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: 1995 REPORTING PERIOD

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 15

COMMONWEALTH OF VIRGINIA
RICHMOND
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STATE CORPORATION COMMISSION

October 18, 1996

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: 1995 Reporting Period.

Respectfully submitted,

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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 (14 VAC 5-190-10 et seq., formerly Insurance Regulation No. 38) require every insurer, health services plan, and health maintenance organization from which a report is deemed necessary to report annually to the Commission cost and utilization information for each of the mandated benefits and mandated providers identified in §§ 38.2-3408 through 38.2-3419, and 38.2-4221 of the Code of Virginia. This document is the Commission's consolidation of reports submitted by affected companies for the 1995 calendar year reporting period.

Of the **903** companies licensed to issue accident and sickness policies or subscription contracts in Virginia, or licensed as health maintenance organizations in Virginia in 1995, **76** were required to file full reports for the 1995 reporting period. Information presented in this report reflects data reported by **52** insurers, exclusive of health maintenance organizations, that provided credible data. Of these companies, **9** issued only individual, **27** issued only group, and **16** issued both individual and group health insurance policies or subscription contracts in Virginia in 1995. This report reflects data reported by companies representing **54.9%** of the Virginia accident and sickness insurance market and **691,247** units of coverage (single and family individual policies and group certificates) subject to Virginia's mandated benefit and provider requirements. The credible reports of **22** health maintenance organizations (HMOs) representing an additional **25.3%** of the Virginia accident and sickness market and **617,434** contracts or certificates (units of coverage) were also used in the preparation of this report. 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 (14 VAC 5-210-10 et seq., formerly 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 data presented in this report varies from the Commission's reports for earlier reporting periods to the extent that figures representing overall averages of benefit and provider categories are reported, both for claims and for premiums. Previous reports displayed subtotals and totals of the percentages attributed to mandated benefits, mandated offers and mandated providers. **Because of this difference in the presentation of information, the average overall percentages can not be compared to the totals and subtotals presented in earlier reports. The overall averages, however, are a more accurate representation of total utilization of providers and services.**

The figures displayed below represent the amount of total average 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.

PREMIUM IMPACT
Percent of Total Average Annual Premium

	Individual		Group	
	Single	**Family**	**Single**	**Family**
Mandated Offers	1.22%	1.48%	1.85%	1.81%
Mandated Benefits*	1.23%	1.35%	1.48%	1.41%
Mandated Providers	.46%	.51%	.52%	.47%
* Excluding mandated offers of coverage				
Benefits, Offers and Providers	.80%	.96%	1.16%	1.14%

In addition to premium information, companies reported their claim experience for each mandate for the calendar year 1995. The following is a summary of this experience.

CLAIM EXPERIENCE
Percent of Average Total Claims

	Individual	Group
Mandated Offers	.46%	1.17%
Mandated Benefits **	.51%	.60%
Mandated Providers	.20%	.26%
** Excluding mandated offers of coverage		
Benefits and Providers	.35%	.57%

Claim information regarding the rate of utilization of the mandated benefits and providers has been reported. 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 from which a report is deemed necessary under regulations adopted by the State Corporation Commission (Commission) 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. 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 1995 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 (14 VAC 5-190-10 et seq., formerly Insurance Regulation No. 38) on July 5, 1991. The rules specify 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. Subsequent reports were issued as follows:

House Document No.	Date Issued	Reporting Period
1994, No. 6	1993	calendar year 1992
1995, No. 3	1994	calendar year 1993
1996, No. 5	1995	calendar year 1994

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 to which the mandate applies (referred to as "mandated benefits"); and

- benefits or provisions which must be offered or made available to anyone purchasing an accident and sickness insurance policy to which the mandate applies (referred to as "mandated offers").

The information presented in this report generally distinguishes between mandated offers and mandated benefits, particularly in the presentation of figures illustrating utilization of benefits and services. The term "mandated benefits," however, as used in the narrative portions of this report, refers to both, unless otherwise noted.

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 simply specify those types of practitioners that must be reimbursed for the provision of covered services.

METHODOLOGY

Study Population

14 VAC 5-190-10 et seq. 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 or licensed as Health Maintenance Organizations in Virginia in 1995, **76** were required to file full reports for the 1995 reporting period. Those companies not required to file a full report pursuant to 14 VAC 5-190-10 et seq. either (i) wrote $500,000 or more of accident and sickness insurance premiums, but less than $500,000 in premiums on policies subject to mandates, and were thus required by 14 VAC 5-190-10 et seq. to file abbreviated reports (there were **152** companies meeting this criterion); (ii) wrote less than $500,000 of accident and sickness premiums in Virginia during calendar year 1995; and/or (iii) did not issue any policies subject to §§ 38.2-3408 through 38.2-3419, or 38.2-4221 of the Code of Virginia during 1995.

In order to ensure that the data used in this analysis was reasonably credible, it was necessary to use only that data contained in reports that were substantially complete. As a result, information presented in this report reflects data reported by **52** companies, exclusive of Health Maintenance Organizations. This report reflects the credible experience of **9** companies that issued individual, **27** companies that issued group, and **16** companies that issued both individual and group health insurance policies or subscription contracts in Virginia in 1995. This report reflects data reported by companies representing **54.9%** of the Virginia accident and sickness insurance market and **691,247** units of coverage (single and family individual policies and group certificates) subject to Virginia's mandated benefit and provider requirements. Twenty two (**22**) health maintenance organizations (HMOs), representing an additional **25.3%** of the Virginia accident and sickness market and **617,434** 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. The combined data in this report, then, represents **80.2%** of the Virginia accident and sickness market, and **1,308,681** units of coverage.

Claim Data

14 VAC 5-190-10 et seq. 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 has updated 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 Physicians' Current Procedural Terminology, Fourth Edition (CPT-4 procedure codes) and the International Classification of Diseases 9th Revision Clinical Modification Fourth 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.

The claim data presented in this report varies from the Commission's earlier reports to the extent that figures representing overall averages of benefit and provider categories are reported. Previous reports displayed subtotals of the percentages attributed to mandated benefits, offers and providers, and totals of

the percentages attributed to mandated benefits and providers. Because of this difference in the presentation of information, the average overall percentages can not be compared to the totals and subtotals presented in earlier reports. The overall averages, however, are a more accurate representation of total utilization of providers and services.

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 that 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 express purpose of complying with § 38.2-3419.1 and 14 VAC 5-190-10 et seq.

The premium data presented in this report varies from the Commission's earlier reports to the extent that figures representing overall averages of benefit and provider categories are reported. Previous reports displayed subtotals of the percentages attributed to mandated benefits, offers and providers, and totals of the percentages attributed to mandated benefits and providers. Because of this difference in the presentation of information, the average overall percentages can not be compared to the totals and subtotals presented in earlier reports. The overall averages, however, are a more accurate representation of total utilization of providers and services.

Data Quality

Although there are a number of companies maintaining a relatively small presence in Virginia that are unable to provide all of the information required by 14 VAC 5-190-10 et seq. and some companies that are unable to devote the level of resources required to generate reliable data, the information presented in this report is believed to be representative of the industry's experience for the calendar year 1995.

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 1995 reporting period.

MANDATED BENEFITS AND MANDATED OFFERS

DEPENDENT CHILDREN

Section 38.2-3409 of the Code of Virginia requires that accident and sickness insurance policies and subscription contracts that 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. This provision is not intended to apply to routine dental services.

NEWBORN CHILDREN

Section 38.2-3411 of the Code of Virginia requires that accident and sickness insurance policies or subscription contracts that 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 any additional premium or fees be made within thirty-one days after the date of birth for coverage to continue beyond the initial thirty-one-day period.

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 age 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.

MENTAL, EMOTIONAL, AND NERVOUS DISORDERS TREATMENT

Section 38.2-3412.1 of the Code of Virginia 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 the 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 and individual contracts covering a family member on an expense incurred basis, the insured or subscriber shall be provided 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 visits; and

c. Medication management visits, which shall be treated as any other illness and shall not be counted as outpatient visits under § 38.2-3412.1.

Prior to July 1, 1996, the above requirement for outpatient benefits applied only to group products. Companies will not be required to provide data relating to this benefit as it applies to individual policies until they report for the 1997 reporting period, which will be the first full year in which this benefit will have been applicable to individual products.

ALCOHOL AND DRUG DEPENDENCE TREATMENT

Section 38.2-3412.1 of the Code of Virginia requires that alcohol and drug dependence treatment benefits meet the standards described above for mental, emotional, and nervous disorders treatment coverage.

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.

OBSTETRICAL BENEFITS - COVERAGE FOR POSTPARTUM SERVICES

Section 38.2-3414.1 of the Code of Virginia requires that insurers, health services plans and health maintenance organizations providing benefits for obstetrical services must provide coverage for postpartum services in accordance with the guidelines outlined in the statute. Because this requirement became effective July 1, 1996, companies will not be required to provide data relating to this benefit until they report for the 1997 reporting period, which represents the first full year in which this benefit will have been available.

MAMMOGRAPHY

Until July 1, 1996, § 38.2-3418.1 of the Code of Virginia required 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. Effective July 1, 1996, however, coverage for mammograms must be provided. Such coverage must allow for one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The benefit can be limited to $50.00 but must not be more restrictive than for physical illness generally.

Because the requirement that mammograms be provided as a mandated benefit rather than a mandated offer was not effective during the 1995 reporting period, the information presented in this report displays this benefit as a "mandated offer", and it will continue to be reported as a mandated offer until the 1997 reporting period, which represents the first full year in which this benefit will have been mandated.

BONE MARROW TRANSPLANTS

Section 38.2-3418.1:1 of the Code of Virginia was effective July 1, 1994, and requires insurers, health services plans and health maintenance organizations to offer and make available coverage for the treatment of breast cancer by dose intensive chemotherapy/autologous bone marrow transplants or stem cell transplants. Data related to bone marrow transplants is being reported this year for the first time, as the 1995 reporting period was the first full year in which this requirement was effective.

PAP SMEARS

Section 38.2-3418.1:2 of the Code of Virginia requires that insurers, health services plans and health maintenance organizations provide coverage for annual pap smears. Because this requirement was effective July 1, 1996, companies will not be required to provide data relating to this benefit until they report for the 1997 reporting period, which represents the first full year in which this benefit will have been mandated.

PROCEDURES INVOLVING BONES AND JOINTS

Section 38.2-3418.2 of the Code of Virginia prohibits insurers, health services plans or health maintenance organizations from excluding coverage or imposing restrictive limits for diagnostic or surgical treatment involving any bone or joint of the head, neck, face or jaw on policies providing this treatment for any bone or joint of the skeletal structure. Because this code section is effective only for policies issued on and after July 1, 1995, companies will not have to provide data on this requirement until they report for the 1996 reporting period.

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 such licensed practitioner.

PREMIUM IMPACT

As indicated in Table 1, .80% and .96% of the overall average annual premium for individual policies is attributable to mandated offers, benefits, and providers for single and family coverage, respectively. In comparison, the impact on premiums per certificate of group coverage is 1.16% and 1.14%, respectively. The premium impact is greater on group business because there are a number of mandated offers of coverage that apply only to group policies and contracts.

TABLE 1

PREMIUM IMPACT
Percent of Overall Average Annual Premium

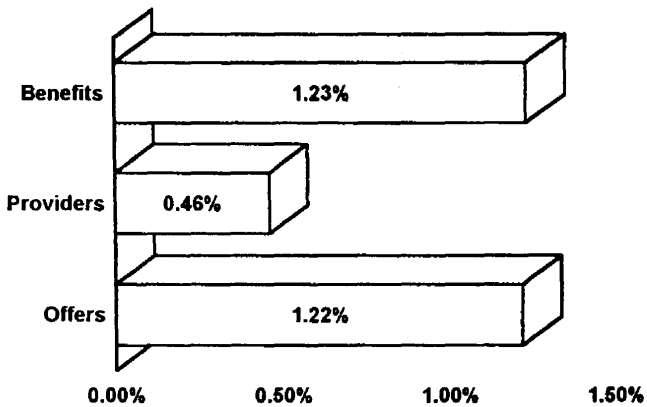
	Individual		Group	
	Single	Family	Single	Family
Mandated Offers	1.22%	1.48%	1.85%	1.81%
Mandated Benefits*	1.23%	1.35%	1.48%	1.41%
Mandated Providers	.46%	.51%	.52%	.47%
*Excluding mandated offers of coverage				
Mandated Offers, Benefits and Providers	.80%	.96%	1.16%	1.14%

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, with slightly higher percentages attributable to group business. This relationship is further illustrated in **Charts 1 and 2.**

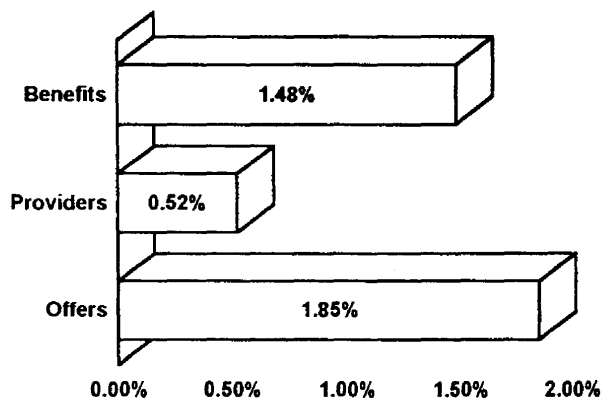
CHART 1

PREMIUM IMPACT

Single Coverage



Individual

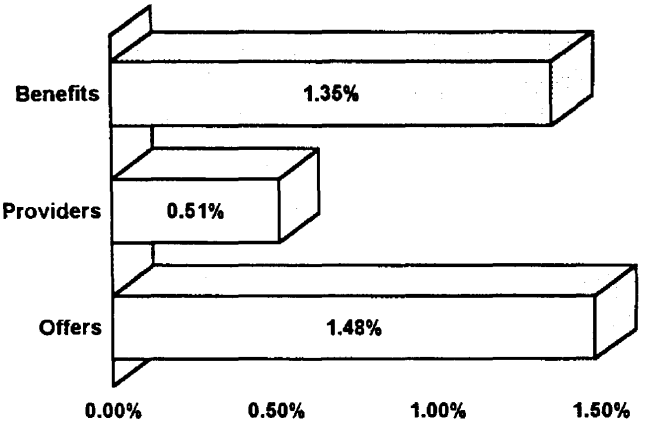


Group

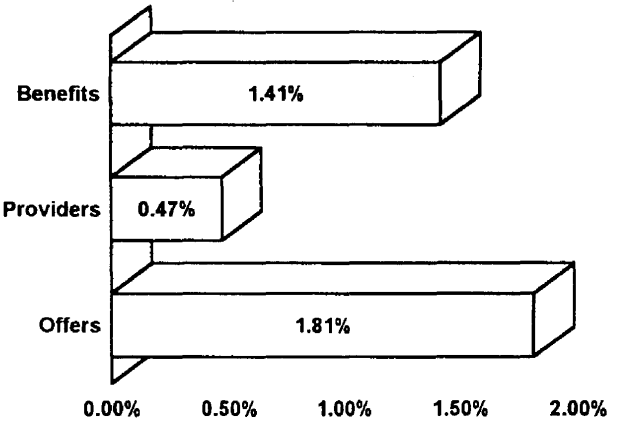
CHART 2

PREMIUM IMPACT

Family Coverage



Individual



Group

For single coverage under a group policy or contract, 1.85% of the overall average premium is attributable to mandated offers. In comparison, 1.48% and .52% are attributable to the other mandated benefits and the mandated providers, respectively. Similarly, for family coverage, mandated offers account for 1.81% of the overall average premium. In comparison, the other mandated benefits and the mandated providers account for 1.41% and .47% of the overall average premium, respectively.

Individual Business

Single Coverage

As is indicated in **Table 2**, approximately .80% of the overall average annual premium for an individual policy with single coverage is attributable to the mandated benefit and mandated provider requirements of Virginia. Mandated benefits represent 1.23% of the overall average premium, while mandated offers represent 1.22% of the overall average premium. The inpatient mental, emotional, and nervous disorders treatment benefit (M/E/N Inpatient) alone accounts for 2.38% of the overall average annual premium The mandated providers represent .46% of the overall average annual premium.

For single coverage under an individual policy, 1.22% of the overall average annual premium is attributable to mandated offers. In comparison, 1.23% and .46% are attributable to the other mandated benefits and the mandated providers, respectively (**Tables 1** and **2**).

TABLE 2

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS

Single Coverage

Mandate Category	Percent of Overall Average Policy Premium	
Doctor/Dentist	.53%	
M/E/N Inpatient	2.38	
M/E/N Partial Hospitalization	.43	
Alcohol & Drug Inpatient	1.32	
Alcohol & Drug Partial Hosp.	.28	
Pregnancy from Rape/Incest	.20	
Mammography *	.85	
Bone Marrow Transplants *	1.21	
Child Health Supervision *	1.92	
* Denotes mandated offer of coverage		
Mandated Offers		**1.22%**
Mandated Benefits		**1.23%**
Chiropractor	.75%	
Optometrist	.28	
Optician	.43	
Psychologist	.76	
Clinical Social Worker	.33	
Podiatrist	.43	
Professional Counselor	.31	
Physical Therapist	.66	
Clinical Nurse Specialist	.12	
Audiologist	.15	
Speech Pathologist	.15	
Mandated Providers		**.46%**
Mandated Providers and Benefits		**.80%**

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 in a standard premium class living in the Richmond area. 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: $250.00 deductible; $1,000 stop-loss limit; 80% coinsurance factor; and $250,000 policy maximum. The average reported annual premium for such a policy without mandates is $1,371.87. The average reported annual premium for such a policy including current mandates is $1,435.69. On average, the mandates represent $64.00 or 4.4% of the average annual premium for the policy containing the current mandates. It should be noted that the percentage of premium attributable to mandates has increased as additional benefits and offers have been mandated.

Family Coverage

As is illustrated in **Table 3**, approximately .96% of the overall average annual premium for an individual policy with family coverage is attributable to mandated benefit and mandated provider requirements. Mandated benefits represent 1.35% of the overall average 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 (2.71% of the overall average annual premium). Mandated providers account for .51% of the overall average annual premium.

For family coverage under an individual policy, 1.48% of the overall average annual premium is attributable to mandated offers. In comparison, 1.35% and .51% are attributable to the other mandated benefits and the mandated providers, respectively **(Tables 1 and 3)**.

TABLE 3

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS

Family Coverage

Mandate Category	Percent of Overall Average Policy Premium	
Dependent Children	.37%	
Doctor/Dentist	.68	
Newborn Children	1.84	
M/E/N Inpatient	2.71	
M/E/N Partial Hospitalization	1.14	
Alcohol & Drug Inpatient	1.58	
Alcohol & Drug Partial Hosp.	.23	
Pregnancy from Rape/Incest	.14	
Mammography *	.69	
Bone Marrow Transplants *	.75	
Child Health Supervision *	2.59	
* Denotes mandated offer of coverage		
Mandated Offers		**1.48%**
Mandated Benefits		**1.35%**
Chiropractor	.69%	
Optometrist	.43	
Optician	.65	
Psychologist	.83	
Clinical Social Worker	.23	
Podiatrist	.51	
Professional Counselor	.46	
Physical Therapist	.82	
Clinical Nurse Specialist	.14	
Audiologist	.16	
Speech Pathologist	.12	
Mandated Providers		**.51%**
Mandated Benefits and Providers		**.96%**

Group Business

Single Coverage

As is indicated in **Table 4**, approximately 1.16% of the overall average 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 and mandated offers account for 1.48% and 1.85% of the overall average annual premium, respectively. 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 one of the four most expensive benefits is a mandated offer of coverage. Mandated providers account for .52% of the overall average annual premium per certificate of single coverage.

TABLE 4

PREMIUM IMPACT ON GROUP CERTIFICATES
Single Coverage

Mandate Category	Percent of Overall Average Policy Premium	
Doctor/Dentist	1.13%	
M/E/N Inpatient	2.72	
M/E/N Partial Hospitalization	.57	
M/E/N Outpatient	1.91	
Alcohol & Drug Inpatient	1.33	
Alcohol & Drug Partial Hosp.	.59	
Alcohol & Drug Outpatient	.48	
Obstetrical - Normal *	3.89	
Obstetrical - All Other *	2.67	
Pregnancy due to Rape/Incest	.33	
Bone Marrow Transplants *	.46	
Mammography *	.64	
Child Health Supervision *	.89	
* Denotes mandated offer of coverage		
Mandated Benefits		**1.48%**
Mandated Offers		**1.85%**
Chiropractor	1.08%	
Optometrist	.26	
Optician	.40	
Psychologist	.74	
Clinical Social Worker	.55	
Podiatrist	.46	
Professional Counselor	.41	
Physical Therapist	.72	
Clinical Nurse Specialist	.12	
Audiologist	.11	
Speech Pathologist	.12	
Mandated Providers		**.52%**
Mandated Benefits and Providers		**1.16%**

For single coverage under a group certificate, mandated offers of coverage account for 1.85% of the overall average annual premium. The mandated benefits account for 1.48% of the overall average annual premium. (**Tables 1** and **4**).

Family Coverage

The financial impact of mandated benefits and mandated providers on the overall average annual premium attributable to a certificate of family coverage issued under a group policy is 1.14% as shown in **Table 5**. Mandated benefits and mandated offers account for 1.41% and 1.81% of the overall average annual premium, respectively. As with single coverage, inpatient and outpatient mental, emotional, and nervous disorders treatment, and obstetrical services coverages have a significant impact on the annual premium. Mandated offers account for the more expensive coverages. Mandated providers account for .47% of the overall average annual premium.

For family coverage under a group certificate, mandated offers of coverage account for 1.81% of the overall average annual premium. The mandated benefits account for 1.41% of the overall average annual premium (**Tables 1** and **5**).

TABLE 5

PREMIUM IMPACT ON GROUP CERTIFICATES
Family Coverage

Mandate Category	Percent of Overall Average Policy Premium	
Dependent Children	.45%	
Doctor/Dentist	3.49	
Newborn Children	1.44	
M/E/N Inpatient	2.34	
M/E/N Partial Hospitalization	.60	
M/E/N Outpatient	1.52	
Alcohol & Drug Inpatient	1.06	
Alcohol & Drug Partial Hosp.	.41	
Alcohol & Drug Outpatient	.41	
Obstetrical - Normal *	4.30	
Obstetrical - All Other *	2.99	
Pregnancy due to Rape/Incest	.28	
Mammography *	.40	
Bone Marrow Transplants *	.53	
Child Health Supervision *	1.03	
* Denotes mandated offer of coverage		
Mandated Benefits		**1.41%**
Mandated Offers		**1.81%**
Chiropractor	.94%	
Optometrist	.25	
Optician	.40	
Psychologist	.68	
Clinical Social Worker	.45	
Podiatrist	.40	
Professional Counselor	.40	
Physical Therapist	.68	
Clinical Nurse Specialist	.13	
Audiologist	.12	
Speech Pathologist	.11	
Mandated Providers		**.47%**
Mandated Benefits and Providers		**1.14%**

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-one and one-half percent (41.5%) 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 $2.00 to $1,134.00 per year. The average reported amount added to the annual group premium for each certificate holder with single coverage was $93.00 per year. For each certificate holder with family coverage the average amount added was $148.00 per year. The median values per unit of single and family coverage were $8.00 and $20.00 respectively. The significant difference between the median and average values is indicative of the wide range of figures reported.

Sixteen and nine-tenths percent (16.9%) of respondents indicated that they add an amount to the annual premium applicable to the individual conversion policy to cover this cost. The amount added ranged from $1.00 to $1,696.00 per year. The average reported amount added to the individual premium for single coverage was $150.00, while the average reported amount added to the individual premium for family coverage was $347.00. The median values per unit of single and family coverage were $36.00 and $130.00, respectively, which, again is indicative of the wide range of figures reported.

Nine and two-tenths percent (9.2%) 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 $500.00 to $15,000.00, with a median value of $3,949.00 for single coverage and $7,212.00 for family coverage.

Forty percent (40%) of respondents reported that they do not access an identifiable charge to either the group or the individual for conversion.

It should be noted that some overlapping of companies applying an additional premium to the group policy as well as the individual policy was reported. In a limited number of cases, companies reported that the manner of application of the additional premium charge would be applied at the option of the group policyholder.

CLAIM EXPERIENCE

Financial Impact

Individual Business

As is illustrated in **Table 6**, the average total claim cost per individual contract for 1995 for mandated benefits and providers was $4.40 or .35% of average total health claims paid. Mandated benefits represent $6.10, or .51% of average total claims, mandated offers represent $7.49 or .46% of average total claims, while mandated providers account for $2.47 or .20% of average total claims. This claim information, when expressed as a percentage of average 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 overall average 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

Mandate Category	Average Claim Cost per Contract	Percent of Average Total Claim
Dependent Children	$0.80	.06%
Doctor/Dentist	4.03	.33
Newborn Children	8.72	.71
M/E/N Inpatient	22.44	1.87
M/E/N Partial Hospitalization	.88	.07
Alcohol & Drug Inpatient	6.55	.57
Alcohol & Drug Partial Hosp.	.82	.07
Pregnancy due to Rape/Incest	.02	.00
Bone Marrow Transplants *	12.39	1.04
Mammography *	1.03	.08
Child Health Supervision *	15.98	.39

* Denotes mandated offer of coverage

Mandated Benefits	**$6.10**	**.51%**
Mandated Offers	**$7.49**	**.46%**

Chiropractor	$8.36	.69%
Optometrist	.38	.03
Optician	0.00	0.00
Psychologist	1.16	.09
Clinical Social Worker	1.85	.15
Podiatrist	2.69	.22
Professional Counselor	.91	.07
Physical Therapist	7.12	.58
Clinical Nurse Specialist	2.23	.17
Audiologist	.16	.01
Speech Pathologist	.18	.01

Mandated Providers	**$2.47**	**.20%**
Benefits and Providers	**$4.40**	**.35%**

Group Business

As is illustrated in **Table 7**, the average claim cost per group certificate for 1995 for mandated benefits and providers was $11.97, or .57% of average total health claims paid for the year. Mandated benefits represent $11.65, or .60% of average total claims, mandated offers represent $31.36 or 1.17% of average total health claims, and the mandated providers account for $5.25, or .26% of average 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 average percent of total annual premium attributed to mandated benefits and providers under a group contract is 1.16% and 1.14%, respectively, for single and family coverage. In comparison, claims for mandated benefits and mandated providers represent .57% of average total claims paid for group business (single and family coverage combined).

TABLE 7

CLAIM EXPERIENCE - GROUP CONTRACTS

Mandate Category	Average Cost per Contract	Percent of Average Total Claim
Dependent Children	$4.98	.28%
Doctor/Dentist	7.65	.39
Newborn Children	20.90	.99
M/E/N Inpatient	22.79	1.13
M/E/N Partial Hospitalization	1.46	.07
M/E/N Outpatient	30.37	1.52
Alcohol & Drug Inpatient	5.03	.29
Alcohol & Drug Partial Hosp.	1.23	.05
Alcohol & Drug Outpatient	1.48	.08
Obstetrical - Normal *	25.31	1.23
Obstetrical - All Other *	71.86	3.11
Pregnancy due to Rape/Incest	.02	.00
Bone Marrow Transplants *	29.49	.94
Mammography *	3.31	.10
Child Health Supervision*	15.33	.46
* Denotes mandated offer of coverage		
Mandated Benefits	**$11.65**	**.60%**
Mandated Offers	**$31.36**	**1.17%**
Chiropractor	$14.60	.74%
Optometrist	1.09	.05
Optician	.32	.01
Psychologist	5.54	.27
Clinical Social Worker	7.49	.33
Podiatrist	6.61	.33
Professional Counselor	4.66	.23
Physical Therapist	9.74	.48
Clinical Nurse Specialist	1.58	.06
Audiologist	1.33	.06
Speech Pathologist	.37	.02
Mandated Providers	**$5.25**	**.26%**
Benefits and Providers	**$11.97**	**.57%**

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 1995 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 exclusively 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 1995 for each benefit is illustrated in **Table 8**. Child Health Supervision Services and outpatient mental, emotional and nervous disorders coverage demonstrated the highest rates of use in terms of visits per certificate (.60 and .59, respectively). Conversely, on this basis, the partial hospitalization for alcohol and drug dependency treatment coverage, the coverage for pregnancy due to rape or incest, and the partial hospitalization for mental, emotional and nervous disorders exhibited the lowest rates of utilization.

TABLE 8

UTILIZATION OF SERVICES: GROUP COVERAGE

Benefit Category	Average Visits per Certificate	Average Days per Certificate
Dependent Children	.04	.00
Doctor/Dentist	.06	.00
Newborn Children	.05	.01
M/E/N Inpatient	.05	.06
M/E/N Partial Hospitalization	.00	.00
M/E/N Outpatient	.59	.04
Alcohol & Drug Inpatient	.01	.01
Alcohol & Drug Partial Hosp.	.00	.00
Alcohol & Drug Outpatient	.02	.00
Obstetrical - Normal *	.10	.01
Obstetrical - All Other *	.26	.04
Pregnancy due to Rape/Incest	.00	.00
Bone Marrow Transplants *	.06	.02
Mammography *	.08	.00
Child Health Supervision*	.60	.02

* Denotes mandated offer of coverage

Utilization information on the number of average days of treatment per certificate for each benefit is also displayed in **Table 8**. The M/E/N inpatient benefit has the highest rate of utilization at .06 days per group certificate.

Utilization figures for the mandated provider categories are displayed in **Table 9**. The categories of chiropractor, physical therapist, and clinical social worker demonstrated the greatest number of average visits per group certificate (.60, .33 and .17, respectively).

TABLE 9

UTILIZATION OF SERVICES: GROUP COVERAGE

Provider Category	Average Visits per Certificate
Chiropractor	.60
Optometrist	.02
Optician	.00
Psychologist	.10
Clinical Social Worker	.17
Podiatrist	.10
Professional Counselor	.11
Physical Therapist	.33
Clinical Nurse Specialist	.04
Audiologist	.01
Speech Pathologist	.00

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 (as 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 average 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 claim cost per visit by provider category for a 45 to 50 minute session of medical psychotherapy is illustrated in **Table 10**. The average claim cost per visit for the mandated providers is $50.32, when viewed as a single group. In comparison, the average claim cost per visit for physicians and psychiatrists is $54.07.

TABLE 10

MEDICAL PSYCHOTHERAPY
45 TO 50 MINUTE SESSION

Provider Category	Average Claim Cost Per Visit
Clinical Nurse Specialist	$50.22
Professional Counselor	47.18
Psychologist	53.62
Clinical Social Worker	48.64
Mandated Provider Summary	50.32
Physician	50.44
Psychiatrist	56.31
Physician Summary	54.07

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 $26.59, $36.21, and $30.19 compared to the psychiatrist average of $51.54.

TABLE 11

GROUP MEDICAL PSYCHOTHERAPY

Provider Category	Average Claim Cost Per Visit
Professional Counselor	$26.59
Psychologist	36.21
Clinical Social Worker	30.19
Physician	41.14
Psychiatrist	51.54

Physical Medicine Treatment

Companies are required to provide claim information for the following three physical medicine treatments: (i) therapeutic exercise (15 minutes); (ii) massage; and (iii) ultrasound. **Tables 12**, **13**, and **14** illustrate the average claim cost per visit for each procedure by provider type. For two of the three procedures, the chiropractor category has the lowest averages.

TABLE 12

PHYSICAL MEDICINE TREATMENT
THERAPEUTIC EXERCISE, 15 MINUTES

Provider Category	Average Claim Cost Per Visit
Chiropractor	$22.05
Physical Therapist	33.57
Podiatrist	14.72
Physician	27.19

TABLE 13

PHYSICAL MEDICINE TREATMENT, MASSAGE

Provider Category	Average Claim Cost Per Visit
Chiropractor	$15.48
Physical Therapist	24.75
Podiatrist	20.57
Physician	21.33

TABLE 14

PHYSICAL MEDICINE TREATMENT, ULTRASOUND

Provider Category	Average Claim Cost Per Visit
Chiropractor	$15.04
Physical Therapist	19.77
Podiatrist	19.53
Physician	16.77

Speech, Language or Hearing Therapy

The average claim cost per visit figures for speech, language or hearing therapy for the physical therapist, speech pathologist, audiologist, and physician categories is displayed in **Table 15**. The average claim cost per visit values for the three categories are $68.78, $40.77, $134.13, and $151.95, respectively.

TABLE 15

SPEECH, LANGUAGE OR HEARING THERAPY

Provider Category	Average Claim Cost Per Visit
Physical Therapist	$68.78
Speech Pathologist	40.77
Audiologist	134.13
Physician	151.95

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 $61.33. The social worker category has the lowest average cost per visit of $37.53. The average claim cost per visit for the physician category is $42.73.

TABLE 16

OFFICE VISIT, INTERMEDIATE SERVICE TO NEW PATIENT

Provider Category	Average Claim Cost Per Visit
Chiropractor	$41.60
Physical Therapist	61.33
Podiatrist	41.18
Psychologist	55.82
Social Worker	37.53
Physician	42.73

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 1995 reporting period, however, too few claims were reported to the Commission to produce a fair comparison between the optometrist and ophthalmologist provider categories.

As is indicated in **Table 17**, the average claim cost per visit attributable to the podiatrist category for the excision of an ingrown toenail is higher than for the physician category.

TABLE 17

EXCISION OF INGROWN TOENAIL

Provider Category	Average Claim Cost Per Visit
Podiatrist	$159.60
Physician	144.21

HEALTH MAINTENANCE ORGANIZATIONS

Health maintenance organizations (HMOs) are subject to 14 VAC 5-210-10 et seq., 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 14 VAC 5-210-10 et seq. , most of the mandated benefit and mandated provider requirements of Chapter 34 (§ 38.2-3400 et seq.) 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 14 VAC 5-190-10 et seq., however, and are required to provide certain limited data. This section presents information collected from HMOs for the 1995 reporting period.

Data from all of the 22 HMOs that were required to file full reports for calendar year 1995 were used in the preparation of this report. These organizations represent 25.3% of the Virginia accident and sickness insurance market and 617,434 units of coverage subject to Virginia's mandated benefit and provider requirements.

The only benefits for which HMOs were required to submit information for the 1995 reporting period were the offers of coverage for mammography and bone marrow transplants. The impact on premium and claims is presented in **Table 18** and **Table 19**.

TABLE 18

PREMIUM IMPACT SUMMARY
Percent of Overall Average Total Annual Premium

	Individual		Group	
	Single	Family	Single	Family
Mammography *	.01%	.31%	.26%	.20%
Bone Marrow Transplants *	.01	.08	.10	.07

* Denotes mandated offer of coverage

TABLE 19

CLAIM EXPERIENCE
Percent of Average Total Claims

	Individual	Group
Mammography *	.57%	.37%
Bone Marrow Transplants *	.72	.71

* Denotes mandated offer of coverage

COMPARISONS

Data has now been collected pursuant to this report for four full reporting periods. The following comparisons of selected mandated benefits, offers and providers, both for claims experience and for premium impact are presented below for the three most recent reporting years, (1993, 1994 and 1995). The format of this presentation of information differs from that which was presented in House Document No. 5 (1995 Session), for reporting year 1994, which compared benefit and provider subtotals and totals of the percentages attributable to mandated benefits and providers. This year's presentation represents overall averages of benefit and provider categories.

PREMIUM IMPACT
Percent of Overall Average Annual Premium

Individual

	Single			Family		
Mandate Category	1993	1994	1995	1993	1994	1995
Doctor/Dentist	.16%	.35%	.52%	.16%	.59%	.68%
M/E/N Inpatient	3.17	2.75	2.38	2.68	3.24	2.71
Mammography*	.50	.19	.85	.49	.14	.69
Bone Marrow Transplants *	¤	¤	1.21	¤	¤	.75
Child Health Supervision *	1.44	.64	1.92	1.54	1.76	2.59
Chiropractor	.58%	.59%	.75%	.55%	.59%	.69%
Psychologist	.40	.40	.76	.42	.44	.83
Physical Therapist	.60	.60	.66	.69	.67	.82
Audiologist	.05	.05	.15	.05	.05	.16
Speech Pathologist	.04	.08	.15	.06	.10	.12

* Denotes mandated offer of coverage
¤ This offer was not required to be reported during the reporting years 1993 and 1994

PREMIUM IMPACT
Percent of Overall Average Annual Premium

Group

Mandate Category	Single			Family		
	1993	1994	1995	1993	1994	1995
Doctor/Dentist	.21%	.41%	1.13%	.23%	.42%	3.49%
M/E/N Inpatient	2.52	2.20	2.72	2.55	2.18	2.34
Mammography*	.61	.35	.64	.54	.33	.40
Bone Marrow Transplants *	¤	¤	.46	¤	¤	.53
Child Health Supervision *	.31	.31	.89	1.13	.84	1.03
Chiropractor	.76	.76	1.08	.65	.64	.94
Psychologist	.40	.41	.74	.39	.40	.68
Physical Therapist	.47	.51	.72	.44	.46	.68
Audiologist	.05	.06	.11	.11	.06	.12
Speech Pathologist	.06	.05	.12	.12	.06	.11

* Denotes mandated offer of coverage
¤ This offer was not required to be reported during the reporting years 1993 and 1994

CLAIMS EXPERIENCE
Percent of Average Total Claims

Individual

Mandate Category	1993	1994	1995
Doctor/Dentist	.24%	.42%	.33%
M/E/N Inpatient	1.18	2.92	1.87
Mammography*	.04	.13	.08
Bone Marrow Transplants *	¤	¤	1.04
Child Health Supervision *	.37	.22	.39
Chiropractor	.53%	.54%	.69%
Psychologist	.17	.37	.09
Physical Therapist	.29	.62	.58
Audiologist	.00	.01	.01
Speech Pathologist	.01	.05	.01

* Denotes mandated offer of coverage

¤ This offer was not required to be reported during the reporting years 1993 and 1994

CLAIMS EXPERIENCE
Percent of Average Total Claims

Group

Mandate Category	1993	1994	1995
Doctor/Dentist	.44%	.34%	.39%
M/E/N Inpatient	1.24	1.49	1.13
Mammography*	.10	.13	.10
Bone Marrow Transplants *	¤	¤	.94
Child Health Supervision *	.46	.42	.46
Chiropractor	.61%	.72%	.74%
Psychologist	.43	.83	.27
Physical Therapist	.46	.67	.48
Audiologist	.09	.01	.06
Speech Pathologist	.03	.02	.02

* Denotes mandated offer of coverage
¤ This offer was not required to be reported during the reporting years 1993 and 1994

Although these comparisons show some variations among categories during the three reporting periods, the percentages illustrate a general overall consistency of premium impact as well as claim experience of mandated benefits and mandated providers during the reporting periods being compared.

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 slightly higher on group business. This is due principally to certain mandates that apply only to policies issued on a group basis. 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 may be somewhat 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.

Generally, the overall ratio of utilization of services and providers to the corresponding premiums attributable to these services and providers appears to be consistent for individual and group contracts.

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.