

Mandated Benefits Data Call

Instructions for Reporting

Introduction

In 2001, the 77th Legislature passed HB 1610 to amend Insurance Code Chapter 38 to add Subchapter F. The subchapter directs TDI to collect and report cost and utilization data for mandated benefits and mandated offers. TDI adopted the rule to implement the statute in 2002 and the rule amendments in 2017. The 2017 data call was the first data call to reflect the rule amendments.

28 Texas Administrative Code Sections 21.3401 – 21.3409 specifies that certain health benefit plan issuers and health maintenance organizations (HMOs) are required to submit data to TDI annually about mandated health benefits and mandated offers of coverage. TDI provides the following instructions, as well as other resources located on the [Mandated benefits data call index page](#), to help issuers collect the data and submit the reports.

Applicability

The data call applies to health benefit plan issuers subject to Insurance Code Section 38.251 and who report to the National Association of Insurance Commissioners (NAIC)¹ a total of \$10 million or more in direct premiums earned in Texas in a particular year for the following:

- individual comprehensive health coverage;
- small group comprehensive health coverage; or
- large group comprehensive health coverage.

Only issuers who meet these requirements are required to submit data relating to mandated health benefits and mandated offers of coverage.

Issuers who **do not** meet these requirements are **not** required to submit exempt reports.

Issuers will need to report data for any enrollees and their dependents covered by plans subject to the mandated benefits and offers regardless of where they reside. This includes situations where enrollees and their dependents live in different states.

¹ NAIC Supplemental Health Care Exhibit – Part 1

Report submission

Per the 2017 rule amendments, the reporting year is the previous calendar year. The report is due each year on June 1.

The following are the guidelines regarding report submission:

- Issuers will submit reports in XML format using the “Submit by Email” button on the form.
- Issuers will submit reports by email to MBSurvey@tdi.texas.gov.
- Different issuers cannot consolidate information into one report.
- Issuers will submit one form to report individual, small group, and large group data.
- Issuers who have both insurance and HMO business must submit separate reports for each.

Reporting form

Issuers required to file a report must complete the data call using an interactive PDF form (LAH345) located on the [Mandated benefits data call index page](#) of TDI’s website. The reporting form contains fillable fields that must be completed electronically using Adobe Reader 9.0 or higher to ensure proper form functionality. TDI recommends downloading the form before entering data.

The reporting form has the following sections:

- Cover sheet;
- Part A: Aggregate data;
- Part B: Mandated benefits – individual data;
- Part C: Mandated benefits – small group data;
- Part D: Mandated benefits – large group data;
- Part E: Mandated offers – individual data;
- Part F: Mandated offers – small group data;
- Part G: Mandated offers – large group data;
- Part H: Mandated benefits and offers claims identification;
- Part I: Additional information; and
- Part J: Data certification.

Cover sheet

Issuers must provide all requested information. If the answer to all three applicability questions is "No," skip to Part J – Data certification.

- **Issuer name:** Enter the issuer's name.
- **NAIC number:** Enter the issuer's NAIC number.
- **Issuer type:** Select either "insurance" or "HMO" using the drop-down menu.
- **Reporting year:** Field is pre-filled with the current reporting year.
- **Submission date:** Select the report submission date using the date picker tool.
- **Issuer mailing address:** Enter the mailing address for the issuer, including the city, state (drop-down menu), and ZIP code.
- Are you a third-party administrator reporting on behalf of the named issuer? Select either "Yes" or "No" using the drop-down menu.
- **Contact name:** Enter the first and last name of the person designated by the issuer to discuss the report with TDI staff.
- **Title:** Enter the title of the contact person.
- **Phone number:** Enter the contact person's direct telephone number. Include an extension, if applicable.
- **Email address:** Enter the contact person's email address.
- **Contact mailing address:** Enter the mailing address for the contact person, including the city, state (drop-down menu), and ZIP code.
- **May TDI release this email address?** Select either "Yes" or "No" using the drop-down menu.
- **Data call applicability – individual:** Select either "Yes" or "No" using the drop-down menu. If the answer is "Yes," the report must be completed and submitted. If the answer is "No," leave Parts B and E of the report blank.
- **Data call applicability – small group:** Select either "Yes" or "No" using the drop-down menu. If the answer is "Yes," the report must be completed and submitted. If the answer is "No," leave Parts C and F of the report blank.
- **Data call applicability – large group:** Select either "Yes" or "No" using the drop-down menu. If the answer is "Yes," the report must be completed and submitted. If the answer is "No," leave Parts D and G of the report blank.

Part A: Aggregate data

Issuers must provide total premiums earned, total claims incurred, and total member months for **all** health benefit plans subject to the mandated benefit and mandated offer requirements in Texas during the reporting year.

- **Total direct premiums earned during the year:** Enter the dollar amount of the total premiums earned for **all** plans subject to mandated benefits and mandated offers during the reporting year. Issuers will round responses to the nearest dollar and not use dollar signs, decimals, or commas.
- **Total claims incurred during the year:** Enter the dollar amount of the total claims incurred for **all** plans subject to mandated benefits and mandated offers during the reporting year. Issuers will round responses to the nearest dollar and not use dollar signs, decimals, or commas.
- **Total member months for the year:** Enter the total number of member months for enrollees of **all** plans subject to mandated benefits and mandated offers for the reporting year. Issuers will enter whole numbers and not use decimals or commas.

Parts B, C, and D: Mandated benefits – individual data, small group data, and large group data

Issuers must provide the following information as applicable:

- **Claims incurred during the year:** Enter the total dollar amount of the claims incurred for each mandated benefit during the reporting year. Issuers will round responses to the nearest dollar and not use dollar signs, decimals, or commas.
- **Number of claims incurred during the year:** Enter the total number of separate claims incurred for each mandated benefit during the reporting year. Issuers will enter whole numbers and not use decimals or commas.
- **Total member months for the year:** Enter the total number of member months for all enrollees covered for each mandated benefit during the reporting year regardless of whether the enrollees incurred claims for the mandated benefit. Issuers will enter whole numbers and not use decimals or commas.

Notes: All mandates listed may not apply to all plan types. If a mandate does not apply, leave the fields blank. If a mandate does apply but has no claims, enter "0" in the claims fields.

Please include any data reported or omitted in this section that needs explanation in Part I – Additional information.

Parts E, F, and G: Mandated offers – individual data, small group data, and large group data

Issuers must provide the following information as applicable:

- **Claims incurred during the year:** Enter the total dollar amount of the claims incurred for each mandated offer during the reporting year. Issuers will round responses to the nearest dollar and not use dollar signs, decimals, or commas.
- **Number of claims incurred during the year:** Enter the total number of separate claims incurred for each mandated offer during the reporting year. Issuers will enter whole numbers and not use decimals or commas.
- **Total member months for the year:** Enter the total number of member months for all enrollees covered for each mandated offer during the reporting year regardless of whether the enrollees incurred claims for the mandated offer. Issuers will enter whole numbers and not use decimals or commas.

Notes: All the offers listed may not apply to all plan types. If an offer does not apply, leave the fields blank. If an offer does apply but has no claims, enter "0" in the claims fields.

Please include any data reported or omitted in this section that needs explanation in Part I – Additional information.

Part H: Mandated benefits and offers claims identification

Issuers must provide the following information:

- **Medical billing codes:** List the medical billing codes and filters used to identify applicable claims for each mandated benefit and mandated offer of coverage.

Issuers must list the medical billing codes and filters in this section of the report. Do not simply state, "See mandated benefits code list" or submit the codes as a separate email attachment. TDI uses this information to better understand the data and identify potential causes of data inconsistencies between responding issuers.

For additional information, please see the methodologies document and code workbook located in the additional resources section on the [Mandated benefits data call index page](#).

Please include any data reported or omitted in this section that needs explanation in Part I – Additional information.

Part I: Additional information

Issuers can use the additional information field to provide important information about their data. This field should contain data clarifications as necessary.

Part J: Data certification

After entering the reporting data, issuers must complete the data certification fields. The form cannot be submitted if these fields are incomplete.

- **Attestation:** Click on the box next to the attestation statement and a checkmark will appear.
- **Contact information:** Provide the name, title, and direct telephone number of a person with authority to certify the 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 data. A separate affidavit is not required.

Data collection codes, methodologies, and frequently asked questions

TDI provides the additional resources shown below on the [Mandated benefits data call index page](#) to help issuers collect and report the data.

Data collection methodologies will ensure report data is consistent and falls within the scope of each mandate. The methodologies include the requirements and limitations for each mandate, as applicable. Age and gender parameters are also provided, as well as information to avoid reporting duplicate data.

Code workbook includes medical billing codes to help issuers identify claims data about the various mandated benefits and mandated offers. The workbook may not include all relevant codes because of the variation in reporting requirements and claims filing procedures for each issuer. Issuers should use these codes as a reference too and may use additional codes as appropriate.

Frequently asked questions provide answers to commonly asked questions about the data call.

Definitions

- **Claims incurred** – Paid claims plus amounts held in reserve for claims that have been incurred but have not yet been paid.
- **Direct premium** – The amount of health premiums earned for comprehensive health coverage as reported on an issuer's submission to the NAIC for the year for which it is reporting data.
- **Health benefit plan** – A benefit plan regulated under Insurance Code Title 8 (Health Insurance and Other Health Coverages), Subtitles A (Health Coverage in General), B (Group Health Coverage), C (Managed Care), D (Provider Plans), and G (Health Coverage Availability).
- **Mandated benefit** – A health benefit listed in the table in the appendix that must be included in a health benefit plan.
- **Mandated offer** – An offer of coverage listed in the table in the appendix that must be offered and made available to the holder or sponsor of an individual or group health benefit plan.
- **Medical billing codes** – Standard code sets used to bill for specific medical services, including the Healthcare Common Procedure Coding System (HCPCS) and diagnosis-related group (DRG) system established by the Centers for Medicare and Medicaid Services (CMS), the Current Procedural Terminology (CPT) code set maintained by the American Medical Association, and the International Classification of Diseases (ICD) code sets developed by the World Health Organization.
- **Member months** – The cumulative number of months that all enrollees were covered during the reporting year.
- **Reporting entity** – A health benefit plan issuer or third-party administrator that performs claims payment services for a health benefit plan issuer subject to this data call.
- **Reporting year** – A one-year period, beginning each January 1 and ending the following December 31, when health benefit plan issuers must collect the data required by this data call.
- **Third-party administrator** – An administrator holding a certificate of authority under Insurance Code Chapter 4151 (Third-Party Administrators).

Interactive form instructions

Issuers will need to complete the reporting form (LAH345) on-screen using Adobe Reader 9.0 or higher. The PDF form can be printed or exported to a separate file after completion. Additional information on how to complete and submit the reporting form is below:

- 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 the 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 cannot 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. Issuers will need to follow these guidelines when entering reporting data:

- **Round currency fields to the nearest dollar—do not use dollar signs, decimals, or commas.** For example, enter \$500,000 as **500000**. Dollar signs and commas will appear after moving to the next field.
- Enter numerical (non-currency) fields with whole numbers—do not use decimals or commas. For example, enter 2,500 as 2500. Commas will appear after moving to the next field.
- **The form will not accept text responses in numerical or currency fields.** If the requested data for a mandate or offer is not applicable, leave the fields blank. Please provide any necessary explanations in Part I – Additional information.

Data submission instructions

Issuers can print a copy of the completed PDF form by clicking “Print Form” at the end of the form. The completed PDF form cannot be saved as a PDF using Adobe Reader. The instructions for submitting the form by email using either a desktop email application or an internet-based email application are included below.

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 and a message with information will appear. Click “OK” and the “Select Email Client” dialog box will appear. Select “Desktop Email Application” and click “OK.” A new email message with an XML file attachment should appear. Address the message to MBSurvey@tdi.texas.gov, and enter “Mandated Benefits Data Call” as the subject of the message followed by the issuer’s NAIC number.

Internet-based email application (Gmail, Hotmail, etc.) – Click “Submit by Email” at the end of the form and a message with information will appear. Click “OK” and the “Select Email Client” dialog box will appear. Select “Internet Email,” click “OK,” and follow the webmail instructions. Address the message to MBSurvey@tdi.texas.gov, and enter “Mandated Benefits Data Call” as the subject of the message followed by the issuer’s NAIC number. Include the issuer’s name in the body of the message.

As previously stated, form LAH345 cannot be submitted if any 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 on “Submit by Email” to convert the data to an XML attachment. TDI will only accept reports submitted in XML format using the prescribed form to ensure that the data is complete and processed correctly. **TDI will not accept any reports submitted as a PDF or in a different format, including scanned PDF files.**

Questions?

Send questions about the mandated benefits data call to MBSurvey@tdi.texas.gov.

Appendix

The following table shows the mandated benefits and offers collected under the revised rule adopted in June 2017.

Mandated Benefits Data Call
Benefits
Acquired Brain Injury
Serious Mental Illness - 45/60
Autism Spectrum Disorder
Low-Dose Mammography Cancer Screening
Reconstructive Surgery Following Mastectomy
Diabetes Equipment, Supplies, and Self-Management Training
Formulas for PKU or Other Heritable Diseases
Temporomandibular Joint (TMJ) Diagnosis and Treatment
Osteoporosis Detection and Prevention
Prostate Cancer Screening
Colorectal Cancer Screening
Childhood Immunizations
Hearing Screening for Children
Chemical Dependency – Inpatient Only
Chemical Dependency – Outpatient Only
Prescription Contraceptive Drugs, Devices, and Related Services
HPV and Cervical Cancer Screening
Ovarian Cancer Screening
Cardiovascular Disease - Early Detection
Amino Acid-Based Elemental Formulas
Offers
Loss or Impairment of Speech or Hearing
In Vitro Fertilization
Developmental Delays in Children