COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

February 10, 1993

ADMINISTRATIVE LETTER 1993-3

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**

Pursuant to Virginia Insurance Regulation No. 38 and § 38.2-3419.1 of the Code of Virginia, all insurers, health services plans, and health maintenance organizations licensed to issue policies of accident and sickness insurance or subscription contracts in Virginia are to report cost and utilization data relating to mandated benefits and mandated providers for the calendar year 1992 to the Bureau of Insurance by May 1, 1993.

Each and every company licensed as described above must submit a report to the Bureau of Insurance. Please note the following:

1. Companies that meet any one of the exemption criteria contained in section 4.B. of Regulation No. 38 for the 1992 reporting period are required to complete and file only the first page of Form MB-1. The fact that a company may have written no applicable business in Virginia during 1992 does not exempt that company from filing for an exemption. **Each licensed company must file either a full report or a request for exemption.**

2. It is not acceptable to consolidate information from companies within the same holding company system. Each licensed company must file its own Form MB-1.

3. This is the second reporting year since Regulation No. 38 became effective. Lack of notice, lack of information, lack of a means of producing the required data, or other such excuses will under no circumstances be accepted this year or in the future.

4. Reports filed in compliance with this regulation must be in the format contained in Form MB-1 (a copy of which is attached to this letter). Companies filing full reports are encouraged to do so on computer diskettes issued by the Bureau of Insurance. Companies may submit their reports in paper form, if typed. Each company wishing to file its report on diskette should complete and return the attached Diskette Request Form. Diskettes supplied by the Bureau of Insurance will contain Form MB-1 and the necessary data entry system.

5. Companies are reminded that Regulation No. 38 contains specific instructions and reference materials which define the data required to complete Form MB-1. A list of instructions is attached to this administrative letter to provide further clarification. In addition, §§ 38.2-3408 through 38.2-3418.1 of the Code of Virginia which require the inclusion or availability of the benefits which are the subject of this regulation should be consulted.

Correspondence regarding this reporting requirement, including Form MB-1 filings, should be directed to:

Mr. Hil Richardson
Senior Insurance Analyst
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23209
Telephone No. (804) 371-9388

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 REQUEST FORM

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

RE: Administrative Letter 1993-3
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 for the 1992 reporting period on computer diskette using the entry system 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, the required data entry system, and instructions to my attention as indicated below.

Name:_____

Title:_____

Company:_____

NAIC Number:_____ Group NAIC Number:_____

Mailing Address:_____

_____

_____

Phone Number:_____ Date:_____

Form MB-1 Instructions

Corrections

The corrections noted below have been made to the copy of Form MB-1 attached to this administrative letter.

1. In **Part A: Benefit Worksheet #1 - Individual** (page 2) the line labeled "Obstetrical Services" should be stricken.

2. In **Part C** (page 6), blanks in the single coverage columns (both individual and group) to the right of the "Newborn Children" heading should be stricken.

3. In **Part C** (page 6), blanks directly to the right of the "Mental/Emotional/Nervous" and "Alcohol and Drug Dependence" headings should be stricken. Separate inpatient and outpatient figures are required for both benefit categories and should be recorded in the appropriate blanks.

4. In **Part C** (page 7), questions #2 and #3, the year "1991" should be replaced by "1992".

5. In **Part C** (page 8), two questions have been added to #5 to accommodate insurers who charge group policyholders a flat fee per conversion to individual coverage.

Parts A and B

1. **Part A** requires disclosure of specific claim data for each mandated benefit and mandated offer for both individual and group business. **Part B** requires similar data for each mandated provider category. In determining the cost of each mandate, it is expected that claim and other actuarial data will be used. Appendix C of Regulation No. 38 lists CPT-4 and ICD-9CM Codes which should be used in collecting the required data. **Correction**: The CPT-4 Codes listed for "Delivery, Antepartum and Postpartum Care" under the "Obstetrical Services" category should read as follows:

   59400 Routine obstetric care including antepartuum care, vaginal delivery (with or without epistiotomy, and/or forceps) and postpartum care

   59410 Vaginal delivery only (with or without epistiotomy and/or forceps) including postpartum care

   59412 External cephalic version, with or without tocolysis (list in addition to code(s) for delivery)

   59414 Delivery of placenta following delivery of infant outside of hospital

   59420 Antepartum care only (separate procedure)

   59430 Postpartum care only (separate procedure)

2. On the worksheets for individual business (pages 2 and 4), for **column d - Number of Contracts**, companies should report the number of individual contracts which contain the benefits and providers listed. For example, benefits which are mandated offers may be present in fewer contracts than mandated coverages.

3. On the worksheets for group business (pages 3 and 5), for **column d - Number of Contracts**, companies should report the number of group **certificates** which contain the benefits and providers listed, not the number of group contracts. 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.

4. **Column f - Annual Administrative Cost** (pages 2-5) should only include 1992 administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

5. **Column g - Percent of Total Health Claims Paid** figures should be calculated using one base for the individual business worksheets (pages 2 and 4) and another base for the group business worksheets (pages 3 and 5). Claim 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.

Part C

1. **Part C** requires the company to identify standard individual and group policies, the annual premium for each type of coverage, and the portion of the annual premium attributable to each mandated benefit, offer, and provider. It is understood that companies do not usually rate each benefit and provider separately. **However, for the purpose of this report it is required that a dollar figure be assigned to each benefit and provider based on the company's actual claim experience, such as that disclosed in Parts A and B, and other relevant actuarial information.**

2. In **Part C** (page 7), question #4, the premium for a policy "with mandates" should include all mandated benefits, offers, and providers.

Part D

1. This section requires that claim data be reported by procedure code, by provider type. The term "physician" refers to medical doctors.

2. Data should only reflect approved claims. Denials should not be included.

General

1. Claim information can be reported on either an incurred or paid basis as long as one is used consistently. Companies using Bureau of Insurance issued diskettes will be prompted to indicate which basis has been used. Companies filing on paper should note which basis has been used in a cover letter accompanying the report.

2. Information provided on Form MB-1 should only reflect the experience of policies or contracts issued or issued for delivery in the Commonwealth of Virginia and subject to Virginia mandated benefit and provider statutes.

3. 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 Cost Per Visit / Adm.	e Number of Contracts	f Claim Cost Per Contract	g Annual Administrative Cost	h 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 : column c divided by either column a or column b (whichever is applicable)
e : number of contracts in force in Virginia
f : cost per contract = column c divided by column e
g : the administrative cost of complying with this mandate during the reporting year
h : 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 Cost Per Visit / Adm.	e Number of Contracts	f Claim Cost Per Contract	g Annual Administrative Cost	h 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

a : number of provider and physician visits

b : number of days in facility (if applicable)

c : total of claims paid for this mandate

d : column c divided by either column a or column b (whichever is applicable)

e : number of certificates in Virginia

f : cost per contract = column c divided by column e

g : the administrative cost of complying with this mandate during the reporting year

h : claims paid for this benefit as a percentage of the total amount of 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	XXXX	_____	XXXX	_____
Mental/Emotional/Nervous (Mental Disabilities)	XXXX	XXXX	XXXX	XXXX
Inpatient	_____	_____	_____	_____
*Outpatient			_____	_____
*Alcohol and Drug Dependence			XXXX	XXXX
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 1992 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, 1992 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_____

If no, is a onetime charge made to the group policyholder for each conversion?
Yes_____No_____

If yes, what is the average dollar amount:
Single _____ Family _____

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			
Optometrist			
Physical Therapist			
Podiatrist			
Profesional Counselor			
Psychologist			

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			

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			

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 92002**
Limited Eye Examination

	Number of Visits	Claims Payments	Cost Per Visit
Ophthalmolgist			
Optician			
Optometrist			

9. **Procedure Code 11765**
Excision of Ingrown Toenail

	Number of Visits	Claims Payments	Cost Per Visit
Physician			
Podiatrist			