MARK C. CHRISTIE
COMMISSIONER

JAMES C. DIMITRI
COMMISSIONER

JUDITH WILLIAMS JAGDMANN
COMMISSIONER

COMMONWEALTH OF VIRGINIA

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P.O. BOX 1197
RICHMOND, VIRGINIA 23218-1197

STATE CORPORATION COMMISSION

October 31, 2016

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 2015 reporting period.

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

Respectfully submitted,

James C. Dimitri, Chairman

Mark C. Christie, Commissioner

Judith Williams Jagdmann, Commissioner

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: 2015 Reporting Period

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRIGNIA
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EXECUTIVE SUMMARY

Section 38.2-3419.1 of the Code of Virginia requires every insurer, health services plan, and health maintenance organization (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. The Commission's Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers (the Rules) at 14 VAC 5-190-10 et seq. specify the detail and form of the information that must be reported by companies.

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. Companies are required to submit their reports no later than May 1 of the year following the reporting period. The Commission is required to submit its report for submission to the Governor and the General Assembly by October 31 of each year. This report provides information relating to the 2015 reporting period. Previous reports are listed in Appendix A.

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 746 companies licensed to issue accident and sickness or subscription contracts in Virginia or licensed as HMOs in Virginia in 2015, only 28 companies met this requirement and, accordingly, submitted data for products which are subject to mandated benefit and provider requirements for the 2015 reporting period. Those companies not required to file a full report pursuant to the Rules at 14 VAC5-190-10 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 167 companies meeting this criterion. Those companies not required to file either a full or abbreviated report either (i) wrote less than $500,000 of accident and sickness premiums in Virginia during calendar year 2015; 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 2015.

Information presented in this report reflects data provided by 18 insurers and 10 HMOs. This report reflects the data of 2 companies that issued only individual contracts, 8 companies that issued group certificates or subscription contracts, and 8 companies that issued both individual contracts and group certificates or subscription contracts in Virginia in 2015. 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.

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).

As discussed in the 2015 report, RD337 - 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, the International Classification of Disease (ICD) Codes, for which cost and utilization data is reported, underwent a major update in 2015. Effective September 30, 2015, the ICD-9 codes were replaced by ICD-10 codes. The combinability of data coded under the new codes has still not been finalized. As a result, insurers were requested to report mandated benefits and utilization for the 9-month period January 1, 2015 through September 30, 2015 for benefits coded utilizing the ICD-9 codes as provided in instructions in the Bureau of Insurance's Administrative Letter 2016-01, dated March 8, 2016. Because of the uncertainty underlying combinability of data, it was determined that requesting 9 months of data would provide data both credible and comparable to previous reports until a full year of ICD-10 coded data becomes available in calendar year 2017.

This report includes summaries of each of the mandated benefit and provider requirements in Virginia, together with information relating to the impact of these requirements on cost and utilization. As in previous years, the data reported by the carriers indicates that individually, Virginia's mandated benefit and provider requirements vary greatly in their impact on health insurance premiums.

The data reported also indicates that 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. The data also suggests that 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.

It is important to note that, while the statutory requirements relative to the mandated benefits, mandated offers, and mandated providers identified in this report remain in effect and applicable to health plans issued in Virginia, the requirements associated with each mandate, in many cases, also apply insofar as the benefit and coverage requirements associated with the mandates are included in the essential health benefit requirements for individual market and small group market health benefit plans pursuant to § 38.2-3451 of the Code of Virginia.

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. All statutory citations referenced below are included in the Code of Virginia. These summaries are included only to provide an overview of the required coverages applicable to the 2015 reporting period.

Mandated Benefits and Mandated Offers

Dependent Children

Section 38.2-3409 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 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 requires that insurers, health services plans, and HMOs provide coverage for hospice services.

Coverage for Childhood Immunizations

Section 38.2-3411.3 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 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 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 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 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 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 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. Tables 1 and 2 identify premium costs for individual business, single coverage and family coverage, respectively, while tables 3 and 4 identify the premium costs for group coverage, individual and family, respectively.

TABLE 1

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS – SINGLE COVERAGE

Mandate Category	Percent of Overall Average Premium
Doctor to Include Dentist	0.25%
Mental Health Services - Inpatient	1.22
Mental Health Services - Partial Hospitalization	0.27
Mental Health Services - Outpatient	1.37
Substance Abuse Services - Inpatient	0.80
Substance Abuse Services - Partial Hospitalization	0.20
Substance Abuse Services - Outpatient	0.92
Postpartum Services	0.62
Pap Smears	0.60
Pregnancy from Rape or Incest	0.65
Bones and Joints	0.80
Mammograms	0.85
Child Health Supervision Services *	0.56
Reconstructive Breast Surgery	0.57
Hemophilia and Congenital Bleeding Disorders	0.98
Early Intervention Services	2.28
PSA Testing	0.46
Clinical Trials for Treatment Studies on Cancer	1.14
Minimum Hospital Stay for Hysterectomy	0.15
Diabetes	1.07
Hospice Care	1.95
Childhood Immunizations	1.33
Colorectal Cancer Screening	1.32
Hospitalization and Anesthesia for Dental Procedures	0.50
Infant Hearing Screening and Related Diagnostics	0.22
Lymphedema	0.49
Prosthetic Devices and Components *	0.55
Telemedicine Services	1.50
Chiropractor	0.28%
Optometrist	0.32
Optician	0.44
Psychologist	0.42
Clinical Social Worker	0.18
Podiatrist	0.29
Professional Counselor	0.40
Physical Therapist	0.75
Clinical Nurse Specialist	0.20
Audiologist	0.17
Speech Pathologist	0.15
Certified Nurse Midwife	0.22
Licensed Acupuncturist	0.09
Marriage and Family Therapist	0.25

* Denotes mandated offer of coverage

TABLE 2

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS – FAMILY COVERAGE

Mandate Category	Percent of Overall Average Premium
Dependent Children	0.06%
Doctor to Include Dentist	0.03
Newborn Children	0.19
Mental Health Services - Inpatient	0.14
Mental Health Services - Partial Hospitalization	0.02
Mental Health Services - Outpatient	0.16
Substance Abuse Services - Inpatient	0.07
Substance Abuse Services - Partial Hospitalization	0.02
Substance Abuse Services - Outpatient	0.10
Postpartum Services	0.43
Pap Smears	0.07
Pregnancy from Rape or Incest	0.07
Bones and Joints	0.07
Mammograms	0.09
Child Health Supervision Services *	0.24
Reconstructive Breast Surgery	0.05
Hemophilia and Congenital Bleeding Disorders	0.09
Early Intervention Services	0.16
PSA Testing	0.05
Clinical Trials for Treatment Studies on Cancer	0.06
Minimum Hospital Stay for Hysterectomy	0.01
Diabetes	0.14
Hospice Care	0.06
Childhood Immunizations	0.26
Colorectal Cancer Screening	0.13
Hospitalization and Anesthesia for Dental Procedures	0.03
Infant Hearing Screening and Related Diagnostics	0.02
Lymphedema	0.05
Prosthetic Devices and Components *	0.06
Telemedicine Services	0.12
Chiropractor	0.03%
Optometrist	0.03
Optician	0.04
Psychologist	0.04
Clinical Social Worker	0.02
Podiatrist	0.03
Professional Counselor	0.04
Physical Therapist	0.09
Clinical Nurse Specialist	0.03
Audiologist	0.01
Speech Pathologist	0.01
Certified Nurse Midwife	0.02
Licensed Acupuncturist	0.01
Marriage and Family Therapist	0.03

* Denotes mandated offer of coverage

TABLE 3

PREMIUM IMPACT ON GROUP CERTIFICATES – SINGLE COVERAGE

Mandate Category	Percent of Overall Average Premium
Doctor to Include Dentist	0.48%
Mental Health Services - Inpatient	0.35
Mental Health Services - Partial Hospitalization	0.04
Mental Health Services - Outpatient	0.66
Substance Abuse Services - Inpatient	0.29
Substance Abuse Services - Partial Hospitalization	0.04
Substance Abuse Services - Outpatient	0.27
Postpartum Services	0.36
Pap Smears	0.34
Obstetrical Services - Normal *	1.46
Obstetrical Services - All Other *	1.58
Pregnancy from Rape or Incest	0.02
Bones and Joints	1.42
Mammograms	0.55
Child Health Supervision Services *	0.71
Reconstructive Breast Surgery	0.39
Hemophilia and Congenital Bleeding Disorders	0.89
Early Intervention Services	1.34
PSA Testing	0.06
Biologically Based Mental Illness	0.72
Clinical Trials for Treatment Studies on Cancer	0.38
Minimum Hospital Stay for Hysterectomy	0.14
Diabetes	0.86
Hospice Care	0.08
Childhood Immunizations	1.21
Colorectal Cancer Screening	1.04
Hospitalization and Anesthesia for Dental Procedures	0.04
Treatment of Morbid Obesity *	1.40
Infant Hearing Screening and Related Diagnostics	0.11
Lymphedema	0.24
Prosthetic Devices and Components *	0.06
Telemedicine Services	6.98
Autism Spectrum Disorder	0.50
Chiropractor	0.60%
Optometrist	0.13
Optician	0.10
Psychologist	0.39
Clinical Social Worker	0.37
Podiatrist	0.30
Professional Counselor	0.20
Physical Therapist	0.84
Clinical Nurse Specialist	0.33
Audiologist	0.07
Speech Pathologist	0.08
Certified Nurse Midwife	0.11
Licensed Acupuncturist	0.13
Marriage and Family Therapist	0.06

* Denotes mandated offer of coverage

TABLE 4

PREMIUM IMPACT ON GROUP CERTIFICATES – FAMILY COVERAGE

Mandate Category	Percent of Overall Average Premium
Dependent Children	0.01%
Doctor to Include Dentist	0.01
Newborn Children	0.03
Mental Health Services - Inpatient	0.01
Mental Health Services - Partial Hospitalization	0.00
Mental Health Services - Outpatient	0.02
Substance Abuse Services - Inpatient	0.00
Substance Abuse Services - Partial Hospitalization	0.00
Substance Abuse Services - Outpatient	0.01
Postpartum Services	0.01
Pap Smears	0.01
Obstetrical Services - Normal *	0.04
Obstetrical Services - All Other *	0.05
Pregnancy from Rape or Incest	0.00
Bones and Joints	0.04
Mammograms	0.01
Child Health Supervision Services *	0.02
Reconstructive Breast Surgery	0.01
Hemophilia and Congenital Bleeding Disorders	0.02
Early Intervention Services	0.03
PSA Testing	0.00
Biologically Based Mental Illness	0.02
Clinical Trials for Treatment Studies on Cancer	0.01
Minimum Hospital Stay for Hysterectomy	0.00
Diabetes	0.02
Hospice Care	0.00
Childhood Immunizations	0.03
Colorectal Cancer Screening	0.02
Hospitalization and Anesthesia for Dental Procedures	0.00
Treatment of Morbid Obesity *	0.02
Infant Hearing Screening and Related Diagnostics	0.00
Lymphedema	0.00
Prosthetic Devices and Components *	0.00
Telemedicine Services	0.13
Autism Spectrum Disorder	0.01
Chiropractor	0.02%
Optometrist	0.00
Optician	0.00
Psychologist	0.01
Clinical Social Worker	0.01
Podiatrist	0.01
Professional Counselor	0.00
Physical Therapist	0.02
Clinical Nurse Specialist	0.01
Audiologist	0.00
Speech Pathologist	0.00
Certified Nurse Midwife	0.00
Licensed Acupuncturist	0.00
Marriage and Family Therapist	0.00

* 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
$858.82	23.68%	$1,226.36	6.73%

TABLE 5

CLAIM EXPERIENCE – INDIVIDUAL CONTRACTS

Mandate Category	Average Claim Cost per Contract	Average Percent of Total Claims
Dependent Children	$ 0.95	0.03%
Doctor to Include Dentist	3.39	0.09
Newborn Children	39.65	1.06
Mental Health Services - Inpatient	68.50	1.82
Mental Health Services - Partial Hospitalization	2.25	0.06
Mental Health Services - Outpatient	79.82	2.15
Substance Abuse Services - Inpatient	49.83	1.42
Substance Abuse Services - Partial Hospitalization	6.56	0.19
Substance Abuse Services - Outpatient	67.91	1.93
Postpartum Services	1.08	0.03
Pap Smears	19.75	0.53
Pregnancy from Rape or Incest	0.03	0.00
Bones and Joints	37.61	1.00
Mammograms	38.98	1.05
Child Health Supervision Services *	23.66	0.64
Reconstructive Breast Surgery	16.55	0.47
Hemophilia and Congenital Bleeding Disorders	36.19	0.97
Early Intervention Services	8.63	0.23
PSA Testing	3.24	0.09
Clinical Trials for Treatment Studies on Cancer	0.41	0.01
Minimum Hospital Stay for Hysterectomy	4.24	0.11
Diabetes	57.42	1.53
Hospice Care	0.80	0.02
Childhood Immunizations	95.92	2.58
Colorectal Cancer Screening	87.59	2.33
Hospitalization and Anesthesia for Dental Procedures	1.07	0.03
Infant Hearing Screening and Related Diagnostics	1.53	0.04
Lymphedema	2.15	0.06
Prosthetic Devices and Components *	1.10	0.03
Telemedicine Services	34.77	0.95
Chiropractor	$ 16.85	0.45%
Optometrist	10.41	0.28
Optician	0.09	0.00
Psychologist	6.04	0.17
Clinical Social Worker	7.56	0.20
Podiatrist	8.48	0.23
Professional Counselor	9.46	0.25
Physical Therapist	28.84	0.78
Clinical Nurse Specialist	5.81	0.16
Audiologist	0.41	0.01
Speech Pathologist	0.20	0.01
Certified Nurse Midwife	0.73	0.02
Licensed Acupuncturist	0.21	0.01
Marriage and Family Therapist	0.12	0.00

* Denotes mandated offer of coverage

TABLE 6

CLAIM EXPERIENCE – GROUP CERTIFICATES

Mandate Category	Average Claim Cost per Certificate	Average Percent of Total Claims
Dependent Children	$ 9.48	0.05%
Doctor to Include Dentist	7.50	0.04
Newborn Children	69.13	0.38
Mental Health Services - Inpatient	44.15	0.24
Mental Health Services - Partial Hospitalization	2.29	0.01
Mental Health Services - Outpatient	76.17	0.41
Substance Abuse Services - Inpatient	20.76	0.11
Substance Abuse Services - Partial Hospitalization	2.82	0.02
Substance Abuse Services - Outpatient	35.47	0.19
Postpartum Services	2.57	0.13
Pap Smears	32.89	0.18
Obstetrical Services - Normal *	144.96	0.79
Obstetrical Services - All Other *	40.49	0.22
Pregnancy from Rape or Incest	0.04	0.00
Bones and Joints	45.64	0.25
Mammograms	17.90	0.10
Child Health Supervision Services *	40.49	0.22
Reconstructive Breast Surgery	15.41	0.41
Hemophilia and Congenital Bleeding Disorders	26.74	0.15
Early Intervention Services	22.36	0.12
PSA Testing	2.97	0.02
Biologically Based Mental Illness	79.20	0.42
Clinical Trials for Treatment Studies on Cancer	47.36	1.24
Minimum Hospital Stay for Hysterectomy	6.13	0.03
Diabetes	61.99	0.34
Hospice Care	0.22	0.00
Childhood Immunizations	139.39	0.76
Colorectal Cancer Screening	39.82	0.22
Hospitalization and Anesthesia for Dental Procedures	1.48	0.01
Treatment of Morbid Obesity *	0.50	0.00
Infant Hearing Screening and Related Diagnostics	4.79	0.03
Lymphedema	3.96	0.02
Prosthetic Devices and Components *	0.05	0.00
Telemedicine Services	78.02	0.43
Autism Spectrum Disorder	2.76	0.02
Chiropractor	$ 23.56	0.13%
Optometrist	10.11	0.06
Optician	0.16	0.00
Psychologist	9.63	0.05
Clinical Social Worker	15.48	0.08
Podiatrist	10.40	0.06
Professional Counselor	7.12	0.04
Physical Therapist	37.65	0.21
Clinical Nurse Specialist	14.19	0.08
Audiologist	1.59	0.01
Speech Pathologist	0.94	0.01
Certified Nurse Midwife	1.54	0.01
Licensed Acupuncturist	0.39	0.00
Marriage and Family Therapist	0.32	0.00

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

TABLE 7

UTILIZATION OF SERVICES - GROUP COVERAGE

Benefit Category	Average Visits per Certificate	Average Days per Certificate
Dependent Children	0.03	0.00
Doctor to Include Dentist	0.02	0.00
Newborn Children	0.06	0.02
Mental Health Services - Inpatient	0.04	0.03
Mental Health Services - Partial Hospitalization	0.02	0.00
Mental Health Services - Outpatient	0.76	0.00
Substance Abuse Services - Inpatient	0.00	0.01
Substance Abuse Services - Partial Hospitalization	0.01	0.00
Substance Abuse Services - Outpatient	0.09	0.00
Postpartum Services	0.01	0.00
Pap Smears	0.38	0.00
Obstetrical Services - Normal *	0.15	0.03
Obstetrical Services - All Other *	0.34	0.00
Pregnancy from Rape or Incest	0.00	0.00
Bones and Joints	0.25	0.01
Mammograms	0.26	0.00
Child Health Supervision Services *	0.34	0.00
Reconstructive Breast Surgery	0.01	0.00
Hemophilia and Congenital Bleeding Disorders	0.11	0.00
Early Intervention Services	0.28	0.03
PSA Testing	0.10	0.00
Biologically Based Mental Illness	0.35	0.03
Clinical Trials for Treatment Studies on Cancer	0.12	0.00
Minimum Hospital Stay for Hysterectomy	0.00	0.00
Diabetes	0.64	0.00
Hospice Care	0.00	0.00
Childhood Immunizations	2.25	0.00
Colorectal Cancer Screening	0.07	0.00
Hospitalization and Anesthesia for Dental Procedures	0.00	0.00
Treatment of Morbid Obesity *	0.00	0.00
Infant Hearing Screening and Related Diagnostics	0.09	0.00
Lymphedema	0.07	0.00
Prosthetic Devices and Components *	0.00	0.00
Telemedicine Services	1.05	0.01
Autism Spectrum Disorder	0.02	0.01

* Denotes mandated offer of coverage

TABLE 8

UTILIZATION OF SERVICES - GROUP COVERAGE

Provider Category	Average Visits per Certificate
Chiropractor	0.63
Optometrist	0.12
Optician	0.00
Psychologist	0.10
Clinical Social Worker	0.28
Podiatrist	0.12
Professional Counselor	0.15
Physical Therapist	0.57
Clinical Nurse Specialist	0.10
Audiologist	0.01
Speech Pathologist	0.01
Certified Nurse Midwife	0.01
Licensed Acupuncturist	0.01
Marriage and Family Therapist	0.01

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.

TABLE 9

PSYCHOTHERAPY
45 To 50 Minute Session

Provider Category	Average Claim Cost Per Visit
Clinical Nurse Specialist	$39.35
Professional Counselor	47.31
Psychologist	70.38
Clinical Social Worker	37.93
Marriage and Family Therapist	40.23
Mandated Provider Summary	50.47
Physician	$69.30
Psychiatrist	59.65
Physician Summary	64.76

Companies are also required to provide claim information regarding group psychotherapy, as indicated in **Table 10.**

TABLE 10

GROUP PSYCHOTHERAPY

Provider Category	Average Claim Cost Per Visit
Professional Counselor	$55.16
Psychologist	30.59
Clinical Social Worker	13.91
Marriage and Family Therapist	39.48
Physician	53.09
Psychiatrist	22.73

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

PHYSICAL MEDICINE TREATMENT, THERAPEUTIC EXERCISE, 15 MINUTES

Provider Category	Average Claim Cost Per Visit
Chiropractor	$33.30
Physical Therapist	44.08
Podiatrist	30.35
Speech Pathologist	94.91
Physician	60.62

TABLE 12

PHYSICAL MEDICINE TREATMENT, MASSAGE

Provider Category	Average Claim Cost Per Visit
Chiropractor	$66.63
Physical Therapist	33.59
Physician	59.68

TABLE 13

PHYSICAL MEDICINE TREATMENT, ULTRASOUND

Provider Category	Average Claim Cost Per Visit
Chiropractor	$19.89
Physical Therapist	18.88
Podiatrist	32.63
Physician	25.25

Speech, Language or Hearing Therapy

Table 14 displays the average claim cost per visit for speech, language or hearing therapy provided by a physical therapist, speech pathologist, audiologist, and physician.

TABLE 14

SPEECH, LANGUAGE OR HEARING THERAPY

Provider Category	Average Claim Cost Per Visit
Physical Therapist	$42.01
Speech Pathologist	139.29
Audiologist	177.36
Physician	132.77

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.

TABLE 15

OFFICE VISIT, INTERMEDIATE SERVICE TO NEW PATIENT

Provider Category	Average Claim Cost Per Visit
Chiropractor	$53.89
Physical Therapist	74.92
Podiatrist	427.53*
Psychologist	30.29
Clinical Social Worker	52.82
Certified Nurse Midwife	144.98
Psychiatrist	86.03
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 $151.43 and for the physician category, $255.87.

TABLE 16

EXCISION OF INGROWN TOENAIL

Provider Category	Average Claim Cost Per Visit
Podiatrist	$151.43
Physician	255.87

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. This section presents information collected from HMOs for the 2015 reporting period.

Data from the 10 HMOs that were required to file full reports for calendar year 2015 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 11-15 and 16).

TABLE 17

PREMIUM IMPACT SUMMARY
Percent of Overall Average Premium

	Individual		Group	
	Single	Family	Single	Family
Mammograms	0.26%	0.17%	0.45%	0.43%
Bones and Joints	0.47	0.38	2.17	1.72
Pap Smears	0.34	0.25	0.24	0.19
Postpartum Services	0.03	0.04	0.42	0.35
Hemophilia and Congenital Bleeding Disorders	1.20	0.06	0.91	1.04
Reconstructive Breast Surgery	0.10	0.04	0.18	0.17
Early Intervention Services	0.23	0.13	0.75	0.66
PSA Testing	0.03	0.01	0.06	0.05
Biologically Based Mental Illness	--	--	0.54	0.61
Clinical Trials for Treatment Studies on Cancer	0.00	0.00	0.18	0.18
Minimum Hospital Stay for Hysterectomy	0.10	0.02	0.10	0.10
Diabetes	0.34	0.39	0.34	0.27
Hospice Care	0.00	0.00	0.51	0.53
Childhood Immunizations	0.11	0.37	0.61	0.64
Colorectal Cancer Screening	0.58	0.40	0.34	0.23
Hospitalization and Anesthesia for Dental Procedures	0.00	0.01	0.06	0.04
Treatment of Morbid Obesity *	--	--	1.52	1.88
Infant Hearing Screening and Related Diagnostics	0.03	0.07	0.08	0.09
Lymphedema	0.15	0.11	0.11	0.12
Prosthetic Devices and Components *	0.00	0.00	0.09	0.09
Telemedicine Services	1.96	2.25	1.40	1.18
Autism Spectrum Disorder	--	--	0.47	0.26

* Denotes mandated offer of coverage
-- Benefit not mandated

TABLE 18

CLAIM EXPERIENCE SUMMARY
Average Percent of Total Claims

	Individual	Group
Mammograms	0.43%	0.24%
Bones and Joints	0.08	0.19
Pap Smears	0.35	0.20
Postpartum Services	0.03	0.02
Hemophilia and Congenital Bleeding Disorders	0.17	0.16
Reconstructive Breast Surgery	0.10	0.07
Early Intervention Services	0.11	0.48
PSA Testing	0.06	0.03
Biologically Based Mental Illness	--	0.39
Clinical Trials for Treatment Studies on Cancer	0.00	0.07
Minimum Hospital Stay for Hysterectomy	0.17	0.10
Diabetes	0.33	0.17
Hospice Care	0.00	0.02
Childhood Immunizations	0.49	0.50
Colorectal Cancer Screening	0.78	0.57
Hospitalization and Anesthesia for Dental Procedures	0.00	0.03
Treatment of Morbid Obesity *	--	0.00
Infant Hearing Screening and Related Diagnostics	0.03	0.04
Lymphedema	0.03	0.06
Prosthetic Devices and Components *	0.00	0.00
Telemedicine Services	4.20	5.99
Autism Spectrum Disorder	--	0.04

* Denotes mandated offer of coverage
-- Benefit not mandated

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.

Document No.	Date Issued	Reporting Period
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
2015, RD337	2015	Calendar year 2014