

**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: 1997  
REPORTING PERIOD**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**

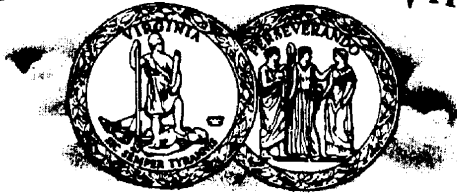


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**COMMONWEALTH OF VIRGINIA  
RICHMOND  
1999**



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## STATE CORPORATION COMMISSION

October 2, 1998

To: The Honorable James S. Gilmore, III  
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: 1997 Reporting Period.

Respectfully submitted,

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Clinton Miller  
Chairman

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Theodore V. Morrison, Jr.  
Commissioner

Handwritten signature of Hullihen Williams Moore in black ink, written over a horizontal line.

Hullihen Williams Moore  
Commissioner



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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 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. The Commission is required to prepare a consolidation of these reports, as represented by this document, for submission to the General Assembly. This document constitutes the Commission's report for the 1997 calendar year reporting period.

Of the 903 companies licensed to issue accident and sickness, or subscription contracts in Virginia, or licensed as HMOs in Virginia in 1997, 68 were required to file full reports for the 1997 reporting period. Information presented in this report reflects data reported by 42 insurers, exclusive of HMOs, that provided credible data. Of these companies, 6 issued only individual, 22 issued only group, and 14 issued both individual contracts and group health insurance certificates or subscription contracts in Virginia in 1997. This report reflects data reported by companies representing 46.22% of the Virginia accident and sickness insurance market and 568,305 units of coverage (single and family individual contracts and group certificates) subject to Virginia's mandated benefit and provider requirements. The credible reports of 18 HMOs, representing an additional 33.18% of the Virginia accident and sickness market and 426,981 contracts or certificates (units of coverage), were also used in the preparation of this report. Because HMOs are not subject to the mandated provider requirement and many of the mandated benefit 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 contracts 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 contract and/or group certificate in Virginia. The total annual premium, per unit of coverage, for individual contracts 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 contract 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 contract 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 1997. The following summary illustrates the average claim cost per contract 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 contract or certificate and the average percentage of total claims this cost represents for each specific mandated benefit, offer or provider.

Individual		Group	
Average Claim Cost Per Contract	Average Percent of Total Claims	Average Claim Cost Per Certificate	Average Percent of Total Claims
\$83.76	8.63%	\$263.27	16.62%

On average, for an individual health insurance contract or subscription contract providing the type of coverage under which mandated benefits, offers and providers are applicable, approximately \$83.76 was paid in claim payments attributable to mandated benefits, offers and providers. This represents approximately 8.63 % of all claim payments made under this type of individual



contract. Likewise, approximately \$263.27 was paid in claim payments under a group certificate providing applicable coverage, which accounts for approximately 16.62% 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 cannot 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, offers 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.



## 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 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 1997 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:

<u>House Document No.</u>	<u>Date Issued</u>	<u>Reporting Period</u>
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
1998, No. 10	1997	calendar year 1996

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

- **benefits or provisions which must be offered and made available to anyone purchasing an accident and sickness insurance contract or certificate 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 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 this report because, during the period of this report, such plans and policies were not subject to the mandated benefit and mandated provider requirements of Virginia.**

Of the 903 companies licensed to issue accident and sickness or subscription contracts or licensed as HMOs in Virginia in 1997, 68 were required to file full reports for the 1997 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 150 companies meeting this criterion); (ii) wrote less than \$500,000 of accident and sickness premiums in Virginia during calendar year 1997; 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 1997.

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 42 companies, exclusive of HMOs. This report reflects the credible experience of 6 companies that issued individual, 22 companies that issued group, and 14 companies that issued both individual contracts and group health insurance certificates or subscription contracts in Virginia in 1997. This report reflects data reported by companies representing 46.22% of the Virginia accident and sickness insurance market and 568,305 units of coverage (single and family individual contracts and group certificates) subject to Virginia's mandated benefit and provider requirements. Eighteen (18) HMOs, representing an additional 33.18% of the Virginia accident and sickness market and 426,981 units of coverage, filed full reports. Because HMOs are not subject to the mandated provider requirement and many of the mandated benefit 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 represents 79.40% of the Virginia accident and sickness market, and 995,286 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 Fifth 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 contract. 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 contract holders 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 1997.

## DEFINITIONS

The following sections contain summary descriptions of the mandated benefit and mandated provider requirements for which companies must provide claim and premium information. These summaries are included only to provide an overview of the required coverages applicable to the 1997 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 are not 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 contract 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 services:

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 certificates. Data relating to this benefit as it applies to individual contracts is being reported for the first time, as the 1997 reporting period represents the first full year in which this benefit was mandated.

#### 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.

#### 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 illness.

#### 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, data relating to this benefit is being reported for the first time, as the 1997 reporting period represents the first full year in which this benefit was mandated.

## Coverage for Victims of Rape or Incest

Section 38.2-3418 of the Code of Virginia requires that each hospital expense, medical surgical expense, major medical expense or hospital confinement indemnity insurance policy issued by an insurer, each individual and group subscription contract providing hospital, medical or surgical benefits issued by a corporation, and each contract issued by a health maintenance organization which provide benefits as a result of an accident or accidental injury shall be construed to include benefits for pregnancy following an act of rape of an insured or subscriber which was reported to the police within seven days following its occurrence, to the same extent as any other covered accident. The seven day requirement is extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

## 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 a mandate. 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 but must not be more restrictive than for physical illness generally.

Data relating to this benefit is displayed as a mandated benefit for the first time, as the 1997 reporting period represents the first full year in which this benefit was mandated rather than required to be offered.

## Bone Marrow Transplants

Section 38.2-3418.1:1 of the Code of Virginia 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. Effective July 1, 1996, coverage for pap smears was mandated. Data relating to this benefit is reported for the first time, as the 1997 reporting period represents the first full year in which this benefit was 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.

### 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.

### Legislative Changes - 1998

During its 1998 legislative session, the General Assembly of the Commonwealth of Virginia passed additional mandated benefits applicable to certain plans delivered, issued for delivery or renewed in Virginia on and after July 1, 1998. Sections 38.2-3418.3, 38.2-3418.4, 38.2-3418.5, and 38.2-3418.7 of the Code of Virginia require coverage for services and supplies for the treatment of hemophilia and congenital bleeding disorders, coverage for reconstructive breast surgery, coverage for early intervention services, and coverage for PSA testing, respectively. Coverage requirements under these new mandated benefits are set forth in the statutes. Data relating to these coverages will be reported in the 1999 reporting year.

## **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 be legally performed by a person licensed in this Commonwealth as a **chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist, speech pathologist, certified nurse midwife, or licensed acupuncturist**, reimbursement under the policy or subscription contract cannot be denied because the service is rendered by the licensed practitioner. The inclusion of a licensed acupuncturist in the category of mandated providers became effective July 1, 1998. Companies will have to provide data relating to licensed acupuncturists in the 1999 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 contracts 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 contract and/or group certificate. The total annual premium is reported, per unit of coverage, for individual contracts and group certificates, single and family coverage. The **overall average premium** utilized in the following tables was calculated as an average of the standard premium reported for single and family coverage, for both individual contracts 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 premium** attributable to each mandated benefit, offer and provider was computed by dividing the average premium applicable to each mandated benefit, offer and provider by the overall average 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 contract 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 2.12% of the overall average premium, while the premium attributable to a clinical nurse specialist represents the most significant portion of premium dollar attributable to mandated providers, 1.62%.

**TABLE 1****PREMIUM IMPACT ON INDIVIDUAL CONTRACTS**

<b>Single Coverage</b>	
<b><u>Mandate Category</u></b>	<b><u>Percent of Overall Average Premium</u></b>
Doctor/Dentist	.38%
M/E/N Inpatient	2.12
M/E/N Partial Hospitalization	.45
M/E/N Outpatient	1.69
Alcohol & Drug Inpatient	.49
Alcohol & Drug Partial Hosp.	.30
Alcohol & Drug Outpatient	.79
Postpartum Services	.90
Pregnancy due to Rape/Incest	.25
Bones/Joints	.62
Pap Smears	.51
Mammography	1.13
Bone Marrow Transplants *	1.50
Child Health Supervision *	1.63

\* Denotes mandated offer of coverage

Chiropractor	.51%
Optometrist	.21
Optician	.30
Psychologist	.41
Clinical Social Worker	.38
Podiatrist	.47
Professional Counselor	.32
Physical Therapist	.63
Clinical Nurse Specialist	1.62
Audiologist	.12
Speech Pathologist	.12

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 contract 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 contract including current mandated benefits and mandated providers under the same conditions. The coverage is defined as follows: \$250 deductible; \$1,000 stop-loss limit; 80% coinsurance factor; and \$250,000 contract maximum. The average reported annual premium for such a contract without mandates is \$1,552.71. The average reported annual premium for such a contract including current mandates is \$1,944. On average, the mandates represent \$391.29 or 20.13% of the average annual premium for the contract 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

For contracts providing family coverage, the outpatient mental, emotional and nervous disorders treatment benefit (M/E/N Outpatient) accounts for a significant portion of the overall average premium, 2.89%. The premium attributable to a clinical nurse specialist represents the most significant portion of premium attributable to mandated providers, 1.69%. See **Table 2**.

### **Group Business**

#### Single Coverage

As is indicated in **Table 3**, the benefits that have the greatest impact on premium are doctor to include dentist, inpatient mental, emotional and nervous disorders treatment benefit (M/E/N Inpatient), obstetrical-normal, and outpatient mental, emotional and nervous disorders treatment benefit (M/E/N Outpatient). Services rendered by chiropractors have the greatest premium impact with respect to mandated providers, 2.54%.

#### Family Coverage

As is shown in **Table 4**, coverages for obstetrical-normal, inpatient mental, emotional, and nervous disorders treatment benefit (M/E/N Inpatient), doctor to include dentist, and obstetrical-all other have a significant impact on the premium. Services rendered by chiropractors have the greatest premium impact with respect to mandated providers, 1.40%.



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

<u>Mandate Category</u>	<u>Percent of Overall Average Premium</u>
Dependent Children	.39 %
Doctor/Dentist	.36
Newborn Children	1.38
M/E/N Inpatient	2.30
M/E/N Partial Hospitalization	.17
M/E/N Outpatient	2.89
Alcohol & Drug Inpatient	.75
Alcohol & Drug Partial Hosp.	.29
Alcohol & Drug Outpatient	.45
Postpartum Services	.72
Pregnancy due to Rape/Incest	.14
Bones/Joints	.63
Pap Smears	.28
Mammography	.54
Bone Marrow Transplants *	.68
Child Health Supervision *	2.23

\* Denotes mandated offer of coverage

Chiropractor	.43%
Optometrist	.38
Optician	.43
Psychologist	.41
Clinical Social Worker	.24
Podiatrist	.58
Professional Counselor	.32
Physical Therapist	.69
Clinical Nurse Specialist	1.69
Audiologist	.11
Speech Pathologist	.09

**TABLE 3****PREMIUM IMPACT ON GROUP CERTIFICATES****Single Coverage**

<u>Mandate Category</u>	<u>Percent of Overall Average Premium</u>
Doctor/Dentist	8.75%
M/E/N Inpatient	5.11
M/E/N Partial Hospitalization	.31
M/E/N Outpatient	3.06
Alcohol & Drug Inpatient	2.40
Alcohol & Drug Partial Hosp.	.11
Alcohol & Drug Outpatient	1.32
Postpartum Services	2.07
Pap Smears	1.22
Bones/Joints	2.81
Obstetrical - Normal *	4.27
Obstetrical - All Other *	1.91
Pregnancy due to Rape/Incest	.19
Mammography	1.11
Bone Marrow Transplants *	2.82
Child Health Supervision *	.43

\* Denotes mandated offer of coverage

Chiropractor	2.54%
Optometrist	.25
Optician	.32
Psychologist	.57
Clinical Social Worker	.35
Podiatrist	.32
Professional Counselor	.26
Physical Therapist	1.96
Clinical Nurse Specialist	.14
Audiologist	.09
Speech Pathologist	1.66

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

<u>Mandate Category</u>	<u>Percent of Overall Average Premium</u>
Dependent Children	.42%
Doctor/Dentist	2.74
Newborn Children	1.85
M/E/N Inpatient	2.96
M/E/N Partial Hospitalization	.33
M/E/N Outpatient	1.94
Alcohol & Drug Inpatient	1.25
Alcohol & Drug Partial Hosp.	.14
Alcohol & Drug Outpatient	.54
Postpartum Services	1.77
Bones/Joints	.90
Pap Smears	.52
Obstetrical - Normal *	3.30
Obstetrical - All Other *	2.50
Pregnancy due to Rape/Incest	.30
Mammography	.53
Bone Marrow Transplants *	.91
Child Health Supervision *	.78
* Denotes mandated offer of coverage	
Chiropractor	1.40%
Optometrist	.28
Optician	.42
Psychologist	.68
Clinical Social Worker	.37
Podiatrist	.35
Professional Counselor	.33
Physical Therapist	.97
Clinical Nurse Specialist	.20
Audiologist	.15
Speech Pathologist	.34

## Conversion from Group to Individual Coverage

Section 38.2-3416 of the Code of Virginia requires that insurers allow individuals covered under a group contract to convert to an individual accident and sickness contract without evidence of insurability upon termination of group coverage eligibility. Forty-four and forty-four-hundredths percent (44.44%) of respondents providing group coverage indicated that they added 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 \$3,753 per year. The average reported amount added to the annual group premium for each certificate holder with single coverage was \$313 per year. For each certificate holder with family coverage the average amount added was \$191 per year. The median values per unit of single and family coverage were \$15 and \$37, respectively. The significant difference between the median and average values is indicative of the wide range of figures reported.

Five and fifty-six-hundredths percent (5.56%) of respondents indicated that they added an amount to the annual premium applicable to the individual conversion contract to cover the cost of conversion. The amount added ranged from \$300 to \$696 per year. The average reported amount added to the individual premium for single coverage was \$301, while the average reported amount added to the individual premium for family coverage was \$498. The median values per unit of single and family coverage were \$301 and \$498, respectively, which, again is indicative of the wide range of figures reported.

Thirteen and eighty-nine-hundredths percent (13.89%) 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 contract holder for each conversion contract issued. The amount of this fee varied from \$6.00 to \$7,260, with a median value of \$500 for single coverage and \$411 for family coverage.

Forty-one and sixty-seven-hundredths percent (41.67%) 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 contract as well as the individual contract 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 contract holder.

## 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 contracts subject to the reporting requirements, for both individual contracts and group certificates. Companies are also required to report the total claims paid or incurred for each individual mandated benefit, offer and provider as well as the total number of contracts or certificates in which coverage is provided for that mandated benefit, offer and 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 and provider by the number of applicable contracts or certificates. The **average percent of total claims** for a specific mandated benefit, offer and provider is computed by dividing the total claim payments associated with the mandated benefit, offer and 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 claims paid for a particular mandated benefit, offer and provider, on average, per contract or certificate, and the percentage of total claims paid on applicable contracts or certificates in Virginia.

The average percentages of total claims and average claim costs per contract 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 (M/E/N Inpatient) was relatively high, as were the costs associated with chiropractors and physical therapists.

### Group Business

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

**TABLE 5****CLAIM EXPERIENCE - INDIVIDUAL CONTRACTS**

<u>Mandate Category</u>	<u>Average Claim Cost per Contract</u>	<u>Average Percent of Total Claims</u>
Dependent Children	\$ 3.28	.23%
Doctor/Dentist	3.25	.33
Newborn Children	9.91	.68
M/E/N Inpatient	15.80	1.48
M/E/N Outpatient	14.97	1.08
M/E/N Partial Hospitalization	.87	.06
Alcohol & Drug Inpatient	5.76	.41
Alcohol & Drug Partial Hosp.	.69	.05
Alcohol & Drug Outpatient	.88	.08
Pregnancy due to Rape/Incest	.00	.00
Bones/Joints	1.16	.08
Pap Smears	5.26	.38
Bone Marrow Transplants *	5.85	.43
Mammography	7.99	.82
Child Health Supervision *	10.63	.74
Postpartum Services	1.16	.09

\* Denotes mandated offer of coverage

Chiropractor	\$ 7.45	.77%
Optometrist	.39	.04
Optician	.00	.00
Psychologist	1.43	.15
Clinical Social Worker	1.93	.19
Podiatrist	2.29	.24
Professional Counselor	1.92	.19
Physical Therapist	6.66	.71
Clinical Nurse Specialist	.22	.02
Audiologist	.13	.01
Speech Pathologist	1.81	.13

TABLE 6

## CLAIM EXPERIENCE - GROUP CERTIFICATES

<u>Mandate Category</u>	<u>Average Claim Cost per Certificate</u>	<u>Average Percent of Total Claims</u>
Dependent Children	\$ 3.63	.21%
Doctor/Dentist	6.76	.43
Newborn Children	30.86	1.44
M/E/N Inpatient	20.92	1.32
M/E/N Partial Hospitalization	3.22	.17
M/E/N Outpatient	30.53	1.92
Alcohol & Drug Inpatient	6.59	.40
Alcohol & Drug Partial Hosp.	.94	.05
Alcohol & Drug Outpatient	3.06	.19
Obstetrical - Normal *	19.18	1.20
Obstetrical - All Other *	77.85	4.65
Pregnancy due to Rape/Incest	.13	.01
Bones/Joints	8.69	.44
Pap Smears	6.94	.42
Bone Marrow Transplants *	3.85	.24
Mammography	2.34	.15
Child Health Supervision*	14.33	.78
Postpartum Services	1.53	.09

\* Denotes mandated offer of coverage

Chiropractor	\$15.80	.99%
Optometrist	1.32	.08
Optician	1.09	.05
Psychologist	5.67	.35
Clinical Social Worker	6.65	.36
Podiatrist	6.50	.41
Professional Counselor	3.28	.20
Physical Therapist	10.41	.65
Clinical Nurse Specialist	.43	.03
Audiologist	.76	.04
Speech Pathologist	.47	.02

## **Administrative Costs**

Companies 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 companies 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 1997 for each benefit is illustrated in **Table 7**. Coverage for obstetrical-all other coverage, outpatient mental, emotional and nervous disorders (M/E/N Outpatient), and child health supervision services demonstrated the highest rates of use in terms of visits per certificate (.66, .60 and .42, respectively). Conversely, on this basis, coverage for partial hospitalization (M/E/N Partial Hospitalization), pregnancy due to rape or incest, partial hospitalization for alcohol and drug dependency treatment and postpartum services exhibited the lowest rates of utilization.



**TABLE 7****UTILIZATION OF SERVICES: GROUP COVERAGE**

<u>Benefit Category</u>	<u>Average Visits per Certificate</u>	<u>Average Days per Certificate</u>
Dependent Children	.02	.00
Doctor/Dentist	.05	.00
Newborn Children	.07	.03
M/E/N Inpatient	.06	.05
M/E/N Partial Hospitalization	.00	.05
M/E/N Outpatient	.60	.00
Alcohol & Drug Inpatient	.03	.01
Alcohol & Drug Partial Hosp.	.01	.00
Alcohol & Drug Outpatient	.04	.00
Postpartum Services	.01	.00
Bones/Joints	.04	.00
Pap Smears	.27	.00
Obstetrical - Normal *	.02	.01
Obstetrical - All Other *	.66	.05
Pregnancy due to Rape/Incest	.00	.00
Bone Marrow Transplants *	.02	.00
Mammography	.10	.00
Child Health Supervision*	.42	.00

\* 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 inpatient and partial hospitalization for mental, emotional and nervous disorders (M/E/N Inpatient/Partial Hospitalization) and obstetrical-all other benefits have the highest rate of utilization at .05 days per certificate.

Utilization figures for the mandated provider categories are displayed in Table 8. The categories of chiropractor, physical therapist, clinical social worker, and psychologist demonstrated the greatest number of average visits per certificate (.63, .31, .16 and .11, respectively).

**TABLE 8****UTILIZATION OF SERVICES: GROUP COVERAGE**

<u>Provider Category</u>	<u>Average Visits per Certificate</u>
Chiropractor	.63
Optometrist	.03
Optician	.01
Psychologist	.11
Clinical Social Worker	.16
Podiatrist	.10
Professional Counselor	.08
Physical Therapist	.31
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 \$50.30, when viewed as a single group. In comparison, the average claim cost per visit for physicians and psychiatrists is \$65.05.

**TABLE 9**

**MEDICAL PSYCHOTHERAPY  
45 TO 50 MINUTE SESSION**

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Clinical Nurse Specialist	\$50.28
Professional Counselor	47.39
Psychologist	53.86
Clinical Social Worker	49.11
Mandated Provider Summary	50.30
Physician	53.85
Psychiatrist	74.39
Physician Summary	65.05

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 \$30.90, \$53.58 and \$30.03 compared to the psychiatrist category of \$38.39.

**TABLE 10**

**GROUP MEDICAL PSYCHOTHERAPY**

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Professional Counselor	\$30.90
Psychologist	53.58
Clinical Social Worker	30.03
Physician	38.32
Psychiatrist	38.39

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 physical therapist category has the highest average claim cost per visit.

**TABLE 11**

**PHYSICAL MEDICINE TREATMENT  
THERAPEUTIC EXERCISE, 15 MINUTES**

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$25.15
Physical Therapist	37.83
Podiatrist	16.89
Physician	36.00

**TABLE 12****PHYSICAL MEDICINE TREATMENT, MASSAGE**

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$20.29
Physical Therapist	20.28
Podiatrist	37.29
Physician	23.77

**TABLE 13****PHYSICAL MEDICINE TREATMENT, ULTRASOUND**

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$17.98
Physical Therapist	23.33
Podiatrist	22.33
Physician	22.75

**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 \$45.16, \$57.01, \$103.71, and \$59.39, respectively. The audiologist category has the highest average claim cost per visit, \$103.71. The physical therapist category has the lowest average claim cost per visit, \$45.16.

**TABLE 14****SPEECH, LANGUAGE OR HEARING THERAPY**

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Physical Therapist	\$45.16
Speech Pathologist	57.01
Audiologist	103.71
Physician	59.39

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 clinical social worker category has the highest average claim cost per visit of \$63.67. The chiropractor category has the lowest average claim cost per visit of \$35.26. The average claim cost per visit for the physician category is \$52.84.

**TABLE 15****OFFICE VISIT, INTERMEDIATE SERVICE TO NEW PATIENT**

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$35.26
Physical Therapist	41.39
Podiatrist	49.45
Psychologist	51.79
Clinical Social Worker	63.67
Professional Counselor	49.34
Physician	52.84

## 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 1997 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 physician category for the excision of an ingrown toenail is higher than for the podiatrist category.

**TABLE 16**

### **EXCISION OF INGROWN TOENAIL**

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Podiatrist	\$200.91
Physician	228.53

## 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., the mandated provider requirement and many of the mandated benefit requirements of Chapter 34 (§ 38.2-3400 et seq.) of Title 38.2 of the Code of Virginia do not apply to HMOs. However, HMOs are subject to § 38.2-3419.1 and 14 VAC 5-190-10 et seq., and are required to provide certain limited data. This section presents information collected from HMOs for the 1997 reporting period.

Data from 18 of the HMOs that were required to file full reports for calendar year 1997 were used in the preparation of this report. These organizations represent 33.18% of the Virginia accident and sickness insurance market and 426,981 units of coverage subject to Virginia's mandated benefit requirements.

The only benefits for which HMOs were required to submit information for the 1997 reporting period were the mandated offers of coverage for bone marrow transplants, and required mandated coverage for mammography, pap smears, procedures involving bones and joints of the head, face, neck or jaw, and postpartum services. The premium impact summary, and claim experience is presented in Table 17 and Table 18, respectively. 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 12 and 19).



**TABLE 17****PREMIUM IMPACT SUMMARY  
Percent of Overall Average Premium**

	<u>Individual</u>		<u>Group</u>	
	<u>Single</u>	<u>Family</u>	<u>Single</u>	<u>Family</u>
Mammography	.07%	.06%	.25%	.22%
Bone Marrow Transplants *	.17	.15	.26	.23
Bones/Joints	.15	.13	.51	.46
Pap Smears	.06	.10	.22	.22
Postpartum Services	.03	.03	.06	.05

\* Denotes mandated offer of coverage

**TABLE 18****CLAIM EXPERIENCE  
Average Percent of Total Claims**

	<u>Individual</u>	<u>Group</u>
Mammography	.44%	.23%
Bone Marrow Transplants*	.92	.11
Bones/Joints	.18	.09
Pap Smears	.01	.10
Postpartum Services	.38	.19

\* Denotes mandated offer of coverage

## COMPARISONS

Data has now been collected pursuant to this report for six 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 - 1995, 1996 and 1997.

<b>PREMIUM IMPACT</b>						
<b>Percent of Overall Average Premium</b>						
<b>Individual</b>						
<u>Mandate Category</u>	<u>Single</u>			<u>Family</u>		
	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>
Doctor/Dentist	.52%	.73%	38.0%	.68%	.48%	.36%
M/E/N Inpatient	2.38	2.93	2.12	2.71	2.14	2.30
Mammography	.85	1.03	1.13	.69	.37	.54
Bone Marrow Transplants *	1.21	.90	1.50	.75	.51	.68
Child Health Supervision *	1.92	1.21	1.63	2.59	1.37	2.23
Chiropractor	.75	.64	.51	.69	.36	.43
Psychologist	.76	.59	.41	.83	.33	.41
Physical Therapist	.66	.89	.63	.82	.70	.69
Audiologist	.15	.16	.12	.16	.09	.11
Speech Pathologist	.15	.18	.12	.12	.09	.09

\* Denotes mandated offer of coverage

**PREMIUM IMPACT**  
**Percent of Overall Average Premium**

**Group**

<u>Mandate Category</u>	<u>Single</u>			<u>Family</u>		
	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>
Doctor/Dentist	1.13%	.52%	8.75%	3.44%	1.54%	2.74%
M/E/N Inpatient	2.72	2.87	5.11	2.34	2.68	2.96
M/E/N Outpatient	1.91	1.68	3.06	1.52	1.61	1.94
Mammography	.64	.50	1.10	.40	.40	.53
Bone Marrow Transplants *	.46	.63	2.82	.53	.58	.91
Child Health Supervision *	.89	.78	.43	1.03	.83	.78
Chiropractor	1.08	1.18	2.54	.94	1.04	1.40
Psychologist	.74	.84	.57	.68	.78	.68
Physical Therapist	.72	.73	1.96	.68	.67	.97
Audiologist	.11	.14	.09	.12	.14	.15
Speech Pathologist	.12	.12	1.66	.11	.10	.34

\* Denotes mandated offer of coverage

**CLAIMS EXPERIENCE**  
**Average Percent of Total Claims**

**Individual**

<u>Mandate Category</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>
Doctor/Dentist	.33%	.29%	.33%
M/E/N Inpatient	1.87	1.76	1.48
Mammography	.08	.13	.82
Bone Marrow Transplants *	1.04	.23	.43
Child Health Supervision *	.39	.46	.74
Chiropractor	.69	.75	.77
Psychologist	.09	.09	.15
Physical Therapist	.58	.80	.71
Audiologist	.01	.01	.01
Speech Pathologist	.01	.03	.13

\* Denotes mandated offer of coverage

**CLAIMS EXPERIENCE**  
**Average Percent of Total Claims**

**Group**

<u>Mandate Category</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>
Doctor/Dentist	.39%	.44%	.43%
M/E/N Inpatient	1.13	1.19	1.32
Mammography	.10	.17	.15
Bone Marrow Transplants *	.94	.55	.24
Child Health Supervision *	.46	.59	.78
Chiropractor	.74	.84	.99
Psychologist	.27	.34	.35
Physical Therapist	.48	.66	.65
Audiologist	.06	.06	.04
Speech Pathologist	.02	.02	.02

\* Denotes mandated offer of coverage

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.

## 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 cannot 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.

