
PPO	Single	\$4,219	\$905	\$5,124
	Family	\$10,210	\$3,823	\$14,033
POS	Single	\$4,265	\$974	\$5,239
	Family	\$8,018	\$5,195	\$13,213
All Plans	Single	\$4,150	\$899	\$5,049
	Family	\$9,773	\$3,997	\$13,770 ¹¹

⁹ A 2010 news release from the United States Bureau of Labor Statistics and information provided by the Tennessee Chapter of the National Federation of Labor Statistics.

¹⁰ The Kaiser Family Foundation and the Health Research and Education Trust published a 2010 Employer Health Benefits Survey of nonfederal private and public employers with three or more workers.

Small Business and the Economy, 2010, the U.S. Small Business Association.

¹¹ Kaiser/HRET Survey of Employer Sponsored Benefits, 2010.

Breakdown of the average percentage of premium paid for single and family coverage by plan type in the southern region:

Type of Plan	Coverage	Employer Contribution	Worker Contribution	Total
HMO	Single	80%	20%	100%
	Family	69%	31%	100%
PPO	Single	81%	19%	100%
	Family	67%	33%	100%
POS	Single	86%	14%	100%
	Family	58%	42%	100%
All Plans	Single	82%	18%	100%
	Family	66%	34%	100%

Based on the estimated impact of health insurance mandates on the total cost of health insurance, it can be estimated that each health benefit mandate will result in an increase to insurance premiums ranging from less than one percent to approximately five percent depending on the coverage. The following chart provides a breakdown of the increase in premiums, ranging from one to five percent, per plan type.

Type of Plan	Coverage	Total	One Percent Increase	Three Percent Increase	Five Percent Increase
HMO	Single	\$5,130	\$5,181	\$5,284	\$5,387
	Family	\$14,125	\$14,266	\$14,549	\$14,831
PPO	Single	\$5,124	\$5,175	\$5,278	\$5,380
	Family	\$14,033	\$14,173	\$14,454	\$14,735
POS	Single	\$5,239	\$5,291	\$5,396	\$5,501
	Family	\$13,213	\$13,345	\$13,609	\$13,874
All Plans	Single	\$5,049	\$5,099	\$5,200	\$5,301
	Family	\$13,770	\$13,908	\$14,183	\$14,459

While a single health benefit mandate may only increase premium rates between \$50 and \$700 dollars annually per employee depending on the plan type and coverage, the accumulation of multiple health benefit mandates can result in a significant increase in the cost of health insurance benefits for small business employers and employees. Even at the lowest annual increase of \$50, 20 mandates will result in an increase in premium costs of at least \$1,000 annually.

Limitations to the Report

The report is based on studies that were performed in other states with similar health mandates or by national agencies that did not provide detailed information as it pertains to mandates in Tennessee. To provide a detailed cost impact and analysis to Tennessee, the collection and analysis of insurance claims data, including hospital, provider, and procedure claims, individual insurance plan data, enrollee data, and rate data would need to be performed over a span of 20 years. The Fiscal Review Committee staff does not have the expertise or knowledge to accurately perform that type of analysis. An independent actuarial service would be better able to provide that type of analysis. Based on similar studies, estimates for an independent contractor to provide that type of actuarial study and report range from \$150,000 to \$300,000 for a first year study depending on the level of detail that is required.

Resources

Albee, Susan K., Esther Blount, Tim D. Lee, Mark Litow, and Mike Sturm. *Cost Impact Study of Mandated Benefits in Texas, Report # 1* (Revised August, 2000).

http://www.tdi.state.tx.us/reports/documents/benefits1_00.pdf.

Albee, Susan K., Esther Blount, Mulloy G. Hanson, Tim D. Lee, Mark Litow, and Mike Sturm. *Cost Impact Study of Mandated Benefits in Texas, Report # 2* (September, 2000).

http://www.tdi.state.tx.us/reports/documents/benefits2_00.pdf.

America's Health Insurance Plans, <http://www.ahip.org>.

Bachman, Sara S., Jim Highland, Kate Nordahl, Maria Schiff, and Han Huang, *Comprehensive Review of Mandated Benefits in Massachusetts, Report to the Legislature*. (July, 2008).

http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits.pdf.

Blue Cross Blue Shield of Tennessee, *Effects of Government Mandated Benefits on Health Care Costs, A White Paper Detail on Higher Health Care Costs from Well-Intentioned Laws*. September, 2004). www.bcbst.com.

Cauchi, Richard, *Memo on: State Insurance Mandates and the ACA Essential Benefits Provisions*. (Updated May 4, 2011).

<http://www.ncsl.org/IssuesResearch/Health/CostContainment23/tabid/19948/Default.aspx?TabId=19948>.

Compass Health Analytics, Inc., *State-Mandated Health Insurance Benefits and Health Insurance Costs in Massachusetts*. (July, 2008).

http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits_compass_report.pdf.

Congressional Budget Office (CBO), <http://www.cbo.gov>.

Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2008*.

http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2008.pdf.

Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2010*.

http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf.

Cubanski, Juliette, and Helen H. Schauffier, *California Health Policy Roundtable Issue Brief, Mandated Health Insurance Benefits: Tradeoffs Among Benefits, Coverage, and Costs?* (July, 2002).

<http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13995>.

Kaiser Family Foundation, <http://www.kff.org>.

Kaiser Family Foundation and Health Research and Educational Trust Fund, *Employer Health Benefits, 2010 Annual Survey*. (September, 2010). <http://ehbs.kff.org>.

Louisiana Department of Insurance, Office of Health Insurance, *Mandated Healthcare Benefits Study 2005-2007*. (2008). <http://www.lda.la.gov/Health>.

Maryland Health Care Commission, *Annual Mandated Health Insurance Services Evaluation*. (January, 2011).
http://mhcc.maryland.gov/health_insurance/annualmandaterpt2010_20110201.pdf.

Maryland Health Care Commission, *Study of Mandated Health Insurance Services: A Comparative Evaluation*. (January, 2008).
http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf.

National Conference of State Legislatures (NCSL), <http://www.ncsl.org>.

National Federation of Small Business: Tennessee, <http://www.nfib.com/tennessee>.

Tennessee Code Annotated, Title 56, Chapter 7, Parts 23 and 25. (LexisNexis, 2010).

Virginia General Assembly, Joint Legislative Audit and Review Commission, *Evaluation of House Bill 83: Mandated Coverage of Autism Spectrum Disorders* (September, 2008).

United States Bureau of Labor Statistics, *Employee Benefits in the United States News Release*. (July, 2010). <http://www.bls.gov/ebs>.

United States Small Business Administration, Office of Advocacy, *Small Business Profile: Tennessee*. (February, 2011). <http://sba.gov/advo>.

United States Small Business Administration, Office of Advocacy, *The Small Business Economy, A Report to the President*. United States Government Printing Office. (Washington, 2010).
http://www.sba.gov/sites/default/files/sb_econ2010.pdf.