COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

January 20, 1994

ADMINISTRATIVE LETTER 1994-4

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 1993 to the Bureau of Insurance by May 1, 1994.

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 1993 reporting period are required to complete and file the first page of Form MB-1. It is the Bureau's position that insurers exempt pursuant to Section 4.B. are NOT exempt from the regulation; they are merely exempt from the full reporting requirement. The fact that a company may have written no applicable business in Virginia during 1993 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 third 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. Please be

advised that disciplinary action was initiated against over 200 companies last year for failing to report in a timely manner.

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 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/jhr
Attachments

DISKETTE REQUEST FORM

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

RE: Administrative Letter 1994-4
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 1993 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

The Form MB-1 attached to this Administrative Letter has been modified from that originally promulgated with the Regulation as follows:

1. In **Part A: Benefit Worksheet #1 - Individual** (page 2) the line labeled "Obstetrical Services" has been deleted.

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

3. In **Part C** (page 6), blanks directly to the right of the "Mental/Emotional/Nervous" and "Alcohol and Drug Dependence" headings have been deleted. 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" has been replaced by "1993".

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.

6. In **Part D** (page 9), the procedure code for "Office Visit, Intermediate Service to a New Patient" has been updated from 90015 to 99203 to reflect changes by the American Medical Association to the Physician's Current Procedural Terminology.

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 1993 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 1993

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

Enter the basis on which claim data presented throughout this report was collected (either paid or incurred): [ ]

* Benefit		a	b	c	d	e	f	g
Va. Code Section	Description	Number of Visits	Number of Days	Total Claims Payments	Number of Contracts	Claim Cost Per Contract	Annual Administrative Cost	Percent of Total Health Claims Paid
38.2–3409	Handicapped Dependent Children							
38.2–3410	Doctor to Include Dentist							
38.2–3411	Newborn Children							
38.2–3412.1	Inpatient Mental / Emotional / Nervous							
38.2–3418	Pregnancy from Rape / Incest							
38.2–3418.1	Mammography							
38.2–3411.1	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 containing the required or optional 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 health claims paid on individual policies or contracts subject to this reporting requirement

Benefit Worksheet # 2 – Group

* Benefit Va. Code Section	Description	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of Certificates	e Claim Cost Per Certificate	f Annual Administrative Cost	g Percent of Total Health Claims Paid
38.2–3409	Handicapped Dependent Children							
38.2–3410	Doctor to Include Dentist							
38.2–3411	Newborn Children							
38.2–3412.1	Mental / Emotional / Nervous:							
	Inpatient							
	Outpatient							
38.2–3412.1	Alcohol and Drug Dependence:							
	Inpatient							
	Outpatient							
38.2–3414	Obstetrical Services							
38.2–3418	Pregnancy from Rape / Incest							
38.2–3418.1	Mammography							
38.2–3411.1	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 containing the required or optional 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 on group contracts subject to this reporting requirement

Part B: Provider Worksheet # 1 – Individual

Provider

Va. Code Sections 38.2–3408 & 38.2–4221	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 individual contracts subject to this reporting requirement
e : cost per contract = column b divided by column d
f : the annual administrative cost associated with compliance of complying with this mandate during the reporting period
g : claims paid for services administered by this provider group as a percentage of the total amount of health claims paid on individual policies or contracts subject to this reporting requirement

Provider Worksheet # 2 – Group

Provider

Va. Code Sections 38.2–3408 & 38.2–4221	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Certificates	e Cost Per Certificate	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 subject to this reporting requirement
e : cost per contract = column b divided by column d
f : the annual administrative cost associated with compliance of complying with this mandate during the reporting period
g : claims paid for services administered by this provider group as a percentage of the total amount of health claims paid on group contracts subject to this reporting requirement

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