REPORT OF THE
STATE CORPORATION COMMISSION

The Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia: 1999 Reporting Period

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 7

COMMONWEALTH OF VIRGINIA
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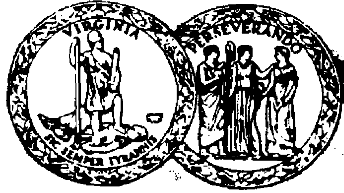

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STATE CORPORATION COMMISSION

October 12, 2000

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: 1999 Reporting Period.

Respectfully submitted,

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EXECUTIVE SUMMARY

Section 38.2-3419.1 of the Code of Virginia and the State Corporation Commission's Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers (14 VAC 5-190-10 et seq.) 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 Governor and the General Assembly. This document constitutes the Commission's report for the 1999 calendar year reporting period.

Of the 896 companies licensed to issue accident and sickness or subscription contracts in Virginia or licensed as HMOs in Virginia in 1999, 62 were required to file full reports; however, only 61 provided credible data for the 1999 reporting period (40 insurers and 21 HMOs). Of the 40 insurers, 9 issued only individual contracts, 21 issued only group certificates or subscription contracts, and 10 issued both individual contracts and group certificates or subscription contracts in Virginia in 1999. This report reflects data provided by 40 companies representing 42.49% of the Virginia accident and sickness insurance market and 460,128 units of coverage (single and family individual contracts and group certificates) subject to Virginia's mandated benefit and provider requirements. The credible data of 21 HMOs, representing an additional 36.32% of the Virginia accident and sickness market and 531,440 contracts or certificates (units of coverage), was also used in the preparation of this report. Because HMOs are not subject to 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 HMOs 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 is reported, per unit of coverage, for individual contracts and group certificates including single and family coverage.

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 calendar year 1999. The following summary illustrates the average claim cost per contract or certificate and the average percentage of total claims that 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 that 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
$100.29	9.11%	$362.73	18.15%

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 $100.29 was paid in claim payments attributable to mandated benefits, offers and providers. This represents approximately 9.11% of all claim payments made under this type of individual

contract. Likewise, approximately $362.73 was paid in claim payments under a group certificate providing applicable coverage, which accounts for approximately 18.15% 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 of the Code of Virginia. 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 Governor and the General Assembly by October 31 of each year. This document constitutes the Commission's report for the 1999 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, which 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
1998, No. 10	1997	Calendar year 1996
1999, No. 6	1998	Calendar year 1997
2000, No. 12	1999	Calendar year 1998

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 is not represented in this report because such plans and policies are generally not subject to the mandated benefit and mandated provider requirements of Virginia.**

Of the 896 companies licensed to issue accident and sickness or subscription contracts or licensed as HMOs in Virginia in 1999, 62 were required to file full reports; however, only 61 provided credible data for the 1999 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 168 companies meeting this criterion); (ii) wrote less than $500,000 of accident and sickness premiums in Virginia during calendar year 1999; 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 1999.

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 provided by 40 companies, exclusive of HMOs. This report reflects the credible data of 9 companies that issued individual contracts, 21 companies that issued group certificates or subscription contracts, and 10 companies that issued both individual contracts and group certificates or subscription contracts in Virginia in 1999. This report reflects data provided by 40 companies representing 42.49% of the Virginia accident and sickness insurance market and 460,128 units of coverage (single and family individual contracts and group certificates) subject to Virginia's mandated benefit and provider requirements. Twenty-one (21) HMOs, representing an additional 36.32% of the Virginia accident and sickness market and 531,440 units of coverage, filed full reports. Because HMOs are not subject to many of the mandated benefit requirements of Title 38.2 of the Code of Virginia, the data provided by HMOs has been analyzed separately from data

provided by insurers and health services plans. The combined data in this report represents 78.81% of the Virginia accident and sickness market and 991,568 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 calendar year 1999.

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 1999 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 Health and Substance Abuse Services

Section 38.2-3412.1 of the Code of Virginia requires that 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 as an inpatient 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 policies and 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.

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.

Conversion from Group to Individual Coverage

Section 38.2-3416 of the Code of Virginia requires that insurers and health services plans offer a conversion (individual) accident and sickness policy or contract without evidence of insurability upon termination of eligibility under the group policy. However, it is not required that the conversion policy contain the same level of benefits as the group policy.

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.

Mammograms

Section 38.2-3418.1 of the Code of Virginia requires insurers, health services plans, and HMOs to provide coverage for low-dose screening mammograms for the purpose of determining the presence of occult breast cancer. Such coverage must allow for one screening mammogram to persons age 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.

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.

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.

Hemophilia and Congenital Bleeding Disorders

Section 38.2-3418.3 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for hemophilia and congenital bleeding disorders. Such coverage shall provide for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center. Cost and utilization relating to this mandate is reported herein for the first time, as 1999 was the first full calendar year during which this coverage was mandated.

Reconstructive Breast Surgery

Section 38.2-3418.4 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for reconstructive breast surgery. The statute defines reconstructive breast surgery as surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or; (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. The reimbursement for reconstructive breast surgery shall have durational limits, dollar limits, deductibles, and coinsurance factors that are no less favorable than for physical illness. Cost and utilization relating to this mandate is reported herein for the first time, as 1999 was the first full calendar year during which this coverage was mandated.

Early Intervention Services

Section 38.2-3418.5 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for early intervention services. Early intervention services is defined as medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services, and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse

Services as eligible for services under Part H of the Individuals with Disabilities Act (20 U.S.C. § 1471 et seq.). Such coverage shall be limited to a benefit of $5,000 per dependent per policy or calendar year and shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer, health services plan, or HMO to or on behalf of the dependent during the dependent's lifetime. Cost and utilization relating to this mandate is reported herein for the first time, as 1999 was the first full calendar year during which this coverage was mandated.

Minimum Hospital Stay for Mastectomy and Certain Lymph Node Dissection Patients

Section 38.2-3418.6 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. This provision is not required where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

PSA Testing

Section 38.2-3418.7 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage (i) to persons age fifty and over and (ii) to persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society (ACS), for one prostate-specific antigen (PSA) test in a twelve-month period and digital rectal examinations, in accordance with the ACS's guidelines. Cost and utilization relating to this mandate is reported herein for the first time, as 1999 was the first full calendar year during which this coverage was mandated.

Legislative Changes

During its last two legislative sessions, the General Assembly of the Commonwealth of Virginia passed additional mandated benefits applicable to certain policies or plans delivered, issued for delivery or renewed in Virginia.

1999 Session

Sections 38.2-3418.8, 38.2-3418.9, 38.2-3418.10, and 38.2-3418.11 of the Code of Virginia requiring coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, minimum hospital stays for hysterectomy, coverage for diabetes, and coverage for hospice care, respectively, became effective July 1, 1999, with respect to certain policies or plans delivered, issued for delivery or renewed in Virginia. Section 38.2-3418.1:2 was amended effective July 1, 1999, to include in the coverage for pap smears annual testing performed by any FDA-approved gynecologic cytology screening technologies. Section 38.2-3412.1:01 became effective January 1, 2000, with respect to certain policies or plans delivered, issued for delivery or renewed in Virginia and requires that insurers, health services plans, and HMOs provide to group policyholders and contract holders coverage for biologically based mental illnesses. Coverage requirements under these new mandated benefits are set forth in the statutes. Cost and utilization data relating to these coverages will be reported to the Commission by carriers for the 2000 reporting period, the first full calendar year during which these requirements will have been in effect.

2000 Session

Additional mandates, including coverage for medically necessary general anesthesia and hospitalization for outpatient dental procedures in certain circumstances, routine immunizations for children from birth to thirty-six (36) months, and colorectal cancer screening in accordance with published recommendations, became effective July 1, 2000, with respect to certain policies or plans delivered, issued for delivery or renewed in Virginia. Also, effective July 1, 2000, carriers are required to offer coverage for the treatment of morbid obesity through gastric bypass surgery or other such methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Data relating to these additional coverage requirements will be reported to the Commission by carriers for the 2001 reporting period, the first full calendar year during which these requirements will have been in effect.

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 shall not be denied because the service is rendered by the licensed practitioner. Cost and utilization relating to licensed acupuncturists is reported herein for the first time, as 1999 was the first full calendar year during which this requirement was effective.

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, including 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 typically 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

<u>Single Coverage</u>

As indicated in **Table 1**, the bone marrow transplants benefit accounts for 1.69% of the overall average premium that represents the highest portion of premium dollar attributable to mandated benefits, while the premium attributable to a physical therapist represents the most significant portion of premium dollar attributable to mandated providers, .64%.

TABLE 1

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS

Single Coverage

Mandate Category	Percent of Overall Average Premium
Doctor/Dentist	1.17%
Mental Inpatient	1.58
Mental Partial Hospitalization	.47
Mental Outpatient	1.50
Substance Abuse Inpatient	1.27
Substance Abuse Partial Hosp.	.30
Substance Abuse Outpatient	.68
Postpartum Services	.55
Pregnancy due to Rape/Incest	.13
Bones/Joints	.65
Pap Smears	.52
Mammograms	.81
Bone Marrow Transplants *	1.69
Child Health Supervision *	1.10
Reconstructive Breast Surgery	.39
Hemophilia/Congenital Bleeding	1.38
Early Intervention	.70
PSA Testing	.28

* Denotes mandated offer of coverage

Mandate Category	Percent of Overall Average Premium
Chiropractor	.46%
Optometrist	.30
Optician	.26
Psychologist	.37
Clinical Social Worker	.29
Podiatrist	.34
Professional Counselor	.31
Physical Therapist	.64
Clinical Nurse Specialist	.18
Audiologist	.12
Speech Pathologist	.12
Certified Nurse Midwife	.10
Licensed Acupuncturist	.10

As an additional measure of the impact of mandated benefits and providers on individual business providing single coverage, 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 $1,879.52. The average reported annual premium for such a contract including current mandates is $1,900.00. On average, the mandates represent $20.48 or 1.01% of the average annual premium for the contract containing the current mandates. It should be noted that there has been a significant decrease in the percentage of premium attributable to mandates since the 1998 reporting period.

Family Coverage

For contracts providing family coverage, the child health supervision benefit accounts for a significant portion of the overall average premium, 2.38%. The premium attributable to a chiropractor represents the most significant portion of premium attributable to mandated providers, .59%. See **Table 2**.

Group Business

Single Coverage

As indicated in **Table 3**, the benefits that have the greatest impact on premium are child health supervision benefit, obstetrical–all other, doctor to include dentist, and obstetrical-normal. Services rendered by chiropractors have the greatest premium impact with respect to mandated providers, .46%.

Family Coverage

As shown in **Table 4**, benefits for obstetrical-all other, newborn children, obstetrical-normal, and PSA testing have a significant impact on the premium. Services rendered by chiropractors have the greatest premium impact with respect to mandated providers, 1.16%.

TABLE 2

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS

Family Coverage

Mandate Category	Percent of Overall Average Premium
Dependent Children	.20%
Doctor/Dentist	.31
Newborn Children	1.28
Mental Inpatient	2.19
Mental Partial Hospitalization	.25
Mental Outpatient	2.16
Substance Abuse Inpatient	.61
Substance Abuse Partial Hosp.	.24
Substance Abuse Outpatient	.60
Postpartum Services	.42
Pregnancy due to Rape/Incest	.13
Bones/Joints	.50
Pap Smears	.43
Mammograms	.57
Bone Marrow Transplants *	.97
Child Health Supervision *	2.38
Reconstructive Breast Surgery	.57
Hemophilia/Congenital Bleeding	.56
Early Intervention	.81
PSA Testing	.15

* Denotes mandated offer of coverage

Chiropractor	.59%
Optometrist	.28
Optician	.38
Psychologist	.45
Clinical Social Worker	.18
Podiatrist	.20
Professional Counselor	.29
Physical Therapist	.54
Clinical Nurse Specialist	.22
Audiologist	.13
Speech Pathologist	.15
Certified Nurse Midwife	.10
Licensed Acupuncturist	.10

TABLE 3

PREMIUM IMPACT ON GROUP CONTRACTS

Single Coverage

Mandate Category	Percent of Overall Average Premium
Doctor/Dentist	1.24%
Mental Inpatient	.48
Mental Partial Hospitalization	.20
Mental Outpatient	.60
Substance Abuse Inpatient	.31
Substance Abuse Partial Hosp.	.07
Substance Abuse Outpatient	.21
Postpartum Services	.26
Pap Smears	.20
Bones/Joints	.32
Obstetrical – Normal *	.71
Obstetrical – All Other *	1.25
Pregnancy due to Rape/Incest	.08
Mammograms	.15
Bone Marrow Transplants *	.41
Child Health Supervision *	7.96
Reconstructive Breast Surgery	.18
Hemophilia/Congenital Bleeding	.46
Early Intervention	.21
PSA Testing	.58

* Denotes mandated offer of coverage

Mandate Category	Percent of Overall Average Premium
Chiropractor	.46%
Optometrist	.10
Optician	.14
Psychologist	.27
Clinical Social Worker	.14
Podiatrist	.18
Professional Counselor	.09
Physical Therapist	.24
Clinical Nurse Specialist	.08
Audiologist	.05
Speech Pathologist	.03
Certified Nurse Midwife	.05
Licensed Acupuncturist	.17

TABLE 4

PREMIUM IMPACT ON GROUP CERTIFICATES

Family Coverage

Mandate Category	Percent of Overall Average Premium
Dependent Children	.70%
Doctor/Dentist	1.17
Newborn Children	2.73
Mental Inpatient	1.48
Mental Partial Hospitalization	.42
Mental Outpatient	1.53
Substance Abuse Inpatient	.93
Substance Abuse Partial Hosp.	.17
Substance Abuse Outpatient	.63
Postpartum Services	.21
Bones/Joints	.58
Pap Smears	.54
Obstetrical – Normal *	2.12
Obstetrical – All Other *	3.00
Pregnancy due to Rape/Incest	.23
Mammograms	.73
Bone Marrow Transplants *	.99
Child Health Supervision *	1.45
Reconstructive Breast Surgery	.41
Hemophilia/Congenital Bleeding	.65
Early Intervention	.66
PSA Testing	1.77

* Denotes mandated offer of coverage

Chiropractor	1.16%
Optometrist	.29
Optician	.43
Psychologist	.85
Clinical Social Worker	.36
Podiatrist	.45
Professional Counselor	.39
Physical Therapist	.73
Clinical Nurse Specialist	.32
Audiologist	.14
Speech Pathologist	.16
Certified Nurse Midwife	.13
Licensed Acupuncturist	.88

Conversion from Group to Individual Coverage

Section 38.2-3416 of the Code of Virginia requires that insurers and health services plans offer to group policyholders and contract holders an option that allows individuals covered under a group policy to convert to an individual accident and sickness contract without evidence of insurability upon termination of eligibility for group coverage. Forty-one and ninety-four hundredths percent (41.94%) of respondents providing group coverage indicate that they added an amount to the annual premium of the group to cover this cost. The amount added by respondents varied widely which accounts for the wide range between the average amount reported for each certificate holder with single coverage ($653 per year), and for each certificate holder with family coverage ($1,024 per year).

One respondent indicates that an additional amount was added to the annual premium applicable to the individual conversion contract to cover the cost of conversion. The reported amount added to the individual premium for single coverage and the individual premium for family coverage is $300.

Sixteen and thirteen hundredths percent (16.13%) of companies indicate 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. Because of the wide variation in the flat fee reported, a credible average or median value could not be determined.

Forty-eight and thirty-nine hundredths percent (48.39%) of respondents report 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 following summary illustrates the average percentages of total claims and average claim costs per contract or certificate for all mandated benefits, offers and providers taken collectively.

Individual		**Group**	
Average Claim Cost Per Contract	Average Percent of Total Claims	Average Claim Cost Per Certificate	Average Percent of Total Claims
$100.29	9.11%	$362.73	18.15%

Individual Business

As illustrated in **Table 5**, the average claim costs associated with hemophilia/congenital bleeding disorders, outpatient mental health treatment (Mental Outpatient), and bone marrow transplants are relatively high, as are the costs associated with chiropractors and physical therapists.

Group Business

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

TABLE 5

CLAIM EXPERIENCE – INDIVIDUAL CONTRACTS

Mandate Category	Average Claim Cost per Contract	Average Percent of Total Claims
Dependent Children	$1.94	.18%
Doctor/Dentist	2.68	.25
Newborn Children	4.25	.39
Mental Inpatient	8.83	.80
Mental Partial Hospitalization	3.93	.38
Mental Outpatient	11.54	1.05
Substance Abuse Inpatient	1.90	.17
Substance Abuse Partial Hosp.	.33	.03
Substance Abuse Outpatient	.72	.07
Pregnancy due to Rape/Incest	1.14	.09
Bones/Joints	1.18	.11
Pap Smears	7.73	.70
Bone Marrow Transplants *	11.19	1.97
Mammograms	3.25	.30
Child Health Supervision *	10.95	.84
Postpartum Services	1.21	.11
Reconstructive Breast Surgery	2.99	.23
Hemophilia/Congenital Bleeding	22.01	1.67
Early Intervention	2.25	.17
PSA Testing	.75	.06

* Denotes mandated offer of coverage

Mandate Category	Average Claim Cost per Contract	Average Percent of Total Claims
Chiropractor	$6.91	.63%
Optometrist	1.16	.11
Optician	.04	.00
Psychologist	1.39	.13
Clinical Social Worker	2.72	.25
Podiatrist	2.37	.22
Professional Counselor	1.70	.16
Physical Therapist	5.64	.52
Clinical Nurse Specialist	.20	.02
Audiologist	.11	.01
Speech Pathologist	1.03	.10
Certified Nurse Midwife	.03	.00
Licensed Acupuncturist	.00	.00

TABLE 6

CLAIM EXPERIENCE – GROUP CERTIFICATES

Mandate Category	Average Claim Cost per Contract	Average Percent of Total Claims
Dependent Children	$6.22	.30%
Doctor/Dentist	10.63	.52
Newborn Children	22.51	1.08
Mental Inpatient	16.92	.83
Mental Partial Hospitalization	1.05	.04
Mental Outpatient	36.45	1.85
Substance Abuse Inpatient	5.20	.27
Substance Abuse Partial Hosp.	.92	.04
Substance Abuse Outpatient	4.86	.24
Obstetrical – Normal *	24.23	1.18
Obstetrical – All Other *	89.95	4.40
Pregnancy due to Rape/Incest	2.10	.10
Bones/Joints	3.42	.17
Pap Smears	11.14	.53
Bone Marrow Transplants *	7.12	.31
Mammograms	9.51	.37
Child Health Supervision *	25.61	1.10
Postpartum Services	1.74	.09
Reconstructive Breast Surgery	3.28	.16
Hemophilia/Congenital Bleeding	6.09	.28
Early Intervention	5.57	.26
PSA Testing	31.19	1.51

* Denotes mandated offer of coverage

Mandate Category	Average Claim Cost per Contract	Average Percent of Total Claims
Chiropractor	$22.54	1.12%
Optometrist	2.00	.10
Optician	.60	.03
Psychologist	6.59	.33
Clinical Social Worker	6.15	.32
Podiatrist	9.66	.48
Professional Counselor	4.47	.21
Physical Therapist	14.62	.72
Clinical Nurse Specialist	1.06	.05
Audiologist	.87	.04
Speech Pathologist	.82	.03
Certified Nurse Midwife	.12	.01
Licensed Acupuncturist	4.23	.21

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 average visit per certificate for 1999 for each benefit is illustrated in **Table 7**. Coverage for PSA testing, outpatient mental health treatment (Mental Outpatient), and hemophilia/congenital bleeding demonstrate the highest rates of utilization of services in terms of visits per certificate, .96, .80, and .66, respectively. Conversely, on this basis, coverage for partial hospitalization for mental health treatment (Mental Partial Hospitalization), reconstructive breast surgery, and postpartum services exhibit the lowest rates of utilization of services.

TABLE 7

UTILIZATION OF SERVICES: GROUP COVERAGE

Benefit Category	Average Visits per Certificate	Average Days per Certificate
Dependent Children	.14	.00
Doctor/Dentist	.13	.00
Newborn Children	.07	.15
Mental Inpatient	.05	.05
Mental Partial Hospitalization	.00	.00
Mental Outpatient	.80	.00
Substance Abuse Inpatient	.04	.01
Substance Abuse Partial Hosp.	.00	.01
Substance Abuse Outpatient	.06	.00
Postpartum Services	.01	.00
Bones/Joints	.05	.00
Pap Smears	.33	.00
Obstetrical – Normal *	.02	.01
Obstetrical – All Other *	.48	.05
Pregnancy due to Rape/Incest	.04	.00
Bone Marrow Transplants *	.06	.00
Mammograms	.24	.00
Child Health Supervision *	.63	.00
Reconstructive Breast Surgery	.00	.00
Hemophilia/Congenital Bleeding	.66	.00
Early Intervention	.23	.00
PSA Testing	.96	.02

* Denotes mandated offer of coverage

Utilization information on the number of average days of service per certificate for each benefit is also displayed in **Table 7**. The newborn children benefit, inpatient mental health (Mental Inpatient), and obstetrical-all other benefits show the highest rate of utilization at .15, .05, and .05 days per certificate, respectively.

Utilization figures for the mandated provider categories are displayed in **Table 8**. The categories for chiropractor, physical therapist, podiatrist, and licensed acupuncturist demonstrate the greatest number of average visits per certificate, 1.08, .60, .19, and .17, respectively.

TABLE 8

UTILIZATION OF SERVICES: GROUP COVERAGE

Provider Category	Average Visits per Certificate
Chiropractor	1.08
Optometrist	.07
Optician	.01
Psychologist	.15
Clinical Social Worker	.16
Podiatrist	.19
Professional Counselor	.11
Physical Therapist	.60
Clinical Nurse Specialist	.04
Audiologist	.01
Speech Pathologist	.03
Certified Nurse Midwife	.00
Licensed Acupuncturist	.17

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 $49.52 when viewed as a single group. In comparison, the average claim cost per visit for physicians and psychiatrists is $61.06.

TABLE 9

MEDICAL PSYCHOTHERAPY
45 TO 50 MINUTE SESSION

Provider Category	Average Claim Cost Per Visit
Clinical Nurse Specialist	$45.12
Professional Counselor	46.47
Psychologist	52.29
Clinical Social Worker	48.61
Mandated Provider Summary	49.52
Physician	55.00
Psychiatrist	64.22
Physician Summary	61.06

Companies are also required to provide claim information regarding group medical psychotherapy. As indicated in **Table 10**, the average claim cost per visit for the mandated provider (non-physician) categories is $21.01, $38.65, and $35.11 compared to the psychiatrist category of $30.22.

TABLE 10

GROUP MEDICAL PSYCHOTHERAPY

Provider Category	Average Claim Cost Per Visit
Professional Counselor	$21.01
Psychologist	38.65
Clinical Social Worker	35.11
Physician	36.95
Psychiatrist	30.22

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. Of the three procedures, the physical therapist category has the highest average claim cost per visit.

TABLE 11

PHYSICAL MEDICINE TREATMENT
THERAPEUTIC EXERCISES, 15 MINUTES

Provider Category	Average Claim Cost Per Visit
Chiropractor	$22.24
Physical Therapist	34.76
Podiatrist	22.55
Physician	34.63

TABLE 12

PHYSICAL MEDICINE TREATMENT, MASSAGE

Provider Category	Average Claim Cost Per Visit
Chiropractor	$24.60
Physical Therapist	20.67
Podiatrist	15.65
Physician	20.76

TABLE 13

PHYSICAL MEDICINE TREATMENT, ULTRASOUND

Provider Category	Average Claim Cost Per Visit
Chiropractor	$16.85
Physical Therapist	18.13
Podiatrist	17.09
Physician	23.93

Speech, Language or Hearing Therapy

The average claim cost per visit for speech, language or hearing therapy provided by a physical therapist, speech pathologist, audiologist, and physician categories is displayed in **Table 14**. The average claim cost per visit for the four providers is $58.68, $45.96, $32.66, and $44.53, respectively. The physical therapist category has the highest average claim cost per visit, $58.68. The audiologist category has the lowest average claim cost per visit, $32.66.

TABLE 14

SPEECH, LANGUAGE OR HEARING THERAPY

Provider Category	Average Claim Cost Per Visit
Physical Therapist	$58.68
Speech Pathologist	45.96
Audiologist	32.66
Physician	44.53

Office Visits

As 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 physician and podiatrist categories have the highest average claim costs per visit of $55.07 and $54.34, respectively. The professional counselor category was not utilized for an office visit providing intermediate service to a new patient.

TABLE 15

OFFICE VISIT, INTERMEDIATE SERVICE TO NEW PATIENT

Provider Category	Average Claim Cost Per Visit
Chiropractor	$40.53
Physical Therapist	44.77
Podiatrist	54.34
Psychologist	53.74
Clinical Social Worker	29.17
Professional Counselor	0.00
Physician	55.07

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 1999 reporting period, however, too few claims were reported to the Commission to produce a fair comparison between the optometrist and ophthalmologist provider categories.

As 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

Provider Category	Average Claim Cost Per Visit
Podiatrist	$159.92
Physician	178.55

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., 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 1999 reporting period.

Data from 21 of the HMOs that were required to file full reports for calendar year 1999 was used in the preparation of this report. These organizations represent 36.32% of the Virginia accident and sickness insurance market and 531,440 units of coverage subject to Virginia's mandated benefit requirements.

HMOs were required to submit information for the 1999 reporting period for the mandated offer of coverage for bone marrow transplants. HMOs were also required to submit information relating to the mandated coverage for mammograms, pap smears, procedures involving bones and joints of the head, face, neck, or jaw, postpartum services, hemophilia and congenital bleeding disorders, reconstructive breast surgery, early intervention services, and PSA testing. The premium impact summary and claim experience are presented in **Tables 17** and **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 14 and 21).

TABLE 17

PREMIUM IMPACT SUMMARY
Percent of Overall Average Premium

	Individual		Group	
	Single	Family	Single	Family
Mammograms	.17%	2.13%	.39%	7.59%
Bone Marrow Transplants *	.04	.04	.88	.84
Bones/Joints	.25	.03	1.93	1.34
Pap Smears	.28	.49	.35	1.22
Postpartum Services	.04	.09	.00	.00
Hemophilia/Congenital Bleeding	.16	.22	.58	.33
Reconstructive Breast Surgery	.04	.07	1.12	1.39
Early Intervention	.21	.01	.05	5.11
PSA Testing	.00	.53	.58	2.05

* Denotes mandated offer of coverage

TABLE 18

CLAIM EXPERIENCE
Average Percent of Total Claims

	Individual	Group
Mammograms	.14%	.25%
Bone Marrow Transplants *	1.56	.44
Bones/Joints	.11	.13
Pap Smears	.13	.19
Postpartum Services	.06	.10
Hemophilia/Congenital Bleeding	.04	.23
Reconstructive Breast Surgery	.12	.04
Early Intervention	.04	.11
PSA Testing	.01	.04

* Denotes mandated offer of coverage

COMPARISONS

Data has now been collected pursuant to this report for eight 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 – 1997, 1998, and 1999.

PREMIUM IMPACT
Percent of Overall Average Premium

Individual

	Single			Family		
Mandate Category	1997	1998	1999	1997	1998	1999
Doctor/Dentist	.38%	.43%	1.17%	.36%	.46%	.31%
Mental Inpatient	2.12	2.61	1.58	2.30	3.77	2.19
Mental Outpatient	1.69	1.49	1.50	2.89	2.24	2.16
Substance Abuse Inpatient	.49	.47	1.27	.75	.66	.61
Substance Abuse Outpatient	.79	.48	.68	.45	.83	.60
Pap Smears	.51	.59	.52	.28	.43	.43
Mammograms	1.13	.78	.81	.54	.56	.57
Bone Marrow Transplants *	1.50	1.36	1.69	.68	1.44	.97
Child Health Supervision *	1.63	1.53	1.10	2.23	2.19	2.38
Hemophilia/Congenital Bleeding	**	**	1.38	**	**	.56
PSA Testing	**	**	.28	**	**	.15
Chiropractor	.51	.63	.46	.43	.58	.59
Psychologist	.41	.43	.37	.41	.49	.45
Physical Therapist	.63	.67	.64	.69	.81	.54
Audiologist	.12	.10	.12	.11	.13	.13
Speech Pathologist	.12	.10	.12	.09	.13	.15
Licensed Acupuncturist	**	**	.10	**	**	.10

* Denotes mandated offer of coverage
** 1999 represents the first full year this benefit was mandated

PREMIUM IMPACT
Percent of Overall Average Premium

Group

Mandate Category	Single			Family		
	1997	1998	1999	1997	1998	1999
Doctor/Dentist	8.75%	.79%	1.24%	2.74%	.80%	1.17%
Mental Inpatient	5.11	2.17	.48	2.96	2.17	1.48
Mental Outpatient	3.06	1.58	.60	1.94	1.64	1.53
Substance Abuse Inpatient	2.40	1.40	.31	1.25	1.12	.93
Substance Abuse Outpatient	1.32	.43	.21	.54	.47	.63
Pap Smears	1.22	.54	.20	.52	.47	.54
Mammograms	1.11	.48	.15	.53	.42	.73
Bone Marrow Transplants *	2.82	.54	.41	.91	.46	.99
Child Health Supervision *	.43	.55	7.96	.78	.90	1.45
Hemophilia/Congenital Bleeding	**	**	.46	**	**	.65
PSA Testing	**	**	.58	**	**	1.77
Chiropractor	2.54	1.02	.46	1.40	.95	1.16
Psychologist	.57	.72	.27	.68	.71	.85
Physical Therapist	1.96	.62	.24	.97	.62	.73
Audiologist	.09	.11	.05	.15	.11	.14
Speech Pathologist	1.66	.10	.03	.34	.10	.16
Licensed Acupuncturist	**	**.	.17	**	**	.18

* Denotes mandated offer of coverage
** 1999 represents the first full year this benefit was mandated

CLAIMS EXPERIENCE
Average Percent of Total Claims

Individual

Mandate Category	1997	1998	1999
Doctor/Dentist	.33%	.36%	.25%
Mental Inpatient	1.48	1.65	.80
Mental Outpatient	1.08	1.34	1.05
Substance Abuse Inpatient	.41	.27	.17
Substance Abuse Outpatient	.08	.09	.07
Pap Smears	.38	.61	.70
Mammograms	.82	.32	.30
Bone Marrow Transplants *	.43	.27	1.97
Child Health Supervision *	.74	1.04	.84
Hemophilia/Congenital Bleeding	**	**	1.67
PSA Testing	**	**	.06
Chiropractor	.77	.86	.63
Psychologist	.15	.09	.13
Physical Therapist	.71	.72	.52
Audiologist	.01	.01	.01
Speech Pathologist	.13	.12	.10
Licensed Acupuncturist	**	**	.00

* Denotes mandated offer of coverage
** 1999 represents the first full year this benefit was mandated

CLAIMS EXPERIENCE
Average Percent of Total Claims

Mandate Category	Group		
	1997	1998	1999
Doctor/Dentist	.43%	.35%	.52%
Mental Inpatient	1.32	1.32	.83
Mental Outpatient	1.92	2.00	1.85
Substance Abuse Inpatient	.40	.39	.27
Substance Abuse Outpatient	.19	.20	.24
Pap Smears	.42	.47	.53
Mammograms	.15	.32	.37
Bone Marrow Transplants *	.24	.18	.31
Child Health Supervision *	.78	1.04	1.10
Hemophilia/Congenital Bleeding	**	**	.28
PSA Testing	**	**	1.51
Chiropractor	.99	1.08	1.12
Psychologist	.35	.43	.33
Physical Therapist	.65	.80	.72
Audiologist	.04	.02	.04
Speech Pathologist	.02	.04	.03
Licensed Acupuncturist	**	**	.21

* Denotes mandated offer of coverage
** 1999 represents the first full year this benefit was mandated

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. It is reasonable to conclude from the data presented in **Tables 1, 2, 3,** and **4** that the premium attributable to mandated benefits and providers represents a measurable portion of the premium dollar. This impact is higher on group business. 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, there is a variation between the overall ratio of utilization of services and providers to the corresponding premiums attributable to these services and providers.

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.