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: 2022 and 2023 Reporting Period

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND

OCTOBER 31, 2024

COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219
TELEPHONE: (804) 371-9741
scc.virginia.gov

October 31, 2024

Transmitted via Email

The Honorable Glenn Youngkin
Governor, Commonwealth of Virginia

Members, Virginia General Assembly

Dear Governor Youngkin and Members of the Virginia General Assembly:

On behalf of the State Corporation Commission, the Bureau of Insurance submits this biennial report on Cost and Utilization of Mandated Health Insurance Benefits and Providers Pursuant to § 38.2-3419.1 of the Code of Virginia: 2022 and 2023 Reporting Period.

Sincerely,

Scott A. White
Commissioner of Insurance

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EXECUTIVE SUMMARY

Pursuant to § 38.2-3419.1 of the Code of Virginia (Code), every insurer, health services plan, and health maintenance organization (HMO) meeting the reporting threshold set forth in Commission regulations must submit certain 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. The Commission is required to consolidate the information into this report of the costs of mandated benefits, the utilization of services under mandated benefits, and any other information the Commission or the General Assembly deems appropriate.

The reporting period for this report is Calendar Years 2022 and 2023, with the initial report issued in 1992. It includes a summary of each mandated benefit and provider requirement in Virginia, together with information assessing 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 this cost represents across all mandated benefits, offers, and providers.

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
$723.48	8.94%	$1,402.42	15.46%

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:

- Companies paid approximately $723 annually for claims attributable to mandated benefits, offers, and providers during the Calendar Year 2022 and 2023 reporting period. This represents approximately 9% annually of all claim payments made under this type of individual contract.

- Companies paid approximately $1,402 annually 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 during the Calendar Year 2022 and 2023 reporting period.

The Bureau continues to monitor insurer compliance with the reporting instructions. However, identification of potential coding issues remains difficult due to changing coding services and the systems utilized by providers to submit claims.

INTRODUCTION

Pursuant to § 38.2-3419.1 of the Code, every insurer, health services plan, and HMO meeting the reporting threshold[1] set forth in Commission regulations is required to submit cost and utilization information to the Commission no less often than biennially 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.[2] The Commission is required to consolidate the company information into a report describing the costs of mandated benefits, the utilization of services under mandated benefits, and such other information as the Commission or the General Assembly may deem appropriate. The Commission administers the statutory reporting requirements pursuant to its *Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers*.[3]

The Commission is required to submit its report to the Governor and to the General Assembly by October 31 of each year in which reports are due. This 2024 report provides information for the Calendar Year 2022 and 2023 reporting period.[4] This has been a longstanding reporting requirement, with the first report issued in 1992. See Appendix A for the complete list of previous reports.

Because of the reporting thresholds, 16 of the 851 companies licensed to issue accident and sickness or subscription contracts in Virginia or licensed as HMOs in Virginia during the reporting period were subject to the reporting requirement for Calendar Years 2022 and 2023. All 16 companies required to submit completed reports for the reporting period did so. he data from each reporting year was aggregated into one combined reporting period and not displayed separately.

The information presented in this report reflects data provided by eight HMOs. HMOs and health services plans are not subject to all of 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. 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.

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.

METHODOLOGY

In accordance with § 38.2-3419.1 of the Code, company reports must be in such detail and form as required under the implementing rules adopted by the Commission in order to provide the information deemed necessary by the Commission to determine the financial impact of each mandated benefit and provider.

Among its provisions, these 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 used in preparing 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 Calendar Year 2022 and 2023 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.

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 to provide an overview of the required coverages applicable to the Calendar Year 2022 and 2023 reporting period.

Mandated Benefits and Mandated Offers

Dependent Children

Section 38.2-3409 of the Code requires accident and sickness insurance policies and subscription contracts to contain a provision that coverage of a dependent child shall terminate upon that child's attainment of a specified age, shall also provide in substance that attainment of the specified age shall not terminate the child's coverage during the continuance of the policy while the dependent 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 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 does not apply to routine dental services.

Newborn Children

Section 38.2-3411 of the Code requires accident and sickness insurance policies, or subscription contracts, and HMOs that provide family coverage to extend this 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 insurers, and health services plans to "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, complete physical examination, developmental assessment, as well as 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 insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to 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 these 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 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 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; be construed to include benefits for pregnancy following an act of rape of an insured or subscriber which was reported to the police within seven days following its occurrence, to the same extent as any other covered accident. The seven-day requirement is extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

Mammograms

Section 38.2-3418.1 of the Code 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. This coverage must allow for one screening mammogram for persons age 35 through 39, one biennially to persons age 40 through 49, and one annually to persons age 50 and over.

Pap Smears

Section 38.2-3418.1:2 of the Code requires insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to provide coverage for colorectal cancer screening.

Clinical Trials for Treatment Studies on Cancer

Section 38.2-3418.8 of the Code requires insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to provide coverage for hospice services.

Coverage for Hospitalization and Anesthesia for Dental Procedures

Section 38.2-3418.12 of the Code requires insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs in the large group market to offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or 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 insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs to offer and make available coverage for medically necessary prosthetic devices, and their repair, fitting, replacement, and components.

Coverage for Telemedicine Services

Section 38.2-3418.16 of the Code requires insurers, health services plans, and HMOs to 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 insurers, health services plans, and HMOs issuing group contracts or subscription contracts to provide coverage for the diagnosis of autism spectrum disorder and for the treatment of autism spectrum disorder in individuals.

Coverage for Formula and Enteral Nutrition Products as Medicine

Section 38.2-3418.18 of the code requires insurers, health services plans, and HMOs to provide coverage for medically necessary formula and enteral nutrition products as medicine and to include coverage for these products for covered individuals requiring treatment for an inherited metabolic disorder.

Mandated Provider Categories

Pursuant to §§ 38.2-3408 and 38.2-4221 of the Code, 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.

PREMIUM IMPACT

To assess the premium impact of coverage for mandated benefits, offers, and providers, the Commission requires companies to report the **total annual premium** that would be charged per unit of coverage for a standard individual health insurance contract and/or group certificate, including single and family coverage. From this, the **overall average premium** was calculated for single and family coverage for both individual contracts and group certificates.

Companies are also required to 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 claims 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** shows 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 the premium costs for individual contracts, both single and family coverages, respectively, while **Tables 3 and 4** identify the premium costs for group certificates, both single and family coverages, respectively.

TABLE 1

PREMIUM IMPACT ON INDIVIDUAL CONTRACTS – SINGLE COVERAGE

Mandate Category	Percent of Overall Average Premium
Doctor to Include Dentist	0.21%
Mental Health Services - Inpatient	1.62
Mental Health Services - Partial Hospitalization	0.01
Mental Health Services - Outpatient	1.92
Substance Abuse Services - Inpatient	0.77
Substance Abuse Services - Partial Hospitalization	0.00
Substance Abuse Services - Outpatient	0.46
Postpartum Services	0.35
Pap Smears	0.13
Pregnancy from Rape or Incest	0.00
Bones and Joints	0.38
Mammograms	0.53
Child Health Supervision Services *	0.02
Reconstructive Breast Surgery	0.19
Hemophilia and Congenital Bleeding Disorders	0.65
Early Intervention Services	0.23
PSA Testing	0.05
Clinical Trials for Treatment Studies on Cancer	0.00
Minimum Hospital Stay for Hysterectomy	0.00
Diabetes	0.47
Hospice Care	0.10
Childhood Immunizations	0.39
Colorectal Cancer Screening	1.11
Hospitalization and Anesthesia for Dental Procedures	0.01
Infant Hearing Screening and Related Diagnostics	0.01
Lymphedema	0.12
Prosthetic Devices and Components *	0.00
Telemedicine Services	3.14
Formula and Enteral Nutrition Products as Medicine	0.00
Chiropractor	0.12%
Optometrist	0.39
Optician	0.06
Psychologist	0.22
Clinical Social Worker	0.12
Podiatrist	0.16
Professional Counselor	0.40
Physical Therapist	0.48
Clinical Nurse Specialist	0.00
Audiologist	0.08
Speech Pathologist	0.03
Certified Nurse Midwife	0.03
Licensed Acupuncturist	0.03
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	0.00%
Doctor to Include Dentist	0.21
Newborn Children	1.00
Mental Health Services - Inpatient	1.47
Mental Health Services - Partial Hospitalization	0.01
Mental Health Services - Outpatient	1.97
Substance Abuse Services - Inpatient	0.62
Substance Abuse Services - Partial Hospitalization	0.00
Substance Abuse Services - Outpatient	0.34
Postpartum Services	0.30
Pap Smears	0.20
Pregnancy from Rape or Incest	0.00
Bones and Joints	0.59
Mammograms	0.58
Child Health Supervision Services *	0.16
Reconstructive Breast Surgery	0.19
Hemophilia and Congenital Bleeding Disorders	0.98
Early Intervention Services	0.41
PSA Testing	0.05
Clinical Trials for Treatment Studies on Cancer	0.00
Minimum Hospital Stay for Hysterectomy	0.00
Diabetes	0.72
Hospice Care	0.10
Childhood Immunizations	0.42
Colorectal Cancer Screening	1.40
Hospitalization and Anesthesia for Dental Procedures	0.01
Infant Hearing Screening and Related Diagnostics	0.03
Lymphedema	0.22
Prosthetic Devices and Components *	0.00
Telemedicine Services	3.91
Formula and Enteral Nutrition Products as Medicine	0.00
Chiropractor	0.16%
Optometrist	0.46
Optician	0.05
Psychologist	0.24
Clinical Social Worker	0.11
Podiatrist	0.19
Professional Counselor	0.44
Physical Therapist	0.58
Clinical Nurse Specialist	0.00
Audiologist	0.08
Speech Pathologist	0.04
Certified Nurse Midwife	0.03
Licensed Acupuncturist	0.04
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	2.94%
Mental Health Services - Inpatient	1.25
Mental Health Services - Partial Hospitalization	0.01
Mental Health Services - Outpatient	3.58
Substance Abuse Services - Inpatient	0.36
Substance Abuse Services - Partial Hospitalization	0.00
Substance Abuse Services - Outpatient	0.31
Postpartum Services	0.03
Pap Smears	0.15
Obstetrical Services - Normal *	0.43
Obstetrical Services - All Other *	0.00
Pregnancy from Rape or Incest	0.00
Bones and Joints	0.30
Mammograms	0.61
Child Health Supervision Services *	0.03
Reconstructive Breast Surgery	0.19
Hemophilia and Congenital Bleeding Disorders	0.50
Early Intervention Services	0.18
PSA Testing	0.04
Clinical Trials for Treatment Studies on Cancer	0.00
Minimum Hospital Stay for Hysterectomy	0.00
Diabetes	0.38
Hospice Care	0.10
Childhood Immunizations	0.61
Colorectal Cancer Screening	1.10
Hospitalization and Anesthesia for Dental Procedures	0.02
Treatment of Morbid Obesity *	0.11
Infant Hearing Screening and Related Diagnostics	0.02
Lymphedema	0.12
Prosthetic Devices and Components *	0.01
Telemedicine Services	2.72
Autism Spectrum Disorder	1.41
Formula and Enteral Nutrition Products as Medicine	0.00
Chiropractor	0.30%
Optometrist	0.24
Optician	0.08
Psychologist	0.53
Clinical Social Worker	0.41
Podiatrist	0.26
Professional Counselor	0.95
Physical Therapist	1.01
Clinical Nurse Specialist	0.00
Audiologist	0.05
Speech Pathologist	0.19
Certified Nurse Midwife	0.03
Licensed Acupuncturist	0.02
Marriage and Family Therapist	0.07

*Denotes mandated offer of coverage

TABLE 4

PREMIUM IMPACT ON GROUP CERTIFICATES – FAMILY COVERAGE

Mandate Category	Percent of Overall Average Premium
Dependent Children	0.00%
Doctor to Include Dentist	3.04
Newborn Children	1.59
Mental Health Services - Inpatient	1.24
Mental Health Services - Partial Hospitalization	0.01
Mental Health Services - Outpatient	3.55
Substance Abuse Services - Inpatient	0.35
Substance Abuse Services - Partial Hospitalization	0.00
Substance Abuse Services - Outpatient	0.30
Postpartum Services	0.04
Pap Smears	0.13
Obstetrical Services - Normal *	0.48
Obstetrical Services - All Other *	0.00
Pregnancy from Rape or Incest	0.00
Bones and Joints	0.32
Mammograms	0.61
Child Health Supervision Services *	0.14
Reconstructive Breast Surgery	0.19
Hemophilia and Congenital Bleeding Disorders	0.50
Early Intervention Services	0.21
PSA Testing	0.04
Clinical Trials for Treatment Studies on Cancer	0.00
Minimum Hospital Stay for Hysterectomy	0.01
Diabetes	0.41
Hospice Care	0.10
Childhood Immunizations	0.64
Colorectal Cancer Screening	1.13
Hospitalization and Anesthesia for Dental Procedures	0.02
Treatment of Morbid Obesity *	0.11
Infant Hearing Screening and Related Diagnostics	0.03
Lymphedema	0.12
Prosthetic Devices and Components *	0.01
Telemedicine Services	2.81
Autism Spectrum Disorder	1.56
Formula and Enteral Nutrition Products as Medicine	0.00
Chiropractor	0.30%
Optometrist	0.22
Optician	0.07
Psychologist	0.51
Clinical Social Worker	0.41
Podiatrist	0.15
Professional Counselor	0.92
Physical Therapist	1.00
Clinical Nurse Specialist	0.00
Audiologist	0.05
Speech Pathologist	0.20
Certified Nurse Midwife	0.03
Licensed Acupuncturist	0.02
Marriage and Family Therapist	0.07

*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 Commission computes the **average claim cost per contract or certificate** 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 Commission computes the **average percent of total claims** for a specific mandated benefit, offer and provider 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 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
$723.48	8.94%	$1,402.42	15.46%

The information presented in **Tables 5** and **6** shows the average cost of claims paid and the average 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.

TABLE 5

CLAIM EXPERIENCE – INDIVIDUAL CONTRACTS

Mandate Category	Average Claim Cost per Contract	Average Percent of Total Claims
Dependent Children	$ 0.40	0.01%
Doctor to Include Dentist	8.46	0.11
Newborn Children	22.88	0.29
Mental Health Services - Inpatient	32.88	0.42
Mental Health Services - Partial Hospitalization	3.42	0.04
Mental Health Services – Outpatient	55.70	0.72
Substance Abuse Services – Inpatient	23.18	0.30
Substance Abuse Services - Partial Hospitalization	2.29	0.03
Substance Abuse Services - Outpatient	28.80	0.37
Postpartum Services	27.26	0.35
Pap Smears	5.44	0.07
Pregnancy from Rape or Incest	0.14	0.00
Bones and Joints	11.94	0.15
Mammograms	51.30	0.66
Child Health Supervision Services *	9.45	0.12
Reconstructive Breast Surgery	5.17	0.07
Hemophilia and Congenital Bleeding Disorders	10.08	0.13
Early Intervention Services	7.17	0.09
PSA Testing	7.93	0.09
Clinical Trials for Treatment Studies on Cancer	4.66	0.06
Minimum Hospital Stay for Hysterectomy	52.53	0.68
Diabetes	11.02	0.12
Hospice Care	1.13	0.01
Childhood Immunizations	41.95	0.54
Colorectal Cancer Screening	76.68	0.99
Hospitalization and Anesthesia for Dental Procedures	0.30	0.00
Infant Hearing Screening and Related Diagnostics	1.25	0.02
Lymphedema	6.84	0.08
Prosthetic Devices and Components *	0.72	0.01
Telemedicine Services	211.46	2.39
Formula and Enteral Nutrition Products as Medicine	1.05	0.01
Chiropractor	$ 4.38	0.04%
Optometrist	94.65	0.78
Optician	5.83	0.05
Psychologist	14.88	0.12
Clinical Social Worker	7.07	0.06
Podiatrist	26.19	0.22
Professional Counselor	20.97	0.17
Physical Therapist	52.99	0.44
Clinical Nurse Specialist	0.42	0.00
Audiologist	21.66	0.18
Speech Pathologist	2.77	0.02
Certified Nurse Midwife	1.17	0.01
Licensed Acupuncturist	1.06	0.01
Marriage and Family Therapist	0.14	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	$ 6.03	0.07%
Doctor to Include Dentist	10.12	0.11
Newborn Children	54.15	0.60
Mental Health Services - Inpatient	47.89	0.53
Mental Health Services - Partial Hospitalization	0.10	0.00
Mental Health Services - Outpatient	103.96	1.15
Substance Abuse Services - Inpatient	23.63	0.26
Substance Abuse Services - Partial Hospitalization	0.02	0.00
Substance Abuse Services - Outpatient	17.02	0.19
Postpartum Services	3.13	0.03
Pap Smears	12.69	0.14
Obstetrical Services - Normal *	23.69	0.26
Obstetrical Services - All Other *	244.88	2.70
Pregnancy from Rape or Incest	0.01	0.00
Bones and Joints	18.26	0.20
Mammograms	17.66	0.43
Child Health Supervision Services *	15.66	0.17
Reconstructive Breast Surgery	8.67	0.10
Hemophilia and Congenital Bleeding Disorders	17.66	0.19
Early Intervention Services	22.17	0.24
PSA Testing	5.26	0.06
Clinical Trials for Treatment Studies on Cancer	4.93	0.05
Minimum Hospital Stay for Hysterectomy	5.56	0.06
Diabetes	19.42	0.21
Hospice Care	2.29	0.03
Childhood Immunizations	64.58	0.71
Colorectal Cancer Screening	102.77	1.13
Hospitalization and Anesthesia for Dental Procedures	0.39	0.00
Treatment of Morbid Obesity *	0.25	0.00
Infant Hearing Screening and Related Diagnostics	2.85	0.03
Lymphedema	5.12	0.06
Prosthetic Devices and Components *	1.13	0.01
Telemedicine Services	385.92	4.26
Autism Spectrum Disorder	18.19	0.20
Formula and Enteral Nutrition Products as Medicine	1.46	0.01
Chiropractor	$ 12.64	0.13%
Optometrist	36.16	0.38
Optician	2.77	0.03
Psychologist	21.79	0.23
Clinical Social Worker	48.80	0.52
Podiatrist	24.94	0.37
Professional Counselor	40.83	0.43
Physical Therapist	49.52	0.52
Clinical Nurse Specialist	34.77	0.37
Audiologist	8.99	0.10
Speech Pathologist	6.29	0.07
Certified Nurse Midwife	5.73	0.06
Licensed Acupuncturist	1.17	0.01
Marriage and Family Therapist	0.92	0.01

*Denotes mandated offer of coverage

UTILIZATION OF SERVICES

The Commission also requires companies 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	0.02	0.00
Doctor to Include Dentist	0.02	0.00
Newborn Children	0.08	0.01
Mental Health Services - Inpatient	0.14	0.03
Mental Health Services - Partial Hospitalization	0.00	0.00
Mental Health Services - Outpatient	0.88	0.00
Substance Abuse Services - Inpatient	0.01	0.02
Substance Abuse Services - Partial Hospitalization	0.00	0.00
Substance Abuse Services - Outpatient	0.13	0.00
Postpartum Services	0.03	0.00
Pap Smears	0.15	0.00
Obstetrical Services - Normal *	0.03	0.00
Obstetrical Services - All Other *	0.18	0.05
Pregnancy from Rape or Incest	0.00	0.00
Bones and Joints	0.15	0.00
Mammograms	0.18	0.00
Child Health Supervision Services *	0.14	0.00
Reconstructive Breast Surgery	0.00	0.00
Hemophilia and Congenital Bleeding Disorders	0.16	0.01
Early Intervention Services	0.28	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	0.15	0.00
Hospice Care	0.00	0.00
Childhood Immunizations	0.49	0.00
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	0.05	0.00
Lymphedema	0.02	0.00
Prosthetic Devices and Components *	0.00	0.00
Telemedicine Services	3.15	0.00
Autism Spectrum Disorder	0.25	0.00
Formula and Enteral Nutrition Products as Medicine	0.00	0.00

*Denotes mandated offer of coverage

TABLE 8

UTILIZATION OF SERVICES - GROUP COVERAGE

Provider Category	Average Visits per Certificate
Chiropractor	0.44
Optometrist	0.29
Optician	0.01
Psychologist	0.16
Clinical Social Worker	0.57
Podiatrist	0.13
Professional Counselor	0.38
Physical Therapist	0.68
Clinical Nurse Specialist	0.18
Audiologist	0.06
Speech Pathologist	0.05
Certified Nurse Midwife	0.03
Licensed Acupuncturist	0.02
Marriage and Family Therapist	0.01

PROVIDER COMPARISONS

To compare the average claim cost per visit for physicians to those of selected mandated providers, the Commission requires companies 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	$59.34
Professional Counselor	34.43
Psychologist	78.80
Clinical Social Worker	85.64
Marriage and Family Therapist	87.72
Physician	62.54
Psychiatrist	86.57

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	$0
Professional Counselor	34.43
Psychologist	86.32
Clinical Social Worker	37.06
Marriage and Family Therapist	24.81
Physician	335.06
Psychiatrist	52.26

Physical Medicine Treatment

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

TABLE 11	
PHYSICAL MEDICINE TREATMENT, THERAPEUTIC EXERCISE, 15 MINUTES	
Provider Category	**Average Claim Cost Per Visit**
Chiropractor	$19.53
Physical Therapist	52.79
Podiatrist	156.76
Speech Pathologist	46.18
Physician	89.32

TABLE 12	
PHYSICAL MEDICINE TREATMENT, MASSAGE	
Provider Category	**Average Claim Cost Per Visit**
Chiropractor	$33.82
Physical Therapist	58.28
Podiatrist	257.58
Physician	32.15

TABLE 13	
PHYSICAL MEDICINE TREATMENT, ULTRASOUND	
Provider Category	**Average Claim Cost Per Visit**
Chiropractor	$8.30
Physical Therapist	27.14
Podiatrist	45.95
Physician	36.21

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	$47.84
Speech Pathologist	126.02
Audiologist	318.77
Physician	160.74

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	$28.98
Physical Therapist	70.12
Podiatrist	105.97
Psychologist	61.44
Clinical Social Worker	74.11
Certified Nurse Midwife	58.77
Professional Counselor	129.90
Physician	112.08
Psychiatrist	55.37

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	$218.67
Physician	140.74

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
2016, RD417	2016	Calendar year 2015
2018, RD408	2018	Calendar years 2016-2017
2020, RD471	2020	Calendar years 2018-2019
2022, RD591	2022	Calendar years 2020-2021

ENDNOTES

[1] 14VAC5-190-50. Reporting and filing requirements: "A. Beginning May 1, 2018, and every other year thereafter, any health insurance issuer licensed to issue an applicable policy or contract in the Commonwealth of Virginia who reported greater than 5,000 covered lives in Virginia during either of the individual calendar years comprising the reporting period shall file with the Bureau of Insurance a separate Form 190-A report for each calendar year in the reporting period." As stated in the Commission's *General Instructions and Information Guide for Completing Form 190-A*, "If the Total Number of Covered Lives reported to Virginia on the NAIC Supplemental Health Care Exhibit for Individual Comprehensive Health Coverage, Small Group Employer Comprehensive Health Coverage, and Large Group Employer Health Coverage combined as defined in the NAIC Annual Statement Instructions is less than 5,000 lives COMBINED, the company is EXEMPT from filing any information and a report is not required."

[2] Per 14 VAC5-190-30, "Mandated benefits" means those benefits that must be included or offered in policies delivered or issued for delivery in the Commonwealth as required by §§ 38.2-3409 through 38.2-3419 of the Code of Virginia. "Mandated providers" means those practitioners that are listed in §§ 38.2-3408 and 38.2-4221 of the Code of Virginia.

[3] Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers,14 VAC5-190-10 et seq. As stated in 14 VAC5-190-10: "The purpose of this regulation is to implement § 38.2-3419.1 of the Code of Virginia with respect to mandated health insurance benefits and providers. This regulation is designed to:

1. Provide the format for the reporting of costs and utilization associated with mandated benefits and providers;
2. Define the information that is required to be reported; and
3. Describe general data reporting elements related to costs and utilization associated with mandated benefits and mandated providers.

[4] Since the company reports received during this reporting period cover the end of the period of the COVID-19 pandemic, reported data may vary from that in previous reports due to the impact of the virus on the utilization of health care from January of 2022 through year-end 2023.