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

# The Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia: 1991 Reporting Period

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA


# HOUSE DOCUMENT NO. 9

COMMONWEALTH OF VIRGINIA
RICHMOND
1993

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**STATE CORPORATION COMMISSION**

October 30, 1992

TO: The Honorable L. Douglas Wilder
Governor of Virginia
and
The General Assembly of Virginia

We are pleased to transmit this Report of the the State Corporation Commission's Bureau of Insurance on The Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia: 1991 Reporting Period.

Respectfully submitted,

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## TABLE OF CONTENTS

## EXECUTIVE SUMMARY

Section 38.2-3419.1 of the Code of Virginia and Insurance Regulation No. 38 require every insurer, health services plan, and health maintenance organization to report annually to the State Corporation Commission (Commission) cost and utilization information for each of the mandated benefits and mandated providers contained in §§ 38.2-3408 through 38.2-3419 and 38.2-4221. This document is the Commission's consolidation of reports submitted by affected companies for the initial reporting period ending December 31, 1991.

Of the **903** companies licensed to issue accident and sickness policies or subscription contracts in Virginia in 1991, **104** were required to file full reports for the initial reporting period of October 1, through December 31, 1991. Although reports were received from each of these companies, the majority contained substantial omissions. As a result, information presented in this report for individually issued health insurance policies and subscription contracts was taken from only **5** companies. Group figures represent information reported by **16** companies. Each of these companies are among the top 20 writers of accident and sickness insurance by premium volume in Virginia. As a result, this report reflects data reported by companies representing **57.50%** of the Virginia accident and sickness insurance market and **923,909** units of coverage (single and family individual policies and group certificates) subject to Virginia's mandated benefit and provider requirements. It is anticipated that future reports will represent a larger percentage of this market as companies complete required changes in their data collection and reporting systems.

The figures displayed below represent the amount of total annual premium which has been reported to be attributable to mandated benefits and mandated providers, for both individual and group business, on a percentage basis. Mandated offers of coverage have been separated from those mandated benefits which must be included in policies and subscription contracts to illustrate their impact on group business.

***PREMIUM IMPACT***
***Percent of Total Annual Premium***

| | *Individual* | | *Group* | |
|---|---|---|---|---|
| | *Single* | *Family* | *Single* | *Family* |
| *Mandated Offers* | *1.85%* | *0.89%* | *9.76%* | *11.66%* |
| *Mandated Benefits ** | *4.09%* | *4.30%* | *3.28%* | *4.50%* |
| *Mandated Providers* | *2.79%* | *3.22%* | *2.24%* | *2.26%* |
| *Total* | *8.73%* | *8.41%* | *15.28%* | *18.42%* |

* Excluding mandated offers of coverage

In addition to premium information, companies reported their claim experience for each mandate for the fourth quarter of 1991. The following is a summary of this experience.

***CLAIM EXPERIENCE***
***Percent of Total Claims***

| | *Individual* | *Group* |
|---|---|---|
| *Mandated Benefits* | *1.96%* | *13.26%* |
| *Mandated Providers* | *0.78%* | *2.55%* |
| *Total* | *2.74%* | *15.81%* |

Reported group claim expenses for this three-month period generally support the annual premium figures reported for group business when compared on a percentage basis. Reported individual claims, however, do not support the premium figures for individual business. This difference may be due to underreporting for individual business as a result of the use of less sophisticated data collection and information systems by companies in this area. Comparisons between premium and claim information will be more reliable in future reporting periods when both are reported on an annual basis.

Claim information regarding the rate of utilization of the mandated benefits and providers has been generated. However, this information will be most useful when compared with results of future reporting periods. It is anticipated that these rates may also be helpful in assessing the relative effect of new mandates and in comparing the changes that occur among providers that render similar services from one reporting period to another.

Claim information specific to certain medical procedures indicates that for those procedures most of the mandated provider categories have lower average and median claim costs per visit than do their physician counterparts. However, in some cases the difference between mandated provider and physician costs is small.

The Commission recognizes that it could be argued in some cases that lower charges by mandated providers result in cost savings to the health care system. The Commission also recognizes the counter-argument that mandated providers increase the utilization of covered services and, therefore, irrespective of the unit cost of services, actually increase the total cost of health care. However, at this time the Commission is unable to substantiate either of these arguments given the data available to it.

## INTRODUCTION

Section 38.2-3419.1 of the Code of Virginia requires every insurer, health services plan, and health maintenance organization to report annually to the State Corporation Commission (Commission) cost and utilization information for each of the mandated benefits and mandated providers contained in §§ 38.2-3408 through 38.2-3419 and 38.2-4221. Companies are required to submit their reports no later than the May 1, following the reporting period. The Commission is required to prepare a consolidation of these reports for submission to the General Assembly by October 31, of each year. This document constitutes the Commission's report for the initial reporting period ending December 31, 1991.

Pursuant to § 38.2-3419.1, the Commission adopted Insurance Regulation No. 38: Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers on July 5, 1991. Insurance Regulation No. 38 specifies the detail and form of the information which must be reported by insurers. Companies were required to file reports by May 1, 1992 for the initial reporting period of October 1, through December 31, 1991. Beginning with 1992, all reporting periods will be full calendar years.

### Background

The State Corporation Commission was requested by the 1989 Session of the General Assembly to study the social and financial impact of mandated health insurance benefits and providers pursuant to Senate Joint Resolution No. 215. In its report (1990 Senate Document No. 15), the Commission suggested that the legislature, if it desired additional information on the subject, could require insurers to collect and report, on a regular basis, information regarding the cost and utilization of mandated benefits and providers. Section 38.2-3419.1 was enacted in 1990 to require such reporting by insurers, beginning in 1991.

Mandated benefit statutes typically require insurers to include, or make available, coverage for a particular treatment or category of treatments, to extend coverage to certain persons, or to continue coverage in certain situations. Virginia's mandated benefit requirements can be divided into two distinct categories:

- benefits or provisions which must be included in all accident and sickness insurance policies; and
- benefits or provisions which must be offered or made available to anyone purchasing an accident and sickness insurance policy.

For the purpose of this report, unless otherwise noted, the term "mandated benefits" refers to the sum of these two categories. The term "mandated offers" refers to those benefits and provisions which must be offered or made available to prospective policyholders.

Virginia's mandated provider statutes (§§ 38.2-3408 and 38.2-4221) prohibit insurers and health services plans from denying reimbursement for covered services which have been legally rendered by certain practitioners licensed by the Commonwealth of Virginia. It should be noted that §§ 38.2-3408 and 38.2-4221 do not mandate that any additional services be covered by an insurance policy or subscription contract. The statutes only specify which categories of practitioners must be reimbursed for the provision of covered services.

## METHODOLOGY

### Study Population

Insurance Regulation No. 38 requires companies to report claim and premium data specific to each benefit and provider category contained in §§ 38.2-3408 through 38.2-3419 and 38.2-4221 of the Code of Virginia. Data regarding self-funded plans and policies issued in other states which provide coverage to residents of Virginia are not represented in these reports because such plans and policies are not subject to the mandated benefit and mandated provider requirements of Virginia.

Of the **903** companies licensed to issue accident and sickness policies or subscription contracts in Virginia in 1991, **104** were required to file full reports for the initial reporting period of October 1, through December 31, 1991. Those companies which were not required to file a full report pursuant to Insurance Regulation No. 38 either (i) wrote less than $500,000 of accident and sickness premiums in Virginia during the calendar year 1991; (ii) did not issue any policies subject to §§ 38.2-3408 through 38.2-3419 or 38.2-4221 of the Code of Virginia during 1991; and/or (iii) are organized as a cooperative nonprofit life benefit company or mutual assessment life, accident and sickness insurer.

### Report Format

Insurance Regulation No. 38 requires that each company provide both claim and premium information relative to each mandated benefit and mandated provider. The first part of the report requires claim data, for both individual and group business. In addition, a standard policy must be defined and its annual premium disclosed. The portion of that total annual premium attributable to the various benefits and providers are to be identified with respect to single and family coverage within both the individual and group classes of business. Finally, claim information must be provided for various health care procedures by provider type. This section is designed to obtain cost and utilization figures to facilitate comparison among provider categories.

### Claim Data

Insurance Regulation No. 38 contains lists of procedure and diagnosis codes which companies are to use when collecting claim information for each mandated benefit. The benefits were defined in this manner in order to ensure a reasonable level of consistency among data collection methodologies employed by

companies. The Commission recognizes that the claim figures for certain categories may be somewhat understated given these restrictions, but believes that such restrictions are necessary to promote consistency. The Commission may update this list of codes, as needed, in order to improve the quality of the data collected. The codes adopted by the Commission have been taken from two widely accepted coding systems used by most hospitals, health care providers, and insurers. These systems are put forth in the Physician's Current Procedural Terminology, Fourth Edition (CPT-4 procedure codes) and the Internal Classification of Disease 9th Revision Clinical Modification Third Edition (ICD-9 diagnosis codes).

With respect to mandated providers, companies are required to identify all claims attributable to each provider category. Because some of these mandated providers render services which are covered by mandated benefits, in some cases claims may be recorded against both a benefit and a provider category. Therefore, it should be recognized that some double counting of claims may occur. It is not believed, however, that such double counting has had a significant effect on this analysis.

It is also recognized that most covered services rendered by non-physician providers can also be performed by appropriately trained medical doctors. Because of this situation, it is reasonable to assume that in the absence of the mandated provider provisions of §§ 38.2-3408 and 38.2-4221, some level of claim costs would be incurred as a result of insureds seeking similar treatment from medical providers. [Note: §§ 38.2-3408 and 38.2-4221 do not mandate that any additional services be covered by an insurance policy or subscription contract. These statutes require insurers and health services plans to reimburse those mandated providers which provide covered services within the scope of their licensure by the Commonwealth of Virginia.]

With respect to the administrative costs associated with mandated benefits and providers, most companies indicated that they were unable to generate reliable information. Therefore, while the Commission recognizes that administrative costs contribute to the financial impact of mandated benefits and providers, the claim information provided in this report does not reflect such costs. It should be noted, however, that the premium information required of companies reflects all costs associated with mandated benefits and providers including administrative costs.

**Premium Data**

Companies are required to use actual claim experience and other relevant actuarial information to determine the premium impact of each mandated benefit and mandated provider category.

The claim information required in other sections of the company report are expected to be used in this process. The premium impact of each benefit and provider category is a relatively complete measure of the effect of the mandates because insurers must take into consideration all costs associated with these requirements.

Most companies have indicated that an additional premium charge is calculated for a benefit or provider category only for the year in which it is added. In subsequent years, the cost of coverage is included in the base rate of the policy. The exception to this practice occurs with mandated offers of coverage. For those companies which do not include the mandated offers of coverage in their base level of benefits, specific rates must be calculated so that policyholders who select such coverages can be appropriately charged for them.

Because companies do not ordinarily develop rates for specific mandated benefits or mandated provider categories, it is recognized that much of the premium data reported to the Commission has been developed for the expressed purpose of complying with § 38.2-3419.1 and Insurance Regulation No. 38.

## Data Quality

The Commission recognizes that there are certain deficiencies in the data used in developing this report. First, most of the companies filing full reports with the Commission were unable to provide all of the information required by Insurance Regulation No. 38. Before the regulation was adopted, many insurers did not collect claim data at the level of detail now required. This is particularly true for individually issued policies and contracts. Because many companies are still in the process of making the necessary changes to their data collection systems, the data which was reported for this initial period may not be truly representative of the industry's experience.

Although reports were received from all of the **104** companies subject to the full reporting requirements of Insurance Regulation No. 38, the majority contained substantial omissions. In order to ensure that the data used in this analysis was reasonably credible, it was necessary to use only data contained in those reports which were substantially complete. As a result, information presented in this report for individually issued health insurance policies and subscription contracts was taken from only **5** companies. Group figures represent information reported by **16** companies. Each of these companies are among the top 20 writers of accident and sickness business in Virginia by premium volume. As a result, this report reflects data reported by companies representing **57.50%** of the Virginia accident and sickness insurance market and **923,909** units of coverage (single

and family individual policies and group certificates) subject to Virginia's mandated benefit and provider requirements. It is anticipated that future reports will represent a larger percentage of this market as companies complete required changes in their data collection and reporting systems.

Contributing to the problem of the low volume of reports is the fact that fewer companies write individual health insurance business than write group business. Therefore, relatively little usable information was collected regarding individual policies and contracts.

Finally, the fact that the initial reporting period is limited to the fourth quarter of 1991 also affects the usefulness of the data. Because health insurance claims are not incurred by companies at a consistent rate during the calendar year, the Commission is unable to present the reported claim information on an annual basis.

## DEFINITIONS

The following sections contain summary descriptions of the mandated benefit and mandated provider requirements for which companies must provide claim and premium information annually. These summaries are included only to provide an overview of the required coverages.

### Mandated Benefits

#### Dependent Children

Section 38.2-3409 of the Code of Virginia requires that accident and sickness insurance policies and subscription contracts which contain the provision that coverage for a dependent child shall terminate upon that child's attainment of a specified age, must continue coverage for the dependent child beyond that specified age for as long as the child is incapable of self-sustaining employment due to mental retardation or physical handicap and is chiefly dependent upon the policyholder for support and maintenance. Insurers and health services plans are permitted to charge an additional premium for such continuation of coverage based on the class of risks applicable to the child.

#### "Doctor" to Include Dentist

Section 38.2-3410 of the Code of Virginia requires that the terms "physician" and "doctor" be construed to include a dentist performing covered services within the scope of his or her professional license when used in any accident and sickness insurance policy or subscription contract.

#### Newborn Children

Section 38.2-3411 of the Code of Virginia requires that accident and sickness insurance policies or subscription contracts which provide family coverage shall extend such coverage to a newly born child. The policy must contain coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The insurer or health services plan may require that it be notified of the birth and that payment of an additional required premium or fees be furnished within thirty-one days after the date of birth for coverage to continue beyond the initial thirty-one-day period.

## Mental, Emotional, and Nervous Disorders Treatment

Section 38.2-3412 of the Code of Virginia requires that accident and sickness insurance policies and subscription contracts contain coverage for a minimum of thirty days of inpatient treatment for mental, emotional, and nervous disorders. These disorders are to include drug and alcohol dependency, unless the insured or subscriber has coverage for such treatment pursuant to § 38.2-3413 of the Code of Virginia. The statute also allows insurers and health services plans to place certain restrictions on the drug and alcohol rehabilitation benefits.

Section 38.2-3412 also requires insurers and health services plans to "make available", to group policyholders only, coverage for outpatient treatment of mental, emotional, and nervous disorders. The statute allows for certain restrictions and requires that the maximum level of benefits for any given benefit period be no less than $1,000.

## Alcohol and Drug Dependence Treatment

Section 38.2-3413 of the Code of Virginia requires insurers and health services plans to "make available as an option" coverage for alcohol and drug dependency treatment to group policyholders. The coverage must not be more restrictive than that for any other illness and must include at least forty-five days of inpatient treatment and forty-five sessions of outpatient counseling during any given benefit period.

## Obstetrical Services

Section 38.2-3414 of the Code of Virginia requires each insurer and health services plan to provide "as an option" coverage for inpatient obstetrical services to group policyholders or contract holders. Such coverage cannot be more restrictive than that provided for the treatment of physical illnesses.

## Mammography

Section 38.2-3418.1 of the Code of Virginia requires that insurers, health services plans, and health maintenance organizations "offer and make available" coverage for low-dose screening mammograms for the purpose of determining the presence of occult breast cancer. Such coverage must allow for one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The benefit can be limited to $50 but must not be more restrictive than for physical illness generally.

## Child Health Supervision Services

Section 38.2-3411.1 of the Code of Virginia requires that insurers "offer and make available" coverage for the periodic examination of children under accident and sickness insurance policies and subscription contracts. The statute defines child health supervision services to include a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests. Coverage must allow for services to be rendered at the following intervals: birth, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years, and six years. Benefits for coverage of these services cannot be subject to copayment, coinsurance, deductible, or other dollar limit provisions. Insurers and health services plans having fewer than 1,000 covered individuals in Virginia or less than $500,000 in premiums in Virginia are not subject to the requirements of this statute.

## Conversion from Group to Individual Coverage

Section 38.2-3416 of the Code of Virginia requires that insurers allow individuals covered under a group policy or subscription contract to convert to an individual accident and sickness policy or contract without evidence of insurability upon termination of group coverage eligibility. However, it is not required that the conversion policy contain the same level of benefits as the group policy.

## Mandated Provider Categories

Sections 38.2-3408 and 38.2-4221 of the Code of Virginia provide that if an accident and sickness insurance policy or subscription contract provides reimbursement for any service that may legally be performed by a person licensed in this Commonwealth as a **chiropractor**, **optometrist**, **optician**, **professional counselor**, **psychologist**, **clinical social worker**, **podiatrist**, **physical therapist**, **clinical nurse specialist** who renders mental health services, **audiologist**, or **speech pathologist**, reimbursement under the policy or subscription contract cannot be denied because the service is rendered by the licensed practitioner.

## PREMIUM IMPACT

As is indicated in **Table 1**, **8.73%** and **8.41%** of the total annual premium for individual policies is attributable to mandated benefits and providers for single and family coverage, respectively. In comparison, the impact on premiums per certificate of group coverage is **15.28%** and **18.42%**. The premium impact is greater on group business because there are several mandated offers of coverage that apply only to group policies and contracts.

***TABLE 1*** ***PREMIUM IMPACT SUMMARY***

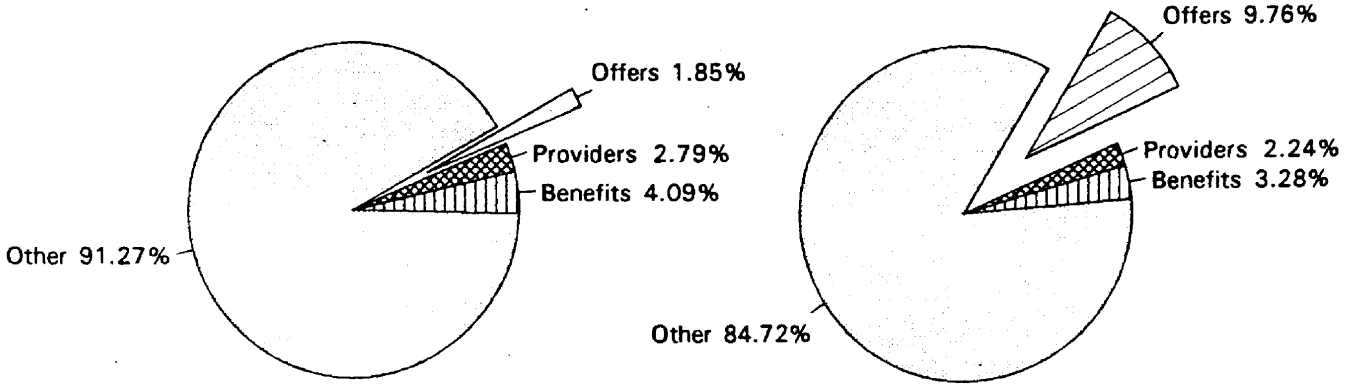
| | *Individual* | | *Group* | |
|---|---|---|---|---|
| | *Single* | *Family* | *Single* | *Family* |
| *Mandated Offers* | *1.85%* | *0.89%* | *9.76%* | *11.66%* |
| *Mandated Benefits ** | *4.09%* | *4.30%* | *3.28%* | *4.50%* |
| *Mandated Providers* | *2.79%* | *3.22%* | *2.24%* | *2.26%* |
| *Total* | *8.73%* | *8.41%* | *15.28%* | *18.42%* |

* Excluding mandated offers of coverage

It is important to consider the significance of mandated offers because policyholders are not required to accept such benefits. As is shown in **Table 1**, mandated offers represent a relatively large percentage of premium for group business. This relationship is further illustrated in **Charts 1** and **2**.

**CHART 1** **PREMIUM IMPACT**

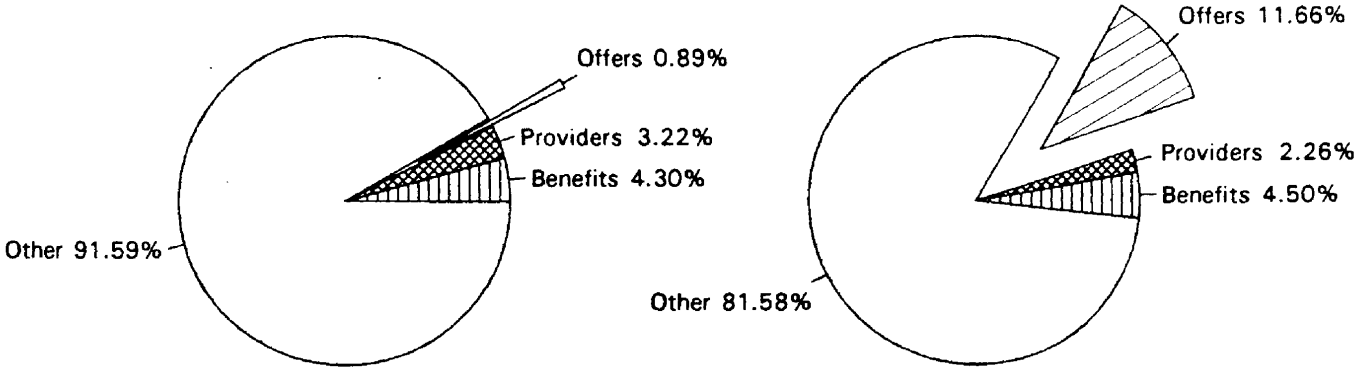
**Single Coverage**




**Individual** **Group**

**CHART 2** **PREMIUM IMPACT**

**Family Coverage**




**Individual** **Group**

For single coverage under a group policy or contract, **9.76%** of the premium is attributable to mandated offers. In comparison, **3.28%** and **2.24%** are attributable to the other mandated benefits and the mandated providers, respectively. Similarly, for family coverage, mandated offers account for **11.66%** of the total annual premium. In comparison, the other mandated benefits and the mandated providers only account for **4.50%** and **2.26%** of the total annual premium, respectively.

## Individual Business

### Single Coverage

As is indicated in **Table 2**, approximately **8.73%** of the total annual premium for an individual policy with single coverage is attributable to the mandated benefit and mandated provider requirements of Virginia. The mandated benefits represent **5.94%** of the total annual premium. The inpatient mental, emotional, and nervous disorders treatment benefit (M/E/N Inpatient) alone accounts for **3.68%** of the total premium. The mandated providers represent **2.79%** of the total annual premium.

Of the **5.94%** of premium attributable to mandated benefits, mandated offers of coverage account for **1.85%** of the total annual premium. The other mandated benefits account for the remaining **4.09%** of the total annual premium (**Tables 1** and **2**).

***TABLE 2*** ***PREMIUM IMPACT ON INDIVIDUAL CONTRACTS***

***Single Coverage***

| | *Percent of Policy Premium* | |
|---|---|---|
| *Doctor/Dentist* | *0.28* | |
| *Newborn Children* | *0.13* | |
| *M/E/N Inpatient* | *3.68* | |
| *Mammography ** | *0.37* | |
| *Child Health Supervision ** | *1.48* | |
| *Benefit Subtotal* | | ***5.94%*** |
| *Chiropractor* | *0.69* | |
| *Optometrist* | *0.23* | |
| *Optician* | *0.28* | |
| *Psychologist* | *0.58* | |
| *Clinical Social Worker* | *0.08* | |
| *Podiatrist* | *0.22* | |
| *Professional Counselor* | *0.25* | |
| *Physical Therapist* | *0.32* | |
| *Clinical Nurse Specialist* | *0.04* | |
| *Audiologist* | *0.09* | |
| *Speech Pathologist* | *0.01* | |
| *Provider Subtotal* | | ***2.79%*** |
| *Total* | | ***8.73%*** |

* Denotes mandated offer of coverage

As an additional measure of the impact of mandated benefits and providers on individual business, companies are required to report the premium charged for a policy covering no mandated benefits or mandated providers and issued to a 30 year old male living in the Richmond area in a standard premium class. Companies are also required to identify the premium that would be charged for a policy including current mandated benefits and mandated providers under the same conditions. The coverage is defined as follows: $250 deductible; $1,000 stop-loss limit; 80% coinsurance factor; and $250,000 policy maximum. The average reported premium for such a policy without mandates is **$1,123**. The average reported premium for such a policy <u>including</u> current mandates is **$1,207**. On average, the mandates represent **$84**, or **6.95%** of the total premium for the policy containing the current mandates.

## Family Coverage

As is illustrated in **Table 3**, approximately **8.41%** of the total annual premium for an individual policy with family coverage is attributable to mandated benefit and mandated provider requirements. Mandated benefits represent **5.19%** of the total annual premium. As with individual policies containing single coverage, the inpatient mental, emotional, and nervous disorders treatment benefit (M/E/N Inpatient) accounts for a significant portion of the total impact on individual policies containing family coverage (**2.55%** of the total annual premium). Mandated providers account for **3.22%** of the total annual premium.

Of the **5.19%** of premium attributable to mandated benefits, mandated offers of coverage account for **0.89%** of the total annual premium. The other mandated benefits account for the remaining **4.30%** of the total annual premium (**Tables 1** and **3**).

***TABLE 3*** ***PREMIUM IMPACT ON INDIVIDUAL CONTRACTS***

***Family Coverage***

| | *Percent of Policy Premium* | |
|---|---|---|
| *Dependent Children* | *0.37* | |
| *Doctor/Dentist* | *0.45* | |
| *Newborn Children* | *0.93* | |
| *M/E/N Inpatient* | *2.55* | |
| *Mammography ** | *0.30* | |
| *Child Health Supervision ** | *0.59* | |
| *Benefit Subtotal* | | **5.19%** |
| *Chiropractor* | *0.73* | |
| *Optometrist* | *0.35* | |
| *Optician* | *0.42* | |
| *Psychologist* | *0.76* | |
| *Clinical Social Worker* | *0.01* | |
| *Podiatrist* | *0.25* | |
| *Professional Counselor* | *0.32* | |
| *Physical Therapist* | *0.19* | |
| *Clinical Nurse Specialist* | *0.06* | |
| *Audiologist* | *0.11* | |
| *Speech Pathologist* | *0.02* | |
| *Provider Subtotal* | | **3.22%** |
| *Total* | | **8.41%** |

* Denotes mandated offer of coverage

## Group Business

### Single Coverage

As is indicated in **Table 4**, approximately **15.28%** of the total annual premium associated with a certificate of single coverage issued under a group policy is attributable to Virginia's mandated benefit and mandated provider requirements. Mandated benefits account for **13.04%** of the total annual premium. The benefits that have the greatest impact on premium are the inpatient and outpatient mental, emotional, and nervous disorders treatment, outpatient alcohol and drug dependency treatment, and obstetrical services coverages. It should be noted that three of these four most exepensive benefits are mandated offers of coverage. Mandated providers account for **2.24%** of the total annual premium per certificate of single coverage.

***TABLE 4*** ***PREMIUM IMPACT ON GROUP CERTIFICATES***

***Single Coverage***

| | *Percent of Policy Premium* | |
|---|---|---|
| *Doctor/Dentist* | *0.25* | |
| *Newborn Children* | *0.60* | |
| *M/E/N Inpatient* | *2.43* | |
| *M/E/N Outpatient ** | *2.24* | |
| *Alc. & Drug Inpatient ** | *2.53* | |
| *Alc. & Drug Outpatient ** | *0.90* | |
| *Obstetrical ** | *3.50* | |
| *Mammography ** | *0.41* | |
| *Child Health Supervision ** | *0.18* | |
| *Benefit Subtotal* | | ***13.04%*** |
| *Chiropractor* | *0.63* | |
| *Optometrist* | *0.08* | |
| *Optician* | *0.06* | |
| *Psychologist* | *0.33* | |
| *Clinical Social Worker* | *0.18* | |
| *Podiatrist* | *0.35* | |
| *Professional Counselor* | *0.06* | |
| *Physical Therapist* | *0.29* | |
| *Clinical Nurse Specialist* | *0.11* | |
| *Audiologist* | *0.07* | |
| *Speech Pathologist* | *0.08* | |
| *Provider Subtotal* | | ***2.24%*** |
| *Total* | | ***15.28%*** |

* Denotes mandated offer of coverage

Of the **13.04%** of premium attributable to mandated benefits, mandated offers of coverage account for **9.76%** of the total annual premium. The other mandated benefits account for the remaining **3.28%** of the total annual premium (**Tables 1** and **4**).

## Family Coverage

The financial impact of mandated benefits and mandated providers on the total annual premium attributable to a certificate of family coverage issued under a group policy is **18.42%**, as shown in **Table 5**. Mandated benefits account for **16.16%** of the total annual premium. As with single coverage, the

***TABLE 5*** ***PREMIUM IMPACT ON GROUP CERTIFICATES***

***Family Coverage***

| | Percent of Policy Premium | |
|---|---|---|
| *Dependent Children* | *0.43* | |
| *Doctor/Dentist* | *0.25* | |
| *Newborn Children* | *1.37* | |
| *M/E/N Inpatient* | *2.45* | |
| *M/E/N Outpatient ** | *2.34* | |
| *Alc. & Drug Inpatient ** | *2.36* | |
| *Alc. & Drug Outpatient ** | *0.88* | |
| *Obstetrical ** | *4.45* | |
| *Mammography ** | *0.50* | |
| *Child Health Supervision ** | *1.13* | |
| *Benefit Subtotal* | | ***16.16%*** |
| *Chiropractor* | *0.64* | |
| *Optometrist* | *0.09* | |
| *Optician* | *0.07* | |
| *Psychologist* | *0.33* | |
| *Clinical Social Worker* | *0.18* | |
| *Podiatrist* | *0.33* | |
| *Professional Counselor* | *0.07* | |
| *Physical Therapist* | *0.29* | |
| *Clinical Nurse Specialist* | *0.10* | |
| *Audiologist* | *0.07* | |
| *Speech Pathologist* | *0.09* | |
| *Provider Subtotal* | | ***2.26%*** |
| *Total* | | ***18.42%*** |

* Denotes mandated offer of coverage

benefits that have the greatest impact on the annual premium are the inpatient and outpatient mental, emotional, and nervous disorders treatment, outpatient alcohol and drug dependency treatment, and obstetrical services coverages. As was noted in the previous section, three of these four most expensive benefits are mandated offers of coverage. Mandated providers account for **2.26%** of the total annual premium.

Of the **16.16%** of premium attributable to mandated benefits, mandated offers of coverage account for **11.66%** of the total annual premium. The other benefits account for the remaining **4.50%** of the total annual premium (**Tables 1** and **5**).

## Conversion from Group to Individual Coverage

Section 38.2-3416 of the Code of Virginia requires that insurers allow individuals covered under a group policy to convert to an individual accident and sickness policy without evidence of insurability upon termination of group coverage eligibility. **Thirty-one percent (31%)** of respondents indicated that they add an amount to the annual premium of the group to cover this cost. The amount added by respondents varied widely. Reported figures ranged from **$3.05** to **$56.71**. The average reported amount added to the annual group premium for each certificate holder with single coverage is **$11.45**. For each certificate holder with family coverage the average amount added is **$27.55**. The median values per unit of single and family coverage are **$5.00** and **$13.00**, respectively. The significant difference between the median and average values is indicative of the wide range of figures reported.

**Thirty-six percent (36%)** of those companies which stated that they do not add an amount to the group premium to cover the cost of conversion indicated that they pass the cost on to the individual certificate holder when they convert to an individual policy. One respondent indicated that while it does not add an amount to the annual group premium, it does charge a fee of **$200.00** per conversion to the group policyholder.

## Financial Impact

### Individual Business

As is illustrated in **Table 6**, the average claim cost per individual contract for the fourth quarter of 1991 for mandated benefits and providers was **$23.36**, or **2.74%** of total health claims paid. Mandated benefits represent **$18.94**, or **1.96%** of total claims for this quarter, while mandated providers account for **$4.42**, or **0.78%** of total claims. This claim information, when expressed as a percentage of total health claims paid, does not support the premium information provided in the premium impact section for individual business. The claim percentages are significantly lower than the percent of total annual premium figures for single and family coverages (**Table 1**). It is believed

***TABLE 6*** ***CLAIM EXPERIENCE - INDIVIDUAL CONTRACTS***
***(October 1, through December 31, 1991)***

| | *Cost per Contract* | *Percent of Total Claims* |
|---|---|---|
| *Dependent Children* | *$0.04* | *0.01* |
| *Doctor/Dentist* | *1.88* | *0.55* |
| *Newborn Children* | *11.99* | *0.52* |
| *M/E/N Inpatient* | *3.56* | *0.73* |
| *Mammography ** | *0.15* | *0.03* |
| *Child Health Supervision ** | *1.32* | *0.12* |
| *Benefit Subtotal* | *$18.94* | *1.96%* |
| *Chiropractor* | *$0.85* | *0.18* |
| *Optometrist* | *0.05* | *0.01* |
| *Optician* | *0.00* | *0.00* |
| *Psychologist* | *1.11* | *0.17* |
| *Clinical Social Worker* | *0.92* | *0.15* |
| *Podiatrist* | *0.33* | *0.06* |
| *Professional Counselor* | *0.04* | *0.01* |
| *Physical Therapist* | *0.98* | *0.17* |
| *Clinical Nurse Specialist* | *0.03* | *0.01* |
| *Audiologist* | *0.08* | *0.01* |
| *Speech Pathologist* | *0.03* | *0.01* |
| *Provider Subtotal* | *$4.42* | *0.78%* |
| *Total* | ***$23.36*** | ***2.74%*** |

* Denotes mandated offer of coverage
The figure "0.00" denotes a value of less than 0.005.

that these discrepancies are the result of companies having relatively unsophisticated information systems for their individual business. Many companies reported that they expected their claim data to be more reliable for group business because they employ more technologically advanced data collection and information systems in this area.

In addition, the comparison of premium and claim information is hampered by the fact that the claim information is only based on three months of experience. In contrast, the premium information is based on annual rates. Because subsequent reporting periods will be full calendar years, this problem should not persist.

## Group Business

As is illustrated in **Table 7**, the average claim cost per group contract per certificate for the fourth quarter of 1991 for mandated benefits and providers was **$206.19**, or **15.81%** of total health claims paid for this quarter. Mandated benefits represent **$185.95**, or **13.26%** of total claims, while the mandated providers account for **$20.24**, or **2.55%** of total claims.

These claim percentages generally support the percent of premium figures for group business presented earlier. As is indicated in **Table 1**, the percent of total premium attributed to mandated benefits and providers under a group contract is **15.28%**

***TABLE 7*** ***CLAIM EXPERIENCE - GROUP CERTIFICATES***
***(October 1, through December 31, 1991)***

| | *Cost per Contract* | *Percent of Total Claims* |
|---|---|---|
| *Dependent Children* | *$5.19* | *0.54* |
| *Doctor/Dentist* | *6.55* | *0.63* |
| *Newborn Children* | *16.30* | *1.21* |
| *M/E/N Inpatient* | *29.06* | *2.04* |
| *M/E/N Outpatient ** | *19.83* | *1.99* |
| *Alc. & Drug Inpatient ** | *49.88* | *1.31* |
| *Alc. & Drug Outpatient ** | *0.63* | *0.06* |
| *Obstetrical ** | *53.10* | *5.18* |
| *Mammography ** | *2.71* | *0.09* |
| *Child Health Supervision ** | *2.70* | *0.21* |
| *Benefit Subtotal* | *$185.95* | *13.26%* |
| *Chiropractor* | *3.95* | *0.63* |
| *Optometrist* | *0.59* | *0.08* |
| *Optician* | *0.02* | *0.01* |
| *Psychologist* | *4.33* | *0.46* |
| *Clinical Social Worker* | *2.63* | *0.34* |
| *Podiatrist* | *3.63* | *0.36* |
| *Professional Counselor* | *0.64* | *0.14* |
| *Physical Therapist* | *4.00* | *0.45* |
| *Clinical Nurse Specialist* | *0.20* | *0.04* |
| *Audiologist* | *0.09* | *0.00* |
| *Speech Pathologist* | *0.16* | *0.04* |
| *Provider Subtotal* | *$20.24* | *2.55%* |
| *Total* | ***$206.19*** | ***15.81%*** |

* Denotes mandated offer of coverage
The figure "0.00" denotes a value of less than 0.005.

and **18.42%**, respectively, for single and family coverage. In comparison, claims for mandated benefits and providers represent **15.81%** of total claims paid for group business (single and family coverage combined).

## Utilization of Services

Companies are required to report the number of visits and the number of days attributable to each mandated benefit and provider category for which claims were paid (or incurred) during the reporting period. It should be noted that companies reported considerable difficulty in generating the required utilization information. Most companies have indicated that they have undertaken appropriate measures in order to provide more reliable information for future reporting periods. Therefore, it should be recognized that this information was developed from limited data and may not be entirely representative of the industry's experience.

This analysis focuses solely on group business because few companies were able to report the necessary information for their individual business. The number of visits per certificate for the fourth quarter of 1991 for each benefit is illustrated in **Table 8**. Inpatient alcohol and drug dependency treatment and obstetrical services coverage demonstrated the highest rates of use in terms of visits per certificate (**0.57** and **0.62**, respectively). Conversely, on this basis, the outpatient alcohol and drug dependency treatment and newborn children coverages exhibited the lowest rates of utilization (**0.01** and **0.03**, respectively).

***TABLE 8*** ***UTILIZATION OF SERVICES: GROUP COVERAGE***
***(October 1, through December 31, 1991)***

| *Benefit* | *Visits per Certificate* | *Days per Certificate* |
|---|---|---|
| *Dependent Children* | *0.03* | *0.00* |
| *Doctor/Dentist* | *0.15* | *0.00* |
| *Newborn Children* | *0.03* | *0.03* |
| *M/E/N Inpatient* | *0.10* | *0.05* |
| *M/E/N Outpatient ** | *0.37* | *0.11* |
| *Alc. & Drug Inpatient ** | *0.57* | *0.06* |
| *Alc. & Drug Outpatient ** | *0.01* | *0.00* |
| *Obstetrical Services ** | *0.62* | *0.07* |
| *Mammography ** | *0.04* | *0.00* |
| *Child Health Supervision ** | *0.09* | *0.00* |

* Denotes mandated offer of coverage
The figure "0.00" denotes a value of less than 0.005 days per certificate.

Utilization information on the number of days of treatment per certificate for each benefit is also displayed in **Table 8**. The outpatient mental, emotional, and nervous disorders treatment

benefit has the highest rate of utilization, **0.11** days per group certificate. Five of the mandated benefits have a day-per-certificate value of **0.00** (less than 0.005 days per certificate).

Utilization figures for the mandated provider categories are displayed in **Table 9**. The categories of chiropractor and physical therapist demonstrated the greatest numbers of visits per group certificate (**0.17** and **0.10**). Four categories had values of **0.00** (less than 0.005 visits per certificate).

***TABLE 9*** ***UTILIZATION OF PROVIDERS: GROUP COVERAGE***
***(October 1, through December 31, 1991)***

| *Provider Category* | *Visits per Certificate* |
|---|---|
| *Chiropractor* | *0.17* |
| *Optometrist* | *0.02* |
| *Optician* | *0.00* |
| *Psychologist* | *0.09* |
| *Clinical Social Worker* | *0.07* |
| *Podiatrist* | *0.05* |
| *Professional Counselor* | *0.02* |
| *Physical Therapist* | *0.10* |
| *Clinical Nurse Specialist* | *0.00* |
| *Audiologist* | *0.00* |
| *Speech Pathologist* | *0.00* |

The figure "0.00" denotes a value of less than 0.005 visits per certificate.

It is anticipated that this type of utilization information will be most useful in identifying changes in the rate of use of various benefits and providers that may occur over a period of years. In particular, these rates may be helpful in assessing the relative impact of new mandated benefits and providers (if and when new mandates are added). Provider utilization rates may also be useful when comparing providers that render similar services and the changes that occur from year to year.

## Provider Comparisons

In order to compare the claim cost per visit for physicians to those of selected mandated providers, companies are required to provide claim information for specific procedures. This claim information must be broken down by provider type.

### Psychotherapy

The average and median claim costs per visit by provider category for a 45 to 50 minute session of medical psychotherapy are illustrated in **Table 10**. The average claim cost per visit for the mandated providers is **$44.96**, when viewed as a single group. In comparison, the average claim cost per visit for physicians and psychiatrists is **$55.60**.

Because of the limited nature of the data used for this analysis, it is instructive to examine the median values attributed to the various provider categories. The median claim cost per visit for the professional counselor category is **$40.45** and the mandated provider and physician medians are **$37.45** and **$54.86**, respectively.

***TABLE 10 MEDICAL PSYCHOTHERAPY, 45 TO 50 MINUTE SESSION***
***(October 1, through December 31, 1991)***

| *Provider Category* | *Avg. Cost Per Visit* | | *Median Cost Per Visit* | |
|---|---|---|---|---|
| *Clinical Nurse Specialist* | *$31.65* | | *$34.63* | |
| *Professional Counselor* | *53.56* | | *40.45* | |
| *Psychologist* | *45.39* | | *47.53* | |
| *Clinical Social Worker* | *44.34* | | *39.19* | |
| *Mandated Provider Summary* | | *$44.96* | | *$37.45* |
| *Physician* | *52.54* | | *50.27* | |
| *Psychiatrist* | *60.18* | | *56.47* | |
| *Physician Summary* | | *$55.60* | | *$54.86* |

Companies are also required to provide claim information regarding group medical psychotherapy. As is indicated in **Table 11**, the average claim cost per visit for the mandated provider categories is **$33.70** compared to the combined physician average of **$46.60**. The median values for the mandated provider and physician categories are **$27.77** and **$37.27**, respectively.

Based on the information provided in **Tables 10** and **11**, it is evident that for these two types of psychotherapy the claim cost

per visit is lowest for clinical nurse specialists. The claim cost per visit for the professional counselor, psychologist, and clinical social worker categories are generally lower than for the physician categories as demonstrated by the median values attributable to each.

***TABLE 11*** ***GROUP MEDICAL PSYCHOTHERAPY***
***(October 1, through December 31, 1991)***

| *Provider Category* | *Avg. Cost Per Visit* | | *Median Cost Per Visit* | |
|---|---|---|---|---|
| *Clinical Nurse Specialist* | *$14.65* | | *$14.65* | |
| *Professional Counselor* | *35.33* | | *34.13* | |
| *Psychologist* | *34.40* | | *33.61* | |
| *Clinical Social Worker* | *36.47* | | *28.44* | |
| *Mandated Provider Summary* | | *$33.70* | | *$27.77* |
| *Physician* | *52.40* | | *38.35* | |
| *Psychiatrist* | *37.90* | | *36.19* | |
| *Physician Summary* | | *$46.60* | | *$37.27* |

**Physical Medicine Treatment**

Companies are required to provide claim information for the following three physical medicine procedures: (i) therapeutic exercise (30 minutes); (ii) massage; and (iii) ultrasound. **Tables 12**, **13**, and **14** illustrate the average and median claim costs per visit for each procedure by provider type. For each of the procedures, the chiropractor category has the lowest average and median costs per visit. As is illustrated in **Table 12** the physical therapist and physician categories have similar average and median cost per visit values.

***TABLE 12*** ***PHYSICAL MEDICINE TREATMENT, THERAPEUTIC EXERCISE***
***(October 1, through December 31, 1991)***

| *Provider Category* | *Avg. Cost Per Visit* | *Median Cost Per Visit* |
|---|---|---|
| *Chiropractor* | *$18.58* | *$15.49* |
| *Physical Therapist* | *25.48* | *25.50* |
| *Physician* | *25.49* | *26.86* |

***TABLE 13*** ***PHYSICAL MEDICINE TREATMENT, MASSAGE***
***(October 1, through December 31, 1991)***

| Provider Category | Avg. Cost Per Visit | Median Cost Per Visit |
|---|---|---|
| *Chiropractor* | *$19.53* | *$15.33* |
| *Physical Therapist* | *19.17* | *18.54* |
| *Podiatrist* | *23.26* | *25.71* |
| *Physician* | *22.52* | *23.29* |

***TABLE 14*** ***PHYSICAL MEDICINE TREATMENT, ULTRASOUND***
***(October 1, through December 31, 1991)***

| Provider Category | Avg. Cost Per Visit | Median Cost Per Visit |
|---|---|---|
| *Chiropractor* | *$14.68* | *$14.00* |
| *Physical Therapist* | *18.21* | *17.53* |
| *Podiatrist* | *20.18* | *21.73* |
| *Physician* | *17.41* | *17.36* |

As is indicated in **Table 13**, the average and median claim costs per visit for the physical therapist category are lower than those attributable to the physician category. For the ultrasound procedure the physical therapist and physician category values are very similar (**Table 14**).

For both the massage and ultrasound procedures (**Tables 13** and **14**), the podiatrist category has slightly higher average and median values than the physician category.

**Speech, Language or Hearing Therapy**

The average and median cost per visit figures for speech, language or hearing therapy for the speech pathologist and physician categories are displayed in **Table 15**. The average cost per visit values for the two categories are **$43.39** and **$41.04**, respectively. Although the speech pathology category has a higher average value than the physician category, its median value is slightly lower. Generally, there appears to be little difference between the two categories with respect to claim cost per visit.

***TABLE 15*** ***SPEECH, LANGUAGE OR HEARING THERAPY***
***(October 1, through December 31, 1991)***

| *Provider Category* | *Avg. Cost Per Visit* | *Median Cost Per Visit* |
|---|---|---|
| *Speech Pathologist* | *$43.39* | *$40.67* |
| *Physician* | *41.04* | *43.98* |

## Office Visits

As is indicated in **Table 16**, some variation exists among the provider categories regarding the average claim cost per visit for an office visit requiring intermediate service to a new patient. The physical therapist category has the highest average claim cost per visit of **$41.80**. The chiropractor and podiatrist categories have the lowest average values of **$24.32** and **$25.86**, respectively. The average claim cost per visit for the physician category is **$31.13**. The median values are slightly lower for the physical therapist and podiatrist categories and slightly higher for the chiropractor and physician categories.

***TABLE 16*** ***OFFICE VISIT, INTERMEDIATE SERVICE TO NEW PATIENT***
***(October 1, through December 31, 1991)***

| *Provider Category* | *Avg. Cost Per Visit* | *Median Cost Per Visit* |
|---|---|---|
| *Chiropractor* | *$24.32* | *$25.27* |
| *Physical Therapist* | *41.80* | *38.27* |
| *Podiatrist* | *25.86* | *23.16* |
| *Physician* | *31.13* | *32.16* |

Claim information regarding additional procedures should be available in future reports. Analysis of information regarding several procedures has not been included in this report because of the limited number of companies which provided data regarding them.

## CONCLUSION

The information reported to the State Corporation Commission's Bureau of Insurance pursuant to § 38.2-3419.1 of the Code of Virginia and Insurance Regulation No. 38 for the initial reporting period of October 1, through December 31, 1991, by insurers, health services plans, and health maintenance organizations was incomplete in most cases. Most companies indicated that changes are still being made to their data collection systems to allow them to generate the necessary information at the required level of detail. Although this report includes information collected from companies representing **57.50%** of the Virginia accident and sickness insurance market and **923,909** units of coverage subject to Virginia's mandated benefit and provider requirements, this analysis has been limited to those areas where the reported information was most complete. It is anticipated that companies will provide the Commission with more complete information for future reporting periods.

This analysis has shown that mandated benefits and mandated providers have a more significant impact on the premium charged for group, than on individual, health insurance. This is primarily due to additional mandated benefit requirements applicable only to group policies and contracts. These additional requirements, however, are all mandated offers of coverage. Therefore, they do not raise the minimum level of benefits required for group policies and subscription contracts. Insurers do, however, incur certain administrative and developmental costs as a result of mandated offers, regardless of whether policyholders select such coverage.

The reported claim experience for mandated benefits and providers generally supports the reported premium figures for group business. For individual business, however, reported claim experience did not support the premium figures. This is likely due to underreporting. Such underreporting may be the result of the employment of less sophisticated data collection and information systems for individual compared to group lines of business by many companies. Comparisons between premium and claim information will be more reliable for future reporting periods because full calendar years will be represented.

The utilization rates presented for both benefits and providers will be most useful when compared with results of future reporting periods. These rates may be helpful in assessing the relative effect of new mandates and in comparing from year to year the changes that occur among providers that render similar services.

Based on the claim information associated with certain medical treatments and procedures, most of the mandated provider categories have lower average and median claim costs per visit

than do the physician categories. However, in some cases the difference between categories was shown to be small.

The Commission recognizes that it could be argued in some instances that because certain non-physician providers charge less for treatment of a particular condition than their medical doctor counterparts, that a higher dollar level of claims would be incurred in the absence of the provider mandates. The counter-argument that mandated provider requirements result in increased utilization of covered services and, therefore, irrespective of the unit cost of services, increase the total cost of health care is also recognized. However, at this time the Commission is unable to confirm or refute either of these arguments given the data available to it.