REPORT OF THE
SPECIAL ADVISORY COMMISSION
ON MANDATED HEALTH INSURANCE BENEFITS ON

THE MANDATED OFFER OF COVERAGE FOR OBSTETRICAL SERVICES PURSUANT TO SECTION 38.2-3414 OF THE CODE OF VIRGINIA

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 24

COMMONWEALTH OF VIRGINIA
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SENATE OF VIRGINIA

CLARENCE A. HOLLAND
7TH SENATORIAL DISTRICT
VIRGINIA BEACH, MOST OF NORTHWESTERN PART
P.O. BOX 5622
VIRGINIA BEACH, VIRGINIA 23455

December 29, 1993

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

The report contained herein has been prepared pursuant to §§ 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of the mandated offer of coverage for obstetrical services pursuant to § 38.2-3414 of the Code of Virginia.

Respectfully submitted,

Clarence A. Holland, M.D., Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

Special Advisory Commission on Mandated Health Insurance Benefits

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Steven T. Foster, ex-officio
Robert B. Stroube, M.D., ex-officio

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INTRODUCTION

Section 38.2-3414 of the Code of Virginia requires insurers to make available to group policyholders, as an option, coverage for obstetrical services. The statute does not apply to individual policies and contracts. The optional coverage for obstetrical services must be provided at the same level as for other medical services with respect to durational limits, dollar limits, deductibles and coinsurance factors. Physician reimbursement for the performance of such services must be determined according to the same formula by which charges are developed for other medical and surgical procedures. This mandated option was enacted in 1978.

The Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) reviewed the obstetrical services mandated offer of coverage as part of its review of Virginia's existing mandated benefit and provider requirements pursuant to §§ 9-298 and 9-299 of the Code of Virginia. The Advisory Commission held a public hearing on September 13, 1993 to receive comments on the issue. Three speakers offered oral comments at the hearing and three organizations submitted written comments.

FINANCIAL IMPACT

Results of a study conducted in 1989 on behalf of Blue Cross and Blue Shield of Virginia (BCBSVA) by KPMG Peat Marwick indicate that the cost per contract year for the optional obstetrical coverage was $65.00 in 1988. During that year, BCBSVA experienced claims of $25,925,421 for 38,117 days of care for obstetrical services at an average cost of $680 per day. The BCBSVA study also indicates that claim expenditures for obstetrical services represented 6.46% of total group contract claims in 1988.

In 1989, the State Corporation Commission's Bureau of Insurance also conducted a study of the impact of mandated benefits and mandated providers. Results of the Bureau's initial survey indicated that 80% of the insurance companies responding to the survey provided coverage for obstetrical services at the level required by § 38.2-3414 prior to its enactment. In addition, two companies provided figures based solely on claims data that indicated for single coverage approximately 6% of total premiums was attributable to the optional obstetrical coverage. For family coverage, 9% of premium was reportedly attributable to the optional obstetrical coverage.

In 1992, the State Corporation Commission (SCC) issued its first annual report on the financial impact of mandated benefits and mandated providers pursuant to § 38.2-3419.1 of the Code of Virginia (1993 House Document No. 9). Insurers were only

required to submit data for the fourth quarter of 1991 for this initial report. Therefore, the results reported in 1993 House Document No. 9 may not be truly representative of insurer experience. Subsequent reports, however, will cover full calendar years. The results presented in the SCC's initial report are as follows:

Portion of Premium Attributable to Obstetrical Coverage

GROUP	
Single	Family
3.50%	4.45%

The SCC also reported that the optional obstetrical coverage was responsible for 5.18% of group claims for the reporting period. These figures are slightly lower than those presented in the earlier BCBSVA and Bureau of Insurance reports, but still indicate that obstetrical coverage represents a significant portion of claims and premiums.

FEDERAL LEGISLATION

In 1978, the Civil Rights Act was amended to require employers with 15 or more employees that provide medical expense benefits for their employees to provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as for all other medical conditions. Prior to this legislative change it was common for obstetrical services to be covered differently from other medical services. Because this federal mandate exists, much of the cost of the Virginia obstetrical services mandated offer of coverage would still be incurred in its absence.

LEGISLATION IN OTHER STATES

According to the National Association of Insurance Commissioners (NAIC) and the Health Benefits Letter approximately 20 states including Virginia have some form of obstetrical services mandate.

REVIEW CRITERIA

Social Impact

a. The extent to which the treatment or service is generally utilized by a significant portion of the population.

The Virginia Obstetrical And Gynecological Society reported that about 100,000 babies are born in Virginia annually. As a result, the utilization of obstetrical services among insured Virginians is relatively high.

b. The extent to which insurance coverage for the treatment or service is already available.

The Civil Rights Act requires employers with 15 or more employees to provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as for all other medical conditions, if they provide medical expense benefits for their employees. The Virginia statute requires insurers to offer obstetrical coverage to all group policyholders. However, it is the group policyholder, not the individual insured, that has the option to accept or reject such coverage. A representative of BCBSVA testified that most of its contracts include obstetrical services as a basic benefit. Small groups and individuals have the option to select contracts that do not include coverage for obstetrical services. Currently, there is no obstetrical services coverage requirement for individual policies.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

Coverage is generally available due to the federal and state mandates and because certain insurers include obstetrical services in their basic benefit package.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

Coverage is generally available due to the federal and state mandates and because certain insurers include obstetrical services in their basic benefit package. BCBSVA reported that their average claim cost per day for obstetrical services was $680 in 1988. According to a Health Insurance Association of America report entitled Research Bulletin: The Cost of Maternity Care and Childbirth in the United States, 1989, nationally, the average cost of a normal delivery in 1989 was $4,334. The average cost for a Cesarean delivery was $7,186. This would be a financial burden for many Virginians.

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

The Virginia Obstetrical And Gynecological Society reported that about 100,000 babies are born in Virginia annually. As a result, the utilization of obstetrical services among insured Virginians is relatively high.

f. The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.

Although no testimony directly addressed this question, it is believed that this type of coverage is desired by many Virginians of child bearing age. The Virginia Obstetrical and Gynecological Society emphasizes the importance of prenatal, delivery, and postnatal care and warns that the social impact of decreasing reimbursement would be significant.

g. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

The Advisory Commission did not receive any information regarding the interest of collective bargaining organizations in negotiating privately for inclusion of coverage for obstetrical services in group contracts during the course of its review.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

The Essential Health Services Panel recommended that a basic health plan include coverage for obstetrical services.

Financial Impact

a. The extent to which the proposed insurance coverage would increase or decrease premiums or the cost of services over the next five years.

Because the coverage is currently mandated as an option and because it has been in place for some time, it is not expected that its continuation will have a significant effect on premiums or the cost of services over the next five years.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

No evidence has been presented that would indicate that the continuation of the existing mandated offer of coverage will significantly increase either the appropriate or inappropriate use of obstetrical services. Proponents contend, however, that without coverage, many women will be less likely to get appropriate prenatal care.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

The field of obstetrics includes a broad range of services. There are no true alternatives to prenatal care, delivery, and postnatal care. The alternative is to go without care or treatment which can result in less satisfactory outcomes.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

It is unlikely that the continuation of the current mandated offer of coverage will significantly affect the number of obstetricians and gynecologists practicing in Virginia. The Virginia Obstetrical and Gynecological Society warns, however, that elimination of the mandated offer could have an adverse effect on the number of obstetricians and gynecologists willing to practice in Virginia.

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

The greatest administrative expenses associated with mandates are generally incurred when a mandate is initially enacted. Policyholders can opt not to accept the offered coverage and therefore can avoid any administrative and premium costs associated with the mandate.

It has been noted, however, that some insurers have made optional coverages part of their basic package of benefits, thus eliminating the policyholder's option to reject such coverage. This can be a problem if the insurer has no other similar product which does not include such coverage or is unwilling to negotiate the terms of coverage.

f. The impact of coverage on the total cost of health care.

Proponents contend that preventive services are cost effective because they reduce the need for more advanced treatment once a disease or other ailment develops. They believe that the total cost of health care would be greater in the absence of coverage for obstetrical services.

Medical Efficacy

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

The medical efficacy of the services covered by the mandate was not challenged.

b. If the legislation seeks to mandate coverage of an additional class of practitioners:

1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.

Not applicable.

2) The methods of the appropriate professional organization that assure clinical proficiency.

Not applicable.

Effects of Balancing the Social, Financial and Medical Efficacy Considerations

a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.

The obstetrical services mandated offer of coverage addresses both a medical and a broader social need. Public demand and the cost effectiveness of obstetrical care has led to the inclusion of such coverage in many individual contracts not affected by the federal and state mandates.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

Although the obstetrical services mandate has a significant impact on premiums, it has been argued that obstetrical services are highly cost effective. Because the mandate is an offer of coverage, groups are not required to accept this coverage. It should also be noted that the federal mandate requires obstetrical services coverage for employer group health plans of 15 or more. Therefore, much of the cost of the Virginia obstetrical services mandated offer of coverage would be incurred in its absence.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

The current requirement is a mandated offer of coverage.

RECOMMENDATIONS

It is the recommendation of the Special Advisory Commission on Mandated Health Insurance Benefits that the mandated offer of coverage for obstetrical services contained in § 38.2-3414 of the Code of Virginia be maintained in its current form. The Advisory Commission adopted this position at its October 4, 1993 meeting (6-Yes, 1-No).

CONCLUSION

In reviewing the mandated offer of coverage for obstetrical services, the Advisory Commission examined social, financial, and medical efficacy considerations. During the course of its review, no interested party recommended to the Advisory Commission, either orally or in writing, that the mandated offer be repealed. Evidence and testimony provided to the Advisory Commission during the course of its review generally supported the continuation of the current requirements of § 38.2-3414 of the Code of Virginia and have led the Advisory Commission to conclude that no change is necessary at this time.

APPENDIX

§ 38.2-3414. Optional coverage for obstetrical services. --- A. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue group hospital, group medical or group major medical subscription contracts shall provide coverage for obstetrical services as an option available to the group policyholder or the contract holder in the case of benefits based upon treatment as an inpatient in a general hospital. The reimbursement for obstetrical services by a physician shall be based on the charges for the services determined according to the same formula by which the charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.

B. This section shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, no to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans. (1978, c. 375, § 38.1-348.9; 1986, c. 562.)