COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

February 12, 1992

ADMINISTRATIVE LETTER
1992-5

To: **All Insurers, Health Services Plans, and Health Maintenance Organizations Licensed to Write Accident and Sickness Insurance in Virginia**

Re: **Virginia Insurance Regulation No. 38: Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers**

On July 5, 1991 the State Corporation Commission of Virginia adopted Insurance Regulation No. 38 pursuant to § 38.2-3419.1 of the Code of Virginia. A copy of this regulation was forwarded to all affected insurers, health services plans, and health maintenance organizations the week of July 8, 1991. Regulation No. 38 became effective October 1, 1991 and requires all insurers, health services plans, and health maintenance organizations issuing policies of accident and sickness insurance or subscription contracts in Virginia to report cost and utilization data relating to mandated benefits and mandated providers to the Bureau of Insurance annually by May 1.

Companies that meet any one of the exemption criteria contained in Section 4.B. of the regulation for a given reporting period will not be required to file a full report for that period. Each company claiming an exemption for a given reporting period must, however, complete and file the first page of form MB-1 as contained in Appendix B of the regulation. A copy of Form MB-1 is attached for your convenience.

Companies that are required to comply with the reporting requirements of Regulation No. 38 for 1991 are reminded that the 1991 reporting period extends from October 1, to December 31. In subsequent years the reporting period will extend from January 1, to December 31. This initial abbreviated reporting period is permitted as a consequence of the October 1, 1991 effective date of Regulation No. 38.

Reports filed in compliance with this regulation must be in the format contained in Form MB-1. Companies filing full reports are encouraged to submit them on computer diskettes issued by the

Bureau of Insurance. However, companies may submit their reports in paper form, if typed. Handwritten reports will not be accepted. Each company wishing to file its report on diskette should complete and return the attached Diskette and File Structure Layout Request Form. Diskettes supplied by the Bureau of Insurance will contain Form MB-1 and the required data entry system. Detailed instructions will also be provided. Companies wishing to submit their reports in ASCII format should use the Diskette and File Structure Request Form to request the required file structure layout. Reports filed in this manner will only be accepted if they are in the form prescribed by the Bureau of Insurance.

Companies are reminded that Regulation No. 38 contains instructions and reference materials which define the data required to complete Form MB-1. A list of additional instructions is attached to provide further clarification.

Should you have any questions, please direct them to:

J. Hil Richardson, Jr.
Senior Insurance Analyst
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23209
Telephone No. (804) 371-0388

Section 38.2-218 of the Code of Virginia provides that any person who knowingly or willfully violates any provision of the insurance laws shall be punished for each violation by a penalty of not more than $5,000. Failure to file a substantially complete and accurate report or exemption request pursuant to the provisions of Regulation No. 38 by the due date may be considered a willful violation and may subject the company to an appropriate penalty.

Sincerely yours,

Steven T. Foster
Commissioner of Insurance

STF/dwr
Attachments

DISKETTE AND FILE STRUCTURE LAYOUT REQUEST FORM

Catherine S. West
Microcomputer Systems Coordinator
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23209

RE: Administrative Letter 1992-5
Annual Report of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia and Regulation No. 38

Dear Ms. West:

We would like to submit the above-referenced report by May 1, 1992:

[ ] on computer diskette using the entry system and diskette to be supplied by the Bureau of Insurance (requiring an IBM or IBM compatible personal computer with DOS and a minimum of 640K of memory). Please forward a:

[ ] 3.5" high density (1.4M) diskette
[ ] 5.25" high density (1.2M) diskette

containing Form MB-1 and the required entry system and detailed instructions to my attention as indicated below.

[ ] in ASCII text format on computer diskette or tape. Please forward the required file structure layout and detailed instructions to my attention as indicated below.

Name: _____

Title: _____

Company: _____

NAIC Number: _____ Group NAIC Number: _____

Mailing Address: _____

_____

_____

Phone Number: _____ Date: _____

EXHIBIT 1
GENERAL LIABILITY CLAIMS REPORTING
COMPLETION INSTRUCTIONS AND DEFINITIONS

The following outline will assist insurers in properly completing the claims reports. Determine the applicable individual reporting method and follow the instructions for that section only. Insurers should review the definitions section at the end of this exhibit for further completion instructions.

Reports for all insurers regardless of reporting method must include the complete verbal name and NAIC number of each individual insurer. Group name and number are required if the reports are on a group basis. Be sure to list all insurers within the group.

Reports must be filed by September 1, 1992.

Determine the applicable reporting method and refer to the following specific instructions for that method.

I. EXEMPT INSURERS:

A. If the insurer had no written premium in 1991 for Line 18 - Products Liability, Line 17 - Other Liability, and Line 11 - Medical Professional Liability as reported on page 14 of the annual statement, then only Exhibit 2 of this Administrative Letter must be filed. Please indicate in the "Zero Premium" column A of Exhibit 2 all of the lines with no written premiums.

B. If the insurer had a combined written premium in 1991 totaling $100,000 or less for Line 17 - Other Liability, Line 18 - Products Liaiblity, and Line 11 - Medical Professional as reported on page 14 of the annual statement, file only Exhibit 2. Indicate those lines with written premiums and those lines with no written premiums by checking the appropriate Column of Exhibit 2.

C. Mutual Assessment insurers are exempt from the data reporting requirements and no further action regarding this Administrative Letter is required.

NOTE: Insurers exempted under A or B above must file Exhibit 2 by September 1, 1992 to record the exemption from the data reporting requirements.

II. INSURERS USING ISO MAGNETIC TAPE REPORTING SERVICES:

A. The ISO Liaison Officer will be the insurers contact for the procurement of these services.

Form MB-1 Supplemental Instructions

1. All questions referring to annual or yearly figures should be interpreted to mean the period October 1, through December 31, 1991 for reports due May 1, 1992. In subsequent years, beginning with the 1992 reporting period, those questions will refer to the full calendar year.

2. Companies are reminded that claims information can be reported on either an "incurred claims" or "paid claims" basis. One basis must be used consistently throughout the report, however. Companies filing on diskettes provided by the Bureau of Insurance will be prompted to indicate on what basis the reported claims data were collected. Companies filing on paper and using an "incurred claims" basis should so note at the top of page 2 of Form MB-1. The Bureau of Insurance will assume that paper reports not containing such a notation were prepared with data collected on a "paid claims" basis.

3. In Part A: Benefit Worksheet #1 - Individual (page 2) the line labeled Obstetrical Services should be ignored and has been stricken on the copy of Form MB-1 attached to Administrative Letter 1992-5. Diskettes distributed by the Bureau of Insurance do not contain data entry blanks for this line.

4. In Part A: Benefit Worksheet #1 - Individual (page 2), column "d - Number of Contracts," companies should report the number of individual contracts which contain the benefits listed. For example, benefits which are mandated offers may be present in fewer contracts than mandated coverages.

5. In Part B: Benefit Worksheet #2 - Group (page 3), column "d - Number of Contracts," companies should report the number of group certificates which contain the benefits listed. Therefore, column "e - Claim Cost per Contract" requires a cost per certificate figure. It is understood that the number of group certificates can change frequently, but every effort should be made to estimate the average number in force during the reporting period.

6. In Part A and Part B, (pages 2-5) column "f - Annual Administrative Cost" should only include fourth-quarter 1991 administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

7. Column "g - Percent of Total Health Claims Paid" figures should be calculated using a base of total individual policy claims for Part A: Benefit Worksheet #1 - Individual (page 2) and for Part B: Provider Worksheet #1 - Individual (page 4) and a base of total group contract claims for Part

A: Benefit Worksheet #2 - Group (page 3) and Part B: Provider Worksheet #2 - Group (page 5). Claims information should be limited to claims on policies or contracts issued or issued for delivery in the Commonwealth of Virginia and subject to Virginia mandated benefit and provider statutes.

8. In Part C (page 6), blanks directly to the right of the Mental, Emotional and Nervous Disorders and Alcohol and Drug Dependence headings which were originally intended for total premium figures should be ignored and have been stricken on the copy of Form MB-1 attached to Administrative Letter 1992-5. Separate inpatient and outpatient figures are required for both benefit categories, however, and should be recorded in the appropriate blanks. Diskettes distributed by the Bureau of Insurance do not contain the stricken blanks.

9. In Part C (page 7), question #4, the premium for a policy with mandates should include all mandated offerings in addition to mandated coverages and mandated providers.

10. Symbols such as "N/A" should not be used in these reports. If a particular question or group of questions are not applicable to a company, then the corresponding blanks should be left empty (an answer of "0" will be given a numeric value of zero). All empty blanks should be explained in a cover letter accompanying the report filing.

Form MB-1

Annual Report of Cost and Utilization Data
Relating to Mandated Benefits and Mandated Providers
Pursuant to §38.2-3419.1 of the Code of Virginia

Reporting Year_____

Company Name _____

Group Name _____

Mailing Address _____

_____

NAIC#_____ Group NAIC #_____

Name of Person Completing Report_____

Title_____

Direct Telephone #_____

Mailing Address_____

_____

Total accident and sickness premiums written in Virginia:

in the year_____ the amount of $ _____

Is the reporting company a cooperative nonprofit life benefit company or mutual assessment life, accident and sickness insurer?

[ ] Yes [ ] No

Does this company solely issue policies not subject to the mandated benefits and mandated provider requirements of §§38.2-3408 through 38.2-3419 and 38.2-4221 of the Code of Virginia?

[ ] Yes [ ] No

Does this company claim an exemption under Section 4 of Regulation No. 38 for this reporting year?

[ ] Yes, and filing only this page. [ ] No, and filing a complete report.

Signature_____ Date_____

Part A: Benefit Worksheet # 1 – Individual

* Benefit	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims Paid
Dependent Children Coverage							
Doctor to Include Dentist							
Newborn Children							
Inpatient Mental / Emotional / Nervous							
~~Obstetrical Services~~							
Pregnancy from Rape / Incest							
Mammography							
Child Health Supervision							

* include information and amounts paid on hospital bills and other providers
a : number of provider and physician visits
b : number of days in facility (if applicable)
c : total of claims paid for this mandate
d : number of contracts in force in Virginia
e : cost per contract = column c divided by column d
f : the administrative cost of complying with this mandate during the reporting year
g : claims paid for this benefit as a percentage of the total amount of health claims paid for Virginia policyholders by this company

Benefit Worksheet # 2 – Group

* Benefit	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims Paid
Dependent Children Coverage							
Doctor to Include Dentist							
Newborn Children							
Mental / Emotional / Nervous:							
Inpatient							
Outpatient							
Alcohol and Drug Dependence:							
Inpatient							
Outpatient							
Obstetrical Services							
Pregnancy from Rape / Incest							
Mammography							
Child Health Supervision							

* include information and amounts paid on hospital bills and other providers [for all health care expenses incurred because of this mandate]

a : number of provider and physician visits
b : number of days in facility (if applicable)
c : total of claims paid for this mandate
d : number of certificates in Virginia [with this coverage]
e : cost per contract = column c divided by column d
f : the administrative cost of complying with this mandate during the reporting year
g : claims paid for this benefit as a percentage of the total amount of [all] health claims paid for Virginia policyholders by this company

Part B: Provider Worksheet # 1 – Individual

Provider	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Contracts	e Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims Paid
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist							
Audiologist							
Speech Pathologist							

a : number of visits to this provider group for which claims were paid in Virginia
b : total dollar amount of claims paid to this provider group in Virginia
c : cost per visit = column b divided by column a
d : number of contracts in force in Virginia
e : cost per contract = column b divided by column d
f : the annual administrative cost associated with compliance with this mandate
g : claims paid for services administered by this provider group as a percentage of the total amount of health claims paid for Virginia policyholders by this company

Provider Worksheet # 2 – Group

Provider	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Contracts	e Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims Paid
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist							
Audiologist							
Speech Pathologist							

a : number of visits to this provider group for which claims were paid in Virginia
b : total dollar amount of claims paid to this provider group in Virginia
c : cost per visit = column b divided by column a
d : number of certificates in Virginia
e : cost per contract = column b divided by column d
f : the annual administrative cost associated with compliance with this mandate
g : claims paid for services administered by this provider group as a percentage of the total amount of health claims paid for Virginia policyholders by this company

Part C

1. Please use what you consider to be your standard policy to answer this question. For the individual policy used as your base calculations in the question below:

- o What is the deductible?_____
- o What is the coinsurance?_____
- o What is the individual/employee out-of-pocket maximum? _____

For the group policy used as your base calculation in the question below:

- o What is the deductible?_____
- o What is the coinsurance?_____
- o What is the individual/employee out-of-pocket maximum? _____

For your health insurance in Virginia, what is the total annual premium including mandates, and what amount is added to the annual premium of each type policy for each mandate listed?

Please indicate where coverage under your policy exceeds Virginia's mandates.

	Individual Policy		Group Certificates	
	Single	Family	Single	Family
Total Annual Policy Premium	_____	_____	_____	_____
Premium for:				
Dependent Children Coverage		_____		_____
Doctor to Include Dentist	_____	_____	_____	_____
Newborn Children	_____	_____	_____	_____
Mental/Emotional/Nervous (Mental Disabilities) Inpatient	_____	_____	_____	_____
* Outpatient			_____	_____
*Alcohol and Drug Dependence			_____	_____
Inpatient			_____	_____
Outpatient			_____	_____
*Obstetrical Services			_____	_____
Pregnancy from Rape or Incest	_____	_____	_____	_____
*Mammography	_____	_____	_____	_____
*Child Health Supervision	_____	_____	_____	_____

* Denotes mandated offering

Chiropractor	_____	_____	_____	_____
Optometrist	_____	_____	_____	_____
Optician	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
Clinical Social Worker	_____	_____	_____	_____
Podiatrist	_____	_____	_____	_____
Professional Counselor	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Clinical Nurse Specialist	_____	_____	_____	_____
Audiologist	_____	_____	_____	_____
Speech Pathologist	_____	_____	_____	_____

2. What is the number of individual policies and/or group certificates issued by your Company in 1991 in Virginia?

	Single	Family
Individual	_____	_____
Group	_____	_____

3. What is the number of individual policies and/or group certificates in force for your company as of December 31, 1991 in Virginia?

	Single	Family
Individual	_____	_____
Group	_____	_____

4. What would be the annual premium for an individual policy with no mandated benefits or mandated providers for a 30 year old male in the Richmond area in your standard premium class? What would be the cost for a policy for the same individual with present mandates? (Assume coverage including $250 deductible, $1,000 stop-loss limit, 80% co-insurance factor, $250,000 policy maximum.) If you do not issue a policy of this type, please provide the premium for a 30 year old male in your standard premium class for the policy that you offer that is most similar to the one described and summarize the differences from the described policy.

Without Mandates $_____

With Mandates $_____

Differences in Policy _____

_____

_____

5. Do you add an amount to the annual premium of a group certificate to cover the cost of conversion to an individual policy? Yes_____ No _____

If yes, what is the average dollar amount:

Single _____ Family _____

If no, is that cost covered in the annual premium of the individual policy? Yes_____No_____

B. Tapes submitted from ISO must be clearly labeled with the names and NAIC numbers of all of the insurers for which data is included on the tape. This label must be attached to the tape reel.

C. Any corrections to the tape data submitted must be made on the ISO paper reports that accompany the tapes. All reports with corrections made must be clearly noted in red ink on the first page of the corrected report.

D. Complete Exhibit 2 to indicate those market definitions with no written premiums in 1991. All other market definitions should be reported by ISO on the tape.

E. The tape, Exhibit 2, and the corrected paper reports, if any, must be filed by September 1, 1992. Failure to submit by this date may subject the insurer to penalties as outlined in the Administrative Letter.

III. INSURERS REPORTING ON PAPER (VCR1-6):

A. Do not change the report layout or format. The form may be enlarged to ensure readability and to ease completion.

B. Only one report should be submitted per market definition and per coverage type. Coverage types are shown on VCR1 (1/92) and market definitions are shown in Exhibit 3. **Do not combine markets or sublines and do not separate classifications within a market definition.**

C. Deductible and non-deductible liability data should be combined within market definitions.

D. Bodily Injury, Property Damage, and Medical payments should be combined within market definitions.

E. Complete Exhibit 2 to indicate those market definitions with no written premiums in 1991.

F. The reports and Exhibit 2 must be filed by September 1, 1992. Failure to submit by this date may subject Insurers to penalties as outlined in the Administrative Letter.

IV. INSURERS REPORTING ON DISKETTE

A. A diskette containing the requested information will not be accepted from any insurer for the 1991 reports.

Part D: Utilization and Expenditures for Selected Procedures by Provider Type

Select Procedure Codes are listed here to obtain information about utilization and costs for specific types of services. Please identify expenditures and only visits for the Procedure Codes indicated. Other claims should not be included here.

1. Procedure Code 90015
Office Visit, Intermediate Service to New Patient

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Clinical Social Worker			
Physical Therapist			
Podiatrist			
Profesional Counselor			
Psychologist			
Physician			

2. Procedure Code 90844
Medical Psychotherapy, 45 to 50 Minute Session

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

3. Procedure Code 90853
Group Medical Psychotherapy

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

4. Procedure Code 92507
Speech, Language or Hearing

	Number of Visits	Claims Payments	Cost Per Visit
Audiologist			
Clinical Social Worker			
Physical Therapist			
Professional Counselor			
Speech Pathologist			
Physician			

5. Procedure Code 97110
Physical Medicine Treatment, 30 Minutes, Therapeutic Exercise

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			
Speech Pathologist			

6. Procedure Code 97124
Physical Medicine Treatment, Massage

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

7. Procedure Code 97128
Physical Medicine Treatment, Ultrasound

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

8. Procedure Code 92352
Fitting of Spectacle Prosthesis for Aphakia

	Number of Visits	Claims Payments	Cost Per Visit
Ophthalmolgist			
Optician			
Optometrist			
Physician			

9. Procedure Code 11765
Excision of Ingrown Toenail

	Number of Visits	Claims Payments	Cost Per Visit
Physician			
Podiatrist			