REPORT OF THE
STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE ON

The Financial And Social Impact Of Mandated Benefits And Mandated Providers

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 15

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

December 21, 1989

TO: The Honorable Gerald L. Baliles
Governor of Virginia
and
The General Assembly of Virginia

I am pleased to transmit this Report of the State Corporation Commission's Bureau of Insurance on the Financial and Social Impact of Mandated Benefits and Mandated Providers.

The study was initiated and the report prepared pursuant to Senate Joint Resolution No. 215 of the 1989 Session of the General Assembly of Virginia.

Respectfully submitt

Steven T. Foster
Commissioner of Insurance

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I. EXECUTIVE SUMMARY

Senate Joint Resolution 215 directed the State Corporation Commission's (SCC) Bureau of Insurance, with the assistance of the Department of Health, to study the social and financial impact of mandated benefits and mandated providers. The study request was made as a result of the work of the joint subcommittee studying health care for all Virginians. The joint subcommittee began its work in 1988 and was continued through 1990. The joint subcommittee is interested in making health insurance more affordable for working Virginians and their families.

The joint subcommittee was concerned that the cost of mandated benefits may significantly increase the cost of health insurance, thereby causing more individuals to be without insurance. There was also concern that the existence and cost of mandates result in more employers becoming self-insured for health care. Self-insureds are exempt from Virginia's insurance laws, including mandated benefits, because of federal legislation.

In its effort to determine the nature and magnitude of the financial and social impact of mandated benefits, the Bureau of Insurance first reviewed available existing data. In order to obtain Virginia specific data, a survey was designed and forwarded to the top 100 insurers writing accident and sickness (health) insurance in the Commonwealth.

The results of the initial insurer survey were disappointing. Only 31 of the insurers returned the survey by the original due date, which was extended. None of the 31 returned surveys answered all of the questions. The Bureau of Insurance requested that the joint subcommittee grant an extension of the study deadline beyond the original due date, September 1, 1989, because of the limited and questionable data received from the surveys.

Another reason for the requested extension was that Blue Cross and Blue Shield of Virginia notified the Bureau of Insurance in late August that it had retained the firm of KPMG Peat Marwick to conduct an internal study to determine the cost of mandated benefits and providers. This study's results would be based upon actual claim data instead of the "circle of experts" approach utilized by Blue Cross and Blue Shield of Virginia in its response to the Bureau's initial survey. Given the inadequate response to the initial study, we felt that such results, from the largest writer of health coverage in Virginia, were worth the delay. Results of the KPMG Peat Marwick study were not provided to the Bureau of Insurance until October 27, 1989, supplemented by additional data provided in mid-November.

During the interim period, the survey instrument was revised and supplemented with additional information. The revised survey was mailed to 53 companies to give them the benefit of the extended deadline and more assistance in providing information. The results of the second survey were also disappointing, but provided at least some viable data upon which conclusions could be based.

Contrary to the impression insurers had previously given in appearances before the General Assembly, most insurers indicated that they do not price each mandate separately and do not know the premium cost associated with each mandate. The most reliable information that eventually was provided was generated after internal study or computer analysis that had not previously been conducted.

While it is difficult to reach firm conclusions on the financial impact of mandated benefits based on the companies' responses, it appears that the cost of Virginia's mandates for providers and benefits account for approximately 10% of the policy premium for individual coverage and almost 20% for group coverage. These figures should be viewed as a maximum attributable to mandates; no reduction in cost has been made because of the substitution of services that would have been provided in the absence of the mandates.

Virginia is not a heavy mandate state in terms of the number of mandates, in fact, many of the mandates required in Virginia were covered by the majority of insurers responding to our survey prior to the Virginia requirement. The cost of mandates that would not be included in a policy in the absence of mandates is approximately 10% of policy premium.

No irrefutable evidence was presented that confirms the belief that employers self-insure solely to avoid mandates. Other reasons for self-insuring include cash flow considerations, investment opportunities, and administrative costs.

The social impact of mandated benefits can generally be characterized as having four major effects. Mandates increase access to care, provide consumer protection, interfere with freedom of choice, and affect societal welfare.

The Bureau of Insurance and the Department of Health held a public meeting to obtain information from all interested parties on the subject of mandated benefits. A number of the speakers' comments focused on the increased access to care that results from mandated benefits and providers. Proponents of the mandates also addressed the problems, social and financial, of untreated mental and physical illnesses. A summary of the comments made at the meeting is contained in Section VII of this report.

The Bureau of Insurance believes that if the legislature desires more information about the costs of mandates, insurers should be required to collect and report, on a regular basis, information of the type requested on the insurer survey. A formal, independent evaluation procedure should also be put in place to separately evaluate the impact of each proposed mandate prior to passage and possibly to reevaluate present mandates.

There are advantages and disadvantages to mandated benefits and providers. Before any existing mandate is repealed, or before any new mandate is added, convincing data should be presented to verify that the particular mandate makes health insurance unaffordable.

An alternative is to allow the sale of a policy without the inclusion or offer of mandated benefits or specific reimbursement requirements. This type of policy should be clearly and distinctively labeled, and there should be full disclosure of its coverage and limitations. The applicant for coverage should also be given the option of purchasing coverage that includes or offers all mandates. Applicants could be required to note their choice in writing with the information retained in the insurer's files. Reporting requirements should also be included to allow the SCC or the General Assembly to monitor the effect of the sale of this type of policy.

SENATE JOINT RESOLUTION NO. 215

Requesting the Bureau of Insurance of the State Corporation Commission, with the assistance of the Department of Health, to study mandated benefits and providers, and recommending a one-year moratorium on the adoption of any additional mandate health insurance benefits and providers.

Agreed to by the Senate, February 23, 1989
Agreed to by the House of Delegates, February 21, 1989

WHEREAS, the joint subcommittee on Health Care For All Virginians was created by Senate Joint Resolution No. 99 and House Joint Resolution No. 78 of the 1988 General Assembly; and

WHEREAS, the joint subcommittee has requested that it be extended for further study of several issues, including the disturbing fact that 880,000 Virginians, more than two-thirds of whom live in households in which at least one family member is currently employed, are not covered by any health insurance of any kind, either public or private; and

WHEREAS, the joint subcommittee has determined that further study is needed to address this situation through determination of appropriate steps to make private health insurance more affordable for working Virginians; and

WHEREAS, the joint subcommittee recognizes that a growing number of mandated health insurance benefits and health care providers are required under Title 38.2, Chapters 34 and 42, of the Code of Virginia, to be included in both commercial and Blue Cross/Blue Shield health insurance plans; and

WHEREAS, the joint subcommittee is concerned that additions to such mandated benefits and providers may have the effect of significantly increasing the cost of health insurance to the consumer; and

WHEREAS, many large employers, including the Commonwealth of Virginia, have chosen in recent years to move towards self-insurance, and are therefore not governed by the mandates contained in state law, and as a result the additional costs imposed by such mandates may fall disproportionately on small businesses and their employees; and

WHEREAS, the joint subcommittee anticipates that legislation may be proposed during the 1989 General Assembly to mandate additional benefits and providers, which would further increase the cost of private health insurance for working Virginians; now, therefore be it

RESOLVED by the Senate, the House of Delegates concurring, That the Bureau of Insurance of the State Corporation Commission, with the assistance of the Department of Health, is requested to study the social and financial impact of all current and proposed mandated benefits and providers, including recommendations to make private health insurance more affordable for working Virginians. In addition, the Joint Subcommittee on Health Care for All Virginians recommends the adoption of a one-year moratorium on the approval of any additional mandated benefits and direct reimbursement to providers pending completion of the study by the Bureau of Insurance.

The Bureau of Insurance shall complete its work in time to submit its findings and recommendations to the Governor and the General Assembly by September 1, 1989, as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

A True Copy, Teste:

J. T. Shropshire

Clerk of the Senate

III. INTRODUCTION

The SCC's Bureau of Insurance was directed by Senate Joint Resolution 215 to study the financial and social impact of all current and proposed mandated benefits and mandated providers. The Department of Health was requested to provide assistance to the SCC. The study request was made as a result of the work of the joint subcommittee studying health care for all Virginians. That subcommittee began its work in 1988 and was continued for two additional years by the 1989 General Assembly. The joint subcommittee is working to find ways to provide increased health care services to Virginians who fall through the gaps in the present health care system. The joint subcommittee is particularly interested in improving the ability of the public to afford health insurance coverage.

Mandated benefits and mandated providers have been viewed by some as contributors to the increased cost of health insurance which has, in turn, resulted in more people being uninsured. Although this concept had been brought before the joint subcommittee, no specific information had been provided on the actual costs of Virginia mandates for consumers. The joint subcommittee believed that prior to the General Assembly undertaking any additional activity in the area of mandates, specific information about the effects of mandated benefits in Virginia should be obtained. The joint subcommittee included in Senate Joint Resolution 215 the request that there be a moratorium on new mandates until the completion of the SCC study.

Mandated Benefits in the United States

Legislative initiatives to mandate insurance coverage began in the late 1960's. The basic intent of this type of legislation is to require that benefits that have not previously been widely available be included in every policy because they are in the best interest of the public. The benefits may have been included at a "low level" or may be considered likely to be eliminated from coverage. Since insurance regulation historically has been the responsibility of the states, mandates are devised and enforced for insured plans by state insurance departments. Many large employer's health benefit plans, however, are self-funded and are not required to comply with state insurance laws. For example, one of Virginia's first mandates was coverage of newborn children. It gave assurance for those couples with existing insurance coverage that a newborn child would be covered for at least 31 days without requiring notification to be given to the insurer. The mandate also requires that coverage include treatment of medically diagnosed congenital defects and birth abnormalities. If notification and premium payment are required by the insurance policy for coverage, the family now has what amounts to a grace period to make the notification and pay the premium. This type of mandate is viewed as desirable because of the belief that many insurance purchasers are uninformed and therefore will not always make rational decisions, such as remembering to add a newborn child to an insurance policy.

Mandated benefits are generally viewed as being of three types:

- benefits that must be included in all accident and sickness (health) policies;
- benefits that must be "offered" to the insured;
- requirements that certain practitioners be reimbursed directly by insurers.

Over the years, legislative activity has shifted more to requiring the "offering" of coverage. This shift is a result of the belief that a mandated offer of coverage is less costly than a mandated requirement for coverage. It should be noted that an "offer of coverage" must be made to the policyholder and that in the case of a group, the policyholder may elect not to include an offered coverage that individual members of the group may have desired.

From the initial mandates in the 1960s, the mandates have grown to average approximately 14 per state. The majority of the benefits require coverage for specific providers, services, or benefits. The remaining mandates cover dependents, continuation of coverage, mandated evaluation, or catastrophic coverage. A summary of the benefits currently mandated is contained in Appendix A.

Mandated Benefits in Virginia

The requirement that the services of dentists be covered if such services were within the scope of their licenses was the first mandated benefit legislation enacted in Virginia (1968). By 1982, eight mandates were in place in Virginia, including a requirement for reimbursement for certain providers and four statutes mandating that specific benefits be "made available" to policyholders.

In 1979, the Bureau of Insurance obtained the services of an independent consultant to examine the effect of mandated benefits. The findings are contained in a report by John Larson, then with Virginia Commonwealth University, that has been used as a source of information in many of the studies of mandated benefits completed in the 1980s. The study focused on the cost impact of mandates, the quality of medical care, and the structure of the health care delivery system in Virginia. The study concluded that individual mandated benefit legislation had been disjointed and that additional problems were generated by a "piecemeal" approach. The study further concluded that the underlying problems in the health care system itself were not being addressed.

The Bureau's Larson study recommended that a moratorium be placed on the mandating of additional benefits and that there be a comprehensive evaluation of the adequacy of health coverage in Virginia. The study also recommended that legislative proposals for additional benefits or reimbursement for

services receive an "exhaustive examination according to uniform evaluation criteria". A sample review criteria was also recommended along with an alternative suggestion for a formal review mechanism operated by an advisory committee.

The General Assembly created the Virginia Commission to Study the Containment of Health Care Costs in 1978 to further examine health care issues in Virginia. After a four year study, the Cost Containment Commission suggested that all mandated insurance provisions be repealed. The recommendation for repeal was included in the final report, but dissenting opinions were made by two ex-officio members of the commission, the Commissioner of Insurance and the Commissioner of Mental Health and Mental Retardation, as well as four legislative members of the commission. As a result of the Cost Containment Commission's position, legislation was enacted in 1982 that requires that any coverage, benefits, or services mandated on or after July 1, 1982, be "offered" as options for any new or renewed group policies or contracts from that date forward (§38.2-3419.).

Another legislative study was conducted in 1982 for further objective analysis and study of the impact of mandated benefits. The 1982 study reconfirmed the conclusion that no additional mandates should be enacted. From 1982 through 1988, no new mandates were passed for benefits, although certain providers were added to §§38.2-3408. and 38.2-4221., requiring that insurers reimburse those practitioners directly.

In 1989, legislation was passed mandating the offering of coverage for a preventive service--mammography, to become effective January 1, 1990. In addition, clinical nurse specialists, speech pathologists, and audiologists were added to the direct reimbursement requirements of §§38.2-3408. and 38.2-4221. in 1989.

Virginia Mandated Benefits

Benefits Required to be Included in Policies

1. Reimbursement of covered services provided by the following:

   a. chiropractors
   b. optometrists
   c. professional counselors
   d. psychologists
   e. clinical social workers
   f. podiatrists
   g. physical therapists
   h. chiropodists
   i. clinical nurse specialists
   j. speech pathologists/audiologists
   k. opticians

2. Coverage for mentally retarded or physically handicapped children of the insured beyond normal termination of coverage date for dependents.

3. Coverage for services provided by a dentist if such services would be covered if performed by a physician.

4. Coverage for newborn children from the moment of birth for injury or sickness including care and treatment of medically diagnosed congenital defects and birth abnormalities.

5. Coverage for inpatient treatment for mental, emotional, and nervous disorders for at least 30 days per policy year.

6. Prohibition against including a provision in a group policy for coordinating benefits with respect to individually underwritten and individually issued accident and sickness policies for which the individual insured has paid the premium.

7. Provision allowing an individual whose eligibility terminates under the group policy to convert to an individual policy without evidence of insurability.

8. Coverage for pregnancy following an act of rape, provided certain reporting conditions are met.

Benefits Required to be Offered in Policies

1. Coverage for outpatient treatment of mental, emotional, and nervous disorders, at various levels of benefits.

2. Coverage for inpatient and outpatient treatment for alcohol and drug dependence for at least 45 days (inpatient) and 45 sessions (outpatient) per policy year or calendar year.

3. Coverage for obstetrical services.

4. Offer of at least one option for deductibles and coinsurance.

5. Coverage for mammograms (effective January 1, 1990).

Virginia Compared to Other States

No two states have the same mandates. In terms of numbers of mandates, Virginia is in the mid-range. Information provided by the 47 states that responded to a survey conducted by the Bureau of Insurance in 1988 revealed that:

- Inpatient treatment of mental, emotional, and nervous disorders, similar to Virginia's mandate is required in 17 (36%) of the states that responded (an additional 11 states require such coverage to be offered, only);

- Less than ½ of the states (49%) require coverage to be offered for the treatment of alcohol and drug dependence as specified in the Virginia insurance statutes (12 other states require the offer of coverage for alcohol treatment, but do not cover drug dependence);

- Less than ¼ (23%) of the states responding require that the services of a professional counselor be reimbursed (percentages of other provider reimbursement mandates include 40% for clinical social workers, 36% for physical therapists, and 38% for chiropodists);

- Almost all states (96%) require coverage for newborn children and 77% require coverage for handicapped children; and

- Sixty-four percent of the states responding to the survey have more mandated benefits than those required in Virginia.

IV. EXISTING INFORMATION ON THE FINANCIAL IMPACT OF MANDATED BENEFITS AND PROVIDERS

Existing Studies on Premium Cost Attributable to Mandates

A number of studies have been done to determine the cost of mandated benefits in recent years as concern about the rising costs of health insurance has increased. The studies that are most often referenced or most relevant to Virginia's study are highlighted here. These studies provide some insight into the financial impact of mandates although no single study has been accepted as definitive in this area.

The 1979 study done for the Bureau of Insurance by consultant John Larson did not include Virginia cost data, but did include information furnished by one Blue Cross and Blue Shield plan. The cost figures provided were dollar amounts added to a monthly premium, and range from $1.60 per month for a policy to include nervous, mental, and alcohol and drug coverage down to $0.01 per month to add optometrists as covered providers.

The 1985 actuarial study done by the Health Insurance Association of America (HIAA) estimated that in the State of Maryland mandates contributed 12% to the premium cost for an individual and 17% to a family group health premium. The November 1985 study done on Maryland mandates for Blue Cross and Blue Shield of the National Capital Area by the Center for Health Policy Studies indicated that "must include" mandates in Maryland constitute 11.2% of the total benefit costs for a typical family contract. The Center for Health Policy Studies also estimated the first year cost, in terms of insurance company expense, of implementing a mandated benefit to be $108,000. These two studies are among those most often cited in discussions of the cost of mandated benefits.

Blue Cross and Blue Shield of Maryland commissioned a study of its incurred claims in 1985 and 1986 for benefits that are required to be included in health insurance policies. The study found that mandated benefits accounted for 21% of all incurred costs. The results of this study were released in February, 1988.

Wisconsin released a report on the first phase of its study of mandated benefits in May, 1989. The Wisconsin study concluded that the mandates they reviewed (coverage for alcoholism, treatment for diabetes, home care, skilled nursing care, kidney disease treatment, and chiropractic services) account for less than 10% of the total medical benefits paid by insurers. Wisconsin also concluded that many of the self-funded plans administered by insurers contain as many of the mandated benefits as insured plans.

The Wisconsin study and the Blue Cross and Blue Shield of Maryland study attempted to determine the costs of mandates based on claims costs. This approach has been criticized because it does not acknowledge the effects of

mandates on other health services that may or may not be covered. The other approach most often used is an actuarial determination of the costs of mandates.

The 1989 study of mandated benefits done by Gabel and Jensen for HIAA used the Hedonic Price Method and determined, in part, chemical dependency treatment coverage increased premiums by 8.8%, psychiatric stay coverage increased premiums by 11.8%, and routine dental services increased premiums by 15%. Home health care was found to reduce premiums by 3.5%.

A 1988 study by the Iowa Insurance Coverage Committee reached a number of conclusions:

- There should be an impartial process to evaluate proposals for mandates, scope of practice, and licensure.
- Measuring the cost of mandates is difficult because insurers may not record claims and expenses according to mandated benefits categories, and procedure descriptions and coding of diagnosis may be inconsistent.
- The Legislative Extended Assistance Group 1988 Study concluded that there are market mechanisms through group plans that already provide a number of benefits that are the subject of potential mandates.
- Mandates add to the cost of the insurance premiums, limit insurer flexibility, deny buyers freedom of choice, and encourage self-insurance.

Evaluation Procedures

Several states have adopted an evaluation procedure of the type recommended by Larson in the 1979 SCC study and by the Iowa Insurance Coverage Committee in 1988. States have initiated these procedures as a way of addressing the difficulty of determining the actual costs of mandated benefits and providers as well as the difficulty of determining whether a mandate is in the best interest of the public.

One evaluation procedure of particular merit is that in use in Pennsylvania. The Commonwealth of Pennsylvania began its evaluation process for mandates in 1987. The Pennsylvania Health Care Cost Containment Act of 1986 created a Health Care Cost Containment Council, which is responsible for reviewing existing or proposed mandates of health insurance benefits when a review is requested by either legislative or executive bodies. The Council is to receive data from proponents and opponents of any legislation. The documentation is to include:

- the need for and current availability of the benefit;
- the public demand for and opposition to the benefit; and
- the financial impact of the benefit.

The documentation must be furnished by both proponents and opponents. Information is then reviewed by an expert panel. The panel must include one expert in economics, one expert in biostatistics, and one expert in health research. Two of the first mandates reviewed were coverage for mammography screenings and coverage for mental disorders. The expert panel believed that neither side made a convincing argument for either benefit. However, for mammography screening, the full Health Care Cost Containment Council recommended adoption in spite of the panel's comments. The Council concluded that the medical value and social benefit of this coverage outweighed any cost increases associated with the addition of the coverage.

The 12 states that have an evaluation process for mandates in addition to Pennsylvania are Arizona, Colorado, Florida, Georgia, Hawaii, Maine, Nebraska, Oregon, Rhode Island, Tennessee, Washington, and Wisconsin. The evaluation procedures focus on the cost of the mandates and the extent to which lack of a mandate results in people going without necessary care.

Other Financial Effects of Mandates

There are, of course, financial consequences in addition to the cost mandates add to an insurance policy. The financial impact of mandates may add to the number of employers who elect to reduce insurance coverage provided to employees by increasing deductible and copayment amounts, requesting lower policy maximums, or altering the benefit package in other ways. The employee is then personally responsible for a greater portion of his or her health care expenses.

Some employers may decide to self-insure their health care as a result of the combination of mandated benefits and other factors. Self-insured plans are not subject to state laws and regulations, including mandates. The social impact is that their employees will not necessarily have all mandated coverages because the federal 1974 Employees Retirement Income and Security Act (ERISA) pre-empts all state laws pertaining to employee benefit plans. The self-insured plans are also completely exempt from state financial requirements that safeguard the employees' interests by assuring that an insurer is able to pay claims when they are due. The employee is then at risk to a greater degree. Statistics on the number of companies that are presently self-insured indicate that as many as half of larger employers now choose to absorb health care costs themselves. A recent national survey by Johnson and Higgins estimated that 46% of the firms they surveyed (large employers) now self-insure. There is no irrefutable evidence that employers become self-insured solely to avoid mandates.

V. VIRGINIA INSURER SURVEY

Initial Survey

In an effort to obtain data specific to the costs of Virginia mandates, a survey was developed to obtain cost and claim data from insurers and health services plans. The survey was reviewed by a consulting actuary and revised to incorporate the consultant's suggestions. The survey was then reviewed by a large writer of health coverage in this Commonwealth and further revised. The decision was made to request responses to the survey from the top 100 writers of health insurance in Virginia, even though the majority of the market is dominated by five or ten companies. The larger number of possible respondents was chosen because of the possibility that some insurers would not be able to respond to the questionnaire.

The survey, contained in Appendix B, was designed to:

obtain individual price components attributable to each mandated benefit on both an individual and group insurance basis;

obtain total policy premiums so that percentage figures could be utilized when the data was compiled;

obtain claim information in both dollar amounts and numbers of visits to determine the utilization levels of mandates;

obtain historical information on the coverage of benefits and reimbursement to providers prior to mandates;

determine the administrative costs of adding a new mandated benefit;

determine the differences in costs for the same/substituted procedure when provided by physicians as opposed to mandated providers; and

determine the financial impact of all Virginia mandates (providers and benefits) on a typical benefit package.

Two additional questions were added to the study to obtain information for another legislatively requested study, 1989 HJR 319, to determine the adequacy of insurance coverage for those with mental disabilities.

The initial survey was mailed on June 12, 1989, with a three-week response deadline. Follow-up requests were mailed on July 10, 1989, requesting responses within two weeks. Every company request for an extended time period was accepted until the end of July. We explained to all participants the need for accurate and timely responses because of the relatively short time period allotted for the study as a result of the September 1, 1989, completion date for the report imposed by the SJR 215 request.

As of August 14, 1989, 31 surveys had been received by the Bureau. Forty-six companies indicated that they were unable to provide meaningful data. Of these 46 companies, eight were unable to supply information because their actuarial and claim systems are not designed to provide the requested information, five companies have withdrawn from the health insurance market, and 33 companies do little or no business in Virginia that is subject to mandated benefits. Credit insurance, disability income insurance, specified disease coverage, and policies not written on an expense incurred basis are not subject to many of the mandates. The majority of companies writing coverage in these categories make no charges for the mandated provisions that do apply to their business. Twenty-three companies failed to respond in writing by August 14, 1989.

Summary of Responses

31	surveys received
8	unable to supply data
5	no longer write health insurance
33	little or no business subject to mandates
23	did not respond by August 14th
100	companies

None of the insurers returned a survey with every question answered. Of the 31 surveys that were received by August 14, 1989, the response rate on individual questions was only 50% or greater for seven questions, and two of these seven were asked for the study of coverage for mental disabilities. One question, regarding the number of certificates or policies issued in 1987, was included for possible use in weighting when aggregating data. Unfortunately, claims payment data was not provided in sufficient degree for utilization in the study.

Seventeen insurers returning the survey do not write individual business in Virginia, and therefore responded only to the questions relating to group insurance. Another eight insurers that do write individual business did not complete the questions, leaving only five respondents to the individual premium portion of those questions.

Evaluation of Low Response Rate

The response rate was even lower than anticipated and confirmed conditions suspected or acknowledged beforehand that:

- a number of companies do not price each mandate separately;
- a number of companies revise rates almost solely based on actual loss experience;
- most group insurance coverage is experience rated;
- some companies price solely on age and territory;

- a number of companies provided the mandated benefits and/or covered the services of mandated providers prior to enactment of the mandates; and

- most companies do not have claims data of the type requested readily available or accessible to any reasonable extent.

Although the number and completeness of responses may have been higher if insurers were given more time to respond, up to six weeks was allowed for responses in many cases.

The design of the survey may also have affected the completeness of responses, but many insurers called for clarification prior to beginning work on the survey and all requests for clarification were handled promptly.

Company Responses to Insurer Survey

A sampling of the written comments received from companies is included here to demonstrate the problems insurers acknowledged in their attempts to complete the survey. Each quote included below is from a different company.

". . . [S]ome of the specific information you've asked for cannot be extracted, or is simply unavailable."

" Manyof the questions in this survey concern matters on which we keep no figures. We rely heavily on national statistics furnished by such professional sources as AHA and AMA . . . since group insurance is experience rated annually, either case by case or, for small groups, in blocks."

" Ourbasic approach in rating newly mandated benefits is to make an intelligent estimate and modify it with experience. This experience is usually obtained through sampling of claim data and/or underwriter's opinion."

" Systemswas unable to produce the information in the time frame requested."

" Themanner in which [name of insurer] captures its claim data and charges for mandated benefits does not lend itself to the detailed information which you are requesting. Therefore, we cannot provide you with claim information by specific benefit nor can the actuarial area readily calculate premiums for a specific mandate."

" Our claim data systems are not designed to provide these types of information." (Response to questions 3, 4, 6, 8, and 12.)

" Wewere unable to answer questions 3, 4, 6, and 8 due to system restraints. We are unable to determine the amount added to the annual premium of each type policy for the benefits listed."

" Ourpolicy is age rated. All mandated benefits are included without specific increments."

"Claim data is not available by type of provider."

"We are a relatively small insurance company. Our pricing is typically based on historical experience. Our non-medical [regional] factors attempt to factor in mandated benefits as well as overall results from a given area. However, the cost for any specific benefit is a relative unknown. Our claims system does not generate reports by state for the various breakdowns that you desired . . . ."

"This data is not readily available. We are unable to furnish this data without a manual review of each policy claim."

"All mandatory benefits have no specific rating adjustment; charges for these benefits are reflected in emerging experience by an adjustment to the area factors."

Summary of Responses

A summary of responses to the four questions with more than a 50% response rate, numbers 1, 2, 7, and 14, follows. The responses to number 11, which questions the total impact of Virginia mandates on a typical health insurance package, is also included because of its significance in this study.

Summary of Responses of 31 Companies
(Rounded to nearest whole number)

1. Percentage of premium charged for:

	Group	
	Single	Family
Dependent children coverage	0	5%
Doctor to include dentist	0	3%
Newborn children	0	0
Mental/emotional/nervous (Mental disabilities)		
Inpatient	2%	3%
Outpatient	1%	2%
Alcohol and drug dependence	1%	1%
Obstetrical services	3%	5%
Pregnancy from rape/incest	0	0

2. Additional amount of premium for mammogram coverage:

	Individual policy		Group coverage	
	Single	Family	Single	Family
Range	0-$50	0-$50	0-$34	0-$50
Average	$13	$15	$7	$13

7. Provision of coverage for benefit/reimbursement to providers prior to mandate:

Benefits		
Dependent children coverage	No 7%	Yes 93%
Doctor to include dentist	No 18%	Yes 82%
Newborn children	No 3%	Yes 97%
Mental/emotional/nervous (Mental disabilities)	No 3%	Yes 97%
Inpatient	No 7%	Yes 93%
Outpatient	No 11%	Yes 89%
Alcohol and drug dependence	No 10%	Yes 90%
Obstetrical services	No 20%	Yes 80%
Pregnancy from rape/incest	No 21%	Yes 79%
Providers		
Chiropractor	No 28%	Yes 72%
Optometrist	No 50%	Yes 50%
Optician	No 59%	Yes 41%
Psychologist	No 17%	Yes 83%
Clinical social worker	No 54%	Yes 46%
Podiatrist	No 17%	Yes 83%
Chiropodist	No 23%	Yes 67%
Professional counselor	No 69%	Yes 31%

Providers

Physical therapist	No 21%	Yes 79%
Clinical nurse specialist	No 54%	Yes 46%
Audiologist/speech pathologist	No 36%	Yes 64%

13. Administrative cost of adding a new benefit (eight responses):

	Must Offer	Must Provide
Maximum	$310,000	$310,000
Minimum	4,500	2,200
Average	71,100	70,119

14. Addition to group certificate premium for cost of conversion to an individual policy:

	Single	Family
Amount charged per certificate	0-$8.50	0-$25.00
Average	$2.70	$4.83

Three insurers assess a one time charge of $200, $300, or $500 for each conversion.

Note: Maximum figures are included for the insurer whose response provided a range, since the ranges offered were from zero to what amounted to 1% or 2% per mandate.

It is difficult to reach many conclusions from the limited data we received from the survey. However, the following information is useful in determining the impact of mandates.

- The average percentage of policy premium attributed to all mandated benefits for group insurance is approximately 10% for single coverage and less than 20% for family coverage.
- The average costs for mammogram coverage, according to the survey, will be approximately $10.00 per year.
- The majority of benefits and providers were covered or reimbursed prior to the mandate; the only categories where less than 50% of the insurers did not reimburse the practitioner prior to the mandate were professional counselors, clinical social workers, clinical nurse specialists, and opticians.

- The insurance coverage for a 30-year-old standard male in Richmond with a $250 deductible, $1,000 stop-loss limit, 80% coinsurance factor, and a $250,000 policy maximum would cost an average of approximately 10% less for a policy that would not include coverage for any mandated benefits or providers. Only nine companies responded to this question; approximately 70% of the state's accident and sickness premiums are written by those responding.

- Only eight insurers responded to the question about the administrative costs for adding a new mandate. The answers varied greatly from $2,200 for a must provide benefit up to $310,000. A number of companies explained that any figure they supplied would be a rough estimate or guess and declined to answer the question entirely.

- For converting to an individual policy, the cost added to a certificate averages less than $5.00. But, three respondents make a one-time charge from $200 to $500 for each conversion.

Revised Survey

The Bureau of Insurance requested an extension of the deadline for this study because of the poor quality and insufficient quantity of responses to the initial survey and because additional data pertinent to the study was expected to be available in October from Blue Cross and Blue Shield of Virginia. In the interim period (September to December), the original survey was revised to provide more background information to insurers, to determine the source of data for the insurer responses, and to allow companies additional time to respond.

The revised survey was mailed to 53 companies to obtain additional data. The companies resurveyed included the 31 companies that returned the initial survey by August 16, 1989, those returning a survey after that date, and the companies that failed to respond to the first survey requests. Nineteen companies returned surveys by November 20, 1989. Six additional companies returned surveys after that date.

Summary of Responses

19	companies returned survey by November 20th
6	companies returned survey after November 20th
2	companies do not write business subject to mandates
4	unable to provide information requested
22	companies did not respond
53	companies resurveyed

Again, company responses indicated that the type of information requested is not readily available. One quote is included below from each of the companies that indicated they were unable to respond.

"Our claims system does not capture the necessary data to analyze claims by type of provider or procedure codes."

" Wedo not keep records that would allow us to respond on this detailed survey."

" Unfortunately, we do not have the resources necessary to keep track of all of the state mandated benefits."

" AfterI reviewed the enclosed questionnaire, I was truly amazed at the level of naivety [sic] that exists within the committee of people who created the questionnaire. . . . Now, think of the compound effect of 25 'base' policies x 35 variations x 219 mandated benefits/provisions x 5 years. Do you really believe a company can maintain an accurate record of the experience for each possible combination? Do you really think a prudent expense conscious company would want to maintain such a record? . . . All that we can do is monitor the overall claims experience for each of our products for each of our states in which we operate. And, on a retrospective basis, we adjust our rates for the experience that develops."

The sources of information used by the companies that returned a survey by November 20, 1989 is summarized below.

Source of Information

4	Actual claims data
0	Consulting manuals used by company
2	Experience knowledge of company staff
13	Some combination of the above
0	Other

Of the four companies responding based on actual claims data, only two completed the majority of the questions. It should be noted that those two companies have the largest share of the market in Virginia and do business only in only Virginia (one respondent) or Virginia and two other jurisdictions.

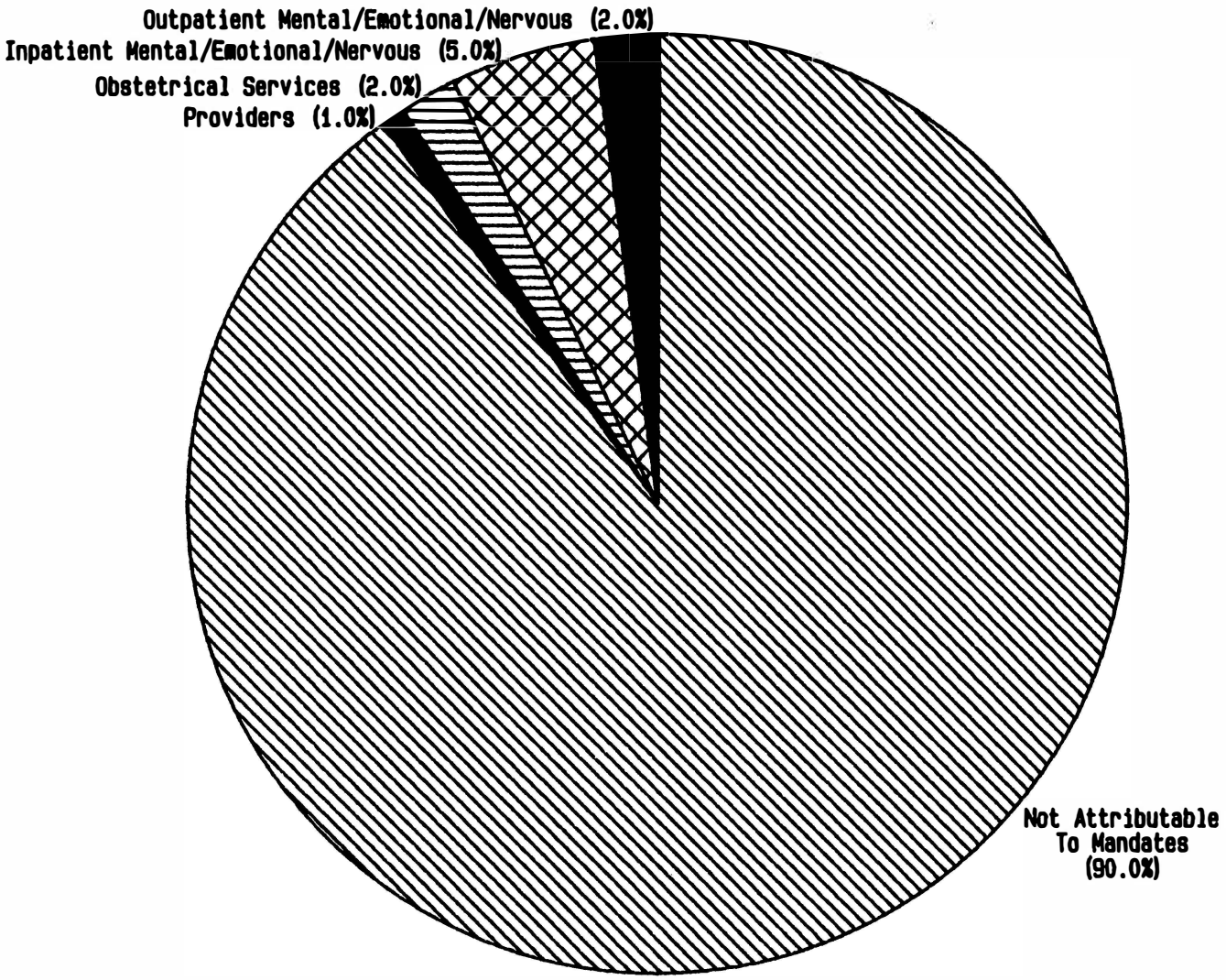
In addition to determining the sources of information, each survey was examined to determine whether all of the information was supplied and whether the number of insureds represented in the survey was large enough to provide statistically significant data. Ten of the surveys were deficient when judged according to this criteria, leaving only nine responses to analyze.

Analysis of Complete Claims-Based Responses

Analysis of the data contained in the two claims-based responses provides some interesting findings. The data was extracted from the actual claims experience of a total of 975,000 single and family policies, an actuarially credible base. Approximately 20% of the group premium is associated with mandated benefits and mandated providers. Most of the claims are concentrated in the mental disabilities, alcohol and drug dependence, and obstetrical services mandates. Charts 1 and 2 on the following pages summarize the claims payments associated with each mandate of significant cost.

INDIVIDUAL √ERAGE

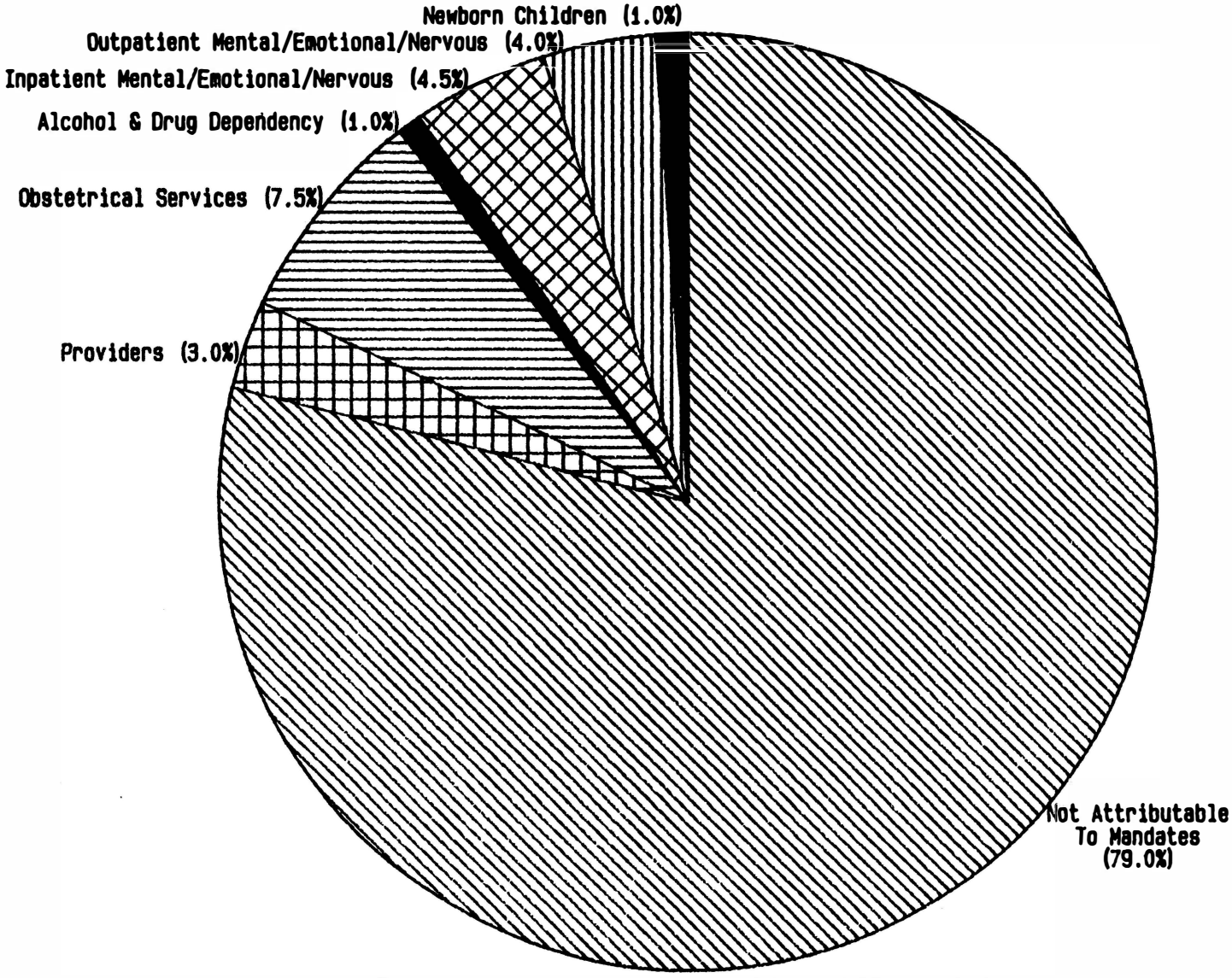
Average Claims Payments



Source: Responses Based Solely on Claims Data

GROUP COVERAGE

Average Claims Payments



Source: Responses Based Solely on Claims Data

The distribution of the premium between mandated benefits and mandated providers is similar for both respondents. Approximately 85% to 90% is associated with mandated benefits and the other 10% to 15% is associated with mandated providers.

Both responses indicate that coverage for mammograms is expected to add approximately 1% to their respective premiums.

Responses to questions 3, 4, and 6 regarding actual claims experience consistently indicate that claims experience is indeed the basis for the premium calculations. This is important because it indicates that the additional premiums for the mandates can be measured, that they represent approximately 20% of the total group premium and 11% of the individual policy premium, and that they are a direct result of the actual claims experience shown.

Both companies indicate by responses to question 7 that they had been covering most of the mandated benefits prior to the effective date of the mandates, including those mandates that generate most of the premiums and associated claims (mental disabilities, alcohol and drug abuse, and obstetrical services). Exceptions were newborn children coverage (enacted in 1976) and pregnancy from rape/incest. Providers not covered prior to the mandate were psychologists, chiropodists, clinical nurse specialists, and professional counselors. These benefits and providers were covered by one of the respondents prior to the mandate.

The survey responses indicate that providers other than physicians generally charge less for services provided in common by both. However, incomplete answers to the questions regarding utilization rates prior to and after mandated providers leaves us unable to determine whether the inclusion of these providers had a beneficial effect on the overall cost of health insurance. One response did indicate that some physicians' fees were reduced after other providers were mandated.

There is one interesting observation that can be made from the responses to question 8. The data seems to suggest that physician average charges for services that they and chiropractors provide in common have come down from $78.00 per service in the year prior to the chiropractic mandate to $76.00 in 1988. The same observation holds for services physicians provide in common with clinical social workers and professional counselors.

Question 9 describes a typical health insurance package for an individual male, age 30, in the Richmond area. The responses indicate that the cost of all mandated benefits and providers for that package is approximately 11% (7% for one respondent, 16% for the other), based on an annual premium of $1,721 with mandates and $1,553 without mandates.

Responses to question 10 factually demonstrate that the charges for some services are provided more cheaply by non-physicians. The only service that was more expensive than the corresponding physician charges were those provided by podiatrists.

Both respondents indicated that mandated benefits add to their overall administrative expense. One of the respondents indicated that for provider mandates, the initial administrative cost would be approximately $110,000 with no difference in premium whether the mandate was "must provide" or "must offer". The other respondent estimated a cost of from $50,000 to $100,000, determined by the complexity of the mandate.

Without complete information on the substitution of providers and utilization rate changes, the information we have summarized should be viewed as the maximum premium costs attributable to mandates.

The Bureau of Insurance also conducted an independent telephone survey of members of the Virginia Academy of Clinical Psychologists to determine the average charge that the members of the association assess for one hour of counseling or psychotherapy (CPT Code 90844). The average charge for the association members for that code was consistent with the responses to the survey question. The responses and the telephone survey indicate clinical psychologists charge approximately 12% less than physicians for an hour of counseling.

Average of Two Claims Based Responses

	Group		Individual	
	Single	Family	Single	Family
Total Percentage of Premium for all mandates	9%	11%	18%	21%
Dependent children coverage	-	-	-	-
Doctor to include dentist	-	-	-	-
Newborn children	-	1%	-	2%
Mental/emotional/nervous (Mental disabilities)				
Inpatient	6%	4%	5%	4%
Outpatient	2%	2%	4%	4%
Alcohol and drug dependence	-	-	1%	1%
Obstetrical services	-	3%	6%	9%
Pregnancy from rape/incest	-	-	-	-
Chiropractor	1%	1%	1%	1%
Optometrist	-	-	-	-
Optician	-	-	-	-

Psychologist	-	-	-	-
Clinical Social Worker	-	-	-	-
Podiatrist	-	-	1%	1%
Chiropodist	-	-	-	-
Professional Counselor	-	-	-	-
Physical Therapist	-	-	-	-
Clinical Nurse Specialist	Data Not Yet Available		Data Not Yet Available	
Audiologist/Speech Pathologist	Data Not Yet Available		Data Not Yet Available	

Note: Where no percentage is shown, the amount is less than ½ of 1%. Answers ranged from zero up to $3.76 per policy/certificate for one response and from $.01 to $17.78 per policy/certificate for the other response.

Findings from the Seven Remaining Surveys

The data from the seven remaining surveys was not based solely on actual data. Each of the respondents indicated that a "combination" of sources was used to answer the questions. Only group data was provided, and together, the respondents insure approximately 183,000 single and family policies. They indicate varying degrees of additional premium associated with the mandated benefits and providers. The associated claims data is incomplete, especially as it relates to mandated providers. All responses indicate that many of the mandated benefits were covered prior to the mandate legislation.

The following table summarizes the number of companies that had already provided services prior to the mandate:

Benefits

Dependent children coverage	No 1	Yes 6
Doctor to include dentist	No 2	Yes 5
Newborn children	No 0	Yes 7
Mental/emotional/nervous (Mental disabilities)		
Inpatient	No 0	Yes 7
Outpatient	No 0	Yes 7
Alcohol and drug dependence	No 0	Yes 7

Benefits

Obstetrical services	No 0	Yes 7
Pregnancy from rape/incest	No 0	Yes 7

Providers

Chiropractor	No 2	Yes 5
Optometrist	No 2	Yes 5
Optician	No 4	Yes 3
Psychologist	No 0	Yes 7
Clinical social worker	No 5	Yes 2
Podiatrist	No 0	Yes 7
Chiropodist	No 2	Yes 5
Professional counselor	No 6	Yes 1
Physical therapist	No 0	Yes 7
Clinical nurse specialist	No 4	Yes 3
Audiologist/speech pathologist	No 0	Yes 7

Although it is clearly not the most valid sample, for this group of respondents, the average group premium for single coverage due to mandates is approximately 11% and for family coverage approximately 19%.

The responses from the resurvey of insurers provides the following information:

- Approximately 10% of individual policy premium is attributable to mandates, 20% for group coverage.
- The majority of the mandated benefits in Virginia were included in standard policies prior to the institution of Virginia mandates.
- Some provider charges are less than charges for the same/substitute procedure performed by physicians.
- A typical individual policy premium could be reduced by approximately $200 a year by removing all Virginia mandates.
- The cost of mandates that would not have been included in a policy without mandates is approximately 10% of policy premium.

VI. SOCIAL IMPACT OF MANDATED BENEFITS AND PROVIDERS

The social impact of mandated benefits and mandated providers is difficult to quantify but very important in considering the relative merit of mandates. Most evaluation procedures measure social impact by attempting to determine to what extent the treatment or service is utilized by a significant portion of the population, to what extent coverage is already generally available, and if not available, how many people go without necessary treatment as a result. These considerations center on the access to care and many of the arguments in favor of mandates involve the access to "adequate" care. The social impact of mandates can be viewed as falling into four major categories:

- increases access to care;
- provides consumer protection;
- interferes with freedom of choice; and
- affects societal welfare.

Increased Access to Care

The major impact of mandated benefits is that the benefit is available to people that would not have access to the coverage in the absence of a mandate. Advocates for certain groups, such as the mentally disabled or those with a specific illness, believe that without mandates, insurance protection will not be available to contribute to the care that a particular group may need.

Access is improved by increasing the supply of health care services as well as improving an individual's coverage. The argument is made that when insurance coverage is available, the development of facilities for a particular illness or condition increases. The coverage for mental disabilities, for example, is anticipated to increase the number of treatment facilities designed specifically for mental disabilities.

Access is also improved by increasing the number of providers who deliver care. For those living in rural areas, the impact of changes in access is more likely to be pronounced. In an area where there is no general medical doctor, a licensed practitioner may be the only choice. The counter argument is made that practitioners are not necessarily more likely to practice in an area with limited access to care than are physicians.

Consumer Protection

The argument is made that consumers need to be protected from purchasing coverage that does not contain certain protections. These coverages have been determined to be desirable from a social perspective. The judgment of those knowledgeable in the area is substituted for that of the consumer who

may not be an informed buyer. There may also be reluctance on the part of the purchaser to ask for a coverage that may have negative implications such as coverage for alcohol or drug abuse treatment.

Interferes with Freedom of Choice

It is generally acknowledged that a buyer's freedom to choose the benefits that he or she desires is eliminated when there is a mandate. The judgment of the necessity or desirability of a particular coverage is made by government and not by the policyholder. In the case of an employer group policy, the employer's alternatives are narrowed. Mandates are also cited as interfering with the collective bargaining process.

Societal Welfare

Many of the conditions covered by mandated benefits have secondary effects on the individual and society. Improving treatment opportunities for those with alcoholism, for example, provides protection for those who may be affected by the actions of someone with an alcohol dependency. The coverage reduces the likelihood that someone will be injured by an automobile driven by a person impaired because of alcohol consumption and, therefore, benefits not only the person using the coverage but society as a whole. Another example is the benefit society derives from the early treatment of mental disabilities. Left untreated, mental disabilities can develop into severe illnesses that may result in actions that damage and destroy lives, families, and communities.

It is difficult to quantify the social impact of mandates with the information available to the Bureau of Insurance. Many of the proponents of mandates addressed the social impact of mandates at the public meeting that is summarized in the next section of this report. The Bureau requested that information supporting the positions expressed at the meeting be forwarded to the SCC.

VII. SUMMARY OF PUBLIC COMMENTS

Public Hearing on SJR 215
Study of Mandated Benefits and Mandated Providers

On Thursday, June 29, 1989, a public meeting was held at 10:15 a.m. in House Room C of the General Assembly Building in Richmond, Virginia. The object of the hearing was to allow all interested parties the opportunity to provide comments concerning Senate Joint Resolution 215 and the social and financial impact of mandated benefits and mandated providers. The Commissioner of the Department of Health, Dr. C. M. G. Buttery, and the Bureau of Insurance received testimony from 20 individuals and organizations concerning SJR 215. The following is a summary of the opinions expressed at that hearing.

1. Dr. W. Ted Tweel: A physician and Manager of Maternal and Child Health Care Services for the Richmond City Health Department, representing the Health Department.

Dr. Tweel submitted a summary of a study conducted by the Richmond City Health Department regarding the relatively high rate of infant deaths in the Richmond area. The study considered the area's 68 cases of infant death which occurred in 1986. Researchers found that most of these deaths were attributable to low birth weight. Dr. Tweel explained that low birth weight is a preventable cause of death when proper prenatal care is administered and that necessary prenatal care is often unavailable to many Virginians because of its high cost. The study therefore recommended that all pregnant women in Virginia should have insurance coverage for prenatal care made available to them.

2. Mr. B. Michael Herman: Representing the Health Insurance Association of America (HIAA) and the American Council of Life Insurance (ACLI).

Mr. Herman began by citing long time opposition to state mandated benefits by both the HIAA and ACLI on the grounds that they directly increase the cost of health insurance. He went on to identify a shift in the interests of legislators from the availability of health care to its affordability, due largely to increasing concern about the high number of uninsured Americans. Mr. Herman further explained that the HIAA commissioned Professor Gail A. Jensen of the University of Illinois at Chicago to study the impact of mandated benefits on health insurance coverage. He submitted a copy of this study and summarized its findings. In her study Dr. Jensen concluded that mandated benefits raise the price of insurance coverage through increased utilization of health care services. Secondly, mandated benefits discourage small employers from providing coverage because of increased costs. Finally, mandated benefits encourage firms to self-insure in order to avoid state regulation.

Following this testimony, Dr. Buttery asked if Mr. Herman was aware of any cost data concerning the effectiveness of mandated preventative intervention, such as blood pressure and cholesterol checks.

Mr. Herman responded that the effects of such mandates are long-term and difficult to predict. Therefore, actuaries are unable to accurately determine the cost associated with such changes.

Dr. Buttery then asked for an industry response to the U. S. Task Force on Preventive Health Services' May 1989 publication.

3. Dr. Gary H. St. Clair: Chairman of the Third Party Care Committee of the Virginia Optometric Association (incorporated comments by Dr. James Cornetta of the Virginia Optometric Association in his presentation).

Dr. St. Clair began by defining the role of optometrists in the health care system and expressed concern over the possible repeal of health care provider mandates. He argued that optometrists provide a low cost alternative to physician care and that mandated reimbursement for providers increases accessibility to necessary health care. He argued that utilization rates level off following the addition of mandated providers and that cost control in the form of deductibles, copayments, and coverage of specific services should be more widely implemented.

Dr. St. Clair further recommended that all health care providers be reimbursed for covered services which fall within their scope of licensure as long as the provider is permitted to practice independently.

Dr. St. Clair also expressed concern over possible discrimination by HMOs who fail to accept optometrists as providers despite their willingness to meet the conditions of the HMOs.

He further suggested that in an effort to control health care costs, fees submitted by providers on claim forms should not be in excess of that provider's usual, customary, and reasonable (UCR) fee for that particular service or be considered a fraudulent claim.

Finally, Dr. St. Clair recommended that coverage for eyeglasses for adults under the Medicaid program be reinstated as it is a basic necessity.

4. Ms. Gail M. Thompson: Legislative Affairs Representative, Blue Cross and Blue Shield of the National Capital Area.

Ms. Thompson began by stating her group's opposition to mandated benefits, based on evidence that they increase administrative and benefit costs unnecessarily. In support of this position, she submitted for review a 1985 study commissioned by BCBSNCA and Blue Cross and Blue Shield of Maryland, examining the effects of mandated benefits in the State of Maryland. She also submitted a BCBSNCA position paper on mandated benefits and providers. The position paper generally argues that: mandated benefits do not always improve access to health care at affordable prices; employers

are deprived of the ability to choose benefit packages which are tailored to their employees' needs and their financial limitations; that mandated benefits cause businesses to self-insure to avoid state regulation; and that mandated benefit laws are often passed without sufficient objective review of the social and financial impact which may result.

Ms. Thompson emphasized that an objective review system should be employed by the Commonwealth of Virginia for the purpose of examining in detail the social and financial impact of future mandated benefit proposals.

Ms. Thompson also argued that approved mandates should be subject to a monitoring process which would attempt to determine whether the mandates actually increase accessibility and availability of services and whether the mandated benefit actually is a substitute or additional health care cost. She also voiced support for a "sunset" provision for mandated benefits to work in conjunction with the monitoring process to evaluate the effectiveness of particular mandates.

5. Ms. Teresa Tempkin: Representing the Virginia Council of Nurse Practitioners of the Virginia Nurses Association, providing comments from Marilyn Pace Maxwell, the Executive Director of the Mountain Empire Older Citizens, Inc. (an area agency on aging with the Virginia Department of Aging, serving the counties of Lee, Wise, and Scott).

Ms. Tempkin, on behalf of Ms. Maxwell, urged that additional providers be mandated to increase the availability and accessibility of primary health care in rural Virginia. Her concerns center around the low number of practicing physicians in rural areas.

Ms. Tempkin offered additional comments based on her own experience as a past employee of an area agency on aging in the Roanoke area. She stated that of the 80 licensed nurse practitioners living in the southwest region of the state, only 23 are employed by the state. She testified that the majority of the remaining practitioners are not employed because of the absence of a reimbursement mechanism.

6. Ms. Barbara A. Wheat: A nurse anesthetist licensed in the Commonwealth of Virginia representing the Virginia Association of Nurse Anesthetists.

Ms. Wheat began by defining the education and role of nurse anesthetists. She argued that although they often perform identical services as those rendered by anesthesiologists, third party reimbursement for nurse anesthetists is unavailable. She contends that this problem is acute in rural areas where nurse anesthetists are the only providers of this type of service.

7. Ms. Jan Johnson: Representing the Virginia Nurses Association.

Ms. Johnson spoke in support of a permissive system of reimbursement which would allow consumers to choose the type of provider that they find appropriate based on cost and type of care. Currently, consumers are

restricted by the reimbursement status of potential providers. She argues that such a system would increase competition and improve access to primary care, especially in rural Virginia.

She also questioned the wisdom of restricting access to groups of providers who are primary providers of preventative care, such as early intervention and health maintenance services.

In support of these arguments, Ms. Johnson forwarded a VNA position paper on SJR 215 and a 1986 study conducted by the Congressional Office of Technology Assessment entitled: "Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis," for consideration.

8. Dr. Walter Lawrence: A member of the Medical Society of Virginia, representing the American Cancer Society.

Dr. Lawrence argued that the focus of cancer treatment should be on early diagnosis and prevention. He contended that certain types of screenings, specifically mammography, clearly reduce the morbidity and mortality of cancer. Dr. Lawrence cited the position of the National Cancer Society, and other major organizations as support for this argument.

9. Ms. Joan M. Gardner: Government Affairs Counsel for Blue Cross and Blue Shield of Virginia.

Ms. Gardner began by voicing BCBSVA's opposition to the practice of mandating benefits and provider reimbursement arrangements. Her first concern was the shrinking of the insurance pool resulting from larger employers shifting to self-funded health benefits programs. She linked this shift to increasing costs due to state mandates. Secondly, Ms. Gardner argued that rising costs attributable to mandated benefits have forced smaller employers to limit or drop coverage, thus adding to the uninsured population. Thirdly, she stated that mandates hinder an insurer's ability to design benefit packages to fit specific customer needs. Finally, Ms. Gardner pointed to increased utilization rates resulting from mandates as a primary cause of cost increases. Ms. Gardner also spoke in support of an evaluation process for future consideration of proposed mandated benefits and providers. BCBSVA submitted the following four articles for consideration: "Freedom of Choice in Health Insurance" by the National Center for Policy Analysis in Dallas, Texas; "The Price of State Mandated Benefits" by the Health Insurance Association of America; "State Mandated Group Health Insurance Coverages" commissioned by the Iowa General Assembly; and "The Erosion of Purchased Health Insurance" by Gail Jensen and John Gable of the HIAA.

Following her conclusion, Ms. Gardner commented on Dr. Buttery's earlier comments concerning preventative health care services and their appropriateness as part of an insurance program. She suggested that wellness and preventative care programs should be a community process and not an issue for insurance because of cost considerations. She emphasized that commercial insurers cover only 30% of insured Virginians and consequently, the Commonwealth of Virginia should look at ways to provide preventative health care through the work place and community health plans.

Dr. Buttery responded that most large employers who now self-fund their health benefit programs do so in order to combine basically mandated benefit programs with their own organization because commercial insurers fail to emphasize preventative care. He then suggested that insurance companies have not fully considered the long-term benefits of health maintenance programs.

Ms. Gardner responded with support for an evaluation mechanism for future mandate proposals as a method for considering Dr. Buttery's suggestions.

10. Mr. William H. Coiner: Representing the Virginia Manufacturers Association.

Mr. Coiner expressed general concern for increasing health care costs and specifically for the effect this has had on the cost of employment through the increased cost of group benefit packages. He supports a review of current mandates to determine what effect, if any, they have had in bringing about affordable health care for Virginians.

11. Dr. Steven F. Peed: Past president and representative of the Virginia Academy of Clinical Psychologists.

Dr. Peed voiced support for mandated minimum benefits and freedom of choice concerning providers. He argued that the profit motive would take precedence over coverage for poorly understood areas of health care such as mental health. He urged that other methods of cost containment, such as better managed care systems and innovative treatment approaches, be explored.

12. Dr. Rick Baither: A member of the Northern Virginia Academy of Clinical Psychologists.

Dr. Baither expressed his concern over the growing need for mental health and substance abuse services in the face of increasing pressure to reduce the availability of these services through limiting benefits. He also argued that freedom of choice mandates ensure that a variety of providers will be available to provide need-specific care at affordable rates. He cited his own involvement in a multi-disciplinary mental health care practice and their success in reducing average inpatient bed days and improving availability of less expensive outpatient treatment alternatives.

13. Dr. Robert W. Hill: A clinical psychologist in private practice in southwestern Virginia.

Dr. Hill argued that by increasing the numbers of acceptable providers and increasing accessibility to needed health care, cost containment will follow. Dr. Hill identified himself as the sole provider of doctoral level clinical psychology services in the 12 counties of southwestern Virginia and argued that without mandated provider status, he would not be in business. He also suggested that most professionals in rural areas are reluctant to seek mental health treatment in mental health centers where bachelor's level

providers administer treatment. Finally, Dr. Hill argued that in rural areas, if mandated providers were barred from third party reimbursement, many of the people who have insurance coverage would essentially be uninsured because they would have no place at which to receive treatment.

14. Dr. Roger Delapp: President of the Tidewater Academy of Clinical Psychology.

Dr. Delapp took exception of the argument that mandated mental health benefits directly raise utilization rates and overall health care costs. He contends that untreated mental health needs cost society in other ways than through premium increases. Dr. Delapp argued that studies show utilization rates only increase until real public need is met. Dr. Delapp submitted several articles for review including: "Freedom of Choice Laws: Empirical Evidence of Their Contribution to Competition in Mental Health Care Delivery" by Richard G. Frank, Ph.D.; "Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums" by Browne and Browne , et al.; and "Claims of Runaway Costs, Unpredictable Utilization Unfounded, Corrigan Testifies" in The Ohio Psychologist, December 1986.

Dr. Delapp closed by describing the changes which occurred in Tidewater, Virginia following freedom of choice regulation. He described a system of collaboration between psychologists, hospitals, and Blue Cross and Blue Shield of Virginia which has reluctantly given way to a more competitive market. Dr. Delapp believes that more needs to be done, however, to encourage a greater shift away from expensive inpatient care.

15. Mr. James C. Bumpas: The Assistant Commissioner for Program Support for the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Mr. Bumpas argued against the repeal of current mandates concerning mental health and substance abuse treatment. Mr. Bumpas argued that public mental health facilities have experienced large increases in the number of people they serve in recent years. His concern is that if fewer people are insured due to rising insurance costs, then additional state revenues and appropriations will be needed to support the public mental health system. He is concerned that availability and accessibility to treatment will suffer if current mandates are removed.

16. Dr. Richard D. Wilson: Representing the Virginia Dental Association.

Dr. Wilson cited a study conducted by the University of North Carolina at Chapel Hill which concluded that dental fees in Virginia and the two Carolinas have risen significantly slower than other medical costs. He further argued that freedom of choice mandates allow competition to contain costs. He further urged that comparable coverage be given to employees who opt for free-choice options as opposed to a closed panel plan in order to protect the consumer's freedom of choice.

17. Dr. Joel J. Silverman: The Chairman of the Department of Psychiatry of the Medical College of Virginia, representing his patients and the citizens of Virginia.

Dr. Silverman emphasized that the demand for mental health care is rising because our population is aging, treatment and diagnostic systems are improving, and the stigma associated with mental illness is eroding. Secondly, he pointed out that mandated coverage for mental health care is necessary because most people are not knowledgeable about mental disease and are not aware that it can strike anyone. Dr. Silverman argued that because of this fundamental difference in public perception, mandates are necessary as an issue of public policy.

18. Dr. William L. Harp: In private practice as a psychiatrist and President of the Psychiatric Society of Virginia, although not formally representing them at this hearing.

Dr. Harp pointed out the importance of mental health services and suggested that any reduction in coverage would be unfortunate considering the rising need for mental health care. He also submitted a summary of a study conducted by Hewitt Associates of Lincolnshire, Illinois entitled: Company Practices in Mental Health Coverage. Dr. Harp noted that the study showed that most companies recognize the need for mental health coverage and that the use of copayments are an effective method of cost containment.

19. Ms. Roberta Meyer: An attorney for the American Council of Life Insurance.

Ms. Meyer voiced concern over the current effects of mandated benefits, specifically in regard to the increasing number of uninsured citizens. She concluded that the mandates have driven costs up to the point that small employers drop coverage and large employers move to self-funded plans. Ms. Meyer concluded with a word of support for an evaluation process for future mandate proposals.

20. Dr. Paul E. Behrens: The State Legislative Chairman for the Virginia Retired Teachers Association.

Dr. Behrens expressed concern over health care for retired teachers. He cited several examples of teachers receiving inadequate pensions and asked that consideration be given to helping retired teachers get adequate medical coverage.

Written Comments on SJR 215
Study of Mandated Benefits and Mandated Providers

In addition to the opinions and comments expressed at the public meeting, the Bureau of Insurance received written comments from an additional 19 individuals and organizations. The following is a summary of those comments.

1. Mr. Harry E. Evans: Executive Vice-President of Franklin Braid Manufacturing Company.

Mr. Evans expressed his concern over the impact of increasing health insurance costs on employers. He argues that recent premium increases have forced employee cost sharing at Franklin Braid and that additional increases could threaten the survival of the entire benefit program. He attributes a large part of these increases to mandated benefits.

Mr. Evans also expressed general concern over increasing health care costs and urged that the health care industry seek drastic measures to ensure cost containment.

2. Mr. Rick Cagan: Executive Director of Rural Virginia, Inc.

Mr. Cagan expressed concern that the issue of health care availability not be overlooked by the study group. Specifically, he argues that rural areas suffer from a shortage of physicians which limits the effectiveness of existing facilities. Mr. Cagan wrote in support of the liberalization of provider status for qualified professionals, such as nurse practitioners, in order to fill health care gaps in rural Virginia. He also indicated that preventative health care is needed in rural areas and that an increase in the number of providers would aid this cause.

3. Mr. William W. Semones: Vice-President for Mental Health Services at Virginia Baptist Hospital in Lynchburg, Virginia.

Mr. Semones noted that prior to mandated mental health benefits, most insurance organizations either provided no coverage for substance abuse or a great deal of coverage, such as 365 days. He pointed out that after the mandates were enacted, most carriers increased or decreased their coverage to the minimum 30 days. Mr. Semones contends that 30 days of inpatient coverage is inadequate in many cases and often leads to premature dismissal from treatment.

Mr. Semones expressed his concern that self-funded employee benefit plans are not subject to state regulation.

Mr. Semones also argued that in the field of mental health, mandates are needed because the average consumer is not knowledgeable about mental disease and substance abuse and its treatment.

4. Ms. Kathy Hans: A concerned citizen.

Ms. Hans expressed concern over the unwillingness of insurance carriers to reimburse certified nurse midwives. She contends that CNMs provide the same professional care as physicians and are therefore being unfairly discriminated against by insurers. She also notes that CNM fees are significantly lower than physician fees for the same service.

5. Ms. Melissa W. Dunning: A concerned citizen.

Ms. Dunning expressed her concern that although she is paying for maternity coverage from Blue Cross and Blue Shield of Virginia, she must pay her certified nurse midwife herself. She contends that the CNM provides a professional service at a lower cost than physicians and she resents the resistance that BCBSVA has shown in its direct reimbursement of CNMs.

6. Ms. Leigh Ann Evans: A concerned citizen.

Ms. Evans expressed concern that she was notified by her husband's employer that although they paid for maternity benefits, the services of a certified nurse midwife would not be covered by the plan. She contends that her CNM provided better health care for her and her baby than a physician and at a lower cost.

7. Mr. Joseph L. Stendig: Holiday Inn of Danville.

Mr. Stendig noted that the annual premium for his group benefits program rose 50% between August, 1987 and August, 1988 and an additional 33% this year. His concern is his ability to continue to operate a profitable business when health insurance costs are increasing to this extent.

8. Mr. Bruce B. Keeney: Executive Director of The Virginia Optometric Association.

Mr. Keeney forwarded information from studies commissioned by the Center for Vision Policy of the State University of New York College of Optometry. The researchers found that optometrists generally include more tests in their routine eye exam fee, are more available for appointments, and charge less to Medicare for the same procedures as ophthalmologists.

Mr. Keeney addressed the argument that providers increase their fees to the level charged by physicians once they have gained third party reimbursement status. He noted that optometrists have been mandated providers for nearly 15 years in Virginia and today their fees are still considerably less than their physician counterparts. He also suggested that insurers incorporate optometric fees in the "fee profile" of ophthalmologists when developing reimbursement fee ceilings for various procedures and services.

9. Dr. Judith Jhirad-Reich: President of the Virginia Chapter of the National Association of Social Workers, Inc.

Dr. Jhirad-Reich wrote in support of the continuation of currently mandated mental health benefits and the existing list of service providers, including licensed clinical social workers. She also recommended that insurance coverage include inpatient and outpatient mental health services. Dr. Jhirad-Reich is particularly concerned that the elimination of mental health benefits will result in a shift of responsibility from insurance

companies and policyholders to the taxpayers. She is concerned that the public mental health care agencies will be unable to meet the needs of the citizens of Virginia.

10. Dr. Jaclyn Miller: President of the Virginia Society for Clinical Social Work, Inc.

Dr. Miller wrote in support of the continued inclusion of licensed clinical social workers (LCSWs) as mandated providers and the mandated minimum levels of mental health coverage. She argues that these mandates are less costly than the effects of untreated mental health problems in both monetary and emotional terms. Furthermore, Dr. Miller pointed out that LCSWs significantly improve access to mental health care in rural areas. Dr. Miller supported mandated mental health benefits on the basis that individuals generally do not realize the need for mental health benefits.

11. Ms. Leith Mullaly: Chairman of the Virginia Section of The Organization for Obstetric, Gynecologic and Neonatal Nurses (NAACOG).

Ms. Mullaly recommended that third party reimbursement status be given to nurse midwives and nurse practitioners. She pointed out that they provide professional care to frequently under-served populations in Virginia. Ms. Mullaly also supported third party coverage for prenatal care and well baby care and cited Virginia's high infant mortality rate as evidence of this need.

12. Ms. Joy M. Lewis: President of the Virginia Perinatal Association.

Ms. Lewis stated that prenatal care has proven to be a cost effective form of prevention. She argues that Virginia Medicaid eligibility should be expanded to 185% of the poverty level and that mandatory maternity coverage should be part of any basic policy. Ms. Lewis sees these steps as significant in improving access to prenatal care for many Virginians.

13. Ms. Mary Ann Bergeron: Executive Director of the Virginia Association of Community Services Boards, Inc.

Ms. Bergeron expressed concern over the financial problems posed by elimination of mandated mental health benefits. She holds that agencies will be unable to meet their demand for services without additional monetary support.

14. Ms. Linda B. Lafoon: Manager of Human Resources Administration for Ukrops Super Markets, Inc.

Ms. Lafoon expressed concern over mandates affecting employee/employer relations. She advocates an environment free of restrictions which allows for open negotiation between employee and employer. Furthermore, Ms. Lafoon contends that competition in the marketplace is a more desirable regulator than state mandates on health care benefits.

15. Mr. Franklin B. Smith: Treasurer of The Madeira School.

Mr. Smith noted his opposition to mandated health benefits, levels of premium expense, and health care providers.

16. Mr. John W. Baggett: Benefits Plans Incorporated.

Mr. Baggett registered his opposition to mandated benefits and providers based on his experience in administering medical benefits for over 20 years. He contends that increasing costs are forcing business owners to cut back on benefits or terminate coverage altogether.

Mr. Baggett supports the development of a basic medical contract covering only serious and expensive medical conditions at an affordable price.

17. Ms. Kathy W. Ratcliffe: A concerned citizen.

Ms. Ratcliffe expressed concern over the high cost of health insurance. Her concern is based on her husband's inability to obtain affordable health insurance because his employer has chosen not to offer insurance coverage. Ms. Ratcliffe feels that all employers should be required to provide some form of health care coverage for their employees.

18. Dr. Robert L. Barth: President of the Virginia Society of Anesthesiologists, Inc.

Dr. Barth and the Virginia Society of Anesthesiologists, Inc. support the position that mandated benefits are not cost saving, discourage small businesses from offering health insurance benefits, and encourage large employers to self-insure. Dr. Barth suggests that additional benefits not be mandated because they raise the cost of insurance premiums to an unreasonable level for many Virginians.

Dr. Barth also expressed concern over the concept of mandating direct reimbursement of nurse anesthetists. He argues that nurse anesthetists are not qualified to provide their service without the supervision of an anesthesiologist. He also states that nurse anesthetists are lobbying to raise the unit reimbursement value for their services to a level higher than participating Medicare anesthesiologists.

19. Dr. George Chirkinian and Mr. J. Kenneth Wood: President-Elect and Chairman, respectively, of the Legislative Committee of the Virginia Chiropractic Association.

Dr. Chirkinian and Mr. Wood assert that chiropractic care is cost efficient and a safer and more effective alternative to the traditional medical approach to neuromuscular-skeletal disorders of the spine and extremities.

With regard to cost effectiveness, the Virginia Chiropractic Association submitted for review a study conducted by Dr. Steve Wolk, the Director of Research for the Foundation for Chiropractic Education and Research, which compared the costs of services rendered by chiropractors and physicians for the same conditions. They summarized the study findings as concluding that periods of disability and lost work days were significantly less for chiropractic patients; the average cost of services was less for chiropractors; chiropractors showed a significantly greater preference for outpatient care than their medical counterparts; and the average overall cost for care was nearly double for physicians than for chiropractors.

VIII. RECOMMENDATIONS

The Bureau of Insurance recognizes that many options exist for changes in the area of mandated benefits and mandated providers. Among these are:

- institute a review process prior to adopting any new mandates, as recommended in the 1979 SCC Study;
- institute a review process for all existing mandates;
- require insurers to capture and report data on mandated benefits and providers;
- expand the moratorium on new mandates now contained in §38.2-3419. to include "must offer" mandates and providers as well as the "must include" mandates;
- revise existing mandates to a "must offer" basis;
- repeal existing mandates selectively; or
- repeal all existing mandates.

Based on the information obtained as a result of this study, the Bureau of Insurance cannot conclude that mandated benefits and mandated provider requirements are desirable or undesirable. Mandates protect the consumer by guaranteeing that certain coverages are available. It is clear that mandates increase the cost of insurance coverage for the average Virginian. What is not clear is the amount of that increase. It must be remembered that Virginia is not a "heavy mandate" state. Many of Virginia's mandates for benefits (newborn children coverage, coverage for handicapped or mentally retarded children, and offer of coverage for obstetrical services) are considered part of the standard benefit package that most insurers routinely offer. And, in fact, one of the most costly mandates, coverage for obstetrical services, is required by federal legislation and would be included in policies sold in Virginia even without a state mandate. Many insurance plans provided such coverage prior to mandates, and many would continue them if mandates were removed. It is the incremental cost of mandates which must be considered in determining the true impact of mandates. The removal of all presently mandated benefits and providers would not necessarily make health coverage affordable.

From the information we have reviewed, it is not certain that Virginia mandates increase the utilization of benefits and services. Basic economic theory does make a sound argument that with increased access to a service, and less cost for the user, more services will be consumed, but it is difficult to prove or disprove. It is difficult to ascertain whether a mandated benefit or provider is truly increasing utilization, or is simply substituting one benefit or service for another that had previously been provided or covered.

We are not able to determine the number of people who are uninsured specifically due to mandates nor those group plans which are self-insured because of mandates. Mandates are only one of the factors contributing to the increasing numbers of both uninsureds and self-insureds. Additional reasons for moving to self-insurance include cash flow considerations, investment opportunities, and administrative costs.

Consideration should be given to allowing existing mandates to remain in place with a moratorium on all new mandates until either a review mechanism is put in place to review the impact of each individual mandate or insurers are required to capture and report all data relative to this issue (at least seven states have requirements of this type in place), or both. With a review procedure in place, or definitive data on Virginia experience, decisions on present and additional mandates can be made with a higher degree of certainty as to the outcome.

An alternative recommendation is to allow the sale of a policy without the inclusion or offer of mandated benefits or specific reimbursement requirements. This type of policy should be clearly and distinctively labeled, and there should be full disclosure of its coverage and limitations. The applicant for coverage should also be given the option of purchasing coverage that includes or offers all mandates. Applicants could be required to note their choice in writing with the information retained in the insurer's files. Reporting requirements should also be included to allow the SCC or the General Assembly to monitor the effect of the sale of this type of policy.

The repeal or revision of existing mandates at this time could result in changes that would prove to be undesirable when more information is available. Therefore, we recommend no changes to existing mandates. There is no clear evidence that the removal of mandates will make health insurance "affordable" to the average Virginian.

IX. CONCLUSION

The Bureau of Insurance cannot determine the exact costs of mandated benefits and providers in Virginia. The information provided in response to our survey requests can be generalized only cautiously. Insurers have different claims practices and recordkeeping systems, and many companies were unable to respond to the survey at all. The data from the survey indicates that all presently mandated benefits and providers, account on average, for no more than 10% of the policy premium for individual coverage and 20% of the policy premium for group coverage.

It is essential when considering these figures to recognize that many of the present mandates, such as obstetrical coverage, would be included without a Virginia requirement. It is the additional or incremental cost of mandates that provides a clearer picture of the costs of mandates in Virginia. We estimate the cost to be no more than 10% based on insurer responses as to what they considered to be part of their standard policy and the coverage that was offered prior to being mandated.

At the present time, there is no evidence that the removal of mandated benefits and providers will make health insurance affordable to the average resident of the Commonwealth.

The Bureau of Insurance believes that if the General Assembly desires more information about the actual cost of mandates, insurers should be required to collect and report, on a regular basis, information of the type requested on the insurer survey. A formal, independent evaluation procedure should also be put in place to separately evaluate the impact of each proposed mandate prior to passage and possibly to reevaluate present mandates. This type of system would provide the data necessary to make more informed decisions.

APPENDIX A

MANDATORY BENEFITS

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA	HI	ID	IL	IN	IA	KS	KY
Adopted Children			85						85	88			81				
Alcoholism	79	88		87	78	76	74		79		88			76		86	78
Ambulatory Surgery			71						77		74						78
Anti-Abortion						85	82										78
Breast Reconstruction			81	78	78				87				80				
Cleft Palate						87						85		85			
Conversion Privilege			85	79	83		75						83		86	78/80	74
Continuation for Dependents				85	76		75/76			80			76/85		86	78/84	80
Continuation for Employees				85	77/84	86			75	86	74	75	84		86	84	80
Dependent Students							82			79							
Drug Abuse		88					76		79		88					78/86	
Home Health			82		78	84	75/76		87								82
Hospice						84	76										
Invitro Fertilization Infertility				87			89				87						
Mammagraphy Screening			88	89	87	89	88		88						89	88	
Maternity				76	76	75/89	76			78	74						
Mental Health		88		83	73	76	75/82 /87		76/83	81/84	88		74/77			78/86	86
Mentally/Physically Handicapped			77	69	71		71		70	72	68	72	67	69/86			
Newborns	75	75	74	75/83	71	75	74	74	80/84	74	74	74	75	76	74	74	76
Orthotic and/or Prosthetic Devices					85		87		87								
Other Health Centers														85			
Preventive Care for Children/Infants					74				86								
Public Institutions																	
Temporomandibular Joint Disorder																	
Mandate Evaluation			85			89			87	89	87						
Misc. Benefits	0	0	1	1	5	3	7	1	0	1	1	1	2	0	1	0	3
Total	2	4	10	12	18	14	22	2	14	10	11	5	10	5	6	8	12

MANDATED BENEFITS

	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND
Adopted Children			79	75		83											
Alcoholism	80	74	80/88	73	74/82	73/82	74	77/85	79	80	83		77	83	82/83	84	75/87
Ambulatory Surgery					84/85	76		75/81							x		
Anti-Abortion								83									79
Breast Reconstruction					85	80					83/89		83		75		
Cleft Palate	89		82			88										82	
Conversion Privilege		82	79	76		77		81	81	78	80			83	71/81	82	83
Continuation for Dependents			77			73/77		69		80	80	81	76/80	83	81	83	87
Continuation for Employees	83	83/86	79			73		85	81	79			82				80
Dependent Students	78		79							76							
Drug Abuse	80	83	79/88		74/82	73/82		80	81		83				87	84	75/87
Home Health		77	79	86					81		75			77	72/75		
Hospice			82		84						83/89				85		
Invitro Fertilization Infertility			85/89	87													
Mammagraphy Screening				87	89	88					89	88			88/89		89
Maternity		75	75			73		73			77				76		
Mental Health	75	79/83	73/86	73/82		75/87		80	81			75/83			77/88		75/87
Mentally/Physically Handicapped	72		X	56	66	69	72		71		76	69	66	69	65	69/73	82
Newborns	73	76	77	74		73	74	74	73	75	76	75	75	75	77	73	79
Orthotic and/or Prostetic Devices			78/88		85												
Other Health Centers		79	76												X		
Preventive Care for Children/Infants			88					89							82		
Public Institutions			67			73			73	84						75	
Temporomandibular Joint Disorder						89					89			89			89
Mandate Evaluation		89								86							
Misc. Benefits	2	2	7	2	3	3	2	0	1	0	2	0	2	1	4	0	1
Total	10	12	26	11	11	19	5	11	10	8	14	5	8	8	19	8	12

MANDAT. NEFITS

	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	Total
Adopted Children							83			85							9
Alcoholism	78		75/81	86	80/88		79	79	81	81	82/85	77/80	74/87	82	74/85		40
Ambulatory Surgery		76								76							10
Anti-Abortion				82													6
Breast Reconstruction																	11
Cleft Palate																	7
Conversion Privilege	75/84		77		78	78	79	80	77	79		82/88	84		80	83	32
Continuation for Dependents					83	78	80	86	79		84		80	83	80		28
Continuation for Employees													73	82	73/80		23
Dependent Students																	5
Drug Abuse					87/88				81/89			77/80			74/85		20
Home Health					84				87		76		83		78		18
Hospice													83				7
Invitro Fertilization Infertility					89				87								6
Mammagraphy Screening		88/89		89	88			89	87			89	89	89			23
Maternity	79		73					84	77			78			82		18
Mental Health	83		73/87					79/80	81		76	76/77	83	77	74/86		30
Mentally/Physically Handicapped	71			68		70		69	81	75		74	69		75	71	34
Newborns	74	84	75	76		74	76	74	73	77	76	76	74/84	75	76	75	48
Orthotic and/or Prosthetic Devices																	5
Other Health Centers									83						75		6
Preventive Care for Children/Infants																	5
Public Institutions	76												87		80	75	9
Temporomandibular Joint Disorder									89				89	89			7
Mandate Evaluation			85	86	88			89					84		88		13
Misc. Benefits	1	0	4	0	2	0	0	1	3	1	0	2	3	2	5	0	83
Total	8	3	10	6	10	4	5	10	16	7	5	10	16	9	18	4	

MANDATED PROVIDERS

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA	HI	ID	IL	IN	IA	KS	KY
Chiropractors	75	83	83/87		76		71	X	76/86	80				74	86	73	80/86
Dentists	75	83	77		76		75				74			74	88	73	
Naturopaths		87					75										
Nurse Anesthetists			85				84										
Nurse Midwives		83	85				84		83								
Nurse Practitioners		88	85				84										
Nurses						87									89		
Occupational Therapists		87			78		82										
Optometrists	67	83			80		75	X	74	88			80	74	83	73	
Oral Surgeons																	
Osteopaths		83															
Physical Therapists		87					75										
Podiatrists	76		77	75	76			X	74				81	74		73	
Professional Counselors					80/81												
Psychiatric Nurses					82		84										
Psychologists	82		83/87	75	80	79	75			80	84			85		74	
Social Workers					76		79									82	
Speech/Hearing Therapists				85	78												
All Licensed Health Professionals				75									82				
Misc. Providers	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0
Total	5	9	7	All	10	2	12	3	5	3	2	0	All	5	4	6	1

MANDATE VIDERS

	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND
Chiropractors	75	86	73		79	73	80	78		67	82		80	84	X	73	79
Dentists	74	75		75		73	74	78	83	75	75		79	77	75		
Naturopaths																	
Nurse Anesthetists			84			83	80		87								
Nurse Midwives	84		78			83	80		87	84			82	85	82		
Nurse Practitioners			79			88	80		87			85					84
Nurses											85		84		84		
Occupational Therapists																	
Optometrists		82	73			73	66	78		69	75		67	77	X		
Oral Surgeons					85							75					
Osteopaths			73							67	75			77			
Physical Therapists													75		73		
Podiatrists			73			73		78		69	75			77	X		
Professional Counselors									85/87			83					
Psychiatric Nurses		83	83	86													
Psychologists	75	75	73	75	68	75	74	83	81	74	80	75	73	77	71	77	87
Social Workers		83	77	82					85			83			85		
Speech/Hearing Therapists								84									
All Licensed Health Professionals			83														
Misc. Providers	0	0	0	0	0	0	0	1	2	0	0	0	0	1	0	0	0
Total	4	6	ALL	4	3	8	7	7	9	7	7	5	7	8	9	2	3

MANDATED PROVIDERS

	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	Total
Chiropractors	80	71		81	87	80		81	79	75		79/88	83		76/87		37
Dentists	73	71	71					74	83						75		27
Naturopaths																	2
Nurse Anesthetists				86			89										8
Nurse Midwives	84	71		82			80			79			81	83			20
Nurse Practitioners			80	86			80						81				13
Nurses				86									81				7
Occupational Therapists																	3
Optometrists	80	71	76	78		85		65	79	75		77			75		31
Oral Surgeons																	2
Osteopaths	80								58			77				71	9
Physical Therapists												87					5
Podiatrists	80	71				72		65	77	75		79	83		75		25
Professional Counselors									89			87					5
Psychiatric Nurses													77				6
Psychologists	74	71	76	78			86	74	77	75		77				85	37
Social Workers							88/89	85	87	75		79/87					14
Speech/Hearing Therapists									83								4
All Licensed Health Professionals							80									71	5
Misc. Providers	0	0	2	0	0	0	0	1	1	0	0	1	0	0	0	0	11
Total	7	6	6	7	1	3	All	7	10	6	0	9	6	1	4	All	

X = Year Unknown
Bold Print = Mandated Offerings

Sources: National Association of Insurance Commissioners
Blue Cross and Blue Shield Association
SCC Bureau of Insurance

APPENDIX B

COMMONWEALTH OF VIRGINIA

STEVEN T. FOSTER
COMMISSIONER OF INSURANCE

Box 1157
RICHMOND, VA 23209
TELEPHONE: (804) 786-3741

STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

June 12, 1989

MEMORANDUM

TO: Company President

FROM: Steven T. Foster
Commissioner of Insurance

RE: SJR 215 - Study of Mandated Benefits and Providers

The General Assembly of the Commonwealth of Virginia has requested that the Bureau of Insurance, with the assistance of the Department of Health, study the social and financial impact of mandated benefits and providers. While arguments concerning the social impact of mandates are well documented, accurate cost/claim data is visibly absent from most current research. In our efforts to conduct a meaningful study, the Bureau has retained an actuarial consultant to assist in the development of the enclosed questionnaire and in the analysis of the resulting cost/claim data. We are surveying the top 100 writers of health coverage by market share. I cannot over-emphasize the importance of your contribution to this portion of our research.

Please fill out the enclosed questionnaire as accurately and completely as possible and return it to the Bureau of Insurance no later than July 3, 1989. If you have any questions regarding the questionnaire or our study, feel free to contact Ann Colley at (804) 786-6813.

Thank you for your cooperation.

STF:mnb

Additional Mandates

AZ - Maternity benefits for natural mother of an adopted child on adopted parents policy (86)

AR - Mammography (89)

CA - Sterilization (70); Prenatal Care (76, 79); Acupuncture (84); Psychiatric Health Facility (84); Diabetic Education (81)

CO - Mammography (89); Pregnancy Expenses (89); Anti-abortion Mandate for State Group Only (85)

CT - Prescription Drugs (75); Non-custodial Children (84); Notice of Termination (82); HMO Rehabilitation Facilities (82); Emergency Ambulance Services (83); Home Health Aides (84); Home Health Aides Under Medicare Supplement Policies (86)

DE - Pap Smears (89)

FL - Acupuncturists (87)

- Heart Transplants (88)

.ı - Prepaid Health Care Plans (74)

ID - Complication of Pregnancy (76)

IL - Rape or Sexual Assault (75, 82); Psychologists (76); Liver Transplants (84)

IA - Diabetic education (84)

KY - Long-Term Care (86); Newborn Nursery Care (80); Nursing Home (86)

LA - Non-group to Age 65 (74); Ambulance/Transport for Newborns (80)

ME - Prescription Drugs (83); Cardiac Rehabilitation (87)

MD - Second Opinion (85); Catastrophic Coverage (78); Partial Psychiatric Hospitalization (76/88); Blood Products (75); Orthopedic Braces (78); OP Benefits Resulting From UR Programs (85); Congenital Deformity Treatment (89)

MA - Cardiac Rehabilitation (86); Pap Smear (87)

MI - Non-group Medicare Complementary Coverage (85); Mental Hospitals (83); OP Breast Cancer Treatment (89)

MN - Hairpieces for Alopecia Areata (87); Acupuncture (89); Catastrophic Coverage (76)

Additional Mandates

MS - Ambulance/Transport for Newborns (79); Pre-existing Conditions (82)

MO - Pharmacists (78)

MT - Denturists (85); Physician Assistants (89); Phenyketouria (PKU) Treatment (89)

NV - Chinese Medicine (75); Binding Arbitration (89)

NJ - Diagnostic X-rays by Chiropractors (76); Second opinion (80)

NM - Ambulance/Transport for Newborns (75); Lay Midwives (85)

NY - Pre-admission Testing (76); Ambulance Cancer Treatment (82); Nursing Home Option (X); Second Opinion (76)

ND - Continued Coverage After HMO Selections (83)

OH - OP Dialysis (72)

OR - Denturists (80); Blanket Health - Educational Institutions (89); Acupuncture (89); Physicians Assistant (89); Prohibits HMO's Re: Participating Provider Status (89); Diabetic Education (87); Long-Term Care (87)

RI - Second Opinion (83); Catastrophic Coverage (74)

TN - School Psychologists (82); Child Restraint Coverage (89)

TX - OP Psychiatric Centers (83); Dietitian (87); PKU (89); Alzheimer's Disease (89)

UT - Diabetic Outpatient (84)

VA - Opticians (77); Termination Notice (82); Mandated Benefit Option (82)

WA - Removal of a Rider (87); Nutrition for PKU Children (88); Neurodevelopmental Therapies for Children Under Age 6 (89)

WV - Long-Term Care (86); Pap Smears (89)

WI - Tuberculosis; Skilled Nursing Homes (75); Kidney Disease (74); Insulin Infusion Pumps (81); Diabetic OP (82); Diabetic Education (84)

INSURER QUESTIONNAIRE

For the purpose of this questionnaire, please supply amounts based on the Virginia mandated coverage.

1. What amount is added to the annual premium of each type policy for:

Benefits	Individual Policy		Group Coverage	
	Single	Family	Single	Family
Total Annual Premium	_____	_____	_____	_____
Dependent Children Coverage	_____	_____	_____	_____
Doctor to Include Dentist	_____	_____	_____	_____
Newborn Children	_____	_____	_____	_____
Mental/Emotional/Nervous (Mental Disabilities)	_____	_____	_____	_____
Inpatient	_____	_____	_____	_____
Outpatient	_____	_____	_____	_____
Alcohol and Drug Dependence	_____	_____	_____	_____
Obstetrical Services	_____	_____	_____	_____
Pregnancy from Rape or Incest	_____	_____	_____	_____

2. What amount do you anticipate adding to the annual premium of each type policy for mammogram coverage as required by 1989 legislation?

Individual Policy	Group Coverage
Single _____ Family _____	Single _____ Family _____

3. What average dollar amount is paid in claims per individual policy/group certificate for a policy year for the following benefits:

Benefits	Individual Policy		Group Coverage	
	Single	Family	Single	Family
Dependent Children Coverage	_____	_____	_____	_____
Doctor to Include Dentist	_____	_____	_____	_____
Newborn Children	_____	_____	_____	_____

Benefits	Individual Policy		Group Coverage	
	Single	Family	Single	Family
Mental/Emotional/Nervous (Mental Disabilities)				
Inpatient				
Outpatient				
Alcohol and Drug Dependence				
Obstetrical Services				
Pregnancy from Rape or Incest				

4. What is the average number of claims (per visit for outpatient services or per confinement for inpatient services) made under an individual policy/group certificate for a policy year for the following benefits:

Benefits	Individual Policy		Group Coverage	
	Single	Family	Single	Family
Dependent Children Coverage				
Doctor to Include Dentist				
Newborn Children				
Mental/Emotional/Nervous (Mental Disabilities)				
Inpatient				
Outpatient				
Alcohol and Drug Dependence				
Obstetrical Services				
Pregnancy from Rape or Incest				

5. What is the number of individual policies/group certificates issued by your Company in 1987?

Please supply the following claim information for your 1987 individual policies/group certificates.

	Total Number of Claims	Total Dollar Amount of Claims
Dependent Children Coverage	_____	_____
Doctor to Include Dentist	_____	_____
Newborn Children	_____	_____
Mental/Emotional/Nervous (Mental Disabilities)	_____	_____
Inpatient	_____	_____
Outpatient	_____	_____
Alcohol and Drug Dependence	_____	_____
Obstetrical Services	_____	_____
Pregnancy from Rape or Incest	_____	_____

Did you offer or provide coverage for the following benefits or reimbursement for providers prior to the institution of mandates? If so, to what maximum?

Benefits			
Dependent Children Coverage	No ___	Yes ___	Maximum _____
Doctor to Include Dentist	No ___	Yes ___	Maximum _____
Newborn Children	No ___	Yes ___	Maximum _____
Mental/Emotional/Nervous (Mental Disabilities)	No ___	Yes ___	Maximum _____
Inpatient	No ___	Yes ___	Maximum _____
Outpatient	No ___	Yes ___	Maximum _____
Alcohol and Drug Dependence	No ___	Yes ___	Maximum _____
Obstetrical Services	No ___	Yes ___	Maximum _____
Pregnancy from Rape or Incest	No ___	Yes ___	Maximum _____

Providers

Chiropractor	No ___	Yes ___	Maximum _____
Optometrist	No ___	Yes ___	Maximum _____
Optician	No ___	Yes ___	Maximum _____
Psychologist	No ___	Yes ___	Maximum _____
Clinical Social Worker	No ___	Yes ___	Maximum _____
Podiatrist	No ___	Yes ___	Maximum _____
Chiropodist	No ___	Yes ___	Maximum _____
Professional Counselor	No ___	Yes ___	Maximum _____
Physical Therapist	No ___	Yes ___	Maximum _____
Clinical Nurse Specialist	No ___	Yes ___	Maximum _____
Audiologist/Speech Pathologist	No ___	Yes ___	Maximum _____

8. Please provide figures on the average annual number of visits for benefits and services that are provided by both physicians and mandated providers. Provid the figures for annual visits per individual policy/group certificate for benefits provided by physicians prior to the mandate and for physicians and mandated providers after the mandate.

Providers	Prior to Mandate Physicians only	After Mandate Physicians	After Mandate Other Providers
Chiropractor	_____	_____	_____
Optometrist	_____	_____	_____
Optician	_____	_____	_____
Psychologist	_____	_____	_____
Clinical Social Worker	_____	_____	_____
Podiatrist	_____	_____	_____
Chiropodist	_____	_____	_____
Professional Counselor	_____	_____	_____
Physical Therapist	_____	_____	_____

Providers	Prior to Mandate Physicians only	After Mandate Physicians	After Mandate Other Providers
Clinical Nurse Specialist	_____	_____	_____
Audiologist/Speech Pathologist	_____	_____	_____

9. What types of services and to what maximum dollar amounts do you provide or offer coverage for mental disabilities (other than alcohol and chemical dependency)?

Mandated Only _____
Additional:
- Inpatient _____
- Outpatient _____
- Residential Setting _____
- Partial Hospital Day _____
- Full Hospital Day _____
- Other _____

What types of services and to what maximum dollar amounts do you provide or offer coverage for alcohol and chemical dependency?

Mandated Only _____
Additional:
- Inpatient _____
- Outpatient _____
- Residential Setting _____
- Partial Hospital Day _____
- Full Hospital Day _____
- Other _____

11. What would be the annual premium for an individual policy with no mandated benefits or mandated providers for a 30 year old standard male in the Richmond area? What would be the cost for a policy for the same individual with present mandates? (Do not include 1989 legislation) ($250 deductible, $1,000 stop-loss limit, 80% co-insurance factor $250,000 policy maximum.)

With Mandates $_____

Without Mandates $_____

12. Do you have figures on the cost of a certain procedure/procedures when performed by a physician compared to the charge for the same/substituted procedure performed by a mandated provider other than a physician? Yes ___ No ___

Procedure	Physician Charge	Provider and	Provider Charge
Limited Eye Exam	_____	Optometrist	_____
Family Counseling (One Hour)	_____	Psychologist	_____
X-Rays	_____	Chiropractor	_____
Excision of Ingrown Toenail	_____	Podiatrist	_____
Heat Treatment	_____	Physical Therapist	_____
Other (Please Specify)	_____	_____	_____

13. What is the average administrative cost to your company of adding a newly mandated benefit?

	Must Offer	Must Provide
Policy Forms	_____	_____
Systems	_____	_____
Claims Procedures	_____	_____
Claims Processing	_____	_____
Other (Please List)		
	_____	_____
	_____	_____
	_____	_____

14. What average dollar amount is added to the annual premium of a group certificate to cover the cost of conversion to an individual policy?

Single _____ Family _____

Company Name:
Respondent's Name:
Title:
Phone No.:

Thank you for completing this questionaire. Please return by July 3, 1989 to Ann Colley, Principal Research Analyst, Bureau of Insurance, P. O. Box 1157, Richmond, VA 23209.

INITIAL SURVEY RESPONSES

Returned Survey by August 14th 31

Aetna Life Insurance Company
Bankers Life and Casualty Company
Blue Cross and Blue Shield of Virginia
Central Life Assurance Company
Colonial Life Insurance Company of America The
Connecticut General Life Insurance Company
Continental Assurance Company
Educators Mutual Life Insurance Company
Federal Home Life Insurance Company
General American Life Insurance Company
Golden Rule Insurance Company
Group Hospitalization and Medical Services, Inc.
Guardian Life Insurance Company The
Home Life Insurance Company
Jefferson-Pilot Life Insurance Company
Lincoln National Life Insurance Company The
Metropolitan Life Insurance Company
Mutual of Omaha Insurance Company
Nationwide Life Insurance Company
Northwestern National Life Insurance Company
Pacific Mutual Life Insurance Company
Paul Revere Life Insurance Company The
Phoenix Mutual Life Insurance Company
Principal Mutual Life Insurance Company
Provident Life and Accident Insurance Company
State Mutual Life Assurance Company of America
Time Insurance Company
Union Bankers Insurance Company
United of Omaha Life Insurance Company
Washington National Insurance Company
World Insurance Company

Does Not Write Applicable Business 33

Acceleration Life Insurance Company
American Bankers Life Assurance Company of Florida
American Family Life Insurance Company of Columbus
Amex Life Assurance Company
Colonial Life and Accident Insurance Company
Combined Insurance Company of America
Connecticut Mutual Life Insurance Company The
Credit Life Insurance Company The
Cudis Insurance Society, Inc.
Durham Life Insurance Company
Ford Life Insurance Company
Globe Life Insurance Company
Independent Life and Accident Insurance Company
Integon Life Insurance Corporation
Life Insurance Company of North America
Life Insurance Company of Virginia The
Minnesota Mutual Life Insurance Company
Mutual Benefit Life Insurance Company
National Home Life Assurance
New York Life Insurance Company
Northwestern Mutual Life Insurance
Pennsylvania Life Insurance Company
Pioneer Life Insurance Company of Illinois
Provident Mutual Life Insurance Company of Philadelphia
Reliance Standard Life Insurance Company
Security of America Life Insurance Company
Security Trust Life Insurance Company
Sturdivant Life Insurance Company
Transport Life Insurance Company
Union Security Life Insurance Company
United Insurance Company of America
USAA Life Insurance Company
Voyager Life Insurance Company

No Longer Writes Applicable Business 5

Allstate Life Insurance Company
John Hancock Mutual Life Insurance Company
Mutual Life Insurance Company of New York
Shenandoah Life Insurance Company
Union Central Life Insurance Company The

To complete this questionnaire, please refer to the information on this page.

In determining the cost or value of the mandate please use actual claims data or actuarial data.

Indicate here what you used as your basis for calculation.

_____ Actual claims data

_____ Consulting manuals used by your company

_____ Experience, knowledge of your company's staff and discussion among yourselves

_____ Some combination of the above

_____ Other - please explain

_____

_____

_____

Please indicate where your coverage exceeds that required by Virginia mandates.

Benefits Required to be Included in Policies

1. Reimbursement of covered services provided by:

   a. chiropractors
   b. optometrists
   c. professional counselors
   d. psychologists
   e. clinical social workers
   f. podiatrists
   g. physical therapists
   h. chiropodists
   i. clinical nurse specialists
   j. speech pathologists/audiologists
   k. opticians

2. Coverage for mentally retarded or physically handicapped children of the insured beyond normal termination of coverage date for dependents (dependent children coverage).

3. Coverage for services provided by a dentist if such services would be covered if performed by a physician (doctor to include dentist).

4. Coverage for newborn children from the moment of birth for injury or sickness including care and treatment of medically diagnosed congenital defects and birth abnormalities. All newborn care first 31 days (newborn children).

   Coverage for inpatient treatment for mental, emotional, and nervous disorders for at least 30 days per policy year (mental disabilities).

6. Coverage for pregnancy followed by an act of rape, provided certain reporting conditions are met (pregnancy from rape or incest).

Benefits Required to be Offered in Policies

1. Coverage for inpatient and outpatient treatment for alcohol and drug dependence for at least 45 days (inpatient) and 45 sessions (outpatient) per policy year or calendar year (alcohol and drug dependence).

2. Coverage for obstetrical services (obstetrical services).

3. Coverage for mammograms (effective January 1, 1990) (mammograms).

INSURER QUESTIONNAIRE

mpany Name: _____
espondent's Name: _____
Title: _____ Phone No.: _____

For the purpose of this questionnaire, please supply amounts based on the Virginia mandated coverage. Please use what you consider to be your standard policy to answer this questionnaire. For the individual policy used as your base calculations in the question below.

- What is the deductible? _____
- What is the coinsurance? _____
- What is the individual/employee out-of-pocket maximum? _____

1. For your health insurance in Virginia, what is the total annual premium including mandates, and what amount is added to the annual premium of each type policy for each mandate listed?

	Individual Policy		Group Certificates	
	Single	Family	Single	Family
Total Annual Policy Premium	_____	_____	_____	_____
Premium for:				
Dependent Children Coverage	_____	_____	_____	_____
Doctor to Include Dentist	_____	_____	_____	_____
Newborn Children	_____	_____	_____	_____
Mental/Emotional/Nervous (Mental Disabilities)	_____	_____	_____	_____
Inpatient	_____	_____	_____	_____
Outpatient	_____	_____	_____	_____
Alcohol and Drug Dependence	_____	_____	_____	_____
Obstetrical Services	_____	_____	_____	_____
Pregnancy from Rape or Incest	_____	_____	_____	_____
Chiropractor	_____	_____	_____	_____
Optometrist	_____	_____	_____	_____
Optician	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
Clinical Social Worker	_____	_____	_____	_____
Podiatrist	_____	_____	_____	_____

	Individual Policy		Group Certificates	
	Single	Family	Single	Family
Chiropodist	_____	_____	_____	_____
Professional Counselor	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Clinical Nurse Specialist	_____	_____	_____	_____
Audiologist/Speech Pathologist	_____	_____	_____	_____

2. What amount do you anticipate adding to the annual premium of each type policy for mammogram coverage as required by 1989 legislation?

Individual Policy	Group Coverage
Single _____ Family _____	Single _____ Family _____

3. What is the average dollar amount paid in claims for a policy year for the following benefits:

Benefits	Individual Policy		Group Coverage	
	Single	Family	Single	Family
Dependent Children Coverage	_____	_____	_____	_____
Doctor to Include Dentist	_____	_____	_____	_____
Newborn Children	_____	_____	_____	_____
Mental/Emotional/Nervous (Mental Disabilities)	_____	_____	_____	_____
Inpatient	_____	_____	_____	_____
Outpatient	_____	_____	_____	_____
Alcohol and Drug Dependence	_____	_____	_____	_____
Obstetrical Services	_____	_____	_____	_____
Pregnancy from Rape or Incest	_____	_____	_____	_____

4. What is the average number of claims (visits for outpatient services or confinement for inpatient services) made during any one year for the following benefits:

Benefits	Individual Policy		Group Coverage	
	Single	Family	Single	Family
Dependent Children Coverage	_____	_____	_____	_____
Doctor to Include Dentist	_____	_____	_____	_____

Benefits	Individual Policy Single	Individual Policy Family	Group Coverage Single	Group Coverage Family
Newborn Children				
Mental/Emotional/Nervous (Mental Disabilities)				
Inpatient				
Outpatient				
Alcohol and Drug Dependence				
Obstetrical Services				
Pregnancy from Rape or Incest				

5. What is the number of individual policies and/or group certificates issued by your Company in 1988 in Virginia?

	Single	Family
Individual		
Group		

What is the number of individual policies and/or group certificates in force for your company as of December 31, 1988 in Virginia?

	Single	Family
Individual		
Group		

6. Please supply the following claim information for your 1988 individual policies/group certificates.

	Individual Policy Number of Claims	Individual Policy Total Claims Dollars	Group Coverage Number of Claims	Group Coverage Total Claims Dollars
Dependent Children Coverage				
Doctor to Include Dentist				
Newborn Children				
Mental/Emotional/Nervous (Mental Disabilities)				
Inpatient				
Outpatient				

	Individual Policy		Group Coverage	
	Number of Claims	Total Claims Dollars	Number of Claims	Total Claims Dollars
Alcohol and Drug Dependence	_____	_____	_____	_____
Obstetrical Services	_____	_____	_____	_____
Pregnancy from Rape or Incest	_____	_____	_____	_____

7. Did you offer or provide coverage for the following benefits or reimbursement for the following providers prior to the institution of relevant mandates? If so, to what maximum?

Dependent Children Coverage	No ____	Yes ____	Maximum _____
Doctor to Include Dentist	No ____	Yes ____	Maximum _____
Newborn Children	No ____	Yes ____	Maximum _____
Mental/Emotional/Nervous (Mental Disabilities)	No ____	Yes ____	Maximum _____
Inpatient	No ____	Yes ____	Maximum _____
Outpatient	No ____	Yes ____	Maximum _____
Alcohol and Drug Dependence	No ____	Yes ____	Maximum _____
Obstetrical Services	No ____	Yes ____	Maximum _____
Pregnancy from Rape or Incest	No ____	Yes ____	Maximum _____
Chiropractor	No ____	Yes ____	Maximum _____
Optometrist	No ____	Yes ____	Maximum _____
Optician	No ____	Yes ____	Maximum _____
Psychologist	No ____	Yes ____	Maximum _____
Clinical Social Worker	No ____	Yes ____	Maximum _____
Podiatrist	No ____	Yes ____	Maximum _____
Chiropodist	No ____	Yes ____	Maximum _____
Professional Counselor	No ____	Yes ____	Maximum _____
Physical Therapist	No ____	Yes ____	Maximum _____
Clinical Nurse Specialist	No ____	Yes ____	Maximum _____
Audiologist/Speech Pathologist	No ____	Yes ____	Maximum _____

8. Please provide the average annual number of visits per individual policy or group certificate for benefits and services that are provided by both physicians and mandated providers. Provide the figures for average annual visits per individual policy/group certificate for benefits provided by physicians prior to the mandate and for physicians and mandated providers after the mandate.

Providers	Prior to Mandate Physicians only	After Mandate Physicians	After Mandate Providers
Chiropractor	_____	_____	_____
Optometrist	_____	_____	_____
Optician	_____	_____	_____
Psychologist	_____	_____	_____
Clinical Social Worker	_____	_____	_____
Podiatrist	_____	_____	_____
Chiropodist	_____	_____	_____
Professional Counselor	_____	_____	_____
Physical Therapist	_____	_____	_____
Clinical Nurse Specialist	_____	_____	_____
Audiologist/Speech Pathologist	_____	_____	_____

What is the average charge per visit for the information provided above?

Providers	Prior to Mandate Physicians only	After Mandate Physicians	After Mandate Providers
Chiropractor	_____	_____	_____
Optometrist	_____	_____	_____
Optician	_____	_____	_____
Psychologist	_____	_____	_____
Clinical Social Worker	_____	_____	_____
Podiatrist	_____	_____	_____
Chiropodist	_____	_____	_____
Professional Counselor	_____	_____	_____
Physical Therapist	_____	_____	_____

Providers	Prior to Mandate Physicians only	After Mandate Physicians	Providers
Clinical Nurse Specialist	_____	_____	_____
Audiologist/Speech Pathologist	_____	_____	_____

9. What would be the annual premium for an individual policy with no mandated benefits or mandated providers for a 30 year old standard male in the Richmond area? What would be the cost for a policy for the same individual with present mandates? (Do not include 1989 legislation) ($250 deductible, $1,000 stop-loss limit, 80% co-insurance factor $250,000 policy maximum.) If you do not issue a policy of this type, please provide the premium for a standard 30 year old male for the policy that you offer that is most similar to the one described and summarize the differences from the described policy.

With Mandates $_____

Without Mandates $_____

10. Please provide information on the cost of a certain procedure or average cost per visit when performed by a physician and the charge for the same/substituted procedure performed by a mandated provider other than a physician to the extent applicable.

CPT Codes	Procedure	Physician Charge	Provider and	Provider Cha
92002	Limited Eye Exam	_____	Optometrist	_____
90844	Family Counseling (One Hour)	_____	Psychologist	_____
72010-72120	X-Rays	_____	Chiropractor	_____
11765	Excision of Ingrown Toenail	_____	Podiatrist	_____
97024	Heat Treatment	_____	Physical Therapist	_____
------	Other (Please Specify)	_____	_____	_____

11. What is the average administrative cost to your company of adding a newly mandated benefit?

	Must Offer		Must Provide	
	Initial	Ongoing	Initial	Ongoing
Policy Forms	_____	_____	_____	_____
Systems	_____	_____	_____	_____
Claims Procedures	_____	_____	_____	_____

	Must Offer		Must Provide	
	Initial	Ongoing	Initial	Ongoing
Claims Processing	_____	_____	_____	_____
Other (Please List)				
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

12. Do you add an amount to the annual premium of a group certificate to cover the cost of conversion to an individual policy? Yes _____ No _____

If yes, what is the average dollar amount:

Single _____ Family _____

If no, is that cost covered in the annual premium of the individual policy?
Yes _____ No _____

Thank you for completing this questionaire. Please return by November 10, 1989 to Ann Colley, Principal Research Analyst, Bureau of Insurance, P. O. Box 1157, Richmond, VA 23209.

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Washington, D. C. 20065

Health Insurance Mandated Benefits: House Joint Resolution 90. Commonwealth of Virginia: State Corporation Commission, Bureau of Insurance, August, 1982.

"Hewitt Study Details Mental Benefits". Eco-Facts. American Psychiatric Association, December, 1987.

House Document No. 28: Extraterritorial Authority Over Accident and Sickness Insurance Policies Out-of-State. Commonwealth of Virginia: State Corporation Commission, Bureau of Insurance, 1989.

Interim Report of the Committee on Mandated Health Insurance Benefits. State of Maryland: Governor's Commission on Health Care Policy and Financing, January, 1989.

Interim Report of the Insurance Committee. Texas House of Representatives, November, 1988.

Jensen, Gail A. and Jon R. Gabel. "The Erosion of Purchased Health Insurance". Inquiry. Blue Cross and Blue Shield Association, Fall, 1988, 25:328-343.

Krohm, Gregory and Mary Grossman. "Study of Costs of Mandated Benefits: Report on Phase I". State of Wisconsin: Office of the Commissioner of Insurance, May, 1989.

Larson, John G. Mandated Health Insurance Coverage: A Study of Review Mechanisms, for the Virginia State Corporation Commission's Bureau of Insurance, 1979.

LeRoy, Lauren. Case Study #16: The Costs and Effectiveness of Nurse Practitioners. Health Policy Program. University of California, San Francisco, July, 1981.

Mandated Benefits Study. Blue Cross and Blue Shield of Maryland, Inc.: Corporate Actuarial, Actuarial Services, February, 1988.

Mellman, Richard J. Maryland Mandated Benefits Report. Health Insurance Association of America, October, 1985.

Musser, Marilyn. Report of the Insurance Coverage Subcommittee on Mandated Benefits. State of Iowa, October, 1988.

Paterson, Andrea. "Mandated Mental Health Insurance: A Complex Case of Pros and Cons". State Legislative Report Vol. 11, No. 10 (July, 1986).

Position Paper of the Virginia Nurses Association on SJR 215: Study of Mandated Benefits and Providers. Virginia Nurses Association, 1989.

Power, M. and A. Ralston. "State-Mandated Group Health Insurance Coverages". Benefits Quarterly, 1989, 1:1-10.

Review of House Bill 2288: Insurance Coverage for Mammography Screenings. Health Care Cost Containment Council of the Commonwealth of Pennsylvania, September, 1988.

Review of House Bill 364: Insurance Coverage for Mental Disorders. Health Care Cost Containment Council of the Commonwealth of Pennsylvania, November, 1987.

Scandlen, Greg. "Mandated Health Care Benefits". Issue Analysis. American Legislative Exchange Council, June, 1988.

Source Book of Health Insurance Data. Health Insurance Association of America, 1989.

Study of the Effectiveness of Senate Bill 26. Texas State Board of Insurance, March, 1985.

Wolk, Steve. An Analysis of Florida Workers' Compensation Medical Claims for Back-Related Injuries. The Foundation for Chiropractic Education and Research, February, 1988.

Wolk, Steve. Chiropractic Versus Medical Care: A Cost Analysis of Disability and Treatment for Back-Related Workers' Compensation Cases. The Foundation for Chiropractic Education and Research, September, 1988.

Working Paper No. 5: State Mandated Benefits. U. S. Congress: House Subcommittee on Labor-Management Relations, January 21, 1987.

Companies Not Responding

Aetna Life Insurance Company
American General Group Insurance Company
Celtic Life Insurance Company
Colonial Life Insurance Company of America
Connecticut General Life Insurance Company
Crown Life Insurance Company
Federal Home Life Insurance Company
Hartford Life Insurance Company
John Alden Life Insurance Company
Lincoln National Health Care Insurance Company
Montgomery Ward Life Insurance Company
Nationwide Insurance Company
New England Mutual Life Insurance Company
Pacific Fidelity Life Insurance Company
Reserve Life Insurance Company
Southland Life Insurance Company
State Mutual Companies
Time Insurance Company
Union Fidelity Life Insurance Company
United States Life Insurance Company in the City of New York
Washington National Life Insurance Company
World Insurance Company

BIBLIOGRAPHY

A Comparison of Charges by Optometrists and Ophthalmologists Under the Medicare Program. Center for Vision Care Policy, State College of Optometry, State University of New York, June, 1989.

Analysis of Infant Deaths Occurring to Richmond Residents in 1986. Richmond City Health Department: Division of Planning and Evaluation, April, 1989.

A Position Paper on Mandated Benefits and Providers. Blue Cross and Blue Shield of the National Capital Area, Washington, D. C., 1989.

Browne, B., et al. "Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums". Journal of the American Society of CLU and ChFC, January, 1987, pp. 74-78.

Case Study #37: Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis. U. S. Congress: Office of Technology Assessment, 1986.

Cost and Availability of Routine Eye Care: A Comparison of Optometrists and Ophthalmologists. Center for Vision Care Policy, State College of Optometry, State University of New York, June, 1989.

Dyckman, Z. and J. Anderson. Mandated Health Benefits in Maryland: A Research Report on Relevant Public Policy Issues. Center for Health Policy Studies, 1985.

Frank, Richard G. "'Freedom of Choice' Laws: Empirical Evidence of Their Contribution to Competition in Mental Health Care Delivery". Health Policy Quarterly, Vol. 2, Summer, 1982, 2:79-97.

Frisman, Linda K., Thomas G. McGuire, and Margo L. Rosenbach. "Costs of Mandates for Outpatient Mental Health Care in Private Health Insurance". Archive of General Psychiatry, June, 1985, 42:558-561.

Gabel, Jon and Gail Jenson. Research Bulletin: The Price of State Mandated Benefits. Health Insurance Association of America, July, 1989.

Goodman, John C. and G. L. Musgrave. Freedom of Choice in Health Insurance. National Center for Policy Analysis, November, 1988.

Guide to Clinical Preventative Services. U. S. Preventative Services Task Force, May, 1989.

Hall, Charles P. "The Economics and Politics of Mandated Health Benefits: A Pennsylvania Case Study". Benefits Quarterly, 1989, 1:11-17.

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Miami, Florida 33102

Government Compliance Officer
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120 Bloor Street East
Toronto, Canada M4W1B8

Government Compliance Officer
Hartford Life Insurance Company
Post Office Box 2999
Hartford, Connecticut 06104

Government Compliance Officer
Montgomery Ward Life Insurance Company
Post Office Box 5033
North Suburban, Illinois 60197

Government Compliance Officer
Monumental General Insurance Company
1111 North Charles Street
`timore, Maryland 21201

overnment Compliance Officer
New England Mutual Life Insurance Company
501 Boylston Street
Boston, Massachusetts 02117

Government Compliance Officer
Pacific Fidelity Life Insurance Company
4333 Edgewood Road, N.E.
Cedar Rapids, Iowa 52499

Government Compliance Officer
Union Fidelity Life Insurance Company
4850 Street Road
Trevose, Pennsylvania 19049

Government Compliance Officer
North American Life and Casualty Company
1750 Hennepin Avenue
Minneapolis, Minnesota 55403

REVISED SURVEY RESPONSES

Companies Returning Survey by November 20th

Bankers Life and Casualty Company
Blue Cross and Blue Shield of Virginia
Continental Insurance Company
Educators Mutual Life Insurance Company
General American Life Insurance Company
Group Hospitalization and Medical Services, Inc. t/a
Blue Cross and Blue Shield of the National Capital Area
Guardian Life Insurance Company
Lincoln National Life Insurance Company
Massachusetts Mutual Insurance Company
Metropolitan Life Insurance Company
Mutual of Omaha Insurance Company
Northwestern National Life Insurance Company
Paul Revere Life Insurance Company
Pacific Mutual and PM Group Life Insurance Company
Phoenix Mutual Life Insurance Company
Provident Life and Accident Insurance Company
Principal Mutual Life Insurance Company
Union Bankers Insurance Company
United of Omaha Insurance Company

Companies Responding After November 20th

Central Life Assurance Company
Consumers United Insurance Company
Golden Rule Insurance Company
Home Life Insurance Company
Travelers Insurance Company The
Unum Life Insurance Company of America

Companies Unable to Respond

American Chambers Life Insurance Company
Jefferson-Pilot Life Insurance Company
North American Life and Casualty Company
United American Insurance Company

Do Not Write Applicable Business

Monumental General Insurance Company
Union Labor Life Insurance Company

Pat Hart
Manual Writer
General American Life Insurance Company
Post Office Box 396
St. Louis, Missouri 63166

Ms. Virginia A. Paton
Health Actuary
Washington National Life Insurance Company
1630 Chicago Avenue
Evanston, Illinois 60201

Ms. Linda Mercer
Phoenix Mutual Life Insurance Company
One American Row
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Mr. Mark E. Billingsley
Vice President and Actuary
World Insurance Company
Post Office Box 128
Omaha, Nebraska 68101

Mr. Donald L. Stevens
[illegible]e President
Colonial Life Insurance Company of America
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Concord, New Hampshire 03301

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Unum Life Insurance Company of America
Post Office Box 9548
Portland, Maine 04122

Mr. Peter Perkins
Blue Cross and Blue Shield of Virginia
2015 Staples Mill Road
Post Office Box 27401
Richmond, Virginia 23279

Ms. Dixie Metheny
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American General Group Insurance Company
Post Office Box 660238
Dallas, Texas 75266-0238

Mr. Russell B. Tucker
Actuary
Reserve Life Insurance Company
Post Office Box 660254
[illegible]las, Texas 75266-0238

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1295 State Street
Springfield, Massachusetts 01111

Ms. Barbara White
Assistant Actuary
American Chambers Life Insurance Company
Post Office Box 3047
Naperville, Illinois 60566

Ms. Brenda McDowell
Assistant to Actuary
Consumers United Insurance Company
2100 M Street, N.W.
Washington, D. C. 20037

Mr. Peter T. Haley
Actuarial Analyst
Union Labor Life Insurance Company
111 Massachusetts Avenue, N.W.
Washington, D. C. 20001

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Southland Life Insurance Company
Post Office Box 220
Dallas, Texas 75221

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New York, New York 10038

Government Compliance Officer
Lincoln National Health Care Insurance Company
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Fort Wayne, Indiana 46801

Government Compliance Officer
United American Insurance Company
Post Office Box 810
Dallas, Texas 75221

Government Compliance Officer
Celtic Life Insurance Company
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Post Office Box 7216
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Supervisor - State Reports
Continental Assurance Company
CNA Plaza
Chicago, Illinois 60685

Ms. Nancy Bleach
Policy Approval
Mutual of Omaha Insurance Company and
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

Ms. Eva LaLonde
Assistant Compliance Analyst
Provident Life and Accident Insurance Company
Mountain Square
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Senior Actuarial Associate (Group)
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Connecticut General Life Insurance Company
Hartford, Connecticut 06152

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Government Relations Associate
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Fort Wayne, Indiana 46801

Mr. Henry W. Frantz ,III
Jefferson Pilot Life Insurance Company
Post Office Box 20727
Greensboro, North Carolina 27420-0727

Mr. Scott Geske
Assistant Actuary
Time Insurance Company
Post Office Box 624
Milwaukee, Wisconsin 53201

Mr. William A. Macomber, Jr.
Associate Actuary
Bankers Life and Casualty
4444 Lawrence Avenue
Chicago, Illinois 60630

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Paul Revere Life Insurance Company
18 Chestnut Street
Worcester, Massachusetts 01608

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Vice President
Golden Rule Insurance Company
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Indianapolis, Indiana 46278

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Group Actuarial Assistant
Pacific Mutual Life Insurance Company
700 Newport Center Drive
Newport Beach, California 92660

Mr. Earl L. Hoffman
Second Vice President and Actuary, Group
Northwestern National Life Insurance Company
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Minneapolis, Minnesota 55440

Mr. Warren R. Jones
Vice President and Chief Actuary
Union Bankers Insurance Company
Post Office Box 665433
Dallas, Texas 75265-5433

Mr. D. Edward Young
Vice President
Educators Mutual Life Insurance Company
Post Office Box 3149
Lancaster, Pennsylvania 17604-3149

Did Not Respond by August 14th 23

Aetna Life Insurance and Annuity Company
Celtic Life Insurance Company
Consumers United Insurance Company
Crown Life Insurance Company
Eastern Insurance Company
Equitable Life Assurance Society of the United States The
Hartford Life Insurance Company
John Alden Life Insurance Company
Lincoln National Health Care Insurance Company
Massachusetts Mutual Life Insurance Company
Montgomery Ward Life Insurance Company
Monumental General Insurance Company
New England Mutual Life Insurance Company
North American Life and Casualty Company
Pacific Fidelity Life Insurance Company
Reserve Life Insurance Company
Southland Life Insurance Company
Travelers Insurance Company
Union Fidelity Life Insurance Company
Union Labor Life Insurance Company The
United American Insurance Company
United States Life Insurance Company in the City of New York
Unum Life Insurance Company of America

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American Chambers Life Insurance Company
American Fidelity Assurance Company
American General Group Insurance Company
American Republic Insurance Company
Cuna Mutual Insurance Society
Gulf Life Insurance Company
Physicians Mutual Insurance Company
Prudential Insurance Company of America The

COMMONWEALTH OF VIRGINIA

STEVEN T. FOSTER
OMMISSIONER OF INSURANCE

Box 1157
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TELEPHONE: (804) 786-3741

STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

October 10, 1989

Mr. Richard E. Bowman, Jr.
Assistant Director
The Travelers Companies
One Tower Square
Hartford, Connecticut 06183

Re: SJR 215 - Study of Mandated Benefits and Providers

Dear Mr. Bowman:

On June 12, 1989, we wrote to your company president requesting cost/claim data pertinent to our study of mandated benefits and providers. Because of time constraints imposed by the Virginia General Assembly, we requested that a completed questionnaire be returned to the Bureau of Insurance by July 3, 1989. We extended the deadline to July 28th in certain cases at companies' requests.

At this time, we are requesting your response to a follow-up survey because more time has been allowed for the study and the additional time may allow your company to provide more information. We have included additional clarification and more specificity that also may assist you in providing more complete responses. The responses to the original survey did not supply the information necessary to respond adequately to the General Assembly's request.

Please complete the attached questionnaire and return it by November 10, 1989 to Ann Colley, Principal Research Analyst, at the above address. If you have any questions, you may reach Ms. Colley at (804) 786-6813.

Sincerely yours,

Steven T. Foster
Commissioner of Insurance

STF/csw

Attachment