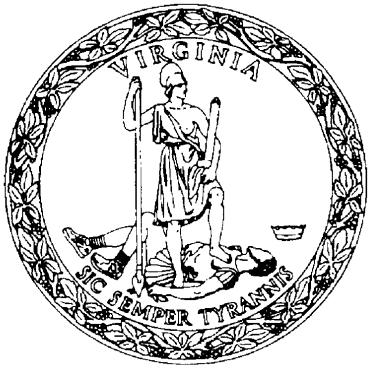
REPORT OF THE
STATE CORPORATION COMMISSION ON

THE FINANCIAL IMPACT OF MANDATED HEALTH INSURANCE BENEFITS AND PROVIDERS PURSUANT TO SECTION 38.2-3419.1 OF THE CODE OF VIRGINIA: 1996 REPORTING PERIOD

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA



HOUSE DOCUMENT NO. 10

COMMONWEALTH OF VIRGINIA
RICHMOND
1998

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COMMONWEALTH OF VIRGINIA

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October 17, 1997

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

We are pleased to submit the 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: 1996 Reporting Period.

Respectfully submitted,

Hullihen Williams Moore
Chairman

Theodore V. Morrison, Jr.
Commissioner

Clinton Miller
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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.) require every insurer, health services plan, and health maintenance organization (HMO) 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 1996 calendar year reporting period.

Of the 902 companies licensed to issue accident and sickness policies or subscription contracts in Virginia, or licensed as HMOs in Virginia in 1996, 74 were required to file full reports for the 1996 reporting period. Information presented in this report reflects data reported by 47 insurers, exclusive of HMOs, that provided credible data. Of these companies, 8 issued only individual, 24 issued only group, and 15 issued both individual and group health insurance policies or subscription contracts in Virginia in 1996. This report reflects data reported by companies representing 48.7% of the Virginia accident and sickness insurance market and 761,048 units of coverage (single and family individual policies and group certificates) subject to Virginia's mandated benefit and provider requirements. The credible reports of 25 HMOs, representing an additional 29.9% of the Virginia accident and sickness market and 703,029 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.) 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.

PREMIUM IMPACT

To assess the impact of mandated benefits, offers and providers on premiums applicable to individual policies and group certificates, the Commission required companies to report the total annual premium that would be charged for what is considered to be a standard health insurance policy and/or group certificate in Virginia. The total annual premium, per unit of coverage, for individual policies and group certificates, single and family coverages was reported.

The figures displayed in this report illustrate, on average, the annual premium which was reported by insurers and health services plans to be attributable to each mandated benefit, offer and provider, for both individual and group business, as a percentage of the average premium for a standard health insurance policy in Virginia. The information appearing in **Tables 1, 2, 3** and **4** is useful in assessing that percentage of overall average premium for a standard health insurance policy or certificate that is associated with specific mandated benefits, offers and providers.

CLAIM EXPERIENCE

In addition to premium information, companies reported their claim experience for each mandated benefit, offer and provider for the calendar year 1996. The following summary illustrates the average claim cost per policy or certificate and the average percentage of total claims this cost represents, for **all** mandated benefits, offers and providers **taken collectively**. **Tables 5** and **6** illustrate the average claim cost per policy or certificate and the average percentage of total claims this cost represents for each specific mandated benefit, offer or provider.

Individual		**Group**	
Cost Per Policy	Average Percent of Total Claims	Cost Per Certificate	Average Percent of Total Claims
$89.65	6.65%	$235.86	13.92%

On average, for an individual health insurance policy or subscription contract providing the type of coverage under which mandated benefits, offers and providers are applicable, approximately $89.65 was paid in claim payments attributable to mandated benefits, offers or providers. This represents approximately 6.65% of all claim payments made under this type of individual policy. Likewise, approximately $235.86 was paid in claim payments under a group certificate providing applicable coverage, which accounts for approximately 13.92% of all claim payments made under this type of group certificate.

The above numbers are useful in assessing the average claim cost of mandates relative to claim costs associated with all other benefits. However, these numbers can not be computed by totaling or averaging the costs associated with individual mandates illustrated elsewhere in this report.

Claim information regarding the rate of utilization of the mandated benefits and providers is also 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.

The format of this report differs from the Commission's previous reports. The information provided with respect to each individual mandated benefit, offer and provider is consistent with earlier reports. To consolidate information and present it in a format that is more useful and understandable to the reader, however, the overall percentages with respect to claim payments illustrate the total effect of mandated benefits, offers and providers on claim payments. More detailed information has also been included regarding the basis by which many of the calculations were made. Readers should refer to the section of the report entitled *Comparisons* for illustrations of the impact of individual mandated benefits, offers and providers over the three most recent reporting years.

INTRODUCTION

Section 38.2-3419.1 of the Code of Virginia requires every insurer, health services plan, and HMO 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 1996 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.) 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
1997, No. 15	1996	calendar year 1995

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").

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 902 companies licensed to issue accident and sickness policies or subscription contracts or licensed as HMOs in Virginia in 1996, 74 were required to file full reports for the 1996 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 permitted by 14 VAC 5-190-10 et seq. to file abbreviated reports (there were 145 companies meeting this criterion); (ii) wrote less than $500,000 of accident and sickness premiums in Virginia during calendar year 1996; 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 1996.

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 47 companies, exclusive of HMOs. This report reflects the credible experience of 8 companies that issued individual, 24 companies that issued group, and 15 companies that issued both individual and group health insurance policies or subscription contracts in Virginia in 1996. This report reflects data reported by companies representing 48.7% of the Virginia accident and sickness insurance market and 761,048 units of coverage (single and family individual policies and group certificates) subject to Virginia's mandated benefit and provider requirements. Twenty-five (25) HMOs, representing an additional 29.9% of the Virginia accident and sickness market and 703,029 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 78.6% of the Virginia accident and sickness market, and 1,464,077 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.

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, health services plans, and HMOs 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.

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 1996.

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 1996 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:

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

2. Limits that shall be no more restrictive than any other illness, except the co-insurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least 50%; and

3. 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 HMOs 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 HMOs "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 became required. 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 effective only during a portion of the 1996 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 HMOs to offer and make available coverage for the treatment of breast cancer by dose intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

PAP SMEARS

Section 38.2-3418.1:2 of the Code of Virginia requires that insurers, health services plans and HMOs 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 HMOs 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 the 1996 reporting period represents the first full year in which this requirement has been in place, data on this requirement is being reported herein for the first time.

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** or **certified nurse midwife**, reimbursement under the policy or subscription contract cannot be denied because the service is rendered by such licensed practitioner. The inclusion of a certified nurse midwife in the category of mandated providers became effective July 1, 1997. Companies will not have to provide data relating to certified nurse midwives until they report for the 1998 reporting period, which represents the first full year in which this requirement will have been in place.

PREMIUM IMPACT

To assess the impact of mandated benefits, offers and providers on premiums applicable to individual policies and group certificates, the Commission requires companies to report the total annual premium that would be charged for what is considered to be a standard health insurance policy and/or group certificate. The total annual premium is reported, per unit of coverage, for individual policies and group certificates, single and family coverage. The **overall average policy premium** utilized in the following tables was calculated as an average of the standard premium reported for single and family coverage, for both individual policies and group certificates. Companies also report the dollar amount of annual premium attributable to each mandated benefit, offer and provider. Although it is generally understood that companies do not usually rate each mandated benefit, offer and provider separately, companies assign a dollar figure to each service and provider based on actual claim experience and other relevant actuarial information. The **percent of overall average policy premium** attributable to each mandated benefit, offer or provider was computed by dividing the average premium applicable to each mandated benefit, offer or provider by the overall average policy premium.

The information presented in **Tables 1, 2, 3** and **4** is useful in assessing, on average, the premium cost of providing coverage for each mandated benefit, offer and provider, relative to the overall cost of a standard policy or certificate in Virginia.

Individual Business

Single Coverage

As is indicated in **Table 1**, the inpatient mental, emotional, and nervous disorders treatment benefit (M/E/N Inpatient) accounts for 2.93% of the overall average annual premium, while the premium attributable to a clinical nurse specialist represents the most significant portion of premium dollar attributable to mandated providers, 3.04%.

TABLE 1

PREMIUM IMPACT ON INDIVIDUAL POLICIES

Single Coverage

Mandate Category	Percent of Overall Average Policy Premium
Doctor/Dentist	.73%
M/E/N Inpatient	2.93
M/E/N Partial Hospitalization	.64
Alcohol & Drug Inpatient	1.27
Alcohol & Drug Partial Hosp.	.46
Pregnancy from Rape/Incest	.23
Bones/Joints	.65
Mammography *	1.03
Bone Marrow Transplants *	.90
Child Health Supervision *	1.21

* Denotes mandated offer of coverage

Chiropractor	.64%
Optometrist	.22
Optician	.28
Psychologist	.59
Clinical Social Worker	.35
Podiatrist	.47
Professional Counselor	.32
Physical Therapist	.89
Clinical Nurse Specialist	3.04
Audiologist	.16
Speech Pathologist	.18

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 a 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 $1,492.95. The average reported annual premium for such a policy including current mandates is $1,539.77. On average, the mandates represent $47.00 or 3.05% 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 with individual policies providing single coverage, the inpatient mental, emotional, and nervous disorders treatment benefit (M/E/N Inpatient) accounts for a significant portion of the overall average premium for policies providing family coverage (2.14%). The premium attributable to a clinical nurse specialist represents the most significant portion of premium attributable to mandated providers, (2.33%). See **Table 2**.

Group Business

Single Coverage

As is indicated in **Table 3**, the benefits that have the greatest impact on premium are the obstetrical-normal, inpatient mental, emotional, and nervous treatment, and obstetrical-all other coverages. It should be noted that two of the three most expensive benefits are mandated offers of coverage. Services rendered by chiropractors have the greatest premium impact with respect to mandated providers, 1.18%.

Family Coverage

As is shown in **Table 4**, inpatient and outpatient mental, emotional, and nervous disorders treatment, newborn children and obstetrical services coverages have a significant impact on the annual premium for family coverage under group contracts. Mandated offers account for the more expensive coverages.

TABLE 2

PREMIUM IMPACT ON INDIVIDUAL POLICIES

Family Coverage

Mandate Category	Percent of Overall Average Policy Premium
Dependent Children	.27%
Doctor/Dentist	.48
Newborn Children	1.24
M/E/N Inpatient	2.14
M/E/N Partial Hospitalization	.70
Alcohol & Drug Inpatient	.97
Alcohol & Drug Partial Hosp.	.19
Pregnancy from Rape/Incest	.12
Bones/Joints	.24
Mammography *	.37
Bone Marrow Transplants *	.51
Child Health Supervision *	1.37

* Denotes mandated offer of coverage

Chiropractor	.36%
Optometrist	.28
Optician	.27
Psychologist	.33
Clinical Social Worker	.15
Podiatrist	.42
Professional Counselor	.22
Physical Therapist	.70
Clinical Nurse Specialist	2.33
Audiologist	.09
Speech Pathologist	.09

TABLE 3

PREMIUM IMPACT ON GROUP CERTIFICATES
Single Coverage

Mandate Category	Percent of Overall Average Policy Premium
Doctor/Dentist	.52%
M/E/N Inpatient	2.87
M/E/N Partial Hospitalization	.65
M/E/N Outpatient	1.68
Alcohol & Drug Inpatient	1.41
Alcohol & Drug Partial Hosp.	.61
Alcohol & Drug Outpatient	.38
Bones/Joints	.51
Obstetrical - Normal *	3.28
Obstetrical - All Other *	2.47
Pregnancy due to Rape/Incest	.29
Bone Marrow Transplants *	.63
Mammography *	.50
Child Health Supervision *	.78

* Denotes mandated offer of coverage

Chiropractor	1.18%
Optometrist	.30
Optician	.50
Psychologist	.84
Clinical Social Worker	.47
Podiatrist	.41
Professional Counselor	.29
Physical Therapist	.73
Clinical Nurse Specialist	.10
Audiologist	.14
Speech Pathologist	.12

TABLE 4

PREMIUM IMPACT ON GROUP CERTIFICATES
Family Coverage

Mandate Category	Percent of Overall Average Policy Premium
Dependent Children	.34%
Doctor/Dentist	1.54
Newborn Children	2.01
M/E/N Inpatient	2.68
M/E/N Partial Hospitalization	.68
M/E/N Outpatient	1.61
Alcohol & Drug Inpatient	1.27
Alcohol & Drug Partial Hosp.	.47
Alcohol & Drug Outpatient	.38
Bones/Joints	.75
Obstetrical - Normal *	3.50
Obstetrical - All Other *	2.81
Pregnancy due to Rape/Incest	.34
Mammography *	.40
Bone Marrow Transplants *	.58
Child Health Supervision *	.83

* Denotes mandated offer of coverage

Chiropractor	1.04%
Optometrist	.29
Optician	.53
Psychologist	.78
Clinical Social Worker	.35
Podiatrist	.36
Professional Counselor	.29
Physical Therapist	.67
Clinical Nurse Specialist	.10
Audiologist	.14
Speech Pathologist	.10

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. Fifty-one and three-tenths percent (51.3%) 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 $1.00 to $15,000.00 per year. The average reported amount added to the annual group premium for each certificate holder with single coverage was $1,135.00 per year. For each certificate holder with family coverage the average amount added was $1,137.00 per year. The median values per unit of single and family coverage were $17.00 and $30.00 respectively. The significant difference between the median and average values is indicative of the wide range of figures reported.

Seven and seven-tenths percent (7.7%) 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 $300.00 to $1,696.00 per year. The average reported amount added to the individual premium for single coverage was $384.00, while the average reported amount added to the individual premium for family coverage was $665.00. The median values per unit of single and family coverage were $301.00 and $998.00, respectively, which, again is indicative of the wide range of figures reported.

Seventeen and nine-tenths percent (17.9%) 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 $4.00 to $6,690.00, with a median value of $587.00 for single coverage and $632.00 for family coverage.

Thirty-eight and five-tenths percent (38.5%) of respondents reported that they do not assess 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

To assess the impact of mandated benefits, offers and providers on claim payments made by insurers and health services plans in Virginia, the Commission requires companies to report the **total claims** paid or incurred under the types of policies subject to the reporting requirements, for both individual policies and group certificates. Companies are also required to report the total claims paid or incurred for each individual mandated benefit, offer or provider as well as the total number of policies or certificates in which coverage is provided for that mandated benefit, offer or provider. The **average claim cost per contract or certificate** is computed for each mandated benefit, offer and provider by dividing the total claims attributable to the mandated benefit, offer or provider by the number of applicable policies or certificates. The **average percent of total claims** for a specific mandated benefit, offer or provider is computed by dividing the total claim payments associated with the mandated benefit, offer or provider by the **total claims** reported by the insurers and health services plans. The information presented in **Tables 5** and **6** is useful in assessing the dollar amount of claim paid for a particular mandated benefit, offer or provider, on average, per policy or certificate, and the percentage this figure represents of all claims paid on applicable policies in Virginia.

The average percentages of total claims and average claim costs per policy or certificate for all mandated benefits, offers and providers collectively are illustrated in the Executive Summary, page ii.

Individual Business

As is illustrated in **Table 5**, the average claim cost associated with inpatient confinements for mental, emotional and nervous disorders was relatively high, as were the costs associated with chiropractors and physical therapists.

Group Business

As is illustrated in **Table 6**, the most significant claim cost was associated with obstetrical coverage, while under the provider category, the cost for services provided by a chiropractor was the most significant.

TABLE 5

CLAIM EXPERIENCE - INDIVIDUAL POLICIES

Mandate Category	Average Claim Cost per Contract	Average Percent of Total Claims
Dependent Children	$2.56	.19%
Doctor/Dentist	3.83	.29
Newborn Children	13.46	1.02
M/E/N Inpatient	22.96	1.76
M/E/N Partial Hospitalization	1.27	.10
Alcohol & Drug Inpatient	7.10	.52
Alcohol & Drug Partial Hosp.	.91	.07
Pregnancy due to Rape/Incest	.37	.03
Bones/Joints	.82	.06
Bone Marrow Transplants *	3.28	.23
Mammography *	1.77	.13
Child Health Supervision *	6.80	.46

* Denotes mandated offer of coverage

Chiropractor	$10.26	.75%
Optometrist	.60	.04
Optician	.00	.00
Psychologist	1.25	.09
Clinical Social Worker	2.59	.19
Podiatrist	3.19	.24
Professional Counselor	1.45	.11
Physical Therapist	10.39	.80
Clinical Nurse Specialist	.48	.04
Audiologist	.10	.01
Speech Pathologist	.41	.03

TABLE 6

CLAIM EXPERIENCE - GROUP CONTRACTS

Mandate Category	Average Claim Cost per Certificate	Average Percent of Total Claims
Dependent Children	$6.95	.43%
Doctor/Dentist	7.04	.44
Newborn Children	30.84	1.19
M/E/N Inpatient	20.48	1.19
M/E/N Partial Hospitalization	1.56	.07
M/E/N Outpatient	28.54	1.65
Alcohol & Drug Inpatient	7.44	.42
Alcohol & Drug Partial Hosp.	1.34	.06
Alcohol & Drug Outpatient	2.61	.16
Obstetrical - Normal *	20.58	1.20
Obstetrical - All Other *	64.87	3.80
Pregnancy due to Rape/Incest	.77	.04
Bones/Joints	2.99	.14
Bone Marrow Transplants *	9.52	.55
Mammography *	2.91	.17
Child Health Supervision*	10.36	.59

* Denotes mandated offer of coverage

Chiropractor	$14.30	.84%
Optometrist	1.44	.08
Optician	.22	.01
Psychologist	5.73	.34
Clinical Social Worker	6.19	.32
Podiatrist	6.30	.38
Professional Counselor	4.99	.26
Physical Therapist	10.37	.66
Clinical Nurse Specialist	.96	.06
Audiologist	1.28	.06
Speech Pathologist	.43	.02

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. Reported data varied greatly among companies. While some indicated that they experienced no discernible administrative costs 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 variation of 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 1996 for each benefit is illustrated in **Table 7**. Outpatient mental, emotional and nervous disorders, child health supervision services and obstetrical-all other coverage demonstrated the highest rates of use in terms of visits per certificate (.59, .34 and .33, 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 7

UTILIZATION OF SERVICES: GROUP COVERAGE

Benefit Category	Average Visits per Certificate	Average Days per Certificate
Dependent Children	.06	.00
Doctor/Dentist	.06	.00
Newborn Children	.09	.04
M/E/N Inpatient	.09	.04
M/E/N Partial Hospitalization	.00	.00
M/E/N Outpatient	.59	.03
Alcohol & Drug Inpatient	.03	.02
Alcohol & Drug Partial Hosp.	.01	.00
Alcohol & Drug Outpatient	.03	.00
Bones/Joints	.03	.01
Obstetrical - Normal *	.07	.01
Obstetrical - All Other *	.33	2.68
Pregnancy due to Rape/Incest	.00	.00
Bone Marrow Transplants *	.05	.01
Mammography *	.07	.00
Child Health Supervision*	.34	.01

* 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 7**. The obstetrical-all other benefit has the highest rate of utilization at 2.68 days per group certificate.

Utilization figures for the mandated provider categories are displayed in **Table 8**. The categories of chiropractor, physical therapist, and clinical social worker demonstrated the greatest number of average visits per group certificate (.56, .33 and .15, respectively).

TABLE 8

UTILIZATION OF SERVICES: GROUP COVERAGE

Provider Category	Average Visits per Certificate
Chiropractor	.56
Optometrist	.03
Optician	.01
Psychologist	.11
Clinical Social Worker	.15
Podiatrist	.10
Professional Counselor	.09
Physical Therapist	.33
Clinical Nurse Specialist	.01
Audiologist	.01
Speech Pathologist	.01

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 9**. The average claim cost per visit for the mandated providers is $57.11, when viewed as a single group. In comparison, the average claim cost per visit for physicians and psychiatrists is $71.29.

TABLE 9

MEDICAL PSYCHOTHERAPY
45 TO 50 MINUTE SESSION

Provider Category	Average Claim Cost Per Visit
Clinical Nurse Specialist	$64.01
Professional Counselor	53.71
Psychologist	64.82
Clinical Social Worker	49.41
Mandated Provider Summary	57.11
Physician	77.91
Psychiatrist	60.70
Physician Summary	71.29

Companies are also required to provide claim information regarding group medical psychotherapy. As is indicated in **Table 10**, the average claim cost per visit for the mandated provider categories are $24.17, $37.91, and $33.19 compared to the physician average of $40.38.

TABLE 10

GROUP MEDICAL PSYCHOTHERAPY

Provider Category	Average Claim Cost Per Visit
Professional Counselor	$24.17
Psychologist	37.91
Clinical Social Worker	33.19
Physician	40.38
Psychiatrist	31.69

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 11**, **12**, and **13** illustrate the average claim cost per visit for each procedure by provider type. For two of the three procedures, the podiatrist category has the lowest averages.

TABLE 11

PHYSICAL MEDICINE TREATMENT
THERAPEUTIC EXERCISE, 15 MINUTES

Provider Category	Average Claim Cost Per Visit
Chiropractor	$23.80
Physical Therapist	29.43
Podiatrist	19.53
Physician	32.98

TABLE 12

PHYSICAL MEDICINE TREATMENT, MASSAGE

Provider Category	Average Claim Cost Per Visit
Chiropractor	$16.94
Physical Therapist	25.97
Podiatrist	16.04
Physician	19.90

TABLE 13

PHYSICAL MEDICINE TREATMENT, ULTRASOUND

Provider Category	Average Claim Cost Per Visit
Chiropractor	$16.04
Physical Therapist	18.85
Podiatrist	17.82
Physician	17.94

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 14**. The average claim cost per visit values for the four categories are $38.50, $34.42, $94.47, and $65.03, respectively.

TABLE 14

SPEECH, LANGUAGE OR HEARING THERAPY

Provider Category	Average Claim Cost Per Visit
Physical Therapist	$38.50
Speech Pathologist	34.42
Audiologist	94.47
Physician	65.03

Office Visits

As is indicated in **Table 15**, 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 professional counselor category has the highest average claim cost per visit of $109.01. The chiropractor category has the lowest average cost per visit of $36.13. The average claim cost per visit for the physician category is $49.40.

TABLE 15

OFFICE VISIT, INTERMEDIATE SERVICE TO NEW PATIENT

Provider Category	Average Claim Cost Per Visit
Chiropractor	$36.13
Physical Therapist	89.07
Podiatrist	46.19
Psychologist	51.16
Social Worker	41.83
Professional Counselor	109.01
Physician	49.40

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 1996 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 16**, 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 16

EXCISION OF INGROWN TOENAIL

Provider Category	Average Claim Cost Per Visit
Podiatrist	$180.68
Physician	176.92

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 1996 reporting period.

Data from all of the 25 HMOs that were required to file full reports for calendar year 1996 were used in the preparation of this report. These organizations represent 29.9% of the Virginia accident and sickness insurance market and 703,029 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 1996 reporting period were the offers of coverage for bone marrow transplants and mammography, and the required coverage for procedures involving bones and joints of the head, face, neck or jaw. The impact on premium and claims is presented in **Table 17** and **Table 18**. The basis of the calculations presented in Tables 17 and 18 are the same as those made for insurers and health services plans, (refer to pages 11 and 18).

TABLE 17

PREMIUM IMPACT SUMMARY
Percent of Overall Average Annual Premium

	Individual		Group	
	Single	Family	Single	Family
Mammography *	.13%	.13%	.09%	.10%
Bone Marrow Transplants *	.27	.09	.21	.18
Bones/Joints	.10	.10	.07	.07

* Denotes mandated offer of coverage

TABLE 18

CLAIM EXPERIENCE
Percent of Average Total Claims

	Individual	Group
Mammography *	.39%	.28%
Bone Marrow Transplants*	.61	2.16
Bones/Joints	.22	.25

* Denotes mandated offer of coverage

COMPARISONS

Data has now been collected pursuant to this report for five 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, 1994, 1995 and 1996.

PREMIUM IMPACT
Percent of Overall Average Annual Premium

Individual

	Single			Family		
Mandate Category	1994	1995	1996	1994	1995	1996
Doctor/Dentist	.35%	.52%	.73%	.59%	.68%	.48%
M/E/N Inpatient	2.75	2.38	2.93	3.24	2.71	2.14
Mammography*	.19	.85	1.03	.14	.69	.37
Bone Marrow Transplants *	¤	1.21	.90	¤	.75	.51
Child Health Supervision *	.64	1.92	1.21	1.76	2.59	1.37
Chiropractor	.59	.75	.64	.59	.69	.36
Psychologist	.40	.76	.59	.44	.83	.33
Physical Therapist	.60	.66	.89	.67	.82	.70
Audiologist	.05	.15	.16	.05	.16	.09
Speech Pathologist	.08	.15	.18	.10	.12	.09

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

PREMIUM IMPACT
Percent of Overall Average Annual Premium

Group

	Single			Family		
Mandate Category	1994	1995	1996	1994	1995	1996
Doctor/Dentist	.41%	1.13%	.52%	.42%	3.44%	1.54%
M/E/N Inpatient	2.20	2.72	2.87	2.18	2.34	2.68
Mammography*	.35	.64	.50	.33	.40	.40
Bone Marrow Transplants *	¤	.46	.63	¤	.53	.58
Child Health Supervision *	.31	.89	.78	.84	1.03	.83
Chiropractor	.76	1.08	1.18	.64	.94	1.04
Psychologist	.41	.74	.84	.40	.68	.78
Physical Therapist	.51	.72	.73	.46	.68	.67
Audiologist	.06	.11	.14	.06	.12	.14
Speech Pathologist	.05	.12	.12	.06	.11	.10

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

CLAIMS EXPERIENCE
Average Percent of Total Claims

Individual

Mandate Category	1994	1995	1996
Doctor/Dentist	.42%	.33%	.29%
M/E/N Inpatient	2.92	1.87	1.76
Mammography*	.13	.08	.13
Bone Marrow Transplants *	¤	1.04	.23
Child Health Supervision *	.22	.39	.46
Chiropractor	.54	.69	.75
Psychologist	.37	.09	.09
Physical Therapist	.62	.58	.80
Audiologist	.01	.01	.01
Speech Pathologist	.05	.01	.03

* Denotes mandated offer of coverage

¤ This offer was not required to be reported during the reporting year 1994

CLAIMS EXPERIENCE
Average Percent of Total Claims

Group

Mandate Category	1994	1995	1996
Doctor/Dentist	.34%	.39%	.44%
M/E/N Inpatient	1.49	1.13	1.19
Mammography*	.13	.10	.17
Bone Marrow Transplants *	¤	.94	.55
Child Health Supervision *	.42	.46	.59
Chiropractor	.72	.74	.84
Psychologist	.83	.27	.34
Physical Therapist	.67	.48	.66
Audiologist	.01	.06	.06
Speech Pathologist	.02	.02	.02

* Denotes mandated offer of coverage
¤ This offer was not required to be reported during the reporting year 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. This impact is higher on group business. This is due principally to certain mandates that apply only to policies issued on a group basis. When mandated offers of coverage are removed from the analysis, however, the aggregate effect of mandated benefits and providers may be somewhat reduced. Although it can not be specifically quantified, it appears that mandated offers may 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.