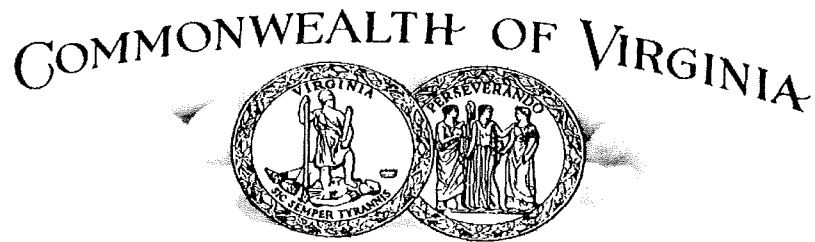


MARK C. CHRISTIE
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P.O. BOX 1197
RICHMOND, VIRGINIA 23218-1197

STATE CORPORATION COMMISSION

October 29, 2015

The Honorable Terry McAuliffe
Governor of Virginia

The General Assembly of Virginia

Dear Governor McAuliffe and Members of the General Assembly:

Section 38.2-3419.1 of the Code of Virginia requires the State Corporation Commission ("Commission") to consolidate certain reports from insurers, health services plans, and health maintenance organizations concerning mandated health insurance benefits and providers. The Commission is to provide the General Assembly a consolidated report of the costs of mandated benefits, the utilization of services under mandated benefits, and other appropriate information.

With this letter, the Commission submits its report on mandated health insurance benefits and providers for the 2014 reporting period.

As always, we will provide additional information or assistance upon request.

Respectfully submitted,

Handwritten signature of Mark C. Christie in black ink, written over a horizontal line.

Mark C. Christie, Chairman

Handwritten signature of James C. Dimitri in black ink, written over a horizontal line.

James C. Dimitri, Commissioner

Handwritten signature of Judith Williams Jagdmann in black ink, written over a horizontal line.

Judith Williams Jagdmann, Commissioner

Attachment

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: 2014 Reporting Period**

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND

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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 (14VAC5-190-10 et seq.) require every insurer, health services plan, and health maintenance organization (HMO) from which a report is deemed necessary to report to the State Corporation Commission (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 2014 calendar year reporting period.

It should be noted that the International Classification of Disease (ICD) Codes, for which cost and utilization data is reported, underwent a major update in 2015. Carriers will receive instructions for reporting data for the 2015 reporting year.

Virginia law requires a company to file an annual cost and utilization report on mandated benefits and providers if the company has annual written premiums of \$500,000 or more for products subject to mandated benefit and provider requirements. Of the 768 companies licensed to issue accident and sickness or subscription contracts in Virginia or licensed as HMOs in Virginia in 2014, only 31 companies met this requirement and, accordingly, submitted data for products which are subject to mandated benefit and provider requirements for the 2014 reporting period. Of the 20 insurers, 1 issued only individual contracts, 12 issued only group certificates or subscription contracts, and 7 issued both individual contracts and group certificates or subscription contracts. The data of 11 HMOs was also used in the preparation of this report. Because HMOs are not subject to all 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 (14VAC5-211-10 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 individual 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, a percentage of the annual premium attributable to each mandated benefit, offer and provider, for both individual and group business as reported by insurers and health services plans for a standard health insurance contract issued 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 2014. 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**. Refer to **Tables 5 and 6** for 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
\$971.78	17.08%	\$1,199.80	24.21%

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 \$972.00 was paid for claims attributable to mandated benefits, offers and providers in 2014. This represents approximately 17% of all claim payments made under this type of individual contract. Likewise, in the 2014 reporting period, approximately \$1,200.00 was paid in claim payments under a group certificate providing applicable coverage, which accounts for approximately 24% 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 2014 calendar year reporting period.

Background

The Commission's Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers (the Rules) at 14VAC5-190-10 et seq. specify the detail and form of the information that must be reported by companies. 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 House Documents and Reports are shown in Appendix A.

Mandated benefit statutes typically require insurers to provide, or offer coverage 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 mandates apply (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 mandates apply (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.

For purposes of this report, and in accordance with the definitions section of 14VAC5-190-30, "applicable policy" or "contract" means any accident and sickness insurance policy providing hospital, medical and surgical or major medical coverage on an expense incurred basis or any accident and sickness subscription contract or any health care plan provided by a health maintenance organization issued or issued for delivery in the Commonwealth of Virginia.

While a definition of "certificate" is not expressed in 14VAC5-190-30, § 38.2-3533 A provides that, "Each group accident and sickness insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth:

1. The insured person's insurance protection, including any limitations, reductions, and exclusions applicable to the coverage provided;
2. To whom the insurance benefits are payable;
3. Any family member's or dependent's coverage; and
4. The rights and conditions set forth in § 38.2-3541."

METHODOLOGY

Study Population

The Rules establish requirements applicable to the reporting of 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.**

Virginia law requires a company to file an annual cost and utilization report on mandated benefits and providers if the company has annual written premiums of \$500,000 or more for products subject to mandated benefit and provider requirements. Of the 768 companies licensed to issue accident and sickness or subscription contracts in Virginia or licensed as HMOs in Virginia in 2014, only 31 companies met this requirement and, accordingly, submitted data for products which are subject to mandated benefit and provider requirements for the 2014 reporting period. Those companies not required to file a full report pursuant to the Rules at 14VAC5-190-10 et seq. wrote \$500,000 or more of accident and sickness insurance premiums, but less than \$500,000 in premiums on policies subject to mandates, and were thus required to file abbreviated reports. There were 149 companies meeting this criterion. Those companies not required to file a report either (i) wrote less than \$500,000 of accident and sickness premiums in Virginia during calendar year 2014; or (ii) did not issue any policies subject to §§ 38.2-3408 through 38.2-3419, or § 38.2-4221 of the Code of Virginia during 2014.

Information presented in this report reflects data provided by 20 insurers and 11 HMOs. This report reflects the data of 1 company that issued only individual contracts, 12 companies that issued group certificates or subscription contracts, and 7 companies that issued both individual contracts and group certificates or subscription contracts in Virginia in 2014. The 11 HMOs are not subject to all of the mandated benefit requirements of Title 38.2 of the Code of Virginia, therefore, the data provided by HMOs has been analyzed separately from data provided by insurers and health services plans.

Claim Data

The Rules require 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 codes utilized in the preparation of this report are part of two widely accepted coding systems used by most hospitals, health care providers, and companies. These systems are outlined in the Physicians' Current Procedural Terminology, 2014 Office Edition (CPT-Plus procedure codes) and the International Classification of Diseases - 9th Revision - Clinical Modification, Sixth Edition, 2014 Office Edition (ICD-9-CM diagnosis codes).

It should be noted that the International Classification of Disease (ICD) Codes, for which cost and utilization data is reported, underwent a major update in 2015. Carriers will receive instructions for reporting data for the 2015 reporting year.

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.

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.

Companies do not specify an additional cost of coverage for a mandated benefit or provider category. An exception may occur 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 developed 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 of the Code of Virginia and 14VAC5-190-10 et seq.

Data Quality

The information presented in this report is believed to be representative of the industry's experience for calendar year 2014.

COVERAGE SUMMARIES

The following sections contain summary descriptions of the mandated benefits, offers and 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 2014 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, and the individual with intellectual disability or physical handicap is chiefly dependent upon the policyholder for support and maintenance. Insurers and health services plans are permitted to charge an additional premium for the 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/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, and HMOs that provide family coverage shall extend such coverage to a newborn 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 31 days after the date of birth for coverage to continue beyond the initial 31-day period.

Child Health Supervision Services

Section 38.2-3411.1 of the Code of Virginia requires that insurers, and health services plans, "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 any 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 except for group health insurance coverage issued to a large employer defined in § 38.2-3431, 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 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 more restrictive than for any other illness.

Except for group health insurance coverage issued to a large employer as defined in § 38.2-3431, policies and contracts providing coverage on an expense-incurred basis for a family member of the insured or subscriber shall provide 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 for any other illness, except the coinsurance 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.
4. Group health insurance coverage issued to a large employer as defined in § 38.2-3431 shall provide mental health and substance use disorder benefits in parity with the medical and surgical benefits contained in the coverage in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110.343).

Biologically Based Mental Illness

Section 38.2-3412.1:01 of the Code of Virginia requires that each insurer, health services plan, and HMO issuing group contracts or subscription contracts provide coverage for the treatment of mental illnesses considered to be biologically based. Benefits for biologically based mental illnesses may not be different or separate from coverage for any other illness, except when such benefits meet the medical criteria necessary to achieve the same outcomes as are achieved by the benefits for any other illness, condition or disorder.

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. The coverage cannot be more restrictive than that provided for the treatment of physical illness generally.

Obstetrical Benefits - Coverage for Postpartum Services

Section 38.2-3414.1 of the Code of Virginia requires insurers, health services plans, and HMOs providing benefits for obstetrical services to provide coverage for postpartum services in accordance with the guidelines outlined in the statute.

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 provides benefits as a result of an accident or accidental injury is 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.

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, including annual testing performed by any FDA-approved gynecological cytology screening technologies.

Procedures Involving Bones and Joints

Section 38.2-3418.2 of the Code of Virginia prohibits insurers, health services plans, and 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 coverage for 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. 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.

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 coincident with or following a mastectomy or following a mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery shall also include coverage for prostheses, and physical complications of mastectomy, including medically necessary treatment of lymphedemas. 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 generally. Coverage shall be provided in a manner determined in consultation with the attending physician and the patient.

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 3 who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Act (20 U.S.C. § 1471 et seq.).

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 50 and over and (ii) to persons age 40 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 12-month period and digital rectal examinations, in accordance with the ACS's guidelines.

Clinical Trials for Treatment Studies on Cancer

Section 38.2-3418.8 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

Minimum Hospital Stay for Hysterectomy

Section 38.2-3418.9 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 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. The attending physician, in consultation with the patient, may determine that a shorter period of hospital stay is appropriate.

Coverage for Diabetes

Section 38.2-3418.10 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-dependent diabetes.

Coverage for Hospice Care

Section 38.2-3418.11 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for hospice services.

Coverage for Childhood Immunizations

Section 38.2-3411.3 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for all routine and necessary immunizations for each newborn child from birth to 36 months of age.

Coverage for Infant Hearing Screening and Related Diagnostics

Section 38.2-3411.4 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for infant hearing screenings and all necessary audiological examinations provided and prescribed for newborn children.

Coverage for Colorectal Cancer Screening

Section 38.2-3418.7:1 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for colorectal cancer screening.

Coverage for Hospitalization and Anesthesia for Dental Procedures

Section 38.2-3418.12 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for certain covered persons who are determined to require general anesthesia and admission to a hospital or outpatient surgery facility for dental care treatment.

Coverage for the Treatment of Morbid Obesity

Section 38.2-3418.13 of the Code of Virginia requires that insurers, health services plans, and HMOs in the large group market offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

Coverage for Lymphedema

Section 38.2-3418.14 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for the treatment of lymphedema, including benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education.

Coverage for Prosthetic Devices and Components

Section 38.2-3418.15 of the Code of Virginia requires that insurers, health services plans, and HMOs offer and make available coverage for medically necessary prosthetic devices, their repair, fitting, replacement, and components.

Coverage for Telemedicine Services

Section 38.2-3418.16 of the Code of Virginia requires that insurers, health services plans, and HMOs provide coverage for the cost of health care services provided through telemedicine services.

Coverage for Autism Spectrum Disorder

Section 38.2-3418.17 of the Code of Virginia requires that insurers, health services plans, and HMOs issuing group contracts or subscription contracts in the large group market provide coverage for the diagnosis of autism spectrum disorder and for the treatment of autism spectrum disorder in individuals from age two through age six.

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, marriage and family therapist or licensed acupuncturist, reimbursement under the policy or subscription contract shall not be denied because the service is rendered by the licensed practitioner. For this report, a podiatrist includes services rendered by a chiropodist.

PREMIUM IMPACT

To assess the impact of coverage for 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 individual 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 total annual 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 develop a separate rate for each mandated benefit, offer and provider, 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

Single Coverage

As indicated in **Table 1**, the benefit for telemedicine services which accounts for 3.05% of the overall average premium, 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, .68%.

Family Coverage

For contracts providing family coverage, the telemedicine services benefit accounts for a significant portion of the overall average premium, 2.14%. The premium attributable to a physical therapist represents the most significant portion of premium attributable to mandated providers, .62%. See **Table 2**.

Group Business

Single Coverage

As indicated in **Table 3**, the benefits that have the greatest impact on premium are the telemedicine services, obstetrical services – normal, obstetrical services – all other, and treatment of morbid obesity. Services rendered by a clinical social worker have the greatest premium impact with respect to mandated providers, .18%.

Family Coverage

As shown in **Table 4**, benefits for telemedicine services, obstetrical services – all other, newborn children, and obstetrical services – normal have a significant impact on the premium. Services rendered by a clinical social worker have the greatest premium impact with respect to mandated providers, .33%.

TABLE 1

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS

<u>Mandate Category</u>	Single Coverage	<u>Percent of Overall Average Premium</u>
Doctor to Include Dentist		.35%
Mental Health Services - Inpatient		.57
Mental Health Services - Partial Hospitalization		.04
Mental Health Services - Outpatient		1.04
Substance Abuse Services - Inpatient		.74
Substance Abuse Services - Partial Hospitalization		.10
Substance Abuse Services - Outpatient		.89
Postpartum Services		.56
Pap Smears		.42
Pregnancy from Rape or Incest		.00
Bones and Joints		.27
Mammograms		.63
Child Health Supervision Services *		.26
Reconstructive Breast Surgery		.11
Hemophilia and Congenital Bleeding Disorders		.44
Early Intervention Services		1.26
PSA Testing		.10
Clinical Trials for Treatment Studies on Cancer		.16
Minimum Hospital Stay for Hysterectomy		.45
Diabetes		.71
Hospice Care		.00
Childhood Immunizations		.77
Colorectal Cancer Screening		1.41
Hospitalization and Anesthesia for Dental Procedures		.42
Infant Hearing Screening and Related Diagnostics		.06
Lymphedema		.29
Prosthetic Devices and Components *		.06
Telemedicine Services		3.05
Chiropractor		.19%
Optometrist		.21
Optician		.19
Psychologist		.17
Clinical Social Worker		.07
Podiatrist		.17
Professional Counselor		.21
Physical Therapist		.68
Clinical Nurse Specialist		.10
Audiologist		.10
Speech Pathologist		.06
Certified Nurse Midwife		.15
Licensed Acupuncturist		.03
Marriage and Family Therapist		.00

* Denotes mandated offer of coverage

TABLE 2

<u>PREMIUM IMPACT ON INDIVIDUAL CONTRACTS</u>	
<u>Mandate Category</u>	<u>Percent of Overall Average Premium</u>
Dependent Children	.04%
Doctor to Include Dentist	.26
Newborn Children	1.20
Mental Health Services - Inpatient	.62
Mental Health Services - Partial Hospitalization	.04
Mental Health Services - Outpatient	1.13
Substance Abuse Services - Inpatient	.20
Substance Abuse Services - Partial Hospitalization	.08
Substance Abuse Services - Outpatient	.71
Postpartum Services	.25
Pap Smears	.51
Pregnancy from Rape or Incest	.00
Bones and Joints	.17
Mammograms	.67
Child Health Supervision Services *	1.04
Reconstructive Breast Surgery	.13
Hemophilia and Congenital Bleeding Disorders	.35
Early Intervention Services	.90
PSA Testing	.07
Clinical Trials for Treatment Studies on Cancer	.13
Minimum Hospital Stay for Hysterectomy	.35
Diabetes	1.00
Hospice Care	.01
Childhood Immunizations	1.59
Colorectal Cancer Screening	1.43
Hospitalization and Anesthesia for Dental Procedures	.12
Infant Hearing Screening and Related Diagnostics	.13
Lymphedema	.24
Prosthetic Devices and Components *	.06
Telemedicine Services	2.14
Chiropractor	.22%
Optometrist	.19
Optician	.15
Psychologist	.19
Clinical Social Worker	.07
Podiatrist	.17
Professional Counselor	.19
Physical Therapist	.62
Clinical Nurse Specialist	.38
Audiologist	.03
Speech Pathologist	.06
Certified Nurse Midwife	.07
Licensed Acupuncturist	.01
Marriage and Family Therapist	.00

* Denotes mandated offer of coverage

TABLE 3

PREMIUM IMPACT ON GROUP CERTIFICATES

<u>Mandate Category</u>	Single Coverage	<u>Percent of Overall Average Premium</u>
Doctor to Include Dentist		.03%
Mental Health Services - Inpatient		.03
Mental Health Services - Partial Hospitalization		.00
Mental Health Services - Outpatient		.05
Substance Abuse Services - Inpatient		.02
Substance Abuse Services - Partial Hospitalization		.00
Substance Abuse Services - Outpatient		.02
Postpartum Services		.02
Pap Smears		.02
Obstetrical Services - Normal *		.11
Obstetrical Services - All Other *		.11
Pregnancy from Rape or Incest		.00
Bones and Joints		.09
Mammograms		.04
Child Health Supervision Services *		.06
Reconstructive Breast Surgery		.01
Hemophilia and Congenital Bleeding Disorders		.06
Early Intervention Services		.08
PSA Testing		.00
Biologically Based Mental Illness		.08
Clinical Trials for Treatment Studies on Cancer		.01
Minimum Hospital Stay for Hysterectomy		.01
Diabetes		.05
Hospice Care		.01
Childhood Immunizations		.07
Colorectal Cancer Screening		.07
Hospitalization and Anesthesia for Dental Procedures		.00
Treatment of Morbid Obesity *		.11
Infant Hearing Screening and Related Diagnostics		.01
Lymphedema		.02
Prosthetic Devices and Components *		.01
Telemedicine Services		.30
Autism Spectrum Disorder		.02
Chiropractor		.04%
Optometrist		.01
Optician		.01
Psychologist		.16
Clinical Social Worker		.18
Podiatrist		.02
Professional Counselor		.02
Physical Therapist		.06
Clinical Nurse Specialist		.02
Audiologist		.01
Speech Pathologist		.01
Certified Nurse Midwife		.01
Licensed Acupuncturist		.01
Marriage and Family Therapist		.01

* Denotes mandated offer of coverage

TABLE 4

PREMIUM IMPACT ON GROUP CERTIFICATES

<u>Mandate Category</u>	<u>Family Coverage</u>	<u>Percent of Overall Average Premium</u>
Dependent Children		.08%
Doctor to Include Dentist		.07
Newborn Children		.27
Mental Health Services - Inpatient		.10
Mental Health Services - Partial Hospitalization		.01
Mental Health Services - Outpatient		.13
Substance Abuse Services - Inpatient		.04
Substance Abuse Services - Partial Hospitalization		.01
Substance Abuse Services - Outpatient		.04
Postpartum Services		.06
Pap Smears		.04
Obstetrical Services - Normal *		.25
Obstetrical Services - All Other *		.31
Pregnancy from Rape or Incest		.00
Bones and Joints		.22
Mammograms		.07
Child Health Supervision Services *		.17
Reconstructive Breast Surgery		.03
Hemophilia and Congenital Bleeding Disorders		.16
Early Intervention Services		.17
PSA Testing		.01
Biologically Based Mental Illness		.17
Clinical Trials for Treatment Studies on Cancer		.02
Minimum Hospital Stay for Hysterectomy		.02
Diabetes		.09
Hospice Care		.02
Childhood Immunizations		.19
Colorectal Cancer Screening		.13
Hospitalization and Anesthesia for Dental Procedures		.01
Treatment of Morbid Obesity *		.23
Infant Hearing Screening and Related Diagnostics		.02
Lymphedema		.03
Prosthetic Devices and Components *		.01
Telemedicine Services		.49
Autism Spectrum Disorder		.03
Chiropractor		.08%
Optometrist		.02
Optician		.01
Psychologist		.30
Clinical Social Worker		.33
Podiatrist		.05
Professional Counselor		.04
Physical Therapist		.13
Clinical Nurse Specialist		.06
Audiologist		.01
Speech Pathologist		.01
Certified Nurse Midwife		.02
Licensed Acupuncturist		.02
Marriage and Family Therapist		.01

* Denotes mandated offer of coverage

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, on average, the cost of claims paid and the percentage of total claims that the cost represents for a particular mandated benefit, offer and provider per individual contract or group certificate on applicable contracts or certificates in Virginia.

The following summary illustrates the average percentage of total claims and average claim cost 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
\$971.78	17.08%	\$1,199.80	24.21%

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	\$ 3.72	.06%
Doctor to Include Dentist	5.38	.13
Newborn Children	30.74	.53
Mental Health Services - Inpatient	48.03	.83
Mental Health Services - Partial Hospitalization	1.88	.03
Mental Health Services - Outpatient	68.08	1.18
Substance Abuse Services - Inpatient	21.97	.38
Substance Abuse Services - Partial Hospitalization	7.03	.12
Substance Abuse Services - Outpatient	25.26	.44
Postpartum Services	1.47	.03
Pap Smears	67.44	1.16
Pregnancy from Rape or Incest	.30	.01
Bones and Joints	15.93	.27
Mammograms	72.65	1.25
Child Health Supervision Services *	40.71	.70
Reconstructive Breast Surgery	15.25	.26
Hemophilia and Congenital Bleeding Disorders	22.32	.38
Early Intervention Services	10.68	.18
PSA Testing	2.51	.04
Clinical Trials for Treatment Studies on Cancer	.15	.00
Minimum Hospital Stay for Hysterectomy	7.00	.12
Diabetes	119.35	2.06
Hospice Care	.01	.00
Childhood Immunizations	225.96	3.90
Colorectal Cancer Screening	26.10	.45
Hospitalization and Anesthesia for Dental Procedures	.22	.00
Infant Hearing Screening and Related Diagnostics	2.33	.04
Lymphedema	3.00	.05
Prosthetic Devices and Components *	.27	.01
Telemedicine Services	31.22	.55
Chiropractor	\$ 21.97	.38%
Optometrist	13.55	.23
Optician	.04	.00
Psychologist	5.49	.09
Clinical Social Worker	9.23	.16
Podiatrist	11.11	.19
Professional Counselor	8.78	.15
Physical Therapist	31.92	.55
Clinical Nurse Specialist	12.76	.22
Audiologist	.71	.01
Speech Pathologist	.88	.02
Certified Nurse Midwife	1.11	.02
Licensed Acupuncturist	.35	.01
Marriage and Family Therapist	.03	.00

* Denotes mandated offer of coverage

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	\$ 8.70	.20%
Doctor to Include Dentist	11.55	.32
Newborn Children	62.87	1.43
Mental Health Services - Inpatient	40.51	.93
Mental Health Services - Partial Hospitalization	1.84	.04
Mental Health Services - Outpatient	82.57	1.91
Substance Abuse Services - Inpatient	20.84	.48
Substance Abuse Services - Partial Hospitalization	.68	.02
Substance Abuse Services - Outpatient	31.93	.74
Postpartum Services	2.47	.05
Pap Smears	37.58	.76
Obstetrical Services - Normal *	33.97	.77
Obstetrical Services - All Other *	200.29	4.54
Pregnancy from Rape or Incest	.03	.00
Bones and Joints	37.37	.75
Mammograms	37.39	.75
Child Health Supervision Services *	35.52	.81
Reconstructive Breast Surgery	10.06	.20
Hemophilia and Congenital Bleeding Disorders	34.07	.69
Early Intervention Services	31.78	.64
PSA Testing	3.36	.07
Biologically Based Mental Illness	78.34	1.59
Clinical Trials for Treatment Studies on Cancer	.45	.01
Minimum Hospital Stay for Hysterectomy	6.45	.13
Diabetes	53.65	1.08
Hospice Care	.28	.01
Childhood Immunizations	121.98	2.46
Colorectal Cancer Screening	75.74	1.53
Hospitalization and Anesthesia for Dental Procedures	1.50	.03
Treatment of Morbid Obesity *	.74	.01
Infant Hearing Screening and Related Diagnostics	2.42	.05
Lymphedema	4.35	.09
Prosthetic Devices and Components *	.19	.00
Telemedicine Services	94.34	1.90
Autism Spectrum Disorder	3.50	.05
Chiropractor	\$ 23.91	.45%
Optometrist	8.40	.16
Optician	.46	.01
Psychologist	11.44	.21
Clinical Social Worker	14.77	.28
Podiatrist	12.07	.23
Professional Counselor	9.47	.17
Physical Therapist	40.43	.76
Clinical Nurse Specialist	16.82	.31
Audiologist	2.41	.04
Speech Pathologist	1.05	.02
Certified Nurse Midwife	1.72	.03
Licensed Acupuncturist	.79	.02
Marriage and Family Therapist	.58	.01

* Denotes mandated offer of coverage

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. **Table 7** represents utilization of services in terms of the average number of visits per certificate for each benefit, and the average number of days per certificate for each benefit.

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	.03	.00
Doctor to Include Dentist	.03	.00
Newborn Children	.05	.01
Mental Health Services - Inpatient	.05	.03
Mental Health Services - Partial Hospitalization	.01	.00
Mental Health Services - Outpatient	.79	.00
Substance Abuse Services - Inpatient	.00	.01
Substance Abuse Services - Partial Hospitalization	.01	.00
Substance Abuse Services - Outpatient	.09	.00
Postpartum Services	.01	.00
Pap Smears	.42	.00
Obstetrical Services - Normal *	.12	.00
Obstetrical Services - All Other *	.20	.05
Pregnancy from Rape or Incest	.00	.00
Bones and Joints	.26	.01
Mammograms	.26	.00
Child Health Supervision Services *	.27	.00
Reconstructive Breast Surgery	.01	.00
Hemophilia and Congenital Bleeding Disorders	.12	.01
Early Intervention Services	.29	.03
PSA Testing	.10	.00
Biologically Based Mental Illness	.36	.03
Clinical Trials for Treatment Studies on Cancer	.00	.00
Minimum Hospital Stay for Hysterectomy	.00	.00
Diabetes	.53	.00
Hospice Care	.00	.00
Childhood Immunizations	1.84	.01
Colorectal Cancer Screening	.16	.00
Hospitalization and Anesthesia for Dental Procedures	.01	.00
Treatment of Morbid Obesity *	.00	.00
Infant Hearing Screening and Related Diagnostics	.05	.00
Lymphedema	.07	.00
Prosthetic Devices and Components *	.00	.00
Telemedicine Services	1.28	.02
Autism Spectrum Disorder	.04	.01

* Denotes mandated offer of coverage

Utilization figures for the mandated provider categories are displayed in **Table 8.**

TABLE 8	
<u>UTILIZATION OF SERVICES - GROUP COVERAGE</u>	
<u>Provider Category</u>	<u>Average Visits per Certificate</u>
Chiropractor	.60
Optometrist	.16
Optician	.00
Psychologist	.12
Clinical Social Worker	.23
Podiatrist	.14
Professional Counselor	.17
Physical Therapist	.57
Clinical Nurse Specialist	.12
Audiologist	.01
Speech Pathologist	.01
Certified Nurse Midwife	.01
Licensed Acupuncturist	.01
Marriage and Family Therapist	.01

This type of utilization information may be most useful in identifying changes in the rate of use of various benefits and providers that may occur over a period of years. 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 psychotherapy is illustrated in **Table 9**. The average claim cost per visit for mandated providers is \$66.12 when viewed as a single group. In comparison, the average claim cost per visit for physicians and psychiatrists is \$67.89.

TABLE 9	
PSYCHOTHERAPY <u>45 To 50 Minute Session</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Clinical Nurse Specialist	\$143.76
Professional Counselor	54.85
Psychologist	74.28
Clinical Social Worker	52.18
Marriage and Family Therapist	45.82
Mandated Provider Summary	66.12
Physician	61.06
Psychiatrist	74.71
Physician Summary	67.89

Companies are also required to provide claim information regarding group psychotherapy. As indicated in **Table 10**, the average claim cost per visit for the mandated provider (non-physician) categories is \$54.60, \$41.92, \$25.86, and \$23.41, compared to the psychiatrist category of \$51.14.

TABLE 10	
<u>GROUP PSYCHOTHERAPY</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Professional Counselor	\$ 54.60
Psychologist	41.92
Clinical Social Worker	23.41
Marriage and Family Therapist	25.86
Physician	70.52
Psychiatrist	51.14

Physical Medicine Treatment

Companies are required to provide claim information for the following 3 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.

TABLE 11	
<u>PHYSICAL MEDICINE TREATMENT, THERAPEUTIC EXERCISE, 15 MINUTES</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$ 34.11
Physical Therapist	72.15
Podiatrist	26.22
Speech Pathologist	32.43
Physician	60.75

TABLE 12

PHYSICAL MEDICINE TREATMENT, MASSAGE

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$ 38.25
Physical Therapist	29.12
Physician	44.30

TABLE 13

PHYSICAL MEDICINE TREATMENT, ULTRASOUND

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$ 15.18
Physical Therapist	21.85
Podiatrist	29.93
Physician	16.75

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 audiologist category has the highest average claim cost per visit, \$48.85. The speech pathologist category has the lowest average claim cost per visit, \$42.34.

TABLE 14

SPEECH, LANGUAGE OR HEARING THERAPY

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Physical Therapist	\$ 47.36
Speech Pathologist	42.34
Audiologist	48.85
Physician	62.13

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 psychologist categories have the highest average claim costs per visit of \$120.44 and \$91.84, respectively.

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$ 51.96
Physical Therapist	67.69
Podiatrist	74.37
Psychologist	91.84
Clinical Social Worker	76.00
Certified Nurse Midwife	86.29
Psychiatrist	34.26
Physician	120.44

As indicated in **Table 16**, the average claim cost per visit attributable to the podiatrist category for the excision of an ingrown toenail is lower than for the physician category. The average claim cost per visit for the podiatrist category is \$176.71 and for the physician category, \$269.96.

<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Podiatrist	\$ 176.71
Physician	269.96

HEALTH MAINTENANCE ORGANIZATIONS

HMOs are subject to 14VAC5-211-10 et seq., Rules Governing Health Maintenance Organizations (the HMO Rules), which define certain basic health care services which must be provided to each covered member, as well as other requirements. In many areas, these requirements differ from those imposed on insurers and health services plans, in recognition of the unique nature of HMOs. Because a minimum level of benefits for HMOs has been established through the HMO Rules, not all of the mandated benefit requirements of Chapter 34 (§ 38.2-3400 et seq.) of Title 38.2 of the Code of Virginia apply to HMOs. However, HMOs are subject to § 38.2-3419.1 and the HMO Rules, and are required to provide certain limited data. This section presents information collected from HMOs for the 2014 reporting period.

Data from the 11 HMOs that were required to file full reports for calendar year 2014 was used in the preparation of this report.

The premium impact summary and claim experience summary are presented in **Tables 17** and **18**, respectively, and the basis of the calculations are the same as those made for insurers and health services plans (refer to pages 13-14 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>
Mammograms	.42%	.39%	.28%	.29%
Bones and Joints	.30	.59	1.27	1.46
Pap Smears	.59	.57	.18	.14
Postpartum Services	.04	.11	.36	.35
Hemophilia and Congenital Bleeding Disorders	.59	.28	1.18	.62
Reconstructive Breast Surgery	.20	.17	.15	.15
Early Intervention Services	.24	.18	.53	.52
PSA Testing	.03	.02	.04	.04
Biologically Based Mental Illness	--	--	.68	.62
Clinical Trials for Treatment Studies on Cancer	.00	.00	.16	.17
Minimum Hospital Stay for Hysterectomy	.10	.03	.11	.10
Diabetes	.42	.62	.30	.29
Hospice Care	.00	.00	.06	.07
Childhood Immunizations	.17	.98	.46	.53
Colorectal Cancer Screening	1.07	.73	.23	.21
Hospitalization and Anesthesia for Dental Procedures	.00	.01	.06	.05
Treatment of Morbid Obesity *	--	--	1.04	1.16
Infant Hearing Screening and Related Diagnostics	.10	.35	.07	.08
Lymphedema	.17	.14	.16	.14
Prosthetic Devices and Components *	.00	.00	.11	.11
Telemedicine Services	1.86	2.79	3.45	2.62
Autism Spectrum Disorder	--	--	.43	.34
* Denotes mandated offer of coverage				
-- Benefit not mandated				

TABLE 18

CLAIM EXPERIENCE SUMMARY
Average Percent of Total Claims

	<u>Individual</u>	<u>Group</u>
Mammograms	.21%	.15%
Bones and Joints	.05	.21
Pap Smears	.08	.27
Postpartum Services	.01	.02
Hemophilia and Congenital Bleeding Disorders	.06	.15
Reconstructive Breast Surgery	.05	.08
Early Intervention Services	.05	.40
PSA Testing	.03	.03
Biologically Based Mental Illness	--	.80
Clinical Trials for Treatment Studies on Cancer	.00	.05
Minimum Hospital Stay for Hysterectomy	.05	.11
Diabetes	.17	.14
Hospice Care	.00	.00
Childhood Immunizations	.16	.48
Colorectal Cancer Screening	.35	.63
Hospitalization and Anesthesia for Dental Procedures	.00	.02
Treatment of Morbid Obesity *	--	.00
Infant Hearing Screening and Related Diagnostics	.01	.04
Lymphedema	.02	.06
Prosthetic Devices and Components *	.00	.00
Telemedicine Services	2.24	4.92
Autism Spectrum Disorder	--	.04

* Denotes mandated offer of coverage

-- Benefit not mandated

COMPARISONS

The following comparisons of mandated benefits, offers and providers, both for premium impact and for claims experience, are presented below for the 3 most recent reporting years – 2012, 2013, and 2014.

PREMIUM IMPACT						
Percent of Overall Average Premium						
<u>Mandate Category</u>	<u>Individual</u>			<u>Family</u>		
	<u>Single</u>		2014			
	<u>2012</u>	<u>2013</u>		<u>2012</u>	<u>2013</u>	<u>2014</u>
Dependent Children	--%	--%	--%	.04%	.06%	.04%
Doctor to Include Dentist	.15	.12	.35	.19	.05	.26
Newborn Children	.00	.00	.00	1.51	.44	1.20
Mental Health Services - Inpatient	.62	.45	.57	.51	.25	.62
Mental Health Services - Partial Hospitalization	.04	.04	.04	.04	.04	.04
Mental Health Services - Outpatient	1.42	.88	1.04	1.17	.71	1.13
Substance Abuse Services - Inpatient	.35	.27	.74	.11	.08	.20
Substance Abuse Services - Partial Hospitalization	.08	.07	.10	.04	.05	.08
Substance Abuse Services - Outpatient	.64	.54	.89	.57	.45	.71
Postpartum Services	.69	.77	.56	.38	.40	.25
Pap Smears	.55	.52	.42	.54	.53	.51
Pregnancy from Rape or Incest	.00	.00	.00	.00	.00	.00
Bones and Joints	.43	.17	.27	1.08	.12	.17
Mammograms	.68	.79	.63	.65	.75	.67
Child Health Supervision Services *	.25	.25	.26	.90	.82	1.04
Reconstructive Breast Surgery	.15	1.40	.11	.14	1.30	.13
Hemophilia and Congenital Bleeding Disorders	.46	.72	.44	.38	.60	.35
Early Intervention Services	1.23	1.22	1.26	.62	.72	.90
PSA Testing	.29	.15	.10	.23	.10	.07
Clinical Trials for Treatment Studies on Cancer	.17	.18	.16	.10	.11	.13
Minimum Hospital Stay for Hysterectomy	.08	.26	.45	.09	.18	.35
Diabetes	.56	.60	.71	.72	.63	1.00
Hospice Care	.08	.00	.00	.02	.01	.01
Childhood Immunizations	.55	.96	.77	1.28	1.37	1.59
Colorectal Cancer Screening	1.10	1.82	1.41	1.25	1.70	1.43
Hospitalization and Anesthesia for Dental Procedures	.36	.38	.42	.13	.09	.12
Treatment of Morbid Obesity *	1.21	1.29	--	.83	.86	--
Infant Hearing Screening and Related Diagnostics	.06	.07	.06	.07	.05	.13
Lymphedema	.18	.18	.29	.17	.14	.24
Prosthetic Devices and Components *	.06	.00	.06	.03	.00	.06
Telemedicine Services	1.99	.97	3.05	2.31	1.12	2.14
Chiropractor	.18	.15	.19	.18	.16	.22
Optometrist	.17	.17	.21	.14	.15	.19
Optician	.33	.35	.19	.22	.23	.15
Psychologist	.18	.09	.17	.07	.07	.19
Clinical Social Worker	.08	.08	.07	.07	.07	.07
Podiatrist	.12	.14	.17	.11	.11	.17
Professional Counselor	.06	.06	.21	.06	.06	.19
Physical Therapist	.49	.52	.68	.95	.32	.62
Clinical Nurse Specialist	.00	.09	.10	.00	.11	.38
Audiologist	.08	.09	.10	.02	.04	.03
Speech Pathologist	.06	.06	.06	.03	.03	.06
Certified Nurse Midwife	.19	.21	.15	.05	.05	.07
Licensed Acupuncturist	.03	.03	.03	.02	.07	.01
Marriage and Family Therapist	.03	.03	.00	.02	.02	.00

* Denotes mandated offer of coverage
 -- Benefit not mandated

PREMIUM IMPACT
Percent of Overall Average Premium

<u>Mandate Category</u>	<u>Group</u>					
	<u>Single</u>			<u>Family</u>		
	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>
Dependent Children	.00%	.00%	.00%	.20%	3.61%	.08%
Doctor to Include Dentist	.22	.25	.03	.21	.26	.07
Newborn Children	.00	.00	.00	1.70	.71	.27
Mental Health Services - Inpatient	.57	.45	.03	.61	.43	.10
Mental Health Services - Partial Hospitalization	.10	.03	.00	.07	.03	.01
Mental Health Services - Outpatient	.76	.48	.05	.77	.49	.13
Substance Abuse Services - Inpatient	.65	.11	.02	.59	.10	.04
Substance Abuse Services - Partial Hospitalization	.11	.03	.00	.10	.04	.01
Substance Abuse Services - Outpatient	.60	.39	.02	.55	.37	.04
Postpartum Services	.33	.18	.02	.18	.17	.06
Pap Smears	.55	.58	.02	.43	.55	.04
Obstetrical Services - Normal *	.75	.60	.11	.79	.65	.25
Obstetrical Services - All Other *	3.19	1.38	.11	3.28	1.71	.31
Pregnancy from Rape or Incest	.05	.02	.00	.04	.01	.00
Bones and Joints	.79	.76	.09	.77	.76	.22
Mammograms	.49	2.00	.04	.44	1.93	.07
Child Health Supervision Services *	.42	.21	.06	.55	.38	.17
Reconstructive Breast Surgery	.26	.81	.01	.23	.69	.03
Hemophilia and Congenital Bleeding Disorders	.50	1.12	.06	.58	1.36	.16
Early Intervention Services	.93	4.41	.08	.81	3.92	.17
PSA Testing	.07	.12	.00	.06	.12	.01
Biologically Based Mental Illness	.77	.58	.08	.84	.64	.17
Clinical Trials for Treatment Studies on Cancer	.12	.07	.01	.13	.08	.02
Minimum Hospital Stay for Hysterectomy	.13	.15	.01	.12	.14	.02
Diabetes	.85	.50	.05	.81	.53	.09
Hospice Care	.18	.04	.01	.16	.03	.02
Childhood Immunizations	.50	1.87	.07	.67	1.86	.19
Colorectal Cancer Screening	.62	4.20	.07	.55	3.84	.13
Hospitalization and Anesthesia for Dental Procedures	.10	.13	.00	.09	.13	.01
Treatment of Morbid Obesity *	.85	.52	.11	.76	.50	.23
Infant Hearing Screening and Related Diagnostics	.10	.26	.01	.11	.21	.02
Lymphedema	.27	.12	.02	.19	.08	.03
Prosthetic Devices and Components *	.15	.06	.01	.10	.07	.01
Telemedicine Services	4.90	20.44	.30	4.55	19.88	.49
Autism Spectrum Disorder	3.08	.05	.02	1.96	.04	.03
Chiropractor	.54	1.17	.04	.46	1.07	.08
Optometrist	.13	.26	.01	.10	.25	.02
Optician	.11	.03	.01	.11	.04	.01
Psychologist	.50	1.07	.16	.46	1.03	.30
Clinical Social Worker	.15	1.08	.18	.14	1.06	.33
Podiatrist	.32	1.04	.02	.27	1.01	.05
Professional Counselor	.20	.14	.02	.18	.15	.04
Physical Therapist	.64	2.08	.06	.60	2.02	.13
Clinical Nurse Specialist	.30	1.23	.02	.09	1.24	.06
Audiologist	.09	.28	.01	.07	.21	.01
Speech Pathologist	.09	.07	.01	.08	.07	.01
Certified Nurse Midwife	.09	.06	.01	.09	.05	.02
Licensed Acupuncturist	.13	.29	.01	.12	.22	.02
Marriage and Family Therapist	.12	.06	.01	.12	.06	.01

* Denotes mandated offer of coverage

CLAIMS EXPERIENCE
Average Percent of Total Claims

Individual

<u>Mandate Category</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>
Dependent Children	.00%	.03%	.06%
Doctor to Include Dentist	.05	.15	.13
Newborn Children	.49	.70	.53
Mental Health Services - Inpatient	.85	1.39	.83
Mental Health Services - Partial Hospitalization	.04	.01	.03
Mental Health Services - Outpatient	1.18	1.58	1.18
Substance Abuse Services - Inpatient	.31	1.19	.38
Substance Abuse Services - Partial Hospitalization	.11	.00	.12
Substance Abuse Services - Outpatient	.13	1.09	.44
Postpartum Services	.01	.02	.03
Pap Smears	1.39	1.45	1.16
Pregnancy from Rape or Incest	.00	.15	.01
Bones and Joints	.19	.17	.27
Mammograms	1.29	1.39	1.25
Child Health Supervision Services *	.83	.76	.70
Reconstructive Breast Surgery	.32	.29	.26
Hemophilia and Congenital Bleeding Disorders	.70	.07	.38
Early Intervention Services	.19	.17	.18
PSA Testing	.05	.05	.04
Clinical Trials for Treatment Studies on Cancer	.00	.01	.00
Minimum Hospital Stay for Hysterectomy	.27	.18	.12
Diabetes	2.66	2.46	2.06
Hospice Care	.00	.00	.00
Childhood Immunizations	4.11	4.66	3.90
Colorectal Cancer Screening	1.64	1.79	.45
Hospitalization and Anesthesia for Dental Procedures	.00	.00	.00
Treatment of Morbid Obesity *	.00	.00	--
Infant Hearing Screening and Related Diagnostics	.05	.05	.04
Lymphedema	.05	.04	.05
Prosthetic Devices and Components *	.00	.00	.01
Telemedicine Services	.95	.54	.55
Chiropractor	.09	.41	.38
Optometrist	.21	.24	.23
Optician	.00	.00	.00
Psychologist	.05	.06	.09
Clinical Social Worker	.13	.18	.16
Podiatrist	.21	.19	.19
Professional Counselor	.15	.15	.15
Physical Therapist	.58	.73	.55
Clinical Nurse Specialist	.00	.12	.22
Audiologist	.01	.01	.01
Speech Pathologist	.02	.00	.02
Certified Nurse Midwife	.01	.02	.02
Licensed Acupuncturist	.00	.00	.01
Marriage and Family Therapist	.01	.00	.00

* Denotes mandated offer of coverage

-- Benefit not mandated

CLAIMS EXPERIENCE
Average Percent of Total Claims

<u>Mandate Category</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>
Dependent Children	.11%	1.02%	.20%
Doctor to Include Dentist	.14	.26	.32
Newborn Children	1.27	1.88	1.43
Mental Health Services - Inpatient	.76	.63	.93
Mental Health Services - Partial Hospitalization	.06	.01	.04
Mental Health Services - Outpatient	1.47	1.33	1.91
Substance Abuse Services - Inpatient	.28	.33	.48
Substance Abuse Services - Partial Hospitalization	.08	.00	.02
Substance Abuse Services - Outpatient	.49	.23	.74
Postpartum Services	.01	.05	.05
Pap Smears	.69	.82	.76
Obstetrical Services - Normal *	.73	.52	.77
Obstetrical Services - All Other *	4.11	2.92	4.54
Pregnancy from Rape or Incest	.00	.00	.00
Bones and Joints	.61	.67	.75
Mammograms	.65	.96	.75
Child Health Supervision Services *	.70	.77	.81
Reconstructive Breast Surgery	.14	.28	.20
Hemophilia and Congenital Bleeding Disorders	.36	.54	.69
Early Intervention Services	.44	1.39	.64
PSA Testing	.06	.23	.07
Biologically Based Mental Illness	1.10	1.23	1.59
Clinical Trials for Treatment Studies on Cancer	.01	.01	.01
Minimum Hospital Stay for Hysterectomy	.19	.17	.13
Diabetes	1.22	1.13	1.08
Hospice Care	.02	.00	.01
Childhood Immunizations	.36	2.81	2.46
Colorectal Cancer Screening	1.19	2.06	1.53
Hospitalization and Anesthesia for Dental Procedures	.03	.05	.03
Treatment of Morbid Obesity *	.00	.01	.01
Infant Hearing Screening and Related Diagnostics	.05	.08	.05
Lymphedema	.10	.10	.09
Prosthetic Devices and Components *	.00	.00	.00
Telemedicine Services	1.42	4.83	1.90
Autism Spectrum Disorder	.04	.06	.05
Chiropractor	.43	.67	.45
Optometrist	.25	.32	.16
Optician	.02	.03	.01
Psychologist	.17	.28	.21
Clinical Social Worker	.15	.30	.28
Podiatrist	.18	.33	.23
Professional Counselor	.18	.17	.17
Physical Therapist	.58	.92	.76
Clinical Nurse Specialist	.02	.41	.31
Audiologist	.03	.06	.04
Speech Pathologist	.02	.02	.02
Certified Nurse Midwife	.02	.03	.03
Licensed Acupuncturist	.00	.03	.02
Marriage and Family Therapist	.01	.01	.01

* Denotes mandated offer of coverage

Although these comparisons show some variations among categories during the 3 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 an added amount to the premium dollar for certain benefits and providers in both individual and 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.

Generally, there is a variation between the overall ratio of utilization of services and providers to the corresponding claim cost attributable to these services and providers, specifically as presented in **Tables 6, 7, and 8** for group business.

Reported utilization rates may vary considerably among benefit and provider categories. Utilization information may be helpful in assessing the utilization patterns for the various mandates and in comparing changes in utilization from one year to the next.

APPENDIX A

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 House Documents and Report Documents are shown below.

<u>Document No.</u>	<u>Date Issued</u>	<u>Reporting Period</u>
1994, HD6	1993	Calendar year 1992
1995, HD3	1994	Calendar year 1993
1996, HD5	1995	Calendar year 1994
1997, HD15	1996	Calendar year 1995
1998, HD10	1997	Calendar year 1996
1999, HD6	1998	Calendar year 1997
2000, HD12	1999	Calendar year 1998
2001, HD7	2000	Calendar year 1999
2002, HD10	2001	Calendar year 2000
2003, HD8	2002	Calendar year 2001
2003, RD49	2003	Calendar year 2002
2004, RD110	2004	Calendar year 2003
2005, RD191	2005	Calendar year 2004
2006, RD289	2006	Calendar year 2005
2007, RD246	2007	Calendar year 2006
2008, RD322	2008	Calendar year 2007
2009, RD294	2009	Calendar year 2008
2010, RD300	2010	Calendar year 2009
2011, RD281	2011	Calendar year 2010
2012, RD290	2012	Calendar year 2011
2013, RD300	2013	Calendar year 2012
2014, RD335	2014	Calendar year 2013