REPORT OF THE
STATE CORPORATION COMMISSION ON

THE FINANCIAL IMPACT OF MANDATED HEALTH INSURANCE BENEFITS AND PROVIDERS PURSUANT TO SECTION 38.2-3419.1 OF THE CODE OF VIRGINIA: 1993 REPORTING PERIOD

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 3

COMMONWEALTH OF VIRGINIA
RICHMOND
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STATE CORPORATION COMMISSION

October 17, 1994

To: The Honorable George Allen
Governor of Virginia
and
The General Assembly of Virginia

We are pleased to transmit this Report of the State Corporation Commission on the Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia: 1993 Reporting Period.

Respectfully submitted,

Hullihen Williams Moore
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EXECUTIVE SUMMARY

Section 38.2-3419.1 of the Code of Virginia and the State Corporation Commission's Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers (Insurance Regulation No. 38) require every insurer, health services plan, and health maintenance organization to report annually to the 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 1993 calendar year reporting period.

Of the **900** companies licensed to issue accident and sickness policies or subscription contracts in Virginia in 1993, **87** were required to file full reports for the 1993 reporting period. Information presented in this report reflects data reported by **52** companies. Of these companies, **11** issued only individual, **33** issued only group, and **8** issued both individual and group health insurance policies or subscription contracts in Virginia in 1993. This report reflects data reported by companies representing **65.60%** of the Virginia accident and sickness insurance market and **931,683** units of coverage (single and family individual policies and group certificates) subject to Virginia's mandated benefit and provider requirements. In addition, **20** health maintenance organizations (HMOs) representing an additional **19.01%** of the Virginia accident and sickness market and **263,107** units of coverage filed full reports. Because HMOs are not subject to most of the mandated benefit and mandated provider requirements of Title 38.2 of the Code of Virginia and are regulated by the Commission's Rules Governing Health Maintenance Organizations (Insurance Regulation No. 28) with regard to the services they must provide, the data reported by these companies has been analyzed separately from data reported by insurers and health services plans.

The figures displayed below represent the amount of total annual premium which has been reported by insurers and health services plans 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	1.94%	2.03%	8.20%	9.34%
Mandated Benefits*	3.33	5.16	2.73	4.42
Mandated Providers	2.58	2.63	2.68	2.64
Total	7.85%	9.82%	13.61%	16.40%

*Excluding mandated offers of coverage

In addition to premium information, companies reported their claim experience for each mandate for the calendar year 1993. The following is a summary of this experience:

CLAIM EXPERIENCE
Percent of Total Claims

	Individual	Group
Mandated Benefits **	2.99%	9.87%
Mandated Providers	1.24	2.35
Total	4.23%	12.22%

** Including mandated offers of coverage

Reported group claim expenses for the 1993 calendar year generally support the annual premium figures reported for group business when compared on a percentage basis. Reported individual claims, however, are somewhat lower than 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 that area and higher administrative costs generally associated with individual policies and contracts.

Claim information regarding the rate of utilization of the mandated benefits and providers has been reported also. This information will be most useful, however, when compared with results from 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 produced mixed results when comparing average claim costs attributable to mandated providers and their physician counterparts. In only a few cases did mandated providers appear to offer a significant cost advantage over physicians on a per visit basis.

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 May 1 of the year 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 1993 calendar year reporting period.

Background

Pursuant to § 38.2-3419.1, the Commission adopted its Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers (Insurance Regulation No. 38) on July 5, 1991. Insurance Regulation No. 38 specifies the detail and form of the information that must be reported by insurers. The Commission's first annual report on the financial impact of mandated health insurance benefits and providers (1993 House Document No. 9) was issued in 1992 for the reporting period of October 1, 1991, through December 31, 1991. The Commission's second annual report (1994 House Document No. 6) was issued in 1993 for the 1992 calendar year reporting period.

Mandated benefit statutes typically require insurers to cover, or make coverage available 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, and unless otherwise noted, the term "mandated benefits" refers to the sum of these two categories. The term "mandated offers" refers only to the second category and is treated as a subclassification of mandated benefits.

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 types of 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 those types of practitioners that 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 **900** companies licensed to issue accident and sickness policies or subscription contracts in Virginia in 1993, **87** were required to file full reports for the 1993 reporting period. 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 1993; (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 1993; and/or (iii) are organized as a cooperative nonprofit life benefit company or mutual assessment life, accident and sickness insurer.

Claim Data

Insurance Regulation No. 38 requires companies to use certain procedure and diagnosis codes when developing claim information for each benefit category. Benefits have been defined in this manner in order to ensure a reasonable level of consistency among data collection methodologies employed by the various 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 are part of two widely accepted coding systems used by most hospitals, health care providers, and insurers. These systems are outlined 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 providers render services that 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 (physicians). Therefore, it may be assumed 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 physicians.

With respect to the administrative costs associated with mandated benefits and providers, most companies indicated that they were unable to generate reliable information. Figures provided by those companies that were able to generate the cost data varied greatly.

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 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 most benefit and 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

In its two previous reports (1993 House Document No. 9 and 1994 House Document No. 6) the Commission addressed certain deficiencies inherent in the data reported for the 1991 and 1992 reporting periods. Although there remain a number of companies maintaining a relatively small presence in Virginia that are unable to provide all of the information required by Insurance Regulation No. 38, the information presented in this report is believed to be representative of the industry's experience for the calendar year 1993.

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 reflects data reported by **52** companies. Of these companies, **11** issued only individual, **33** issued only group, and **8** issued both individual and group health insurance policies or subscription contracts in Virginia in 1993. This report reflects data reported by companies representing **65.60%** of the Virginia accident and sickness insurance market and **931,683** units of coverage (single and family individual policies and group certificates) subject to Virginia's mandated benefit and provider requirements. In addition, **20** health maintenance organizations (HMOs) representing an additional **19.01** of the Virginia accident and sickness market and **263,107** units of coverage filed full reports. Because HMOs are not subject to most of the mandated benefit and mandated provider requirements of Title 38.2 of the Code of Virginia, the data reported by these companies has been analyzed separately from data reported by insurers and health services plans.

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 applicable to the 1993 reporting period.

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 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

Until July 1, 1993, § 38.2-3412 of the Code of Virginia required 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 were to include drug and alcohol dependency, unless the insured or subscriber had coverage for such treatment pursuant to § 38.2-3413 of the Code of Virginia. The statute also allowed insurers and health services plans to place certain restrictions on the drug and alcohol rehabilitation benefits.

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

Sections 38.2-3412 and 38.2-3413 were repealed and replaced by § 38.2-3412.1 effective July 1, 1993. Section 38.2-3412.1 requires that individual and group accident and sickness policies and subscription contracts providing coverage on an expense incurred basis to a family member shall provide the following inpatient and partial hospitalization mental health and substance abuse services:

1. Treatment for an adult as an inpatient for at least 20 days per policy or calendar year;

2. Treatment for a child or adolescent for at least 25 days per policy or contract year;

3. Up to 10 days of inpatient benefit that may be converted, when medically necessary, at the option of the person or parent of a child or adolescent, to partial hospitalization (the conversion shall be at least 1.5 days of partial hospitalization for each inpatient day); and

4. Limits on the inpatient and partial hospitalization coverage which are not to be more restrictive than for any other illness.

With regard to group contracts covering a family member on an expense incurred basis, the insured or subscriber shall provide the following outpatient coverage for mental health and substance abuse:

a. At least 20 visits for an adult, child or adolescent in each policy or contract year;

b. Limits that shall be no more restrictive than any other illness except the co-insurance factor shall be at least 50% after the first five (5) visits; and

c. Medication management visits which shall be treated as any other illness and shall not be counted as outpatient visits under this section.

Because the mental, emotional, and nervous disorders treatment coverage requirements were changed midway through the 1993 reporting period, companies were allowed to provide information for the entire reporting period based on those requirements in effect prior to July 1, 1993. For the 1994 reporting period, all companies must provide information which reflects the new coverage requirements.

Alcohol and Drug Dependence Treatment

Until July 1, 1993, § 38.2-3413 of the Code of Virginia required insurers and health services plans to "make available as an option" coverage for alcohol and drug dependency treatment to group policyholders. The coverage could not be more restrictive than that for any other illness and had to include at least forty-five days of inpatient treatment and forty-five sessions of outpatient counseling during any given benefit period.

Section 38.2-3413 was repealed and replaced by § 38.2-3412.1 effective July 1, 1993. Alcohol and drug dependence treatment benefits must meet the standards described above for mental, emotional, and nervous disorders treatment coverage.

Because the alcohol and drug dependency treatment coverage requirements were changed midway through the 1993 reporting period, companies were allowed to provide information for the entire reporting period based on those requirements in effect prior to July 1,

1993. For the 1994 reporting period, all companies must provide information which reflects the new coverage requirements.

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**, **7.85%** and **9.82%** 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 **13.61%** and **16.40%**. 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**
Percent of Total Annual Premium

	Individual		Group	
	Single	**Family**	**Single**	**Family**
Mandated Offers	1.94%	2.03%	8.20%	9.34%
Mandated Benefits *	3.33	5.16	2.73	4.42
Mandated Providers	2.58	2.63	2.68	2.64
Total	7.85%	9.82%	13.61%	16.40%

* 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

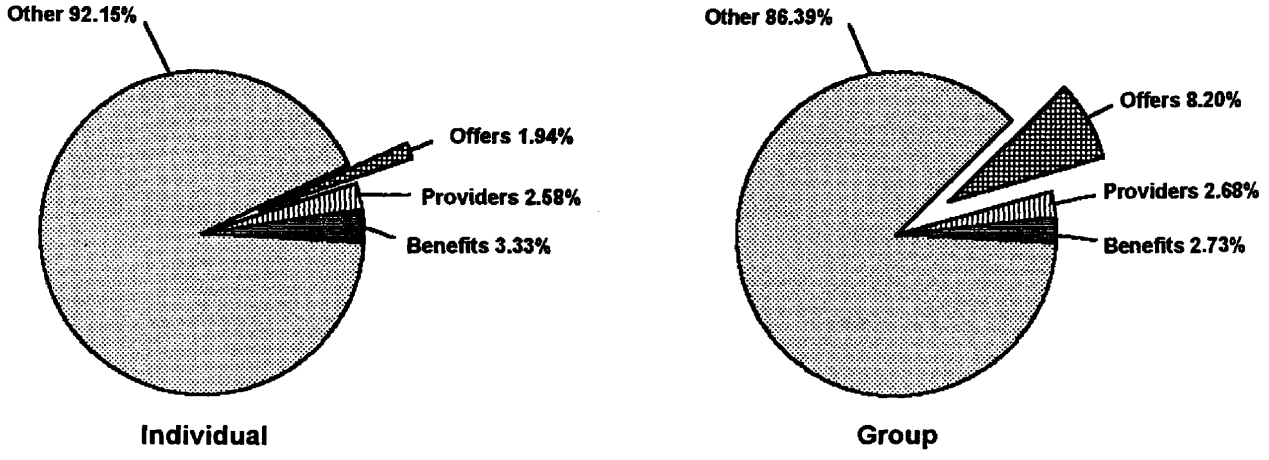
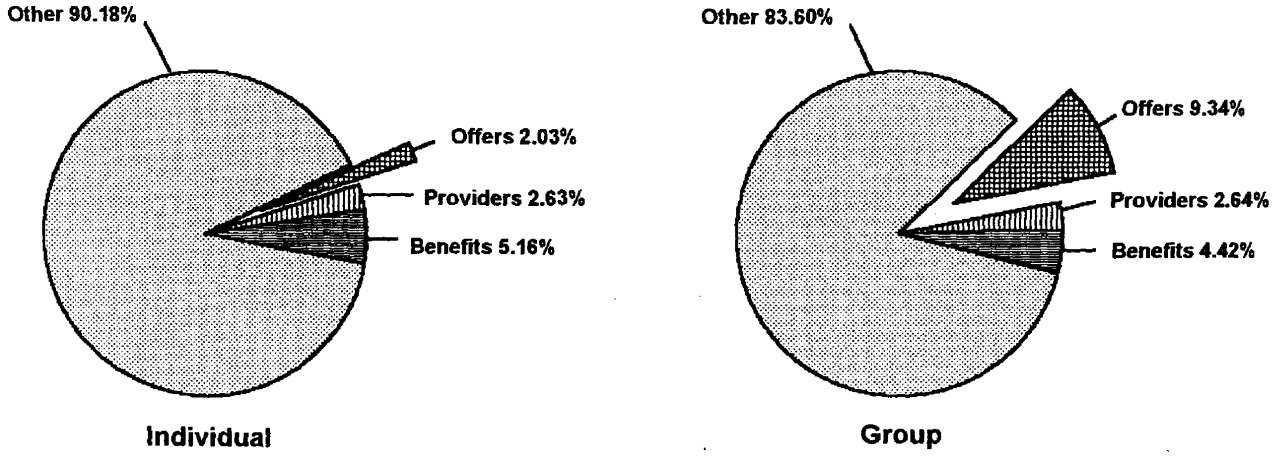


CHART 2

PREMIUM IMPACT

Family Coverage



For single coverage under a group policy or contract, **8.20%** of the premium is attributable to mandated offers. In comparison, **2.73%** and **2.68%** are attributable to the other mandated benefits and the mandated providers, respectively. Similarly, for family coverage, mandated offers account for **9.34%** of the total annual premium. In comparison, the other mandated benefits and the mandated providers only account for **4.42%** and **2.64%** of the total annual premium, respectively.

Individual Business

Single Coverage

As is indicated in **Table 2**, approximately **7.85%** of the total annual premium for an individual policy with single coverage is attributable to the mandated benefit and mandated provider requirements of Virginia. Mandated benefits represent **5.27%** of the total annual premium. The inpatient mental, emotional, and nervous disorders treatment benefit (M/E/N Inpatient) alone accounts for **3.17%** of the total premium. The mandated providers represent **2.58%** of the total annual premium.

Of the **5.27%** of premium attributable to mandated benefits, mandated offers of coverage account for **1.94%** of the total annual premium. The other mandated benefits account for the remaining **3.33%** of the total annual premium (**Tables 1** and **2**).

TABLE 2 PREMIUM IMPACT ON INDIVIDUAL CONTRACTS

Single Coverage

Mandate Category	Percent of Policy Premium	
Doctor/Dentist	0.16%	
M/E/N Inpatient	3.17	
Mammography *	0.50	
Child Health Supervision *	1.44	
Benefit Subtotal		**5.27%**
Chiropractor	0.58%	
Optometrist	0.03	
Optician	0.02	
Psychologist	0.40	
Clinical Social Worker	0.32	
Podiatrist	0.24	
Professional Counselor	0.20	
Physical Therapist	0.60	
Clinical Nurse Specialist	0.10	
Audiologist	0.05	
Speech Pathologist	0.04	
Provider Subtotal		**2.58%**
Total		**7.85%**

* 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 that would be charged for a hypothetical 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 **$1,184**. The average reported premium

for such a policy including current mandates is **$1,279**. On average, the mandates represent **$96**, or **7.50%** of the total premium for the policy containing the current mandates.

Family Coverage

As is illustrated in **Table 3**, approximately **9.82%** of the total annual premium for an individual policy with family coverage is attributable to mandated benefit and mandated provider requirements. Mandated benefits represent **7.19%** 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 (**2.68%** of the total annual premium). Mandated providers account for **2.63%** of the total annual premium.

Of the **7.19%** of premium attributable to mandated benefits, mandated offers of coverage account for **2.03%** of the total annual premium. The other mandated benefits account for the remaining **5.16%** of the total annual premium (**Tables 1** and **3**).

TABLE 3 **PREMIUM IMPACT ON INDIVIDUAL CONTRACTS**

Family Coverage

Mandate Category	Percent of Policy Premium	
Dependent Children	0.29%	
Doctor/Dentist	0.16	
Newborn Children	2.03	
M/E/N Inpatient	2.68	
Mammography *	0.49	
Child Health Supervision *	1.54	
Benefit Subtotal		**7.19%**
Chiropractor	0.55%	
Optometrist	0.06	
Optician	0.03	
Psychologist	0.42	
Clinical Social Worker	0.21	
Podiatrist	0.28	
Professional Counselor	0.18	
Physical Therapist	0.69	
Clinical Nurse Specialist	0.10	
Audiologist	0.05	
Speech Pathologist	0.06	
Provider Subtotal		**2.63%**
Total		**9.82%**

* Denotes mandated offer of coverage

Group Business

Single Coverage

As is indicated in **Table 4**, approximately **13.61%** 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 **10.93%** 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, inpatient alcohol and drug dependency treatment, and obstetrical services coverages. It should be noted that three of the four most expensive benefits are mandated offers of coverage. Mandated providers account for **2.68%** of the total annual premium per certificate of single coverage.

TABLE 4 **PREMIUM IMPACT ON GROUP CERTIFICATES**

Single Coverage

Mandate Category	Percent of Policy Premium	
Doctor/Dentist	0.21%	
M/E/N Inpatient	2.52	
M/E/N Outpatient *	1.86	
Alcohol & Drug Inpatient *	1.54	
Alcohol & Drug Outpatient *	0.68	
Obstetrical *	3.20	
Mammography *	0.61	
Child Health Supervision *	0.31	
Benefit Subtotal		**10.93%**
Chiropractor	0.76%	
Optometrist	0.12	
Optician	0.08	
Psychologist	0.40	
Clinical Social Worker	0.30	
Podiatrist	0.24	
Professional Counselor	0.13	
Physical Therapist	0.47	
Clinical Nurse Specialist	0.07	
Audiologist	0.05	
Speech Pathologist	0.06	
Provider Subtotal		**2.68%**
Total		**13.61%**

* Denotes mandated offer of coverage

Of the **10.93%** of premium attributable to mandated benefits, mandated offers of coverage account for **8.20%** of the total annual premium. The other mandated benefits account for the remaining **2.73%** 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 **16.40%**, as shown in **Table 5**. Mandated benefits account for **13.76%** of the total annual premium. As with single coverage, the benefits that have the greatest impact on the annual premium are the inpatient and outpatient mental, emotional, and nervous disorders treatment, inpatient 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 **2.64%** of the total annual premium.

Of the **13.76%** of premium attributable to mandated benefits, mandated offers of coverage account for **9.34%** of the total annual premium. The other benefits account for the remaining **4.42%** of the total annual premium (**Tables 1** and **5**).

TABLE 5 **PREMIUM IMPACT ON GROUP CERTIFICATES**

Family Coverage

Mandate Category	Percent of Policy Premium	
Dependent Children	0.36%	
Doctor/Dentist	0.23	
Newborn Children	1.28	
M/E/N Inpatient	2.55	
M/E/N Outpatient *	1.76	
Alcohol & Drug Inpatient *	1.36	
Alcohol & Drug Outpatient *	0.62	
Obstetrical *	3.93	
Mammography *	0.54	
Child Health Supervision *	1.13	
Benefit Subtotal		**13.76%**
Chiropractor	0.65%	
Optometrist	0.14	
Optician	0.09	
Psychologist	0.39	
Clinical Social Worker	0.26	
Podiatrist	0.23	
Professional Counselor	0.14	
Physical Therapist	0.44	
Clinical Nurse Specialist	0.07	
Audiologist	0.11	
Speech Pathologist	0.12	
Provider Subtotal		**2.64%**
Total		**16.40%**

* Denotes mandated offer of coverage

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. **Forty-four percent (44%)** of respondents providing group coverage 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 **$1.92** to **$54.16** per year. The average reported amount added to the annual group premium for each certificate holder with single coverage is **$8.28** per year. For each certificate holder with family coverage the average amount added is **$15.39**. The median values per unit of single and family coverage are **$6.63** and **$11.74**, respectively. The significant difference between the median and average values is indicative of the wide range of figures reported.

Twenty-two percent (22%) of companies indicated that while they do not add an amount to the annual group premium, they do charge a flat fee to the group policyholder for each conversion policy issued. The amount of this fee varied from **$2.30** to **$13,500**, with a median value of **$1,800** for single coverage and **$1,800** for family coverage. **Five percent (5%)** of companies indicated that they recover the cost of conversion through the premium charged for an individual policy. The remaining **29%** of respondents reported that they do not assess an identifiable charge to either the group or the individual for conversion.

CLAIM EXPERIENCE

Financial Impact

Individual Business

As is illustrated in **Table 6**, the average claim cost per individual contract for 1993 for mandated benefits and providers was **$135.18**, or **4.23%** of total health claims paid. Mandated benefits represent **$113.95**, or **2.99%** of total claims, while mandated providers account for **$21.23**, or **1.24%** of total claims. This claim information, when expressed as a percentage of total health claims paid, does not fully 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 that these inconsistencies 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 that area.

TABLE 6 CLAIM EXPERIENCE - INDIVIDUAL CONTRACTS

Mandated Category	Cost per Contract		Percent of Total Claim	
Dependent Children	$ 0.38		0.03%	
Doctor/Dentist	3.06		0.24	
Newborn Children	38.55		1.13	
M/E/N Inpatient	42.05		1.18	
Mammography *	1.71		0.04	
Child Health Supervision *	28.20		0.37	
Benefit Subtotal		**$113.95**		**2.99%**
Chiropractor	$5.43		0.53%	
Optometrist	0.20		0.01	
Optician	0.01		0.00	
Psychologist	3.94		0.17	
Clinical Social Worker	2.28		0.07	
Podiatrist	0.94		0.04	
Professional Counselor	1.35		0.08	
Physical Therapist	6.20		0.29	
Clinical Nurse Specialist	0.62		0.04	
Audiologist	0.09		0.00	
Speech Pathologist	0.17		0.01	
Provider Subtotal		**$21.23**		**1.24%**
Total		**$135.18**		**4.23%**

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

Group Business

As is illustrated in **Table 7**, the average claim cost per group contract per certificate for 1993 for mandated benefits and providers was **$426.76**, or **12.22%** of total health claims paid for this year. Mandated benefits represent **$360.62**, or **9.87%** of total claims, while the mandated providers account for **$66.14**, or **2.35%** of total claims.

These claim percentages are generally consistent with 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 **13.61%** and **16.40%**, respectively, for single and family coverage. In comparison, claims for mandated benefits and represent **12.22%** of total claims paid for group business (single and family coverage combined).

TABLE 7 **CLAIM EXPERIENCE - GROUP CERTIFICATES**

Mandate Category	Cost per Contract		Percent of Total Claim	
Dependent Children	$16.87		0.14%	
Doctor/Dentist	10.41		0.44	
Newborn Children	58.91		1.72	
M/E/N Inpatient	64.75		1.24	
M/E/N Outpatient *	41.50		1.15	
Alcohol & Drug Inpatient *	22.42		0.59	
Alcohol & Drug Outpatient *	4.53		0.18	
Obstetrical *	116.47		3.85	
Mammography *	10.04		0.10	
Child Health Supervision *	14.72		0.46	
Benefit Subtotal		**$360.62**		**9.87%**
Chiropractor	$18.87		0.61%	
Optometrist	2.21		0.11	
Optician	0.44		0.02	
Psychologist	15.18		0.43	
Clinical Social Worker	5.77		0.20	
Podiatrist	7.27		0.27	
Professional Counselor	2.55		0.09	
Physical Therapist	10.27		0.46	
Clinical Nurse Specialist	0.61		0.04	
Audiologist	1.16		0.09	
Speech Pathologist	1.81		0.03	
Provider Subtotal		**$66.14**		**2.35%**
Total		**$426.76**		**12.22%**

* Denotes mandated offer of coverage

Administrative Costs

Insurers have reported that they incur both developmental and ongoing administrative costs as a result of Virginia's mandated benefit and mandated provider requirements. However, the majority of reporting companies were unable to isolate those administrative costs for the 1993 reporting period. Most companies that were able to report such data indicated that they multiplied a per claim cost figure by the number of claims for each category. Reported data varied greatly among companies. While some indicated that they experienced no discernible administrative cost as a result of mandated benefits and providers, others assigned relatively high values to them. Therefore, while it is reasonable to assume that insurers do incur certain administrative costs relative to mandated benefits and providers, the extent of these costs cannot be determined given the limited data provided by companies for this reporting period.

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.

This analysis focuses solely on group business because the group data is believed to be significantly more reliable than that reported for individual business. The number of visits per certificate for 1993 for each benefit is illustrated in **Table 8**. Outpatient mental, emotional, and nervous disorders treatment and obstetrical services coverage demonstrated the highest rates of use in terms of visits per certificate (**1.04** and **1.12**, respectively). Conversely, on this basis, the outpatient alcohol and drug dependency treatment and dependent children coverages exhibited the lowest rates of utilization (**0.09**).

TABLE 8 UTILIZATION OF SERVICES: GROUP COVERAGE

Benefit Category	Visits per Certificate	Days per Certificate
Dependent Children	0.22	0.02
Doctor/Dentist	0.16	0.02
Newborn Children	0.24	0.14
M/E/N Inpatient		0.16
M/E/N Outpatient *	1.04	
Alcohol & Drug Inpatient*		0.06
Alcohol & Drug Outpatient *	0.09	
Obstetrical *	1.12	1.05
Mammography *	0.28	0.03
Child Health Supervision *	0.71	0.14

* Denotes mandated offer of coverage

Utilization information on the number of days of treatment per certificate for each benefit is also displayed in **Table 8**. The obstetrical services benefit has the highest rate of utilization: **1.05** days per group certificate.

Utilization figures for the mandated provider categories are displayed in **Table 9**. The categories of chiropractor, physical therapist, and psychologist demonstrated the greatest numbers of visits per group certificate (**0.88**, **0.34**, and **0.30**).

TABLE 9 UTILIZATION OF SERVICES: GROUP COVERAGE

Provider Category	Visits per Certificate
Chiropractor	0.88
Optometrist	0.08
Optician	0.01
Psychologist	0.30
Clinical Social Worker	0.20
Podiatrist	0.13
Professional Counselor	0.04
Physical Therapist	0.34
Clinical Nurse Specialist	0.01
Audiologist	0.02
Speech Pathologist	0.03

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 **$49.75**, when viewed as a single group. In comparison, the average claim cost per visit for physicians and psychiatrists is **$55.10**.

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 mandated provider and physician groups are **$38.95** and **$49.49**, respectively.

TABLE 10 **MEDICAL PSYCHOTHERAPY**
45 TO 50 MINUTE SESSION

Provider Category	Average Cost Per Visit		Median Cost Per Visit	
Clinical Nurse Specialist	$50.65		$43.00	
Professional Counselor	46.55		39.00	
Psychologist	54.35		47.56	
Clinical Social Worker	45.90		38.30	
Mandated Provider Summary		$49.75		$38.95
Physician	$54.70		$48.59	
Psychiatrist	55.50		50.45	
Physician Summary		$55.10		$49.49

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 are **$34.19**, **$45.45**, and **$35.38** compared to the psychiatrist average of **$40.14**. The median values for the mandated provider and psychiatrist categories are **$29.00**, **$31.87**, **$30.83** and **$31.23**, respectively.

TABLE 11 **GROUP MEDICAL PSYCHOTHERAPY**

Provider Category	Average Cost Per Visit	Median Cost Per Visit
Professional Counselor	$34.19	$29.00
Psychologist	45.45	31.87
Clinical Social Worker	35.38	30.83
Physician	43.19	35.50
Psychiatrist	40.14	$31.23

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.

TABLE 12 **PHYSICAL MEDICINE TREATMENT**
THERAPEUTIC EXERCISE, 30 MINUTES

Provider Category	Average Cost Per Visit	Median Cost Per Visit
Chiropractor	$20.55	$17.03
Physical Therapist	32.83	25.88
Podiatrist	47.26	32.00
Physician	30.85	28.36

TABLE 13 **PHYSICAL MEDICINE TREATMENT, MASSAGE**

Provider Category	Average Cost Per Visit	Median Cost Per Visit
Chiropractor	$17.59	$13.09
Physical Therapist	24.02	18.23
Podiatrist	41.67	24.68
Physician	20.65	20.69

TABLE 14 **PHYSICAL MEDICINE TREATMENT, ULTRASOUND**

Provider Category	Average Cost Per Visit	Median Cost Per Visit
Chiropractor	$17.05	$13.22
Physical Therapist	22.36	19.35
Podiatrist	19.69	17.83
Physician	17.77	16.80

Speech, Language or Hearing Therapy

The average and median cost per visit figures for speech, language or hearing therapy for the physical therapist, speech pathologist, and physician categories are displayed in **Table 15**. The average cost per visit values for the three categories are **$65.99**, **$52.54** and **$50.17**, respectively. The values attributed to the physical therapist category are somewhat higher than those attributed to the speech pathologist and physician categories.

TABLE 15 **SPEECH, LANGUAGE OR HEARING THERAPY**

Provider Category	Average Cost Per Visit	Median Cost Per Visit
Physical Therapist	$65.99	$50.00
Speech Pathologist	52.54	42.10
Physician	50.17	33.37

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 psychologist category has the highest average claim cost per visit of **$58.75**. The chiropractor category has the lowest average value of **$29.88**. The average claim cost per visit for the physician category is **$42.71**.

TABLE 16 OFFICE VISIT, INTERMEDIATE SERVICE TO NEW PATIENT

Provider Category	Average Cost Per Visit	Median Cost Per Visit
Chiropractor	$29.88	$28.33
Physical Therapist	44.96	38.00
Podiatrist	41.62	32.00
Psychologist	58.75	52.25
Social Worker	49.31	48.05
Physician	42.71	41.00

Other Procedures

Companies are required to report claim information specific to the fitting of a spectacle prosthesis for aphakia (a condition characterized by the absence of a lens behind the pupil of the eye). For the 1993 reporting period, however, too few claims were reported to the Commission to produce a fair comparison between the optometrist and ophthalmologist provider categories. Therefore, **Table 17** as it appeared in previous reports has not been updated here.

TABLE 17 FITTING OF SPECTACLE PROSTHESIS FOR APHAKIA

(Insufficient number of claims reported for 1993 reporting period for analysis)

As is indicated in **Table 18**, the average claim costs per visit attributable to the podiatrist and physician categories for the excision of an ingrown toenail are not significantly different. The median cost per visit is lower for the podiatrist category, however.

TABLE 18 EXCISION OF INGROWN TOENAIL

Provider Category	Average Cost Per Visit	Median Cost Per Visit
Podiatrist	$79.63	$47.35
Physician	85.95	65.00

HEALTH MAINTENANCE ORGANIZATIONS

Health maintenance organizations (HMOs) are subject to Insurance Regulation No. 28: Rules Governing Health Maintenance Organizations, which defines certain basic health care services which must be provided to each insured as well as other requirements. In many areas these requirements differ from those imposed on other insurers in recognition of the unique nature of HMOs. Because a minimum level of benefits for HMOs has been established through Insurance Regulation No. 28, most of the mandated benefit and mandated provider requirements of Chapter 34 of Title 38.2 of the Code of Virginia have not been designed to apply to HMOs. HMOs are subject to 38.2-3419.1 and Insurance Regulation No. 38, however, and are required to provide certain limited data. This section presents information collected from HMOs for the 1993 reporting period.

Twenty (20) HMOs were required to file full reports for the calendar year 1993. These organizations represent **19.01%** of the Virginia accident and sickness insurance market and **263,107** units of coverage subject to Virginia's mandated benefit and provider requirements.

The only benefit for which HMOs were required to submit information for the 1993 reporting period was the offer of coverage for mammography. The impact on premium and claims is presented below in **Table 19** and **Table 20**.

TABLE 19

PREMIUM IMPACT SUMMARY
Percent of Total Annual Premium

	Single	Family	Single	Family
Mammography *	0.39%	0.40%	0.35%	0.33%

* Denotes mandated offer of coverage

TABLE 20

CLAIM EXPERIENCE
Percent of Total Claims

	Individual	Group
Mammography *	2.18%	$1.75

* Denotes mandated offer of coverage

CONCLUSION

Individually, Virginia's mandated benefit and provider requirements vary greatly in their impact on health insurance premiums. Collectively, though, mandated benefits and providers represent a significant portion of the premium dollar. The impact is greatest on group business. This is principally due to several mandates which apply only to policies issued on a group basis. Each of these mandates, however, are offers of coverage and policyholders are not required to purchase those benefits. When mandated offers of coverage are removed from the analysis, the aggregate effect of mandated benefits and providers is considerably reduced. Mandated offers do result in additional administrative and developmental costs to insurers and some have elected to include such benefits in their standard package to reduce such costs and to reduce problems with pricing optional benefits.

Claim data for group coverage is consistent with the reported premium amounts attributable to mandated benefits and providers. For individual business, however, reported claim experience is not consistent with the reported 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 business than for group business by many companies. In addition, higher administrative cost are generally attributable to individual policies and contracts. Most companies, however, were unable to isolate administrative costs associated with the mandates for the 1993 reporting period. Figures reported by those companies that were able to generate such cost information varied greatly.

Reported utilization rates vary considerably among benefit and provider categories. Utilization information may be helpful in assessing the relative impact of new mandates and in comparing changes from one year to the next.

Claim information associated with certain medical treatments and procedures produced mixed results when comparing average claim costs attributable to mandated providers and their physician counterparts. In only a few cases did mandated providers appear to offer a significant cost advantage over physicians on a per visit basis.

The Commission's findings for the 1993 reporting period are consistent with those of the two prior reporting periods.