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COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION

October 31, 2018

The Honorable Ralph S. Northam
Governor of Virginia

The General Assembly of Virginia

Dear Governor Northam and Members of the General Assembly:

Section 38.2-3419.1 of the Code of Virginia requires the State Corporation Commission ("Commission") to consolidate 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 2016/2017 reporting period.

Respectfully submitted,

Mark C. Christie
Chairman

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: 2016/2017 Reporting Period

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRIGNIA
RICHMOND

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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, no less often than biennially, 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 14VAC5-190-10 *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.

In Case No. INS-2016-00223, the Commission amended the Rules to streamline the data reporting process. In doing so, the reporting period was changed to every other year, with each year in the period reported separately. The first data reports were due May 1, 2018, covering calendar years 2016 and 2017. In addition, the basis for reporting was changed from annual written premiums to covered lives to further streamline reporting. Pursuant to this change, any health insurance issuer reporting greater than 5,000 covered lives in Virginia to the National Association of Insurance Commissioners for certain lines of comprehensive health coverage must file the cost and utilization data reports on mandated benefits and providers for each year exceeding the threshold. The subject lines are individual comprehensive health coverage, small group employer comprehensive coverage, and large group employer comprehensive coverage.

The Commission is required to submit its report to the Governor and the General Assembly by October 31 of each year in which reports are due. This report provides information relating to the 2016/2017 reporting period. Previous reports are listed in Appendix A.

Pursuant to the streamlined reporting thresholds, 17 of the 763 companies licensed to issue accident and sickness or subscription contracts in Virginia or licensed as HMOs in Virginia during the reporting period met the reporting threshold for 2016, while 16 met the reporting threshold for 2017. All required companies submitted completed reports for the required periods. For the purposes of streamlined reporting, the data from each reporting year was aggregated into one combined reporting period, 2016/2017, and not displayed separately.

Information presented in this report reflects data provided by 8 insurers for 2016 and 2017 and data provided by 9 HMOs for 2016 and 8 HMOs for 2017.

HMOs and health services plans are not subject to all of the mandated benefit requirements of Title 38.2 of the Code of Virginia; however, the data provided by HMOs and health services plans has been included in the data provided by insurers for the purposes of reporting claims costs and utilization as well as premium impact summaries.

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 - 10th Revision - (ICD-10-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. As a result, insurers were requested to report mandated benefits and utilization for the 9-month period of January 1, 2015, through September 30, 2015, for benefits coded utilizing the ICD-9.

The Bureau of Insurance provided an ICD-9 to ICD-10 crosswalk for the purposes of the 2016/2017 reporting period. Because of the significant differences between the two coding systems, the data reported in this report will not be compared to any data from prior reports. For example, ICD-9 code V70.5 was used to identify Health Examination of Defined Subpopulations, Children. The equivalent ICD-10 code changed to Z021 - Encounter for Pre-Employment Examination, Z023 – Encounter for Examination for Recruitment to Armed Forces, or Z0289 – Encounter for Other Administrative Examinations. Only Z0289 would be considered the reporting code for Child Health Supervision Services. Furthermore, it is apparent from analysis of the changes in ICD coding that insurers are less able to identify for the purposes of this report those claims falling under the mandated benefits and provider reporting requirements. The Bureau is monitoring insurers' compliance with the reporting instructions and will identify potential ICD coding issues in order to amend the instructions to address identified issues for future reports.

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. The following chart represents, on an aggregate basis, the average claim cost per individual contract or group certificate and the average percentage of total claims that this cost represents 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
$747.00	14.03%	$1,237.95	17.04%

This chart illustrates that, 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 $747 was paid for claims attributable to mandated benefits, offers and providers during the 2016/2017 biennium. This represents approximately 14% of all claim payments made under this type of individual contract. Likewise, during the 2016/2017 biennium, approximately $1,238 was paid in claims payments under a group certificate providing applicable contracts or certificates in Virginia.

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.[1] 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 2016/2017 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, health services plan, or HMO 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.

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1 Generally, a “mandated benefit” refers to a benefit or provision that an insurance company is required to include in all accident and sickness insurance contracts and certificates to which the mandate applies (for example, coverage for newborn children). The term mandated offer generally refers to a benefit or provision that an insurance company must make available to anyone purchasing an accident and sickness insurance contract or certificate to which the mandate applies (for example, child health supervision services).

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 individual and group health insurance coverage as defined in § 38.2-3431 to provide mental health and substance use disorder benefits in parity with medical and surgical benefits. Any small group grandfathered plan defined in § 38.2-3438 shall continue to provide such benefits in parity or as follows:

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.

Outpatient 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. For visits in which all covered expenses apply to the deductible, such visits shall not count towards the outpatient maximum.

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.

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 (i) coincident with or following a mastectomy, or (ii) 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 ten.

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	0.14%
Mental Health Services - Inpatient	0.82
Mental Health Services - Partial Hospitalization	0.02
Mental Health Services - Outpatient	1.06
Substance Abuse Services - Inpatient	0.59
Substance Abuse Services - Partial Hospitalization	0.02
Substance Abuse Services - Outpatient	0.42
Postpartum Services	0.37
Pap Smears	0.23
Pregnancy from Rape or Incest	0.05
Bones and Joints	0.16
Mammograms	0.48
Child Health Supervision Services *	0.23
Reconstructive Breast Surgery	0.16
Hemophilia and Congenital Bleeding Disorders	0.61
Early Intervention Services	0.90
PSA Testing	0.10
Clinical Trials for Treatment Studies on Cancer	0.07
Minimum Hospital Stay for Hysterectomy	0.05
Diabetes	0.39
Hospice Care	0.01
Childhood Immunizations	0.81
Colorectal Cancer Screening	0.72
Hospitalization and Anesthesia for Dental Procedures	0.13
Infant Hearing Screening and Related Diagnostics	0.05
Lymphedema	0.07
Prosthetic Devices and Components *	0.32
Telemedicine Services	2.13
Chiropractor	0.21%
Optometrist	0.36
Optician	0.11
Psychologist	0.36
Clinical Social Worker	0.07
Podiatrist	0.23
Professional Counselor	0.17
Physical Therapist	0.66
Clinical Nurse Specialist	0.04
Audiologist	0.04
Speech Pathologist	0.03
Certified Nurse Midwife	0.06
Licensed Acupuncturist	0.01
Marriage and Family Therapist	0.01

* Denotes mandated offer of coverage

TABLE 2

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS – FAMILY COVERAGE

Mandate Category	Percent of Overall Average Premium
Dependent Children	0.08%
Doctor to Include Dentist	0.13
Newborn Children	0.88
Mental Health Services - Inpatient	0.71
Mental Health Services - Partial Hospitalization	0.01
Mental Health Services - Outpatient	0.97
Substance Abuse Services - Inpatient	0.39
Substance Abuse Services - Partial Hospitalization	0.01
Substance Abuse Services - Outpatient	0.31
Postpartum Services	0.38
Pap Smears	0.27
Pregnancy from Rape or Incest	0.03
Bones and Joints	0.25
Mammograms	0.63
Child Health Supervision Services *	0.54
Reconstructive Breast Surgery	0.15
Hemophilia and Congenital Bleeding Disorders	0.36
Early Intervention Services	0.81
PSA Testing	0.09
Clinical Trials for Treatment Studies on Cancer	0.06
Minimum Hospital Stay for Hysterectomy	0.06
Diabetes	0.61
Hospice Care	0.01
Childhood Immunizations	1.16
Colorectal Cancer Screening	0.88
Hospitalization and Anesthesia for Dental Procedures	0.11
Infant Hearing Screening and Related Diagnostics	0.08
Lymphedema	0.08
Prosthetic Devices and Components *	0.39
Telemedicine Services	1.37
Chiropractor	0.26%
Optometrist	0.32
Optician	0.09
Psychologist	0.33
Clinical Social Worker	0.11
Podiatrist	0.26
Professional Counselor	0.17
Physical Therapist	0.69
Clinical Nurse Specialist	0.05
Audiologist	0.04
Speech Pathologist	0.03
Certified Nurse Midwife	0.06
Licensed Acupuncturist	0.01
Marriage and Family Therapist	0.01

* 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	0.43%
Mental Health Services - Inpatient	0.47
Mental Health Services - Partial Hospitalization	0.01
Mental Health Services - Outpatient	0.73
Substance Abuse Services - Inpatient	0.15
Substance Abuse Services - Partial Hospitalization	0.01
Substance Abuse Services - Outpatient	0.11
Postpartum Services	0.27
Pap Smears	0.18
Obstetrical Services - Normal *	1.51
Obstetrical Services - All Other *	1.33
Pregnancy from Rape or Incest	0.00
Bones and Joints	1.22
Mammograms	0.44
Child Health Supervision Services *	0.65
Reconstructive Breast Surgery	0.15
Hemophilia and Congenital Bleeding Disorders	0.67
Early Intervention Services	0.68
PSA Testing	0.05
Clinical Trials for Treatment Studies on Cancer	0.18
Minimum Hospital Stay for Hysterectomy	0.13
Diabetes	0.51
Hospice Care	0.04
Childhood Immunizations	1.06
Colorectal Cancer Screening	0.44
Hospitalization and Anesthesia for Dental Procedures	0.03
Treatment of Morbid Obesity *	0.87
Infant Hearing Screening and Related Diagnostics	0.06
Lymphedema	0.06
Prosthetic Devices and Components *	0.01
Telemedicine Services	1.94
Autism Spectrum Disorder	0.11
Chiropractor	0.37%
Optometrist	0.15
Optician	0.04
Psychologist	0.26
Clinical Social Worker	0.11
Podiatrist	0.22
Professional Counselor	0.17
Physical Therapist	0.84
Clinical Nurse Specialist	0.02
Audiologist	0.05
Speech Pathologist	0.03
Certified Nurse Midwife	0.09
Licensed Acupuncturist	0.05
Marriage and Family Therapist	0.01

* Denotes mandated offer of coverage

TABLE 4

PREMIUM IMPACT ON GROUP CERTIFICATES – FAMILY COVERAGE

Mandate Category	Percent of Overall Average Premium
Dependent Children	0.15%
Doctor to Include Dentist	0.42
Newborn Children	1.82
Mental Health Services - Inpatient	0.53
Mental Health Services - Partial Hospitalization	0.01
Mental Health Services - Outpatient	0.75
Substance Abuse Services - Inpatient	0.15
Substance Abuse Services - Partial Hospitalization	0.01
Substance Abuse Services - Outpatient	0.11
Postpartum Services	0.28
Pap Smears	0.14
Obstetrical Services - Normal *	1.63
Obstetrical Services - All Other *	1.56
Pregnancy from Rape or Incest	0.00
Bones and Joints	1.24
Mammograms	0.41
Child Health Supervision Services *	0.87
Reconstructive Breast Surgery	0.15
Hemophilia and Congenital Bleeding Disorders	0.81
Early Intervention Services	0.69
PSA Testing	0.05
Clinical Trials for Treatment Studies on Cancer	0.17
Minimum Hospital Stay for Hysterectomy	0.13
Diabetes	0.42
Hospice Care	0.04
Childhood Immunizations	1.06
Colorectal Cancer Screening	0.44
Hospitalization and Anesthesia for Dental Procedures	0.03
Treatment of Morbid Obesity *	0.90
Infant Hearing Screening and Related Diagnostics	0.07
Lymphedema	0.05
Prosthetic Devices and Components *	0.02
Telemedicine Services	1.86
Autism Spectrum Disorder	0.13
Chiropractor	0.38%
Optometrist	0.14
Optician	0.04
Psychologist	0.25
Clinical Social Worker	0.13
Podiatrist	0.23
Professional Counselor	0.17
Physical Therapist	0.83
Clinical Nurse Specialist	0.03
Audiologist	0.05
Speech Pathologist	0.04
Certified Nurse Midwife	0.10
Licensed Acupuncturist	0.05
Marriage and Family Therapist	0.01

* Denotes mandated offer of coverage

Financial Impact

To assess the impact of mandated benefits, offers and providers on claim payments made by insurers, health services plans, and HMOs 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, health services plans, and HMOs. 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
$747.00	14.03%	$1,237.95	17.04%

TABLE 5

CLAIM EXPERIENCE – INDIVIDUAL CONTRACTS

Mandate Category	Average Claim Cost per Contract	Average Percent of Total Claims
Dependent Children	$ 0.50	0.01%
Doctor to Include Dentist	7.19	0.15
Newborn Children	21.73	0.44
Mental Health Services - Inpatient	32.47	0.66
Mental Health Services - Partial Hospitalization	0.17	0.00
Mental Health Services – Outpatient	67.90	1.38
Substance Abuse Services – Inpatient	27.76	0.56
Substance Abuse Services - Partial Hospitalization	0.08	0.00
Substance Abuse Services - Outpatient	21.17	0.43
Postpartum Services	16.69	0.34
Pap Smears	8.32	0.17
Pregnancy from Rape or Incest	0.01	0.00
Bones and Joints	10.71	0.22
Mammograms	36.24	0.74
Child Health Supervision Services *	9.24	0.19
Reconstructive Breast Surgery	5.61	0.11
Hemophilia and Congenital Bleeding Disorders	21.31	0.43
Early Intervention Services	4.61	0.09
PSA Testing	1.69	0.03
Clinical Trials for Treatment Studies on Cancer	2.48	0.05
Minimum Hospital Stay for Hysterectomy	3.26	0.07
Diabetes	19.86	0.40
Hospice Care	1.00	0.02
Childhood Immunizations	43.47	0.88
Colorectal Cancer Screening	55.00	1.12
Hospitalization and Anesthesia for Dental Procedures	0.47	0.01
Infant Hearing Screening and Related Diagnostics	1.83	0.04
Lymphedema	2.64	0.05
Prosthetic Devices and Components *	0.04	0.00
Telemedicine Services	179.72	3.65
Chiropractor	$ 9.65	0.12%
Optometrist	27.71	0.34
Optician	3.21	0.04
Psychologist	7.73	0.10
Clinical Social Worker	5.79	0.07
Podiatrist	18.12	0.22
Professional Counselor	9.18	0.11
Physical Therapist	52.03	0.64
Clinical Nurse Specialist	6.49	0.08
Audiologist	1.89	0.02
Speech Pathologist	0.50	0.01
Certified Nurse Midwife	1.20	0.01
Licensed Acupuncturist	0.23	0.00
Marriage and Family Therapist	0.09	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	$ 9.29	0.13%
Doctor to Include Dentist	11.74	0.16
Newborn Children	75.16	1.05
Mental Health Services - Inpatient	48.67	0.68
Mental Health Services - Partial Hospitalization	0.29	0.00
Mental Health Services - Outpatient	77.52	1.09
Substance Abuse Services - Inpatient	21.77	0.30
Substance Abuse Services - Partial Hospitalization	0.53	0.01
Substance Abuse Services - Outpatient	14.96	0.21
Postpartum Services	3.50	0.05
Pap Smears	18.01	0.25
Obstetrical Services - Normal *	31.14	0.44
Obstetrical Services - All Other *	151.84	2.13
Pregnancy from Rape or Incest	0.04	0.00
Bones and Joints	20.40	0.29
Mammograms	47.56	0.67
Child Health Supervision Services *	30.17	0.42
Reconstructive Breast Surgery	9.59	0.13
Hemophilia and Congenital Bleeding Disorders	62.85	0.88
Early Intervention Services	15.26	0.21
PSA Testing	2.02	0.03
Clinical Trials for Treatment Studies on Cancer	2.78	0.04
Minimum Hospital Stay for Hysterectomy	5.31	0.07
Diabetes	44.32	0.62
Hospice Care	3.97	0.06
Childhood Immunizations	82.34	1.15
Colorectal Cancer Screening	73.41	1.03
Hospitalization and Anesthesia for Dental Procedures	0.58	0.01
Treatment of Morbid Obesity *	0.15	0.00
Infant Hearing Screening and Related Diagnostics	5.58	0.08
Lymphedema	4.97	0.07
Prosthetic Devices and Components *	0.44	0.01
Telemedicine Services	186.65	2.61
Autism Spectrum Disorder	20.74	0.29
Chiropractor	$ 36.99	0.45%
Optometrist	32.87	0.40
Optician	0.41	0.01
Psychologist	24.87	0.30
Clinical Social Worker	35.58	0.42
Podiatrist	32.29	0.39
Professional Counselor	19.41	0.23
Physical Therapist	96.08	1.16
Clinical Nurse Specialist	15.41	0.19
Audiologist	4.38	0.05
Speech Pathologist	2.78	0.03
Certified Nurse Midwife	6.52	0.08
Licensed Acupuncturist	1.25	0.01
Marriage and Family Therapist	0.42	0.01

* 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 (the number of provider and physician visits) per certificate for each benefit, and the average number of days (number of inpatient or partial hospital 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	0.04	0.01
Doctor to Include Dentist	0.04	0.00
Newborn Children	0.07	0.15
Mental Health Services - Inpatient	0.09	0.11
Mental Health Services - Partial Hospitalization	0.00	0.00
Mental Health Services - Outpatient	0.70	0.00
Substance Abuse Services - Inpatient	0.01	0.05
Substance Abuse Services - Partial Hospitalization	0.00	0.00
Substance Abuse Services - Outpatient	0.09	- . -
Postpartum Services	0.02	0.00
Pap Smears	0.25	0.00
Obstetrical Services - Normal *	0.10	0.00
Obstetrical Services - All Other *	0.22	0.12
Pregnancy from Rape or Incest	0.00	0.00
Bones and Joints	0.19	0.02
Mammograms	0.29	0.00
Child Health Supervision Services *	0.23	0.00
Reconstructive Breast Surgery	0.01	0.00
Hemophilia and Congenital Bleeding Disorders	0.15	0.09
Early Intervention Services	0.21	0.00
PSA Testing	0.10	0.00
Clinical Trials for Treatment Studies on Cancer	0.00	0.00
Minimum Hospital Stay for Hysterectomy	0.00	0.00
Diabetes	0.50	0.00
Hospice Care	0.00	0.04
Childhood Immunizations	1.18	0.02
Colorectal Cancer Screening	0.19	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	0.08	0.00
Lymphedema	0.06	0.00
Prosthetic Devices and Components *	0.00	0.00
Telemedicine Services	2.02	0.00
Autism Spectrum Disorder	0.65	0.01

* Denotes mandated offer of coverage

TABLE 8

UTILIZATION OF SERVICES - GROUP COVERAGE

Provider Category	Average Visits per Certificate
Chiropractor	0.74
Optometrist	0.22
Optician	0.00
Psychologist	0.15
Clinical Social Worker	0.29
Podiatrist	0.18
Professional Counselor	0.16
Physical Therapist	0.97
Clinical Nurse Specialist	0.07
Audiologist	0.02
Speech Pathologist	0.02
Certified Nurse Midwife	0.04
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	$37.21
Professional Counselor	37.66
Psychologist	53.45
Clinical Social Worker	35.54
Marriage and Family Therapist	31.81
Physician	$35.07
Psychiatrist	86.70

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
Clinical Nurse Specialist	$20.58
Professional Counselor	17.41
Psychologist	20.82
Clinical Social Worker	17.97
Marriage and Family Therapist	26.89
Physician	14.75
Psychiatrist	35.32

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	$17.08
Physical Therapist	37.89
Podiatrist	20.98
Speech Pathologist	28.97
Physician	31.71

TABLE 12

PHYSICAL MEDICINE TREATMENT, MASSAGE

Provider Category	Average Claim Cost Per Visit
Chiropractor	$24.03
Physical Therapist	10.75
Podiatrist	10.52
Physician	35.32

TABLE 13

PHYSICAL MEDICINE TREATMENT, ULTRASOUND

Provider Category	Average Claim Cost Per Visit
Chiropractor	$6.46
Physical Therapist	10.89
Podiatrist	7.50
Physician	8.43

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	$47.94
Speech Pathologist	53.00
Audiologist	51.68
Physician	98.52

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	$32.64
Physical Therapist	138.26
Podiatrist	81.41
Psychologist	44.55
Clinical Social Worker	33.39
Certified Nurse Midwife	61.47
Psychiatrist	68.50
Professional Counselor	94.99
Physician	72.61
Psychiatrist	68.50

Table 16 shows the average claim cost per visit for the excision of an ingrown toenail.

TABLE 16

EXCISION OF INGROWN TOENAIL

Provider Category	Average Claim Cost Per Visit
Podiatrist	$190.24
Physician	124.34

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 prior reports, the premium impact summaries were provided separately for HMOs. However, the BOI has discontinued this practice given the changes in the past decade regarding the provision and pricing of health plan coverage regardless of whether the provision is by an insurer or health services plan or by an HMO. The BOI does not distinguish by type of carrier in submission requirements related to rate filings that support health insurance coverage nor does the NAIC have a separate Health Care Insurance Exhibit for HMOs.

CONCLUSION

Historically, Virginia's mandated benefit and provider requirements have varied greatly in their impact on health insurance premiums. This continues to be demonstrated in the 2016/2017 reporting period data. The data presented in **Tables 1, 2, 3, and 4** continues to show that the costs attributable to these mandated benefits and providers represent demonstrable added amounts to the premium dollars charged for both individual and group business. Past and current ratemaking rules have and continue to allow these costs to be included in the premiums charged to Virginians. Also, as observed in prior reports, there continues to be a variation between the overall ratio of utilization of services and providers to the corresponding claim costs attributable to these services and providers in the 2016/2017 period.

The Commission will continue to monitor changes to the coding systems used by most hospitals, health care providers, and companies with the goal of enabling comparisons of the premium and utilization data reported by the companies from one biennial reporting period to the next. Barring changes to the coding systems like the changes from ICD-9 to ICD-10, the Commission anticipates providing additional analysis of changes over time in its next biennial report, to be issued in October 2020.

APPENDIX A – LIST OF MANDATED BENEFITS REPORTS

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
2016, RD417	2016	Calendar year 2015