Guidance for reporting Medicare Advantage and Medicare Part D Stand-Alone Plans in the Supplemental Health Care Exhibit for Annual 2014

This document represents assistance in completing the Supplemental Health Care Exhibit. This document was developed in order to answer questions reporting entities may have as a result of the Health and Human Services/Centers for Medicare & Medicaid Services (HHS) final rule: 42 CFR Parts 422 and 423 dated May 23, 2013 regarding the 85% MLR requirement for Medicare Advantage Part C and Medicare Part D plans. This document was developed for assistance only and has not been formally adopted as part of the annual statement instructions.

Note: This guidance is intended only to provide additional assistance for reporting Medicare Advantage Part C and Medicare Part D plans as a result of the Health and Human Services/Centers for Medicare & Medicaid Services (HHS) final rule: 42 CFR Parts 422 and 423 dated May 23, 2013 for those reporting entities that are required to file the Supplemental Health Care Exhibit as defined in the instructions adopted for 2014 reporting.

ANNUAL STATEMENT

SUPPLEMENTAL HEALTH CARE EXHIBIT

COLUMN DEFINITIONS FOR SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1 AND 2

Where specifically stated, the reporting instructions and definitions contained in the supplement should be used. When not specifically stated, use the annual statement instructions and definitions. Amounts reported in the columns below are mutually exclusive to each other and should not be duplicated in another column.

Column 1 – Comprehensive Health Coverage – Individual

Include: Health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes group conversion policies.

Column 2 – Comprehensive Health Coverage – Small Group Employer

All policies issued to small group employers.

Include small group health plans. “Small group health plan” means a health plan offered in the small group market as such term is defined in state law, consistent with the group’s state of situs reporting, in accordance with the Public Health Service Act.

Column 3 – Comprehensive Health Coverage – Large Group Employer

All policies issued to large group employers (including Federal Employees Health Benefit Plan and similar insured state and local fully insured programs).

Include: TRICARE plans.

Column 4 – Mini-med plans – Individual

Column 5 – Mini-med plans – Small Group Employer

Column 6 – Mini-med plans – Large Group Employer

Include “mini-med” plans also referred to as “limited benefit indemnity health insurance plans” in Section 158.120(d)(3) of the MLR Interim Final Rule for policies that have a total annual limit of $250,000 or less.

The definition of individual, small group employer and large group employer is the same definition as used for Comprehensive Health Coverage (Columns 1 through 3) above.
<table>
<thead>
<tr>
<th>Column 7</th>
<th>Expatriate plans – Small Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 8</td>
<td>Expatriate plans – Large Group</td>
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Include expatriate plans referenced in Section 158.120(d)(4) of the MLR Interim Final Rule as policies that provide coverage for employees, substantially all of whom are: working outside their country of citizenship; working outside of their country of citizenship and outside the employer’s country of domicile; or non-U.S. citizens working in their home country.

These policies can be reported on a nationwide, aggregated basis, in the respective small group/large group columns. The amounts should be reported on the appropriate, domiciliary state page.

| Column 9          | Student Health Plans               |

Include student health plans referenced in Section 147.145(a) of the MLR Interim Final Rule

These policies can be reported on a nationwide, aggregated basis. The amounts should be reported on the appropriate, domiciliary state page.

| Column 10         | Government Business (Excluded by Statute) |

Include government programs that are excluded by statute, such as Medicare Title XVIII (including Medicare Advantage Part C and Medicare Part D plans, notwithstanding that, effective in 2014, these coverages are no longer “excluded by statute” pursuant to the May 23, 2013 ACA final rule, 42 CFR Parts 422 and 423 and will be excluded from this column in future filings), Medicaid Title XIX, State Children’s Insurance Health Program (SCHIP) Medicaid Program Title XXI risk contracts, and other federal or state government-sponsored coverage.

| Column 11         | Other Health Business               |

Other Business (Excluded by Statute):

Health plan arrangements that do not provide comprehensive coverage as defined by statute.

Include short-term limited duration insurance and Medicare supplemental health coverage as defined under Section 1882(g)(1) of the Social Security Act, if offered as a separate policy, including student health plans meeting this criteria. Include coverage supplemental to the coverage provided under chapter 55 of title 10, United State Code, and similar supplemental coverage provided under a group health plan, hospital or other fixed indemnity coverage, specified disease or illness coverage and other limited benefit plans as specified by regulations promulgated by HHS in consultation with the NAIC.

All other health care business included in the Accident and Health Experience Exhibit that is not reported in Columns 1 through 10, including the stand-alone dental and vision coverages, long-term care, disability income, etc.

For insurers that assume health business via aggregate stop-loss reinsurance or other reinsurance that applied to a reinsured entity’s or group of entities’ entire business that would not be allocable to comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student plans in Columns 1 through 9 of Parts 1 and 2 of the supplement: report such assumed reinsurance on Line 1.9 (premiums) and Line 5.1 (claims) in Column 11 (Other Health Business) for the state page corresponding to the ceding insurer’s state of domicile.

| Column 12         | Aggregate (2% rule) |

This column may be used by an insurer if the Columns 1 through 9 earned premiums are less than 2% of its total health earned premiums in that state, to combine all other health business in this column; or, the insurer can opt to skip this column and provide the breakout amounts for Columns 10 and 11.

This column cannot be used by insurers with earned premiums in Columns 1 through 9 that are 2% or greater of their total health earned premiums in a particular state.