

2016 Mandated Benefits Data Call Instructions to accompany Form LHL657

Reporting Period: October 1, 2015, to September 30, 2016

Introduction

The Texas Department of Insurance (TDI) has provided the following instructions to help health benefit plan issuers file data relating to mandated health benefits and mandated offers of coverage as required under [Title 28 Texas Administrative Code \(28 TAC\) Chapter 21, Subchapter Z, Sections 21.3401–21.3409](#).

An issuer is exempt from filing the forms relating to **individual** coverage if the 2015 annual statement indicates a total of less than **\$2 million** in direct premiums for individual plans in Texas. An issuer is exempt from filing the forms relating to **group** coverage if the 2015 annual statement indicates less than **\$10 million** in direct premiums for group policies in Texas. Issuers may refer to 28 TAC Section 21.3401 for additional information on the applicability of the data call.

Each issuer required to file a report must submit a reporting form. Information from different issuers shouldn't be consolidated on one reporting form. Issuers should indicate on the form cover sheet whether they are responding as an Accident and Health (indemnity) issuer or a Health Maintenance Organization (HMO). Issuers that have both indemnity and HMO business must file a separate form for each. Issuers should use one form to report individual and group coverages as noted on Form LHL657.

When completing the data call, refer to the information provided on the Mandated Benefits Data Call Index Page at www.tdi.texas.gov/health/mbindex.html. The "Mandated Benefits Data Call Code List" file includes applicable codes from both Current Procedural Terminology (CPT)¹ and the International Classification of Diseases (ICD). These codes may assist issuers in identifying claims data related to the various mandated benefits and mandated offers. This file may not include all relevant codes due to the variation among issuers' reporting requirements and claims filing procedures. Therefore, issuers should use these codes as a reference tool, but may add additional codes as appropriate.

¹CPT is a registered trademark of the American Medical Association.

The code list also includes statutory citations and detailed descriptions for each mandated benefit and mandated offer of coverage. Because some mandated benefits apply only to specific groups of people, issuers should carefully review these descriptions, and only report claims for insureds covered by the applicable mandated benefit requirement. Issuers are responsible for ensuring that reported data is consistent with Texas statutory requirements. For example, the mammography screening mandated benefit applies only to women 35 years of age or older. As such, issuers shouldn't report mammography claims data for women under the age of 35 or for men.

Terminology

These instructions and other materials associated with the 2016 Mandated Benefits Data Call use the following generic terminology:

- issuer means indemnity insurer or HMO, as applicable;
- policy means policy or evidence of coverage (EOC), as applicable;
- certificate means certificate or EOC, as applicable; and
- claim means claim or medical expense, as applicable.

Data Call Overview

Issuers must complete the 2016 data call using an interactive PDF form available on the TDI website under the designation "LHL657" at www.tdi.texas.gov/health/mbindex.html. This form contains fields that must be completed on-screen using Adobe Reader 9.0 (or higher) to ensure proper form functionality.

When completed, click "Submit by Email" to convert the data to an XML attachment. Submit the XML file to TDI by email to MBSurvey@tdi.texas.gov by **December 1, 2016**. TDI will only accept surveys returned in XML format using the prescribed form. **TDI will not accept any survey returned in a different format, including scanned PDF files.**

Form LHL657 has eight sections:

- Cover Sheet;
- Part A: Claim Information for Individual Benefits;
- Part B: Claim Information for Group Benefits;
- Part C: Premium Information for Individual Benefits;
- Part D: Premium Information for Group Benefits;
- Part E: Mandated Benefit Claims Identification;

- Part F: Additional Information; and
- Part G: Data Certification.

Cover Sheet

Issuers must provide all requested identifying information, including the name, issuer NAIC number, group name, group NAIC number, and complete mailing address. Issuers must also provide information about the primary contact person, including the person's name, title, direct phone number, email address, and mailing address.

Issuers must provide total premiums written and total claims paid for all health benefit plans subject to the mandated benefit and mandated offer requirements in Texas during the reporting period. This information is required for each of the coverage categories captured by the data call, as follows:

Total Premiums Written for Applicable Individual Health Benefit Plans

This amount includes the total premium written in Texas on applicable individual plans that are subject to mandated benefits and mandated offers for the reporting period. Include only written premiums on applicable policies. Round responses to the nearest dollar.

Total Claims Paid for Applicable Individual Health Benefit Plans

This amount includes the total dollar amount of all claims paid in Texas on applicable individual policies that are subject to mandated benefits and mandated offers for the reporting period. This total amount includes claims paid for **all** covered services, including both mandated benefits and claims for **all** other covered services. Round responses to the nearest dollar.

Total Premiums Written for Applicable Group Health Benefit Plans

This amount includes the total premium written in Texas on applicable group policies that are subject to mandated benefits and mandated offers for the reporting period. Include only written premiums on applicable policies. Round responses to the nearest dollar.

Total Claims Paid for Applicable Group Health Benefit Plans

This amount includes the total dollar amount of all claims paid on applicable group policies that are subject to mandated benefits and mandated offers for the reporting period. This total amount includes claims paid for **all** covered services, including both

mandated benefits and claims for **all** other covered services. Round responses to the nearest dollar.

Issuers that did not have applicable business in a specific coverage category should enter **\$0** for both total premiums and total claims in that category on the cover sheet.

Issuers must indicate if they offered individual health benefit plans subject to mandated benefits and mandated offers with premiums in excess of \$2 million for the reporting period. Issuers that indicate “No” may leave Parts A and C blank. Issuers must also indicate if they offered group health benefit plans subject to mandated benefits and mandated offers with premiums in excess of \$10 million for the reporting period. Issuers that indicate “No” may leave Parts B and D blank. Issuers that answer “No” to both of these questions may proceed to Data Certification (Part G).

Claim Information Worksheets (Parts A-B)

This section requires specific claim data for each mandated benefit and mandated offer. **Issuers must complete the detailed claim and premium worksheets for each applicable coverage category (individual, group) as indicated on the cover sheet. Issuers should leave these detailed worksheets blank for any coverage category that does not apply.** When compiling the data, refer to the suggested ICD and CPT codes listed on the index page as described on page 1.

Number of Claims Paid

Enter the total number of separate claims paid for each mandated benefit and mandated offer during the reporting period.

Total Mandated Benefit Claims Paid

Enter the total dollar amount of claims paid for each mandated benefit and mandated offer. Round responses to the nearest whole dollar.

Number of Individual Policies or Group Certificates

For individual benefits, enter the number of individual policies issued or renewed in Texas that provided coverage for each specified mandated benefit and mandated offer during the reporting period. Each primary insured represents one individual policy. For group benefits, enter the number of group certificates (not the number of group contracts) issued or renewed in Texas that provided coverage for each specified mandated benefit and mandated offer during the reporting period. Each enrolled employee represents one group certificate.

Annual Administrative Cost

Enter the total annual administrative costs directly associated with each mandated benefit and mandated offer. Start-up costs, such as the cost of revising policy forms during the first year an issuer implements a new mandate, shouldn't be included unless the issuer incurred those costs during the reporting period. Responses should reflect the total cost to the issuer and be rounded to the nearest whole dollar. Issuers may use a logical allocation base to derive these costs. Each issuer has discretion to determine the most logical allocation methodology.

If the issuer has claims to report for a listed mandate in a specific coverage category, complete all data columns for that mandate (including the number of claims paid, value of claims paid, number of policies or certificates, and annual administrative cost) on the claim information worksheet.

Premium Information Worksheets (Parts C-D)

Table 1 on each premium information worksheet requires issuers to indicate the average annual premium paid by primary insureds for each mandated benefit and mandated offer during the reporting period. Provide data separately for individual and group health benefit plans. Within each of these coverage categories, report data separately for members enrolled in single coverage and members enrolled in family coverage. **For claims data reported for a specific mandate in a specific coverage category on the claim information worksheet, report the average annual premium data for that mandate on the corresponding premium information worksheet.**

Table 2 on each premium information worksheet requires issuers to indicate the number of individual policies or group certificates issued or renewed during the reporting period, and the number of policies or certificates in force on the last day of the reporting period.

Table 3 requires similar information for the number of lives covered under these policies or certificates.

The following is additional detail on the data requested in these tables:

Average Annual Premium Cost per Policy or Certificate Attributable to Each Mandate

This section requires issuers to estimate the average premium in dollars paid by primary insureds for each mandated benefit and mandated offer during the reporting period.

Report this data on the policy level for individual plans, and report it on the certificate

level for group plans. Provide annual premium costs separately for single coverage (primary insured only) and family coverage (primary insured plus all dependents, including spouse and children). These categories represent the least and most expensive coverage tiers. Don't provide premium information for the other available coverage tiers, such as "plus spouse" and "plus children."

An issuer may base the premium estimates on the actual claims experience as disclosed in the claim information worksheets in this data call. If average costs across all applicable policies or certificates can't be determined, the issuer may base the estimates on the issuer's most popular standard policy or certificate in the appropriate coverage category. Even if there were no claims for a given mandate, premium estimates shouldn't reflect zero since premiums are calculated on the possibility that claims will occur. Provide data separately for individual and group health benefit plans.

When entering data for this section, round dollar amounts to the nearest cent. Don't enter the dollar sign (\$), it will appear once the data has been entered. Include a decimal point for any numbers with values that include cents, such as \$2.25. Without the decimal, the value will display incorrectly as \$225. It is not necessary to enter a decimal point and zeroes for a whole dollar amount, such as \$2.00. For example, if an issuer estimates the average annual cost of providing benefits for mammography screening at \$4.00 for individual policies covering a single person and \$5.25 for individual policies that provide family coverage, enter **4.00** or **4** under the "Single" column heading, and **5.25** under the "Family" column heading.

The reporting form includes calculated fields at the bottom of Table 1 that display the sum of reported premiums for single and family coverage. **Issuers should verify that the stated totals accurately reflect the average premium paid by each primary insured for the specified mandates for 12 months of coverage.**

Number of Policies or Certificates

On the first line, provide the total number of applicable individual policies or group certificates issued or renewed during the reporting period. Report this data separately for policies or certificates providing single coverage and policies or certificates providing family coverage.

On the second line, provide the total number of individual policies or group certificates in force on the last day of the reporting period. Report this data separately for policies

or certificates providing single coverage and policies or certificates providing family coverage.

Number of Lives Covered

On the first line, provide the total number of lives covered under individual policies or group certificates issued or renewed during the reporting period. Report this data separately for policies or certificates providing single coverage and policies or certificates providing family coverage. Include all covered family members in the calculations for family coverage. This includes primary insured, spouse, and all dependents.

On the second line, provide the total number of lives covered under individual policies or group certificates in force on the last day of the reporting period. Report this data separately for policies or certificates providing single coverage and policies or certificates providing family coverage. Include all covered family members in the calculations for family coverage. This includes primary insured, spouse, and all dependents.

Mandated Benefit Claims Identification Worksheet (Part E)

This worksheet requires issuers to indicate either the ICD codes, CPT codes, or both used to identify applicable claims for each mandated benefit and mandated offer of coverage. This information will allow TDI to better understand issuers' data and identify potential causes of data inconsistencies between responding issuers.

The following are examples on providing the code information:

In cases where an issuer uses a **single ICD or CPT code** to identify applicable claims, simply specify that code. For example, if an issuer identified osteoporosis detection claims by the presence of ICD code Z13.820, enter ***ICD Z13.820***.

In cases where **only one in a series of similar ICD or CPT codes** was used to identify applicable claims, list all acceptable codes with the "OR" parameter. For example, if an issuer identified AIDS and HIV claims by the presence of ICD code B20, B97.35, Z21, B59, or R75, enter ***ICD B20, B97.35, Z21, B59, OR R75***.

In cases where **two codes must both be present** to identify applicable claims, list both acceptable codes with the "AND" parameter. For example, if an issuer identified in vitro

fertilization claims by the presence of ICD N97.X in conjunction with CPT 89250, enter **ICD N97.X AND CPT 89250**.

In cases that are more complex, use the guidelines outlined above to be as clear and descriptive as possible. In addition, when applicable, identify additional query constraints that are relevant to a specific benefit, such as a specific patient age range. For example, low-dose mammography responses should also include **limited to females 35 years of age or older**.

Additional Information (Part F)

The additional information field gives issuers the opportunity to provide important information to TDI about their data. This field should contain data clarifications and explanations regarding certain calculation methodologies used to complete Part E. **This field is required if any of the following conditions apply:**

If any requested data is **not applicable**, identify the fields and provide an explanation regarding why they don't apply.

If any requested data is **not available**, identify the fields and provide a detailed explanation regarding why the information is not available.

If any block of business captured by the data call is **closed or in run-off**, identify the applicable coverage category (individual, group) and provide the number of lives covered by that block of business.

Data Certification (Part G)

After entering the required data, complete the data certification fields – **an issuer can't submit the form if these fields are incomplete**. The box next to the attestation statement must be marked. Provide the name, title, and phone number of a person with the authority to certify the issuer's data. This individual should be a corporate officer, actuary, attorney, or accountant. If an authorized agent is completing the data call on behalf of this individual, include both parties in the name field. For example, enter **Bob Jones, on behalf of Pam Smith**. However, the title field should only specify the title of the person with the authority to certify the issuer's data. A separate affidavit is not required.

Interactive Form Instructions

Form LHL657 contains form fields that will be completed on-screen using Adobe Reader 9.0 (or higher). The PDF form can be printed or exported to a separate file after completion. The following is additional detail on how to complete and submit the data collection form:

Select the “Hand” tool or use the tab key to navigate between form fields.

Do either of the following in the Document Message Bar to make form fields easier to identify in the PDF file:

Select *Highlight Fields* to display a light blue color in the background of all form fields.

Select *Highlight Required Fields* to display a red outline around all required form fields. **The issuer can’t submit the form if all of the required fields are not completed.**

The form fields are preformatted, and the correct formatting will appear after clicking “Tab” to go to the next field. The following examples demonstrate the correct data entry format:

Round currency fields on the cover sheet and the detailed claim worksheets to the nearest dollar and enter without dollar signs or commas. For example, enter \$500,000 as **500000**.

Round currency fields on the detailed premium worksheets to the nearest cent. For example, for an average premium of \$5.25 enter **5.25**.

Enter numerical (non-currency) fields on the detailed claim worksheets without commas. For example, enter 2,500 claims as **2500**.

The form will not accept text responses in numerical or currency fields. If requested data is not applicable or not available, provide an explanation in the additional information field as described on page 8.

Complete the claim information and premium information worksheets for each applicable coverage category (individual, group) as indicated on the cover sheet. Leave the claim and premium worksheets blank for any coverage category that does not apply.

If the issuer has claims to report for a specific mandate in a specific coverage category, complete all data columns for that mandate (including the number of claims paid, value of claims paid, number of policies or certificates, and annual administrative cost) on the claim information worksheet. Provide the average annual premium data for that mandate on the corresponding premium information worksheet.

Data Submission Instructions

To print a copy of the completed PDF form, click “Print Form” at the end of the form. The completed PDF form can’t be saved as a PDF using Adobe Reader.

The following are the instructions for submitting the form:

Desktop Email Application

Open the applicable email application before attempting to submit the form. Then, click “Submit by Email” at the end of the form. A new email message with an XML file attachment should appear. Address the message to MBSurvey@tdi.texas.gov, and enter “2016 Mandated Benefits Data Call” as the subject of the message followed by the NAIC number.

Internet-based Email Application (Gmail, Hotmail, etc.)

Click “Submit by Email” at the end of the form and the Select Email Client dialog box will appear. Select “Internet Email” and click “OK.” Follow the webmail instructions. Address the message to MBSurvey@tdi.texas.gov, and enter “2016 Mandated Benefits Data Call” as the subject of the message followed by the NAIC number. Include the issuer’s name in the body of the message.

As previously stated, form LHL657 will not be able to be submitted if all of the required fields have not been completed. If an issuer clicks on “Submit by Email” and a required field is blank, an error message will display and a red border will appear around the fields that require completion. Once all of the fields are completed, click “Submit by Email” to submit the data. TDI will only accept surveys returned in XML format as described above to ensure that the data is complete and processed correctly. TDI will not accept any survey returned in a different format, including scanned PDF files.

Send all questions concerning the mandated benefits data call by email to MBSurvey@tdi.texas.gov.