

General Instructions and Information Guide for Completing Form MB-1

If the Total Annual Written Premium reported to Virginia for all Accident and Sickness Lines is less than \$500,000 or the company is licensed to issue only credit accident and sickness insurance, the company is EXEMPT from filing any information and a report is not required. Please do not continue.

Electronic submission of Form MB-1 is encouraged; however, other means as described in 14VAC5-190-50 C. are permitted by the Bureau of Insurance. Submissions may also be faxed to the Bureau of Insurance at (804) 371-9944. The General Instructions and Information Guide is to be used for electronic submissions and may be modified (where applicable) for non-electronic submissions. For downloading blank forms and for on-line submissions, please visit our website at www.scc.virginia.gov/boi/co/health/mandben.aspx.

NOTE: PLEASE ALLOW ADEQUATE TIME FOR THE PREPARATION AND SUBMISSION OF FORM MB-1 BY THE MAY 1, 2016, DUE DATE. INABILITY TO SUBMIT FORM MB-1 ELECTRONICALLY WILL NOT RESULT IN AUTOMATIC WAIVER OF THE REQUIREMENT FOR A TIMELY FILING. IF TECHNICAL PROBLEMS OCCUR WHILE TRYING TO COMPLETE OR SUBMIT THE FORM ELECTRONICALLY, PLEASE CONTACT ANDREW IVERSON AT (804) 371-9851 or andrew.iverson@scc.virginia.gov. FOR OTHER CONCERNS, PLEASE CONTACT ERIC LOWE AT (804) 371-9628 or eric.lowe@scc.virginia.gov.

Effective September 30, 2015, the ICD-9 codes were replaced by ICD-10 codes. As such, the combinability of data coded under the new codes has not been finalized. As a result, the 2015 reporting of mandated benefits and utilization must be made for the 9-month period January 1, 2015 through September 30, 2015 for benefits coded utilizing the ICD-9 codes as provided in these instructions.

Carriers are reminded that failure to submit a substantially complete and accurate report pursuant to the provisions of 14VAC5-190-10 et seq., by May 1, 2016, may be considered a violation subject to a penalty as set forth in § 38.2-218 of the Code of Virginia. Lack of notice, lack of information, lack of means of producing the required data, or other similar reasons will not be accepted for not submitting a complete and accurate report in a timely manner.

COVER SHEET:

1. The amount entered for **Total Premium for all Accident and Sickness Lines** should be consistent with the total accident and sickness premium written in Virginia as **reported on the Company's Annual Statement for the 2015 reporting period** for all accident and sickness lines (if the amount entered is not within \$500 of the amount reported in the Company's Annual Statement, a message will appear). This includes all categories of accident and sickness insurance without regard to the applicability of the provisions of § 38.2-3408 or § 38.2-4221 and §§ 38.2-3409 through 38.2-3419 of the Code of Virginia. **This amount should not be adjusted except to subtract any premium reported for credit accident and sickness insurance.**
2. The amount entered for **Total Premium on Applicable Policies and Contracts** should be the total accident and sickness premiums written in Virginia on applicable policies and contracts, as defined in 14VAC5-190-30 that are subject to the Mandated Benefits and Offers as set forth in § 38.2-3408 or § 38.2-4221, and §§ 38.2-3409 through 38.2-3419 for the reporting period. Only written premiums on applicable policies and contracts should be included. Policies issued to discretionary groups situated outside of Virginia that provide coverage to residents of Virginia for which the company is unable to provide the documentation required in § 38.2-3522.1, and are subject to Mandated Benefits and Offers as provided in § 38.2-3408 or § 38.2-4221 and §§ 38.2-3409 through 38.2-3419, are considered applicable policies and contracts.
3. **Report Type (Abbreviated or Complete)** - The company must determine eligibility to file an

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abbreviated report under 14VAC5-190-40 C or a full and complete report under 14VAC5-190-40 A for the **2015 reporting period**. Based on the amount of premium entered, an abbreviated report will be identified by an A and a complete report by a C.

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ABBREVIATED REPORT

Companies filing an **abbreviated** report must complete the cover sheet of Form MB-1 to provide the breakdown of premium by policy type (e.g. Medicare supplement, major medical, disability income, limited benefit) and by situs (e.g. Illinois) in accordance with 14VAC5-190-40 D and the contact sheet. The instructions for completing the contact sheet and ending the report are on page 5.

COMPLETE REPORT

Companies filing a **complete** report must complete the cover sheet of Form MB-1 (including the claim basis which must be reported as either Paid (enter P) or Incurred (enter I) and continue with completion of the **Worksheets for Parts A-D**.

PART A: CLAIM INFORMATION – BENEFITS

Part A requires disclosure of specific claim data for each mandated benefit and mandated offer for both individual and group business.

Total claims paid or incurred for individual contracts and group certificates refer to all claims paid or incurred under the types of policies that are subject to the Mandated Benefits. This amount should not be the total of claim payments entered in column c, rather a total of all claims paid or incurred under applicable contracts or certificates for all covered services, including both mandated benefits and those not mandated. **This amount is required to assess the information reported and it must be entered in column g.** This amount is the only data entered in column g, part A.

Columns a and b - "Number of Visits" or "Number of Days" refer to the number of provider and physician visits and the number of inpatient or partial hospital days, as applicable. The numbers reported should be consistent with the type of service rendered. For example, number of days (column b) should not be reported unless the claim dollars being reported were paid or incurred for inpatient or partial hospitalization.

Claims reported for § 38.2-3409, Dependent Children (Handicapped) should include only those claims paid or incurred as a result of a continuation of coverage because the dependent has attained the specified age as set forth in the policy for a dependent child.

Claims reported for § 38.2-3410, Doctor to Include Dentist, should include only claims for treatment normally provided by a physician, but was provided by a dentist. Claims for normal or routine dental services should not be reported.

Column c -Total Claim Payments - companies should enter the total of claims paid or incurred for the mandate.

Column d - Number of Contracts/Certificates

Individual business - companies should report the number of individual **contracts** issued or renewed in Virginia during the reporting period which contain the benefits and providers listed. The number of contracts should be consistent throughout column d, except in the case of mandated offers, which may be less.

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Group business - companies should report the number of group **certificates** issued or renewed in Virginia during the reporting period which contain the benefits and providers listed, not the number of group policies. This number should also be consistent throughout column d, except in the case of mandated offers, which may be less.

Column e - Claim Cost Per Contract/Certificate. This figure is computed by dividing the amount entered in column c by the number entered in column d. **The Bureau's software will compute this amount automatically.**

Column f - Annual Administrative Cost should only include **2015** administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

Column g - The Percentage of Total Health Claims computed in column g will be computed automatically by the Bureau's software.

PART B: CLAIM INFORMATION – PROVIDERS

Not applicable to Health Maintenance Organizations (HMOs)

In determining the cost of each mandate, it is expected that claim and other actuarial data will be used. A listing of the CPT and ICD-9-CM Codes which is useful in collecting the required data is **available on line** for your convenience at: <http://www.scc.virginia.gov/boi/co/health/mandben.aspx>. Worksheets must be completed for both individual business and group business if the company has both types of business.

Column a - Number of Visits is the number of visits to the provider type for which claims were paid or incurred.

Column b - Total Claims Payments is the total dollar amount of claims paid or incurred for services provided by the provider type.

Column c - Cost Per Visit is computed by dividing the amount entered in column b by the number entered in column a. **The Bureau's software will compute this figure automatically.**

Column d - Number of Contracts/Certificates

Individual business - report the number of individual **contracts** issued or renewed in Virginia during this reporting period that are subject to this reporting requirement.

Group business - report the number of group **certificates** issued or renewed in Virginia during this reporting period that are subject to this reporting requirement.

Column e - Claim Cost Per Contract/Certificate is the number entered in column b divided by the number entered in column d. **The Bureau's software will compute this number automatically.**

Column f - Annual Administrative Cost should only include **2015** administrative costs (not start-up costs, unless those costs were incurred during the reporting period).

Column g - Percent of Total Health Claims is the claims paid or incurred for services administered by each provider type as a percentage of the total amount of all health claims paid or incurred subject to this reporting requirement. **The Bureau's software will compute this number automatically.**

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PART C: PREMIUM INFORMATION

Standard Policy

Use what you consider to be your standard individual policy and/or group certificate to complete the deductible amount, the coinsurance paid by the insurer, and the individual/employee out-of-pocket maximum. These amounts should be entered under the heading of Individual Policy and/or Group Certificates.

For your standard health insurance policy and/or group certificate in Virginia, provide the total **annual premium** that would be charged per unit of coverage assuming inclusion of all of the benefits and providers listed. A separate annual premium should be provided for Individual policies and Group certificates, both single and family. If the company does not have a "family" rating category, coverage for two adults and two children is to be used when calculating the required family premium figures.

Premium Attributable to Each Mandate

Provide the portion (dollar amount) of the annual premium for each policy that is attributable to each mandated benefit, offer and provider.

Please indicate where coverage under your policy exceeds Virginia mandates. 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 amount 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.**

Number of Contracts/Certificates

Provide the number of individual contracts and/or group certificates *issued and/or renewed* in Virginia **during the reporting period (01/01/15 – 09/30/15)** in the appropriate fields under each heading.

Provide the number of individual contracts and/or group certificates *in force* in Virginia as of the **last day of the reporting period (09/30/15)** in the appropriate fields under each heading.

Annual Premium for Individual Standard Policy (30 year old male in Richmond)

Enter 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 in the appropriate field. Enter the cost for a policy for the same individual with mandates in the appropriate field. (Assume coverage that includes a \$250 deductible, and 80% co-insurance factor). If you do not issue a policy of this type, 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 in a separate form. The premium for a policy "with mandates" should include all mandated benefits, offers and providers.

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PART D - UTILIZATION AND EXPENDITURES FOR SELECTED PROCEDURES BY PROVIDER TYPE

Not applicable to Health Maintenance Organizations (HMOs)

Selected Procedure Codes are listed in Part D to obtain information about utilization and costs for specific types of services. Please identify expenditures and visits for the Procedure Codes indicated. Other claims should not be included in this Part. Individual and group data must be combined for this part.

Claim data should be reported by procedure code and provider type. "Physician" refers to medical doctors.

Data should only reflect paid claims. Unpaid claims should not be included.

The Bureau's software will compute the cost per visit amount automatically.

CONTACT SHEET:

In order to complete the contact sheet and end the report, the Company's name, NAIC number and other information concerning the Company and name of the contact person responsible for the report must be entered. After completing the contact sheet and clicking on SUBMIT, all sections of Form MB-1 (cover sheet, worksheets and contact sheet) will be transmitted electronically to the Bureau of Insurance.

Companies should not enter information in the shaded fields.

NOTE:

Information provided on Form MB-1 should only reflect the experience of policies or certificates delivered or issued for delivery in the Commonwealth of Virginia or a policy issued to a discretionary group situated in another state that provides coverage to Virginia residents and the policies and certificates are subject to Virginia mandated benefits, mandated offers and provider statutes.