

**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

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

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- |  |   |  |
|--|---|--|
| <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 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

**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.

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1  
(To Be Filled by April 1 – Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION

2.

(LOCATION)

NAIC Group Code	BUSINESS IN THE STATE OF	DURING THE YEAR			NAIC Company Code			8 Uninsured Plans	9 Total 7+8
		1 Individual	2 Comprehensive Health Coverage Small Group Employer	3 Large Group Employer	4 Government Business (excluded by statute)	5 Other Business (excluded by Statute)	6 Other Health		
1.	Premium: 1.1 Health premiums earned (From Part 2)..... 1.2 Federal high risk pools..... 1.3 State high risk pools..... 1.4 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)..... 1.5 Federal taxes and federal assessments..... 1.6 State and local insurance taxes..... 1.7 State and local premium taxes..... 1.8 Regulatory authority licenses and fees..... 1.9 Adjusted Premiums Earned (Lines 1.4 - 1.5 - 1.6 - 1.7 - 1.8)..... 1.10 Assumed reinsurance premiums earned..... 1.11 Ceded reinsurance premiums earned..... 1.12 Risk Revenue..... 1.13 Net adjusted premiums earned after reinsurance (Lines 1.9 + 1.10 - 1.11 + 1.12).....							XXX XXX XXX XXX	
2.	Claims: 2.1 Incurred claims excluding prescription drugs..... 2.2 Prescription drugs..... 2.3 Pharmaceutical rebates..... 2.4 State stop loss, market stabilization and claim/census based assessments..... Incurred medical incentive pools and bonuses.....							XXX XXX XXX XXX XXX	
3.	4.0 Total Incurred Claims (Lines 2.1 + 2.2 - 2.3 - 2.4 + 3) (From Part 2).....							XXX	
4.	4.1 Assumed reinsurance claims incurred..... 4.2 Ceded reinsurance claims incurred..... 4.3 Rebates Paid..... 4.4 Estimated rebates unpaid prior year..... 4.5 Estimated rebates unpaid current year..... 4.6 Fee for service and co-pay revenue..... 4.7 Net incurred claims after reinsurance (Lines 4.0 + 4.1 - 4.2 + 4.3 - 4.4 + 4.5 - 4.6).....							XXX XXX XXX XXX XXX XXX XXX	
5.	Improving Health Care Quality Expenses Incurred: 5.1 Type A. Expenses for health improvements other than Health Information Technology..... 5.2 Type B. Health Information Technology expenses related to health improvement..... 5.3 Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 5.1 + 5.2).....							XXX	
6.	<b>Preliminary</b> Medical Loss Ratio: MLR (Lines 4.0 + 5.3) / Line 1.9.....							XXX	
7.	Claims Adjustment Expenses: 7.1 Cost containment expenses not included in quality of care expenses in Line 5.3..... 7.2 All other claims adjustment expenses..... 7.3 Total claims adjustment expenses (Lines 7.1 + 7.2).....							XXX	
8.	Claims Adjustment Expense Ratio (Line 7.3 / Line 1.9).....							XXX	
9.	General and Administrative (G&A) Expenses: 9.1 Direct sales salaries and benefits..... 9.2 Agents and brokers fees and commissions..... 9.3 Other taxes (excluding taxes on Lines 1.5 through 1.8 and Line 13 below)..... 9.4 Other general and administrative expenses..... 9.5 Total general and administrative (Lines 9.1 + 9.2 + 9.3 + 9.4).....							XXX	
10.	Underwritings Gain/(Loss) (Lines 1.9 - 4.0 - 5.3 - 7.3 - 9.5).....							XXX	
11.	Income from fees of uninsured plans.....							XXX	
12.	Net investment and other gain/(loss).....							XXX	
13.	Federal income taxes (excluding taxes on Line 1.5 above).....							XXX	
14.	Net gain or (loss) (Lines 10 + 11 + 12 - 13).....							XXX	
	<b>OTHER INDICATORS:</b>								
1.	Number of certificates / policies.....								
2.	Number of Covered Lives.....								
3.	Number of Groups.....								
4.	Member Months.....								

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2  
(To Be Filled by April 1 –Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION \_\_\_\_\_ 2. \_\_\_\_\_ (LOCATION)

NAIC Group Code \_\_\_\_\_ BUSINESS IN THE STATE OF \_\_\_\_\_ DURING THE YEAR \_\_\_\_\_ NAIC Company Code \_\_\_\_\_

	1		2		3	4	5	6	7
	Individual	Comprehensive Health Coverage	Small Group Employer	Large Group Employer					
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)..... 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).....								
2.									

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

(To Be Filled by April 1 –Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION

2.

(LOCATION)

NAIC Group Code BUSINESS IN THE STATE OF

DURING THE YEAR

NAIC Company Code

	1 Improve Health Outcomes	Improving Health Care Quality Expenses				6 Total (1 to 5)	Claims Adjustment Expenses			10 Total Expenses (7 to 9)
		2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses		7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	9 General Administrative 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 (1.1 to 1.6) ..... 1.8 Reimbursements by uninsured plans and fiscal intermediaries ..... 1.9 Taxes, Licenses and Fees (in total, for-tying purposes) ..... 1.10 Total (1.7 to 1.9) .....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
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 (2.1 to 2.6) ..... 2.8 Reimbursements by uninsured plans and fiscal intermediaries ..... 2.9 Taxes, Licenses and Fees (in total, for-tying purposes) ..... 2.10 Total (2.7 to 2.9) .....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
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 (3.1 to 3.6) ..... 3.8 Reimbursements by uninsured plans and fiscal intermediaries ..... 3.9 Taxes, Licenses and Fees (in total, for-tying purposes) ..... 3.10 Total (3.7 to 3.9) .....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

	Improving Health Care Quality Expenses					
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 Total (1 to 4)	
1.	Individual Comprehensive Coverage Expenses: 1.1 HIT expenses ..... 1.2 Other than HIT expenses ..... Small Group Comprehensive Coverage Expenses: 2.1 HIT expenses ..... 2.2 Other than HIT expenses ..... Large Group Comprehensive Coverage Expenses: 3.1 HIT Expenses ..... 3.2 Other than HIT expenses .....					
2.						
3.						
4.						

**ANNUAL STATEMENT INSTRUCTIONS – LIFE, HEALTH, PROPERTY & FRATERNAL**

**SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1, 2 AND 3**

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 2718(b) of the **Public Health Service Act (PHSA)** and for purposes of submitting a report to the Secretary required by Section 2718(a) of the **PHSA**. The supplemental exhibit is also intended to track and compare financial results of healthcare business as reported in the annual financial statements. Thus, the numbers included in this supplemental exhibit are not the exact numbers that will be utilized for rebate purposes **due to possible revisions for claim reserve run-off subsequent to year end, statistical credibility concerns and other defined adjustments** (note: regulators will continue to consider the need for a reconciliation from the data in this supplemental exhibit to the data used for rebate purposes).

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 and claims 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 allocation shall be based on the issue state of the certificate of coverage. For small employer business issued through a group trust, the allocation 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. uninsured 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 DEFINITIONS FOR SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1 AND 2**

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)
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.

Column 5	<p>Other Business (Excluded by Statute)</p> <p>Health plan arrangements that do not provide comprehensive coverage as defined by statute.</p> <p>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 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.</p>
Column 6	<p>Other Health</p> <p>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.</p>
Column 8	<p>Uninsured Plans</p> <p>Refer to <i>SSAP 47-Uninsured Plans</i> for additional guidance.</p>

## 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.
- Advertising required by law, regulation or ruling, except advertising associated with investments.
- State and local income, excise, and business 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 and local premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes.
- Payments for community **benefit** expenditures in lieu of premium tax but limited to the state premium tax rate times the allocated premium amount.
- 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
- 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 Claims Related 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 market stabilization payments or receipts by insurers that are directly tied to claims incurred and other claims based 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.
- Refer to SSAP 35 (Guaranty Fund and Other Assessments).
- Line 3 – Incurred Medical Incentive Pools and Bonuses
- Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers to promote quality improvements as defined in the **PHSA** (section 2717).
- Should agree to Supplemental Health Care Exhibit – Part 2, Column 8, Line 2.8.
- Line 4.0 – Total Incurred Claims (Lines 2.1 + 2.2 – 2.3 – 2.4 + 3)
- Should agree with Supplemental Health Care Exhibit – Part 2, Line 2.10.
- 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  
See the definitions included in Part 3 of this Exhibit.
- Line 5.1 - Expenses for Health Care Quality Improvements other than HIT  
Include expenses meeting the definition of Improving Health Care Quality in Part 3 that are not health information technology expenses. The amounts represented in Line 5.1 should agree with the amounts reported in Part 3, Columns 1 through 4.
- Line 5.2 - HIT Expenses for Health Care Quality Improvements  
Include expenses meeting the definition of Improving Health Care Quality in Part 3 that are health information technology expenses. The amounts represented in Line 5.2 should agree with the amounts reported in Part 3, Column 5.
- Line 7.1 - Cost Containment Expenses not Included in Quality of Care Expenses in Line 5.3
- 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 5.3. 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 not Included in Quality of Care Expenses in Line 5.3.
- 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 not Included in Line 5.3 or Line 7.3.
- 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 Line 13 below)
- 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**

These should be allocated to jurisdictions in the same manner as premium.

- 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:

### 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

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*

Line 2.1 Paid Claims during the Year

Report payments net of risk share amount collected.

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.

*Include:* Unpaid Claims

Report the 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.

Incurred but not Reported

Report the claims incurred but not reported **in the** 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.

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. Refer to *SSAP 54 – Individual and Group Accident and Health Contracts* for guidance.

*Include:* Contract reserves and other claims related 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, Line 4.0.

## 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 below, as well as the amount of those expenses that is used for other activities, and reported separately for the Individual, Small Group and Large Group amounts.

### Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are 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 for health plan enrollees and advance the delivery of patient-centered medical care.. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of PHSA; improvement must be capable of being objectively measured and produce results and achievements that can be verified to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates, or;
- Increase wellness and promote health activities.

QI Standards: QI expenses should be based on standards developed independent of any particular health insurer, and be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies or government agencies. They should not be designed solely or primarily to control or contain cost.

### COLUMNS:

#### Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer, providers and the enrollee (e.g., face-to-face, telephonic, web-based interactions or other means of communication between and among patients and their providers) to improve health outcomes for the patient under the plan or coverage. This category can include costs for associated activities such as:

- Effective case management (not just general case management), Care coordination, and Chronic Disease Management, including:
  - Patient centered intervention such as:
    - Making/verifying appointments,
    - Medication and care compliance initiatives,
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center), and
    - Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;
  - Incorporating feedback from the insured to effectively monitor compliance;
  - Providing coaching to encourage compliance with evidence based medicine;
  - Activities to identify and encourage evidence based medicine;
  - Use of the medical homes model as defined for purposes of section 3602 of PPACA); and
  - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
- Quality reporting and documentation of care;
- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above, and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; and
- Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs improve the quality of healthcare as set out in the first paragraph above; the burden shall be on the proponent to show that the expenses meet these criteria.

#### Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Post discharge reinforcement of care instructions by an appropriate health care professional; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above, and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; and
- Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs are designed to prevent hospital readmissions. The burden shall be on the proponent to show that the expenses meet these criteria.

#### Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors under the patient’s plan or coverage through:

- The appropriate identification and use of best clinical practices;
- Activities to identify and encourage evidence based medicine;
- Activities to lower risk of facility acquired infections;
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:
  - Data extraction, analysis and transmission in support of the activities described above, and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; or
  - Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs improve patient safety or reduce medical errors. The burden shall be on the proponent to show that the expenses meet these criteria.

#### Column 4 – Wellness & Health Promotion Activities

Programs that provide interaction with the enrollee (e.g., face-to-face, telephonic or web-based interactions or other forms of communication between and among patients and their providers) that promote:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate members on clinically effective methods for dealing with a specific chronic disease or condition; and
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); or
- Health information technology expenses to support these activities (Report in Column 5 – See instructions).

#### Column 5 – 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, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 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 including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;
2. Advancing the ability of patients, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include Personal Health Records accessible by patients and appropriate providers to monitor and document an individual patient’s medical history;

3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes; or
4. Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs support the activities described in columns 1 through 4 or otherwise support monitoring, measuring, or reporting health care quality improvement. The burden shall be on the proponent to show that the expenses meet these criteria.

**Exclude:** Costs associated with maintaining a compliant claims adjudication system, including cost 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, including the new ICD-10 requirements. (Discuss – Exclude as administrative or include as Fed requirement)

**Expense Allocation:** A separate, regulator only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in columns 1 through 4 must include a detailed description of such expenses. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

**Note:** 24 Hour Nurse Hotlines: Expenses for 24 hour nurse hotlines should be included in Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities. Any other expenses for 24 hour nurse hotlines (e.g., answering member questions) 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 the criteria of this section:

- 24 Hour Nurse Hotlines (except as noted above);
- Utilization Review;
- Fraud Prevention activities;
- Network Management;
- Provider Contracting;
- Accreditation Fees;
- Costs associated with calculating and administering individual enrollee or employee incentives. This includes rewards or bonuses associated with wellness or health promotion programs (e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities); and
- Any function not expressly included in Columns 1 through 5.

LINES:

For questions on definitions, refer to the instructions for the Annual Statement Expenses Schedule, i.e., the Underwriting and Investment Exhibit, Part 3 for P/C and Health, and Exhibit 2 for Life and Fraternal, for the line references provided below. **DIFFERENT FROM A/S EXPENSE REPORTING:** for non-affiliated management agreements/outsourced services, report all amounts in the supplement's Line 1.2, 2.2 or 3.2 for Outsourced Services (not just those amounts less than 10% of total expenses). Continue to allocate all affiliated management agreements/outsourced services to the appropriate expense lines as if the costs had been borne directly by the insurer.

Lines 1.1, 2.1, 3.1- Salaries

**Life/Fraternal:**

- Exhibit 2, Line 2 Salaries and wages
- Exhibit 2, Line 3.11 Contributions for benefit plans for employees
- Exhibit 2, Line 3.12 Contributions for benefit plans for agents
- Exhibit 2, Line 3.21 Payments to employees under non-funded benefit plans
- Exhibit 2, Line 3.22 Payments to agents under non-funded benefit plans
- Exhibit 2, Line 3.31 Other employee welfare
- Exhibit 2, Line 3.32 Other agent welfare

Health:  
U&I Part 3, Line 2 Salaries, wages and other benefits

P/C:  
U&I Part 3, Line 8.1 Salaries  
U&I Part 3, Line 11 Directors' fees

Lines 1.2, 2.2, 3.2- Outsourced Services

Include: All non-affiliated expenses for administrative services, claim management services, new programming, membership services, and other similar services, regardless of amount. Thus, non-affiliated amounts greater than the 10% threshold that are reported in the various expense categories (e.g., salaries, rent) for A/S Expense Exhibit reporting will be backed out of the expense categories and reported in Outsourced Services in the Supplemental Health Care Exhibit, Part 3. In addition, the non-affiliated amounts less than the 10% threshold will be included in Outsourced Services (reported as follows in the A/S Expense Exhibit):

Life/Fraternal:  
Exhibit 2, Line 4.5 Expense of investigation and settlement of policy claims  
Outsourced portion of Exhibit 2, Line 7.1 Agency expense allowance

Health:  
U&I Part 3, Line 14 Outsourced services including EDP, claims, and other services

P/C:  
Outsourced portion of U&I Part 3, Line 1.4 Net claim adjustment services  
Outsourced portion of U&I Part 3, Line 2.8 Net commission/brokerage  
Outsourced portion of U&I Part 3, Line 3 Allowances to manager and agents

Exclude: Services provided by affiliates under management agreements.

Lines 1.3, 2.3, 3.3- EDP Equipment and Software

Life/Fraternal:  
Exhibit 2, Line 5.7 Cost or depreciation of EDP equipment and software

Health:  
U&I Part 3, Line 13 Cost or depreciation of EDP equipment and software

P/C:  
U&I Part 3, Line 15 Cost or depreciation of EDP equipment and software

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

Life/Fraternal:  
Exhibit 2, Line 5.6 Rental of equipment  
Equipment amounts from Exhibit 2, Line 5.5 Cost or depreciation of furniture/equipment

Health:  
U&I Part 3, Line 12 Equipment

P/C:  
U&I Part 3, Line 14 Equipment

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 Committee on Quality Assurance (NCQA), and American Accreditation Healthcare Commission (URAC).

**Life/Fraternal:**

Applicable portion of Exhibit 2, Line 6.2 Bureau and association fees

**Health:**

U&I Part 3, Line 5 Certification and Accreditation

**P/C:**

Applicable portion of U&I Part 3, Line 5 Boards, bureaus and associations

Exclude: Rating agencies and other similar organizations.

Lines 1.6, 2.6, 3.6 - Other Expenses

Include: Any additional expenses not included in another category.

**Life/Fraternal:**

- Exhibit 2, Line 1 Rent
- Exhibit 2, Line 4.1 Legal fees and expenses
- Exhibit 2, Line 4.2 Medical examination fees
- Exhibit 2, Line 4.3 Inspection report fees
- Exhibit 2, Line 4.4 Fees of public accountants and consulting actuaries
- Exhibit 2, Line 5.1 Traveling expenses
- Exhibit 2, Line 5.2 Advertising
- Exhibit 2, Line 5.3 Postage, express, telegraph and telephone
- Exhibit 2, Line 5.4 Printing and stationery
- Furniture portion of Exhibit 2, Line 5.5 Cost or depreciation of furniture/equipment
- Exhibit 2, Line 6.1 Books and periodicals
- Non-accreditation portion of Exhibit 2, Line 6.2 Bureau and association fees
- Exhibit 2, Line 6.3 Insurance, except on real estate
- Exhibit 2, Line 6.4 Miscellaneous losses
- Exhibit 2, Line 6.5 Collection and bank service charges
- Exhibit 2, Line 6.6 Sundry general expenses
- In house portion of Exhibit 2, Line 7.1 Agency expense allowance
- Exhibit 2, Line 7.2 Agents' balances charged off (less \$\_\_ recovered)
- Exhibit 2, Line 7.3 Agency conferences other than local meetings
- Exhibit 2, Line 9.1 Real estate expenses
- Exhibit 2, Line 9.2 Investment expenses not included elsewhere
- Exhibit 2, Line 9.3 Aggregate write-ins for expenses

**Health:**

- U&I Part 3, Line 1 Rent
- U&I Part 3, Line 3 Commissions
- U&I Part 3, Line 4 Legal fees
- U&I Part 3, Line 6 Auditing, actuarial and other consulting
- U&I Part 3, Line 7 Traveling expenses
- U&I Part 3, Line 8 Marketing and advertising
- U&I Part 3, Line 9 Postage, express and telephone
- U&I Part 3, Line 10 Printing and office supplies
- U&I Part 3, Line 11 Occupancy, depreciation and amortization
- U&I Part 3, Line 15 Boards, bureaus and association fees
- U&I Part 3, Line 16 Insurance, except on real estate
- U&I Part 3, Line 17 Collection and bank service charges
- U&I Part 3, Line 18 Group service and administration fees
- U&I Part 3, Line 21 Real estate expenses
- U&I Part 3, Line 24 Investment expenses not included elsewhere
- U&I Part 3, Line 25 Aggregate write-ins

P/C:

- In house portion of U&I Part 3, Line 1.4 Net claim adjustment services
- In house portion of U&I Part 3, Line 2.8 Net commission/brokerage
- In house portion of U&I Part 3, Line 3 Allowances to manager and agents
- U&I Part 3, Line 4 Advertising
- Non-accreditation portion of U&I Part 3, Line 5 Boards, bureaus and associations
- U&I Part 3, Line 6 Surveys and underwriting reports
- U&I Part 3, Line 7 Audit of assured's records
- U&I Part 3, Line 10 Insurance
- U&I Part 3, Line 12 Travel and travel items
- U&I Part 3, Line 14 Rent and rent items
- U&I Part 3, Line 16 Printing and stationery
- U&I Part 3, Line 17 Postage, telephone and telegraph, exchange and express
- U&I Part 3, Line 18 Legal and auditing
- U&I Part 3, Line 21 Real estate expenses
- U&I Part 3, Line 24 Aggregate write-ins

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

Life/Fraternal:

- Exhibit 2, Line 6.7 Group service and administration fees
- Exhibit 2, Line 6.8 Reimbursements by uninsured plans

Health:

- U&I Part 3, Line 19 Reimbursements by uninsured plans
- U&I Part 3, Line 20 Reimbursements from fiscal intermediaries (e.g., Medicare, CHAMPUS, other governmental)

P/C:

- U&I Part 3, Line 23 Reimbursements by uninsured plans

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

Life/Fraternal:

- Exhibit 3, Line 1 Real estate taxes
- Exhibit 3, Line 2 State insurance department licenses and fees
- Exhibit 3, Line 3 State taxes on premiums
- Exhibit 3, Line 4 Other state taxes, incl \$\_\_ for employee benefits
- Exhibit 3, Line 5 U.S. Social Security taxes
- Exhibit 3, Line 6 All other taxes

Health:

- U&I Part 3, Line 22 Real Estate Taxes
- U&I Part 3, Line 23.1 State and local insurance taxes
- U&I Part 3, Line 23.2 State premium taxes
- U&I Part 3, Line 23.3 Regulatory authority licenses and fees
- U&I Part 3, Line 23.4 Payroll taxes
- U&I Part 3, Line 23.5 Other (excluding federal income and real estate)

P/C:

- U&I Part 3, Line 8.2 Payroll taxes
- U&I Part 3, Line 20.1 State and local insurance taxes, deducting guaranty association credits of \$\_\_
- U&I Part 3, Line 20.2 Insurance department licenses and fees
- U&I Part 3, Line 20.3 Gross guaranty association assessments
- U&I Part 3, Line 20.4 All other taxes, licenses and fees (excluding federal and foreign income and real estate)
- U&I Part 3, Line 22 Real estate taxes