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STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

January 10, 1995

ADMINISTRATIVE LETTER 1995-3

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

On November 22, 1994, the Virginia State Corporation Commission adopted revisions to its Insurance Regulation No. 38, as amended, which substantially alter the reporting requirements imposed by the Regulation. Please note the following, pursuant to Virginia Insurance Regulation No. 38 and § 38.2- 3419.1 of the Code of Virginia:

1. Any insurer, health services plan, or health maintenance organization whose total Virginia annual written premiums for all accident and sickness policies or subscription contracts, as reported on its Annual Statement for 1994 is less than $500,000 shall, for that reporting period, be exempt from filing a report as required by Regulation No. 38, and shall not be required to notify the Commission of such exemption other than through the timely filing of its Annual Statement.

2. Any insurer, health services plan, or health maintenance organization that does not qualify for an exemption as described above may file an abbreviated report if its annual written premiums for applicable policies or contracts that were subject to Virginia's mandated benefit and provider requirements total less than $500,000. An abbreviated report must contain a completed page 1 of Form MB-1 and an accounting of all Virginia accident and sickness premiums by policy type and by situs (e.g. Virginia, Maryland).

3. Any insurer, health services plan, or health maintenance organization that does not qualify under either of the exceptions outlined above must file a complete Form MB-1 report.

4. 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.

5. This is the fourth 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.

6. 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. **However, please be advised that the Bureau's diskette reporting system cannot be run in the Windows environment.** 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.

7. Companies are reminded that Regulation No. 38 contains specific instructions and reference materials which define the data required to complete Form MB-1. A partial 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:

Robert L. Wright, III
Principal Insurance Analyst
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23209
Telephone No.: 804-371-9586

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 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/
Attachments

Form MB-1 Instructions

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 B of Regulation No. 38 lists CPT-4 and ICD-9CM Codes which should be used in collecting the required data.

2. On the worksheets for individual business 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 for **column d - Number of Certificates**, companies should report the number of group **certificates** which contain the benefits and providers listed, not the number of group contracts. 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** should only include 1994 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 and another base for the group business worksheets. 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**, 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.

2. Information provided on Form MB-1 should only reflect the experience of policies or contracts delivered 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.