

REPORT OF THE
STATE CORPORATION COMMISSION ON

**Cost and Utilization of Mandated Health
Insurance Benefits and Providers Pursuant
to Section 38.2-3419.1 of the Code of
Virginia: 2020 and 2021 Reporting Period**

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA



COMMONWEALTH OF VIRGINIA
RICHMOND

OCTOBER 31, 2022

COMMONWEALTH OF VIRGINIA

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October 31, 2022

Transmitted via Email

The Honorable Glenn Youngkin
Governor
Commonwealth of Virginia

Members of the Virginia General Assembly

Dear Governor Youngkin and Members of the Virginia General Assembly:

Section [38.2-3419.1](#) of the Code of Virginia requires every insurer, health services plan, and health maintenance organization from which a report is deemed necessary under regulations adopted by the State Corporation 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. This report to the Governor and the General Assembly provides this information for the 2020 and 2021 reporting period.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Scott A. White', written over a horizontal line.

Scott A. White
Commissioner of Insurance

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EXECUTIVE SUMMARY

Section [38.2-3419.1](#) of the Code of Virginia (Code) 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 cost and utilization information to the Commission 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. The reporting period shall be not less often than biennially, and the reports shall be submitted no later than the next May 1 following the reporting period. The Commission's *Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers* (Rules) at 14 VAC5-190-10 *et seq.* of the Virginia Administrative Code 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. 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 these plans and policies are generally not subject to Virginia's mandated benefit and mandated provider requirements.

This report includes summaries of each of Virginia's mandated benefit and provider requirements, 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 Annual Claim Cost Per Contract	Average Annual Percent of Total Claims	Average Annual Claim Cost Per Certificate	Average Annual Percent of Total Claims
\$703.21	8.98%	\$1,356.56	16.03%

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 \$703 was paid annually for claims attributable to mandated benefits, offers and providers during the 2020/2021 biennium. This represents approximately 9% annually of all claim payments made under this type of individual contract. Likewise, during the 2020/2021 biennium, approximately \$1,357 was paid in claims payments under a group certificate providing applicable contracts or certificates in Virginia,

representing approximately 16% of all claim payments made under this type of group contract.

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 2020/2021 reporting period. Previous reports are listed in Appendix A.

This report covers the period of the COVID-19 pandemic. As such, reported data may vary from that seen in the Commission's previous reports due to the impact of the virus on the utilization of health care from March of 2020 through year-end 2021.

Pursuant to the streamlined reporting thresholds, 16 of the 812 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 2020 and 2021. 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 and not displayed separately.

Information presented in this report reflects data provided by eight HMOs. HMOs and health services plans are not subject to all the mandated benefit requirements of Title 38.2 of the Code; 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 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, Office Edition (CPT-Plus procedure codes) and the International Classification of Diseases - 10th Revision - (ICD-10-CM diagnosis codes).

The Bureau of Insurance (Bureau) again provided an ICD-9 to ICD-10 crosswalk for the purposes of the 2020/2021 reporting period. As noted in the 2018 report, *RD408 – The Financial Impact of Mandate Health Insurance Benefits and Providers Pursuant to Section 38.2-3419: 2016/2017 Reporting Period*, changes in ICD coding continue to impact the ability of insurers to identify for the purposes of this report those claims falling under the mandated benefits and provider reporting requirements. The Bureau continues to monitor insurers' compliance with the reporting instructions. However, identification of potential ICD coding issues remains difficult due to changing coding services and the systems utilized by providers to submit claims. The Bureau will continue to review any identified coding issues in order to amend the instructions for future reports.

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.

COVERAGE SUMMARIES

The following sections contain summary descriptions of the mandated benefits, offers and provider requirements for which companies must provide claim and premium information. These summaries are included only to provide an overview of the required coverages applicable to the 2020/2021 reporting period.

MANDATED BENEFITS AND MANDATED OFFERS

Dependent Children

Section 38.2-3409 of the Code requires that accident and sickness insurance policies and subscription contracts that contain the provision that coverage for a dependent child shall terminate upon that child's attainment of a specified age must continue coverage for the dependent child beyond that specified age for as long as the child is incapable of self-sustaining employment, and the individual with intellectual disability or physical handicap is chiefly dependent upon the policyholder for support and maintenance. Insurers and health services plans are permitted to charge an additional premium for the continuation of coverage based on the class of risks applicable to the child.

"Doctor" to Include Dentist

Section 38.2-3410 of the Code requires that the terms "physician" and "doctor" be construed to include a dentist performing covered services within the scope of his/her professional license when used in any accident and sickness insurance policy or subscription contract. This provision is not intended to apply to routine dental services.

Newborn Children

Section 38.2-3411 of the Code 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.

Child Health Supervision Services

Section 38.2-3411.1 of the Code 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.

Coverage for Childhood Immunizations

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

Coverage for Infant Hearing Screening and Related Diagnostics

Section 38.2-3411.4 of the Code 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.

Mental Health and Substance Abuse Services

Section 38.2-3412.1 of the Code requires individual and group health insurance coverage as defined in § 38.2-3431 of the Code 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 of the Code 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%;
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; and
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 of the Code requires each insurer and health services plan to provide, as an option, coverage for inpatient obstetrical services to group policyholders or contract holders. The coverage cannot be more restrictive than that provided for the treatment of physical illness generally.

Obstetrical Benefits - Coverage for Postpartum Services

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

Coverage for Victims of Rape or Incest

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

Mammograms

Section 38.2-3418.1 of the Code 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 of the Code requires that insurers, health services plans, and HMOs provide coverage for annual pap smears, including annual testing performed by any FDA-approved gynecological cytology screening technologies.

Procedures Involving Bones and Joints

Section 38.2-3418.2 of the Code prohibits insurers, health services plans, and HMOs from excluding coverage or imposing restrictive limits for diagnostic or surgical treatment involving any bone or joint of the head, neck, face or jaw on policies providing coverage for this treatment for any bone or joint of the skeletal structure.

Hemophilia and Congenital Bleeding Disorders

Section 38.2-3418.3 of the Code requires that insurers, health services plans, and HMOs provide coverage for hemophilia and congenital bleeding disorders. Coverage shall provide for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

Reconstructive Breast Surgery

Section 38.2-3418.4 of the Code requires that insurers, health services plans, and HMOs provide coverage for reconstructive breast surgery. The statute defines reconstructive breast surgery as surgery performed coincident with or following a mastectomy or following a mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery shall also include coverage for prostheses, and physical complications of mastectomy, including medically necessary treatment of lymphedemas. The reimbursement for reconstructive breast surgery shall have durational limits, dollar limits, deductibles, and coinsurance factors that are no less favorable than for physical illness generally. Coverage shall be provided in a manner determined in consultation with the attending physician and the patient.

Early Intervention Services

Section 38.2-3418.5 of the Code requires that insurers, health services plans, and HMOs provide coverage for early intervention services. Early intervention services is defined as medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services, and devices for dependents from birth to age 3 who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Act (20 U.S.C. § 1471 et seq.).

PSA Testing

Section 38.2-3418.7 of the Code 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.

Coverage for Colorectal Cancer Screening

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

Clinical Trials for Treatment Studies on Cancer

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

Minimum Hospital Stay for Hysterectomy

Section 38.2-3418.9 of the Code requires that insurers, health services plans, and HMOs provide coverage for a minimum stay in the hospital of not less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. The attending physician, in consultation with the patient, may determine that a shorter period of hospital stay is appropriate.

Coverage for Diabetes

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

Coverage for Hospice Care

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

Coverage for Hospitalization and Anesthesia for Dental Procedures

Section 38.2-3418.12 of the Code 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 requires that insurers, health services plans, and HMOs in the large group market offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

Coverage for Lymphedema

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

Coverage for Prosthetic Devices and Components

Section 38.2-3418.15 of the Code 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 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 requires that insurers, health services plans, and HMOs issuing group contracts or subscription contracts provide coverage for the diagnosis of autism spectrum disorder and for the treatment of autism spectrum disorder in individuals.

MANDATED PROVIDER CATEGORIES

Sections 38.2-3408 and 38.2-4221 of the Code provide that if an accident and sickness insurance policy or subscription contract provides reimbursement for any service that may be legally performed by a person licensed in this Commonwealth as a chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist, speech pathologist, certified nurse midwife or other nurse practitioner, 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.

IMPACT OF COVID-19

The reports received for the period 2020/2021 cover the period of the COVID-19 pandemic. As such, reported data may vary from that seen in the Commission's previous reports due to the impact of the virus on the utilization of health care from March of 2020 through year-end 2021.

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

<u>PREMIUM IMPACT ON INDIVIDUAL CONTRACTS – SINGLE COVERAGE</u>	
<u>Mandate Category</u>	<u>Percent of Overall Average Premium</u>
Doctor to Include Dentist	0.15%
Mental Health Services - Inpatient	0.73
Mental Health Services - Partial Hospitalization	0.01
Mental Health Services - Outpatient	0.85
Substance Abuse Services - Inpatient	0.91
Substance Abuse Services - Partial Hospitalization	0.01
Substance Abuse Services - Outpatient	0.85
Postpartum Services	0.26
Pap Smears	0.13
Pregnancy from Rape or Incest	0.00
Bones and Joints	0.21
Mammograms	0.31
Child Health Supervision Services *	0.07
Reconstructive Breast Surgery	0.17
Hemophilia and Congenital Bleeding Disorders	2.32
Early Intervention Services	0.23
PSA Testing	0.05
Clinical Trials for Treatment Studies on Cancer	0.05
Minimum Hospital Stay for Hysterectomy	0.03
Diabetes	0.46
Hospice Care	0.01
Childhood Immunizations	0.27
Colorectal Cancer Screening	0.65
Hospitalization and Anesthesia for Dental Procedures	0.01
Infant Hearing Screening and Related Diagnostics	0.02
Lymphedema	0.09
Prosthetic Devices and Components *	0.01
Telemedicine Services	2.76
Chiropractor	0.09%
Optometrist	0.38
Optician	0.05
Psychologist	0.19
Clinical Social Worker	0.05
Podiatrist	0.16
Professional Counselor	0.13
Physical Therapist	0.35
Clinical Nurse Specialist	0.76
Audiologist	0.04
Speech Pathologist	0.01
Certified Nurse Midwife	0.01
Licensed Acupuncturist	0.01
Marriage and Family Therapist	0.00
* Denotes mandated offer of coverage	

TABLE 2

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS – FAMILY COVERAGE

<u>Mandate Category</u>	<u>Percent of Overall Average Premium</u>
Dependent Children	0.30%
Doctor to Include Dentist	0.11
Newborn Children	0.64
Mental Health Services - Inpatient	0.38
Mental Health Services - Partial Hospitalization	0.00
Mental Health Services - Outpatient	1.20
Substance Abuse Services - Inpatient	0.58
Substance Abuse Services - Partial Hospitalization	0.00
Substance Abuse Services - Outpatient	0.38
Postpartum Services	0.23
Pap Smears	0.25
Pregnancy from Rape or Incest	0.00
Bones and Joints	0.66
Mammograms	0.49
Child Health Supervision Services *	0.34
Reconstructive Breast Surgery	0.15
Hemophilia and Congenital Bleeding Disorders	2.46
Early Intervention Services	0.42
PSA Testing	0.05
Clinical Trials for Treatment Studies on Cancer	0.04
Minimum Hospital Stay for Hysterectomy	0.07
Diabetes	0.90
Hospice Care	0.00
Childhood Immunizations	0.43
Colorectal Cancer Screening	0.89
Hospitalization and Anesthesia for Dental Procedures	0.01
Infant Hearing Screening and Related Diagnostics	0.05
Lymphedema	0.15
Prosthetic Devices and Components *	0.01
Telemedicine Services	3.67
Chiropractor	0.16%
Optometrist	0.42
Optician	0.05
Psychologist	0.24
Clinical Social Worker	0.05
Podiatrist	0.17
Professional Counselor	0.17
Physical Therapist	0.57
Clinical Nurse Specialist	0.53
Audiologist	0.03
Speech Pathologist	0.01
Certified Nurse Midwife	0.01
Licensed Acupuncturist	0.02
Marriage and Family Therapist	0.00

* Denotes mandated offer of coverage

TABLE 3

PREMIUM IMPACT ON GROUP CERTIFICATES – SINGLE COVERAGE

<u>Mandate Category</u>	<u>Percent of Overall Average Premium</u>
Doctor to Include Dentist	3.97%
Mental Health Services - Inpatient	0.46
Mental Health Services - Partial Hospitalization	0.02
Mental Health Services - Outpatient	1.06
Substance Abuse Services - Inpatient	0.19
Substance Abuse Services - Partial Hospitalization	0.01
Substance Abuse Services - Outpatient	0.14
Postpartum Services	0.60
Pap Smears	0.14
Obstetrical Services - Normal *	1.94
Obstetrical Services - All Other *	1.28
Pregnancy from Rape or Incest	0.00
Bones and Joints	1.50
Mammograms	0.56
Child Health Supervision Services *	0.88
Reconstructive Breast Surgery	0.24
Hemophilia and Congenital Bleeding Disorders	2.24
Early Intervention Services	0.83
PSA Testing	0.06
Clinical Trials for Treatment Studies on Cancer	0.12
Minimum Hospital Stay for Hysterectomy	0.15
Diabetes	0.57
Hospice Care	0.04
Childhood Immunizations	1.34
Colorectal Cancer Screening	0.12
Hospitalization and Anesthesia for Dental Procedures	0.02
Treatment of Morbid Obesity *	1.13
Infant Hearing Screening and Related Diagnostics	0.08
Lymphedema	0.07
Prosthetic Devices and Components *	0.16
Telemedicine Services	1.84
Autism Spectrum Disorder	0.22
Chiropractor	0.42%
Optometrist	0.18
Optician	0.12
Psychologist	0.38
Clinical Social Worker	0.16
Podiatrist	0.27
Professional Counselor	0.30
Physical Therapist	1.16
Clinical Nurse Specialist	0.10
Audiologist	0.12
Speech Pathologist	0.14
Certified Nurse Midwife	0.13
Licensed Acupuncturist	0.07
Marriage and Family Therapist	0.02

* Denotes mandated offer of coverage

TABLE 4

PREMIUM IMPACT ON GROUP CERTIFICATES – FAMILY COVERAGE

<u>Mandate Category</u>	<u>Percent of Overall Average Premium</u>
Dependent Children	0.35%
Doctor to Include Dentist	4.69
Newborn Children	0.18
Mental Health Services - Inpatient	0.43
Mental Health Services - Partial Hospitalization	0.02
Mental Health Services - Outpatient	1.02
Substance Abuse Services - Inpatient	0.15
Substance Abuse Services - Partial Hospitalization	0.01
Substance Abuse Services - Outpatient	0.14
Postpartum Services	0.58
Pap Smears	0.13
Obstetrical Services - Normal *	1.98
Obstetrical Services - All Other *	1.56
Pregnancy from Rape or Incest	0.00
Bones and Joints	1.51
Mammograms	0.50
Child Health Supervision Services *	1.09
Reconstructive Breast Surgery	0.23
Hemophilia and Congenital Bleeding Disorders	1.35
Early Intervention Services	0.86
PSA Testing	0.06
Clinical Trials for Treatment Studies on Cancer	0.12
Minimum Hospital Stay for Hysterectomy	0.15
Diabetes	0.48
Hospice Care	0.04
Childhood Immunizations	1.40
Colorectal Cancer Screening	0.46
Hospitalization and Anesthesia for Dental Procedures	0.02
Treatment of Morbid Obesity *	1.13
Infant Hearing Screening and Related Diagnostics	0.09
Lymphedema	0.07
Prosthetic Devices and Components *	0.16
Telemedicine Services	1.93
Autism Spectrum Disorder	0.25
Chiropractor	0.41%
Optometrist	0.18
Optician	0.07
Psychologist	0.37
Clinical Social Worker	0.16
Podiatrist	0.17
Professional Counselor	0.28
Physical Therapist	1.15
Clinical Nurse Specialist	0.13
Audiologist	0.08
Speech Pathologist	0.14
Certified Nurse Midwife	0.13
Licensed Acupuncturist	0.08
Marriage and Family Therapist	0.02

* 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, 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 annual 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 annual 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 annual percentage of total claims and average annual claim cost per contract or certificate for all mandated benefits, offers and providers taken collectively.

Individual		Group	
Average Annual Claim Cost Per Contract	Average Annual Percent of Total Claims	Average Annual Claim Cost Per Certificate	Average Annual Percent of Total Claims
\$703.21	8.98%	\$1,356.56	16.03%

TABLE 5

CLAIM EXPERIENCE – INDIVIDUAL CONTRACTS

<u>Mandate Category</u>	<u>Average Claim Cost per Contract</u>	<u>Average Percent of Total Claims</u>
Dependent Children	\$ 7.33	0.00%
Doctor to Include Dentist	12.37	0.09
Newborn Children	53.71	0.23
Mental Health Services - Inpatient	30.93	0.26
Mental Health Services - Partial Hospitalization	0.16	0.00
Mental Health Services – Outpatient	68.78	0.41
Substance Abuse Services – Inpatient	19.08	0.31
Substance Abuse Services - Partial Hospitalization	0.18	0.00
Substance Abuse Services - Outpatient	16.42	0.19
Postpartum Services	18.93	0.25
Pap Smears	9.17	0.12
Pregnancy from Rape or Incest	0.01	0.00
Bones and Joints	12.50	0.16
Mammograms	44.16	0.58
Child Health Supervision Services *	9.29	0.12
Reconstructive Breast Surgery	5.71	0.07
Hemophilia and Congenital Bleeding Disorders	38.83	0.51
Early Intervention Services	12.98	0.17
PSA Testing	6.77	0.09
Clinical Trials for Treatment Studies on Cancer	3.18	0.04
Minimum Hospital Stay for Hysterectomy	3.11	0.04
Diabetes	10.21	0.13
Hospice Care	1.98	0.03
Childhood Immunizations	43.21	0.57
Colorectal Cancer Screening	64.13	0.84
Hospitalization and Anesthesia for Dental Procedures	0.56	0.01
Infant Hearing Screening and Related Diagnostics	1.42	0.02
Lymphedema	3.99	0.05
Prosthetic Devices and Components *	0.99	0.01
Telemedicine Services	198.56	2.60
Chiropractor	\$ 3.35	0.04%
Optometrist	6.00	0.06
Optician	4.50	0.05
Psychologist	20.41	0.22
Clinical Social Worker	17.22	0.19
Podiatrist	6.90	0.07
Professional Counselor	6.03	0.06
Physical Therapist	28.15	0.30
Clinical Nurse Specialist	0.10	0.00
Audiologist	2.83	0.03
Speech Pathologist	0.19	0.00
Certified Nurse Midwife	1.39	0.01
Licensed Acupuncturist	0.73	0.01
Marriage and Family Therapist	0.00	0.00

* Denotes mandated offer of coverage

TABLE 6

CLAIM EXPERIENCE – GROUP CERTIFICATES

<u>Mandate Category</u>	<u>Average Claim Cost per Certificate</u>	<u>Average Percent of Total Claims</u>
Dependent Children	\$ 11.68	0.09%
Doctor to Include Dentist	11.11	0.15
Newborn Children	36.43	0.64
Mental Health Services - Inpatient	24.19	0.37
Mental Health Services - Partial Hospitalization	0.18	0.00
Mental Health Services - Outpatient	61.75	0.82
Substance Abuse Services - Inpatient	15.12	0.23
Substance Abuse Services - Partial Hospitalization	0.29	0.00
Substance Abuse Services - Outpatient	9.44	0.20
Postpartum Services	2.17	0.32
Pap Smears	12.35	0.16
Obstetrical Services - Normal *	25.69	0.31
Obstetrical Services - All Other *	206.23	2.47
Pregnancy from Rape or Incest	0.03	0.00
Bones and Joints	16.61	0.20
Mammograms	37.06	0.59
Child Health Supervision Services *	15.23	0.21
Reconstructive Breast Surgery	6.76	0.13
Hemophilia and Congenital Bleeding Disorders	26.05	0.31
Early Intervention Services	20.98	0.25
PSA Testing	3.00	0.04
Clinical Trials for Treatment Studies on Cancer	7.51	0.09
Minimum Hospital Stay for Hysterectomy	4.76	0.06
Diabetes	17.63	0.21
Hospice Care	2.56	0.03
Childhood Immunizations	60.73	0.73
Colorectal Cancer Screening	76.85	0.92
Hospitalization and Anesthesia for Dental Procedures	0.42	0.01
Treatment of Morbid Obesity *	0.18	0.00
Infant Hearing Screening and Related Diagnostics	3.06	0.04
Lymphedema	3.35	0.04
Prosthetic Devices and Components *	0.92	0.01
Telemedicine Services	340.50	4.08
Autism Spectrum Disorder	20.59	0.25
Chiropractor	\$ 14.11	0.15%
Optometrist	9.92	0.11
Optician	8.74	0.10
Psychologist	36.61	0.40
Clinical Social Worker	31.99	0.35
Podiatrist	9.65	0.11
Professional Counselor	31.37	0.34
Physical Therapist	57.42	0.63
Clinical Nurse Specialist	1.87	0.02
Audiologist	3.46	0.04
Speech Pathologist	1.03	0.01
Certified Nurse Midwife	3.29	0.04
Licensed Acupuncturist	0.87	0.01
Marriage and Family Therapist	0.61	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 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

<u>Benefit Category</u>	<u>Average Visits per Certificate</u>	<u>Average Days per Certificate</u>
Dependent Children	0.02	0.00
Doctor to Include Dentist	0.03	0.00
Newborn Children	0.08	0.01
Mental Health Services - Inpatient	0.07	0.02
Mental Health Services - Partial Hospitalization	0.00	0.00
Mental Health Services - Outpatient	0.68	0.00
Substance Abuse Services - Inpatient	0.01	0.02
Substance Abuse Services - Partial Hospitalization	0.00	0.00
Substance Abuse Services - Outpatient	0.12	0.00
Postpartum Services	0.04	0.00
Pap Smears	0.15	0.00
Obstetrical Services - Normal *	0.04	0.00
Obstetrical Services - All Other *	0.17	0.04
Pregnancy from Rape or Incest	0.00	0.00
Bones and Joints	0.13	0.00
Mammograms	0.17	0.00
Child Health Supervision Services *	0.14	0.00
Reconstructive Breast Surgery	0.00	0.00
Hemophilia and Congenital Bleeding Disorders	0.18	0.01
Early Intervention Services	0.27	0.00
PSA Testing	0.09	0.00
Clinical Trials for Treatment Studies on Cancer	0.00	0.00
Minimum Hospital Stay for Hysterectomy	0.00	0.00
Diabetes	0.15	0.00
Hospice Care	0.00	0.00
Childhood Immunizations	0.59	0.00
Colorectal Cancer Screening	0.14	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	0.05	0.00
Lymphedema	0.02	0.00
Prosthetic Devices and Components *	0.00	0.00
Telemedicine Services	3.21	0.00
Autism Spectrum Disorder	0.28	0.00

* Denotes mandated offer of coverage

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

<u>Provider Category</u>	<u>Average Visits per Certificate</u>
Chiropractor	0.53
Optometrist	0.15
Optician	0.04
Psychologist	0.29
Clinical Social Worker	0.45
Podiatrist	0.11
Professional Counselor	0.34
Physical Therapist	0.68
Clinical Nurse Specialist	0.01
Audiologist	0.04
Speech Pathologist	0.02
Certified Nurse Midwife	0.02
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	
<u>PSYCHOTHERAPY</u> <u>45 To 50 Minute Session</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Clinical Nurse Specialist	\$42.28
Professional Counselor	81.05
Psychologist	74.95
Clinical Social Worker	96.54
Marriage and Family Therapist	85.53
Physician	56.47
Psychiatrist	75.49

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

TABLE 10	
<u>GROUP PSYCHOTHERAPY</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Clinical Nurse Specialist	\$16.81
Professional Counselor	44.44
Psychologist	94.01
Clinical Social Worker	58.85
Marriage and Family Therapist	38.85
Physician	279.29
Psychiatrist	46.67

Physical Medicine Treatment

Companies are required to provide claim information for the following 3 physical medicine treatments: (i) therapeutic exercise (15 minutes); (ii) massage; and (iii) ultrasound. Tables 11, 12, and 13 illustrate the average claim cost per visit for each procedure by provider type.

TABLE 11	
<u>PHYSICAL MEDICINE TREATMENT, THERAPEUTIC EXERCISE, 15 MINUTES</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$19.43
Physical Therapist	67.34
Podiatrist	143.06
Speech Pathologist	44.88
Physician	52.41

TABLE 12	
<u>PHYSICAL MEDICINE TREATMENT, MASSAGE</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$29.67
Physical Therapist	53.99
Podiatrist	15.19
Physician	37.06

TABLE 13	
<u>PHYSICAL MEDICINE TREATMENT, ULTRASOUND</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$10.19
Physical Therapist	41.40
Podiatrist	52.63
Physician	9.94

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	
<u>SPEECH, LANGUAGE OR HEARING THERAPY</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Physical Therapist	\$52.67
Speech Pathologist	123.32
Audiologist	20.72
Physician	196.84

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	
<u>OFFICE VISIT, INTERMEDIATE SERVICE TO NEW PATIENT</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Chiropractor	\$34.93
Physical Therapist	77.69
Podiatrist	96.39
Psychologist	51.32
Clinical Social Worker	25.98
Certified Nurse Midwife	88.42
Professional Counselor	91.44
Physician	114.69
Psychiatrist	67.64

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

TABLE 16	
<u>EXCISION OF INGROWN TOENAIL</u>	
<u>Provider Category</u>	<u>Average Claim Cost Per Visit</u>
Podiatrist	\$272.58
Physician	253.24

APPENDIX A

The Commission's first annual report on the financial impact of mandated health insurance benefits and providers (1993 House Document No. 9) was issued in 1992 for the reporting period of October 1, 1991 through December 31, 1991. Subsequent House Documents and Report Documents are shown below.

<u>Document No.</u>	<u>Date Issued</u>	<u>Reporting Period</u>
1994, HD6	1993	Calendar year 1992
1995, HD3	1994	Calendar year 1993
1996, HD5	1995	Calendar year 1994
1997, HD15	1996	Calendar year 1995
1998, HD10	1997	Calendar year 1996
1999, HD6	1998	Calendar year 1997
2000, HD12	1999	Calendar year 1998
2001, HD7	2000	Calendar year 1999
2002, HD10	2001	Calendar year 2000
2003, HD8	2002	Calendar year 2001
2003, RD49	2003	Calendar year 2002
2004, RD110	2004	Calendar year 2003
2005, RD191	2005	Calendar year 2004
2006, RD289	2006	Calendar year 2005
2007, RD246	2007	Calendar year 2006
2008, RD322	2008	Calendar year 2007
2009, RD294	2009	Calendar year 2008
2010, RD300	2010	Calendar year 2009
2011, RD281	2011	Calendar year 2010
2012, RD290	2012	Calendar year 2011
2013, RD300	2013	Calendar year 2012
2014, RD335	2014	Calendar year 2013
2015, RD337	2015	Calendar year 2014
2016, RD417	2016	Calendar year 2015
2018, RD408	2018	Calendar years 2016-2017
2020, RD471	2020	Calendar years 2018-2019