

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: _____ CONTACT PERSON: _____ TELEPHONE: _____ EMAIL ADDRESS: _____ ON BEHALF OF: <u>Health Reform Solvency Impact (E) Subgroup</u> NAME: <u>Lou Felice</u> TITLE: <u>Chair of the Subgroup</u> AFFILIATION: <u>New York State Department of Insurance</u> ADDRESS: <u>25 Beaver Street</u> <u>New York City, NY 10004</u>	FOR NAIC USE ONLY		
	Agenda Item # _____ Year _____ Changes to Existing Reporting <input type="checkbox"/> <input type="checkbox"/> New Reporting Requirement <input type="checkbox"/> <input type="checkbox"/>	REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT	
	No Impact <input type="checkbox"/> <input type="checkbox"/> Modifies Required Disclosure <input type="checkbox"/> <input type="checkbox"/>	DISPOSITION	
	<input type="checkbox"/> <input type="checkbox"/> Rejected For Public Comment <input type="checkbox"/> <input type="checkbox"/> Referred To Another NAIC Group <input type="checkbox"/> <input type="checkbox"/> Received For Public Comment <input type="checkbox"/> <input type="checkbox"/> Adopted Date _____ <input type="checkbox"/> <input type="checkbox"/> Rejected Date _____ <input type="checkbox"/> <input type="checkbox"/> Deferred Date _____ <input type="checkbox"/> <input type="checkbox"/> Other (Specify) _____		

BLANK(S) TO WHICH PROPOSAL APPLIES

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| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input type="checkbox"/> QUARTERLY STATEMENT | |
| <input checked="" type="checkbox"/> INSTRUCTIONS | <input checked="" type="checkbox"/> CROSSCHECKS | <input checked="" type="checkbox"/> BLANK |
| <input checked="" type="checkbox"/> Life and Accident & Health | <input checked="" type="checkbox"/> Property/Casualty | <input checked="" type="checkbox"/> Health |
| <input type="checkbox"/> Separate Accounts | <input checked="" type="checkbox"/> Fraternal | <input type="checkbox"/> Title |
| <input type="checkbox"/> Other Specify | | |

Anticipated Effective Date: Annual 2010, Quarterly 2011

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new supplement and instructions for the recording of comprehensive major medical health insurance business for large group employer, small group employer, and individual.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

To assist regulators in identifying and analyzing the medical loss ratio for comprehensive major medical health insurance as required in the Patient Protection and Affordable Care Act (PPACA) of 2009 (H.R. 3590).

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

Revised 6/13/2009

REPORT FOR: 1. CORPORATION _____ 2. _____
 (LOCATION)

NAIC Group Code _____ BUSINESS IN THE STATE OF _____ DURING THE YEAR _____ NAIC Company Code _____

	Comprehensive Health Coverage				5 Other Business (excluded by Statute)	6 Other 1 (Placeholder)	7 Other Health	8 Total
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Government Business (excluded by statute)				
1.	Health Premiums Earned:							
1.1	Direct premiums written							
1.2	Unearned premium prior year							
1.3	Unearned premium current year							
1.4	Change in unearned premium (Lines 1.2 – 1.3)							
1.5	Reserve for rate credits prior year							
1.6	Reserve for rate credits current year							
1.7	Change in reserve for rate credits (Lines 1.5 – 1.6)							
1.8	Total direct premiums earned (Lines 1.1 – 1.4 – 1.7)							
1.9	Assumed premiums earned from non-affiliates							
1.10	Assumed premiums earned from affiliates							
1.11	Ceded premiums earned to non-affiliates							
1.12	Ceded premiums earned to affiliates							
1.13	Net premiums earned (Lines 1.8 + 1.9 + 1.10 – 1.11 – 1.12)							
2.	Direct Claims Incurred:							
2.1	Paid claims during the year							
2.2	Direct claim liability current year							
2.3	Direct claim liability prior year							
2.4	Direct claim reserves current year							
2.5	Direct claim reserves prior year							
2.6	Direct contract reserves current year							
2.7	Direct contract reserves prior year							
2.8	Incurred medical incentive pools and bonuses (Lines 2.8a + 2.8b – 2.8c)							
2.8a	Paid medical incentive pools and bonuses current year							
2.8b	Accrued medical incentive pools and bonuses current year							
2.8c	Accrued medical incentive pools and bonuses prior year							
2.9	Net healthcare receivables (Lines 2.9a – 2.9b)							
2.9a	Healthcare receivables current year							
2.9b	Healthcare receivables prior year							
2.10	Total Incurred Claims (Lines 2.1 + 2.2 – 2.3 + 2.4 – 2.5 + 2.6 – 2.7 + 2.8 – 2.9)							
2.11	Assumed Incurred Claims from non-affiliates							
2.12	Assumed Incurred Claims from affiliates							
2.13	Ceded Incurred Claims to non-affiliates							
2.14	Ceded Incurred Claims to affiliates							
2.15	Net Incurred Claims (Lines 2.10 + 2.11 + 2.12 – 2.13 – 2.14)							

REPORT FOR: 1. CORPORATION _____ 2. _____
 (LOCATION)

NAIC Group Code _____ BUSINESS IN THE STATE OF _____ DURING THE YEAR _____ NAIC Company Code _____

		Improving Health Care Quality Expenses					Claims Adjustment Expenses		9 General Administrative Expenses	10 Total Expenses (6 to 9)
		1 Care Coordination	2 Chronic Disease Management	3 Preventive Care and Wellness Programs	4 Other Approved Expenses	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses		
1.	Individual Comprehensive Coverage Expenses:									
	1.1 Salaries									
	1.2 Outsourced Services									
	1.3 EDP Equipment and Software									
	1.4 Other Equipment (excluding EDP)									
	1.5 Accreditation and Certification									
	1.6 Other Expenses									
	1.7 Subtotal before Reimbursements and Taxes									
	1.8 Reimbursements by uninsured plans and fiscal intermediaries....									
	1.9 Taxes, Licenses and Fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
	1.10 Total.....									
2.	Small Group Comprehensive Coverage Expenses:									
	2.1 Salaries									
	2.2 Outsourced Services									
	2.3 EDP Equipment and Software									
	2.4 Other Equipment (excluding EDP)									
	2.5 Accreditation and Certification									
	2.6 Other Expenses									
	2.7 Subtotal before Reimbursements and Taxes									
	2.8 Reimbursements by uninsured plans and fiscal intermediaries....									
	2.9 Taxes, Licenses and Fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
	2.10 Total.....									
3.	Large Group Comprehensive Coverage Expenses:									
	3.1 Salaries									
	3.2 Outsourced Services									
	3.3 EDP Equipment and Software									
	3.4 Other Equipment (excluding EDP)									
	3.5 Accreditation and Certification									
	3.6 Other Expenses									
	3.7 Subtotal before Reimbursements and Taxes									
	3.8 Reimbursements by uninsured plans and fiscal intermediaries....									
	3.9 Taxes, Licenses and Fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
	3.10 Total.....									

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ANNUAL AND QUARTERLY STATEMENT INSTRUCTIONS – LIFE, HEALTH, PROPERTY & FRATERNAL

SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1 AND 2

The purpose of this supplemental exhibit is to assist state and federal regulators in identifying and defining elements that make up the medical loss ratio as described in Section 2818(b) of the Patient Protection and Affordable Care Act (PPACA) of 2009 (H.R. 3590) and for purposes of submitting a report to the Secretary required by Section 2718(a) of the Act. The supplemental exhibit is also intended to track and compare financial results of healthcare business as reported in the annual and quarterly financial statements.

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Deleted: Public Health Service

A schedule must be prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical health business, or has direct amounts paid, incurred or unpaid for provisions of health care services. In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company. The allocation of premium between jurisdictions should be based upon situs of the contract. For purpose of this exhibit, situs of the contract is defined as “the jurisdiction in which the contract is issued or delivered as stated in the contract.” For individual business sold through an association, the situs of the contract shall be based on the issue state of the certificate of coverage. For small employer business issued through a group trust, the situs of the contract shall be based on the location of the small employer.

Include only in this schedule the business issued by this reporting entity. Business that is written by an unaffiliated entity as part of a package provided to the consumer (e.g., inpatient written by this legal entity, outpatient written by unaffiliated separate entity) should not be included in this exhibit. Similarly, business written by an affiliated legal entity as part of a package provided as an option to the group employer (e.g., out of network coverage written by an affiliated entity and in-network coverage written via this legal entity) should not be included in this exhibit.

Comprehensive health coverage, columns 1 through 3, includes business that provides for medical coverages including hospital, surgical and major medical. Include risk contracts and Federal Employees Health Benefit Plan (FEHBP).

Do not include business specifically identified in other columns (e.g. self-insured business, Medicare Title XVIII, Medicaid Title XIX, vision only, dental only business, Insurance Program (SCHIP), Medicaid Program Title XXI risk contracts, and short-term limited duration insurance).

Column 1 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 conversions from group policies.

Exclude: Policies reported in other columns.

Column 2 All policies issued to Small Group Employers
Includes groups with up to 100 employees, except in states exercising an option under PPACA §1304(b)(3) to define small group as groups up to 50 employees until 2016.

Column 3 All policies issued to Large Group Employer (including Federal Employees Health Benefit Program and similar insured State and local fully insured programs)

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Column 4 Government Business (Excluded by Statute)
Include government programs that are excluded by statute such as Medicare Title XVIII, Medicaid Title XIX, Insurance Program (SCHIP), Medicaid Program Title XXI risk contracts, and other Federal, or State government sponsored coverage.

Deleted: similar

Column 5 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. Include coverage supplemental to the coverage provided under chapter 55 of title 10, United State Code, and similar

Deleted: plans

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.

Column 6

Other Health

All other health care business not reported in columns 1 through 6 including the stand-alone dental, and vision coverages, long-term care, disability income, etc.

Column 8

Uninsured Plans

Refer to *SSAP 47-Uninsured Plans* for additional guidance.

DISCUSSION DRAFT

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1

- Line 1.1 – Health Premiums Earned
- Include: Direct written premium plus the change in unearned premium reserves and the change in reserve for rate credits.
- Premiums earned on novated policies and on 100% assumption reinsurance where policyholders have consented (via opt in or failure to opt out) to the replacement of the original policy issuer (including cases where full servicing of premiums and claims have been transferred) by the assuming reinsurer.
- Line 1.2 – Federal High Risk Pools
- Include: Subsidies received or (assessments paid) under Federal High risk Pools as provided in PPACA of 2009 (HR. 3590 – site sections for initial High Risk and Future risk adjustment mechanisms).
- Line 1.3 – State High Risk Pools
- Include: Subsidies received or (assessments paid) under State high risk pools.
- Exclude: Items included on line 2.4.
- Line 1.5 – Federal Taxes and Federal Assessments
- Include: All federal taxes and assessments allocated to health insurance coverage reported under §2718 of the Public Health Service Act.
- Exclude: Federal income taxes on investment income and capital gains.
- Line 1.6 – State and Local Insurance Taxes and Assessments
- Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the state.
- Guaranty fund assessments
- Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states. Canadian and other foreign taxes are to be included appropriately.
- Advertising required by law, regulation or ruling, except advertising associated with investments.
- State income taxes other than premium taxes.
- Exclude: State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.
- Line 1.7 – State and Local Premium Taxes
- Include: State taxes based on policy reserves, if in lieu of premium taxes. Canadian and other foreign taxes should be included appropriately.
- Payments for community based expenditures in lieu of premium tax but limited to the state premium tax rate.

Exclude: Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.

Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

Line 1.8 – Regulatory Authority Licenses and Fees

Include: Statutory assessments to defray operating expenses of any state insurance department. Examination fees in lieu of premium taxes as specified by state law.

Exclude: Fines and penalties of regulatory authorities.

Fees for examinations by state departments other than as referenced above.

Line 1.10 – Assumed Reinsurance Premiums Earned

Should agree with Supplemental Health Care Exhibit - Part 2, Line 1.9 plus Line 1.10 for each column.

Line 1.11 – Ceded Reinsurance Premiums Earned

Ceded reinsurance premiums written plus the change in unearned premium reserve that is transferred to the company assuming the risk plus the change in reserve credit taken other than for unearned premiums.

Should agree with Supplemental Health Care Exhibit - Part 2, Line 1.11 plus Line 1.12 for each column.

Line 1.12 – Risk Revenue

Include: Amounts charged by the reporting entity as a provider or intermediary for specified medical services (e.g., full professional, dental, radiology, etc.) provided to the policyholders or members of another insurer or reporting entity.

Unlike premiums that are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payment, made by another insurer or reporting entity to the reporting entity in exchange for services to be provided or offered by such organization.

Line 2.1 – Incurred Claims Excluding Prescription Drugs:

Hospital/Medical Benefits

Include: Expenses for physician services provided under contractual arrangement to the reporting entity.

Salaries, including fringe benefits, paid to physicians for delivery of medical services. Capitation payments by the reporting entity to physicians for delivery of medical services to reporting entity subscribers.

Fees paid by the reporting entity to physicians on a fee-for-service basis for delivery of medical services to reporting entity subscribers. This includes capitated referrals.

Inpatient hospital costs of routine and ancillary services for reporting entity members while confined to an acute care hospital.

Charges for non-reporting entity physician services provided in a hospital are included in this line item only if included as an undefined portion of charges by a hospital to the reporting entity. (If separately itemized or billed, physician charges should be included in outside referrals, below.)

The cost of utilizing skilled nursing and intermediate care facilities.

Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.

Ancillary services may also include laboratory, radiology, drugs, delivery room, physical therapy services, other special items and services for which charges are customarily made in addition to a routine service charge.

Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation service.

Intermediate care facilities are for individuals who do not require the degree of care and treatment that a hospital or skilled nursing-care facility provides, but that do require care and services above the level of room and board.

Other Professional Services

Include: Expenses for other professional providers under contractual arrangement to the reporting entity.

Salaries, as well as fringe benefits, paid by the reporting entity to non-physician providers licensed, accredited or certified to perform specified clinical health services, consistent with state law, engaged in the delivery of medical services to reporting entity enrollees. Capitation payments by the reporting entity to such clinical service.

Deleted: providers for delivery of medical services to reporting entity subscribers. ¶

Compensation to personnel engaged in activities in direct support of the provision of medical services.

Exclude: Professional services not meeting this definition. Report these services as administrative expenses. For example, exclude compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks.

Outside Referrals

Include: Expenses for providers not under arrangement with the reporting entity to provide services, such as consultations, or out-of-network providers.

Emergency Room and Out-of-Area

Include: Expenses for other health delivery services including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital.

In the event a member is admitted to the health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.

Aggregate Write-ins for Other Hospital and Medical

Include: Direct Paid Claims during the Year

Report payments before ceded reinsurance, but net of risk share amount collected.

Change in Unpaid Claims

Report the change between prior year and current year unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation.

Change in Incurred but not Reported

Report the change in claims incurred but not reported from prior year to current year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.

Change in Contract & Other Reserves

Exclude: MLR rebates paid during the year.

Prescription drugs reported in line 2.2.

Pharmaceutical rebates received during the year, reported in line 2.3.

Medical incentive pools and bonuses.

Line 2.2 – Prescription Drugs

Include: Expenses for Prescription Drugs and other pharmacy benefits covered by the reporting entity.

Exclude: Prescription drug charges that are included in a hospital billing which should be classified as Hospital/Medical Benefits on Line 2.1.

Line 2.3 – Pharmaceutical Rebates

Refer to SSAP 84.

Line 2.4 – State Stop Loss, Market Stabilization and Claim/Census Based Assessments

Any payments by insurers that are directly tied to claims or census based assessments.

State subsidies based on a stop-loss payment methodology.

Unsubsidized State programs designed to address distribution of health risks across health insurers via charges to low risk carriers that are distributed to high risk carriers.

Line 3 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings or promote quality improvements as defined in the PPACA (section....)

Line 4.1 – Assumed Reinsurance Claims Incurred

Assumed reinsurance claims paid plus the change in the assumed reinsurance claims liability and aggregate assumed reinsurance claims reserve.

Should agree with Supplemental Health Care Exhibit - Part 2, Line 2.11 plus Line 2.12 for each column.

Line 4.2 – Ceded Reinsurance Claims Incurred

Ceded reinsurance claims paid plus the change in the ceded reinsurance claims liability and aggregate ceded reinsurance claims reserve less the change in claims related reinsurance recoverables.

Should agree with Supplemental Health Care Exhibit - Part 2, Line 2.13 plus 2.14 for each column.

Line 4.3 – Rebates Paid

MLR Rebates paid during the year.

Line 4.4 – Estimated Rebates Unpaid at the end of the Prior Year

Line 4.5 – Estimated Rebates Unpaid at the end of the Current Year

MLR rebates estimated but unpaid as of reporting period.

Line 4.6 – Fee-for-Service and Co-Pay Revenue (net of expenses)

Include: Revenue recognized by the reporting entity for collection of co-payments from members and revenue derived from health services rendered by reporting entity providers that are not included in member policies.

Deduct: Medical expenses associated with fee-for-service business.

Line 5 – Expenses for Health Care Quality Improvements

Expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care in ways that can be objectively measured and verified. Section 2717 of the PPACA lists the following activities that may in whole or in part improve quality of care as follows:

- effective case management;
- care coordination;
- chronic disease management;
- medication and care compliance initiatives;
- prevention of hospital readmissions;
- activities to improve patient safety and reduce medical errors by using best clinical practices,
- activities to encourage evidence based medicine,
- wellness and health promotion activities.

These activities are embedded in the following 4 categories that will be included as quality of care expenses for the purposes of reporting in this supplemental filing and calculating the medical loss ratio (MLR):

1. **Care coordination** (not just general care management) - the direct interaction between the insurer and the enrollee (e.g. face-to-face, telephonic or web-based interactions or other modalities with patients and their providers) to coordinate a patient's care between multiple providers (*care coordination* such as making sure medical records are shared between all the patient's physicians and *activities to improve patient safety* and *reduce medical errors by using best clinical practices*, and *effective case management* such as making/verifying appointments and *medication and care compliance initiatives* [not involved with chronic disease management]) and arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center and *prevention of hospital readmissions*); care coordination *activities to encourage evidence based medicine*; and *health information technology* expenses to support these activities.
2. **Chronic Disease Management** Individually tailored *chronic disease management* programs for specific chronic conditions that interact with the insured (e.g. face-to-face, telephonic or web-based interactions or other modalities with patients and their providers) to provide *medication and care compliance initiatives* such as: (a) remind insured of doctor appointment, (b) check that insured is following a medically effective prescribed regimen for dealing with the specific disease/condition, (c) incorporating feedback from insured in the management program, (d) provide coaching on dealing with the disease/condition; chronic disease

management activities to encourage evidence based medicine; and health information technology expenses to support these activities.

3. **Preventive Care and Wellness Programs:** Programs that interact with the insured (e.g. face-to-face, telephonic or web-based interactions or other modalities with patients and their providers) related to: *Wellness* assessment, wellness/lifestyle coaching programs, coaching programs designed to educate members on clinically effective methods for dealing with a specific chronic disease, and coaching or education programs and *health promotion activities* designed to change member behavior (e.g., smoking, obesity); preventive care and wellness program activities to encourage evidence based medicine; and health information technology expenses to support these activities.
4. **Other costs** approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

Note: 24 Hour Nurse Hotlines: Expenses for 24 hour nurse hotlines should be included in care coordination, chronic disease management, and preventive care and wellness programs to the extent they meet those expense requirements. Any other expenses for 24 hour nurse hotlines should be excluded from Improving Health Care Quality Expenses and instead included in Claims Adjustment Expenses.

The following items are broadly excluded as not meeting this criteria:

- 24 Hour Nurse Hotlines except as noted above
- Utilization Review
- Fraud Prevention activities
- Network Management
- Provider Contracting
- Any function not expressly included in Type A items 1 through 4, above

Line 5.1 – Expenses for Health Care Quality Improvements other than HIT

Include expenses meeting the Line 5 definition that are not health information technology expenses.

Line 5.2 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates “Health Information Technology” as a function that may in whole or in part improve quality of care. Include health information technology expenses required to accomplish the activities reported in Line 5.1, that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information in the following ways;

1. Monitoring, measuring, or reporting clinical effectiveness;
2. Advancing the ability of providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

Exclude:

Costs directly related to upgrades in HIT that are required to be made in order to comply with new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended. (Discuss – Exclude as administrative or include as Fed requirement)

- Line 7.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 5.4
- Include: Expenses that actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses which improve the quality of health care reported in line 5.4. The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services:
- Post and concurrent claim case management activities associated with past or ongoing specific care;
 - Utilization review;
 - Detection and prevention of payment for fraudulent requests for reimbursement;
 - Expenses for internal and external appeals processes.
 - Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting.
- Line 7.2 – All Other Claims Adjustment Expenses
- Include: Costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in subparagraphs 6 a. and 6 b. of SSAP No. 55. Further, Claim Adjustment Expenses for Managed Care Reporting Entities are those costs expected to be incurred in connection with the adjustment and recording of managed care claims defined in subparagraph 7 a. of SSAP No. 55.
- Examples of other claim adjustment expenses are:
- Estimating the amounts of losses and disbursing loss payments;
 - Maintaining records, general clerical, and secretarial;
 - Office maintenance, occupancy costs, utilities, and computer maintenance;
 - Supervisory and executive duties; and
 - Supplies and postage.
- Line 9 – General & Administrative Expenses
- Line 9.1 – Direct Sales Salaries, Force Salaries and Benefits
- Line 9.2 – Agents and Brokers Fees and Commissions
- Line 9.3 – Other Taxes (Excluding Taxes on Lines 1.5 through 1.8 above and Federal Income Tax)
- Include: Taxes of Canada or of any other foreign country not specifically provided for elsewhere.
- Sales taxes, other than state sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.
- Line 9.4 – Other General & Administrative Expenses

OTHER INDICATORS

Line 1 – Number of Certificates / Policies

This is the number of individual policies (for individual business) or certificates issued to individuals covered under a group policy in force as of end of the reporting period. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Line 2 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of the reporting period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Line 3 – Number of Groups

This is the total number of insurance groups issued as of the end of the reporting period.

Line 4 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Drafting note for discussion:

The Working Group should discuss the usefulness of a subsequent “roll forward” schedule that reflects claims run-off and reconciles to a future date. (Possibly a subsequent date when rebates would be calculated.)

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2

- Line 1.8 – Total Direct Health Premiums Earned
- Include: Direct written premium plus the change in unearned premium reserves and reserve for rate credits.
- Line 2 – Direct Claims Incurred:
- Include: Paid Claims during the Year
- Report payments net of risk share amount collected.
- Change in Unpaid Claims
- Report the change between prior year and current year unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation.
- Change in Incurred but not Reported
- Report the change in claims incurred but not reported from prior year to current year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.
- Change in Contract & Other Reserves
- Line 2.2 – Direct Claim Liability Current Year
- Report the outstanding liabilities for healthcare services related to claims in the process of adjustment, incurred but not reported, amounts withheld from paid claims and capitations.
- Line 2.4 – Direct Claim Reserves Current Year
- Report reserves related to healthcare services for present value of amounts not yet due on claims and the claims related portion for reserve for future contingent benefits.
- Line 2.6 – Direct Contract Reserve Current Year
- Report the amount of reserves required when due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves.
- Line 2.8 – Incurred Medical Incentive Pools and Bonuses
- Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.
- Line 2.9 – Net Healthcare Receivables
- Report the change between prior year healthcare receivables and current year healthcare receivables. The amounts on this line are the gross healthcare receivable assets, not just the admitted portion. This amount should not include those healthcare receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.
- Line 2.10 – Should agree to Supplemental Health Care Exhibit - Part 1, Column 9, Line 4.0 minus Line 2.4.

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

This exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality as defined in Part 1 as well as the amount of those expenses that are used for other activities.

For the Individual, Small Group and Large Group amounts reported as Improving Health Care Quality Expenses Incurred in Part 1, report the amounts for the following expense lines for each of the appropriate major expense type columns.

Columns:

Other Approved Expenses Column: This column will be utilized if HHS establishes other major expense types subsequent to the adoption of the Blanks Proposal.

Other Approved HIT Expenses Column: This column will be utilized if HHS establishes other major HIT expense types subsequent to the adoption of the Blanks Proposal.

Lines 1.1, 2.1, 3.1 - Salaries

Lines 1.2, 2.2, 3.2 - Outsourced Services

Include: Expenses for administrative services, claim management services, new programming, membership services, and other similar services.

Exclude: Services provided by affiliates under management agreements.

Lines 1.3, 2.3, 3.3 - EDP Equipment and Software

Lines 1.4, 2.4, 3.4 - Other Equipment (excluding EDP)

Lines 1.5, 2.5, 3.5 - Accreditation and Certification

Include: Fees associated with the certification and accreditation of a health plan, including but not limited to, fees paid to Joint Commission on Accreditation of Healthcare Organizations (JCAHO); National Commission on Quality Assurance (NCQA); American Association for Health Care Certification (Utilization Review Accreditation Commission (URAC)).

Exclude: Rating agencies and other similar organizations.

Lines 1.6, 2.6, 3.6 - Other Expenses

Include: Commissions, legal fees and expenses, auditing, actuarial and other consulting services, as well as any additional expenses not included in another category.

Lines 1.8, 2.8, 3.8 - Reimbursement by uninsured plans and fiscal intermediaries

Reimbursements by Uninsured Plans:

Report as a negative amount, pharmaceutical rebates of uninsured plans that are received or change in due and uncollected by the reporting entity, to the extent that they are in excess of amounts to be remitted to the uninsured plan, administrative fees, direct reimbursement of expenses, or other similar receipts or credits attributable to uninsured health plans and the uninsured portion of partially insured accident and health plans. Deduct administrative fees and related reimbursements from general administrative expenses or claim adjustment expenses if the administrative services provided include services for claim adjustment expenses as defined in SSAP No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses.

Refer to SSAP No. 84, Certain Health Care Receivables and Receivables Under Government Insured Plans, for accounting guidance.

Reimbursements from Fiscal Intermediaries:

Report as a negative amount, administrative fees, direct reimbursement of expenses, or other similar receipts or credits attributable to Medicare, CHAMPUS and other federal and local governmental agencies.

Lines 1.9, 2.9, 3.9 - Taxes, Licenses and Fees

Include: State and local insurance taxes, state premium taxes, regulatory authority licenses and fees, payroll taxes, and any other taxes licenses or fees excluding federal income and real estate taxes.

DISCUSSION DRAFT