

This document is intended to provide additional guidance for completing the Supplemental Health Care Exhibit by providing additional clarification and instruction. The guidance highlighted below has been approved by the NAIC Financial Condition E Committee.

Guidance added 12/21/2010. Guidance added 02/14/2011.

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. However, insurers that have no business that would be included in Columns 1 through 3 of Part 1 **for ANY of the states** are not required to complete this supplement **at all. If an insurer is required to file the supplement, then the insurer must complete Parts 1 and 2 for each state in which the insurer has any accident and health business, even if a particular state will show \$0 business reported in Columns 1, 2 and 3 of Part 1 (see the 2% instruction below). Also, Part 3 must be completed for any state in which there are non-zero amounts in Columns 1, 2 or 3 of Part 1.** Similarly, insurers in run off (major medical claims incurred with zero major medical **earned** premiums) or that only have assumed and no direct written major medical business **in any of the states** are not required to complete this supplement. However, 100% assumption reinsurance **(or 100% indemnity reinsurance for administration of a block of business entered into prior to March 23, 2010 - see HHS Reg. 158.130 (a)(3))** is treated as direct business for purposes of this supplement **(included as direct business for the assuming reinsurer and excluded from direct business for the ceding insurer).** Otherwise, ~~The~~ the reinsurance data required in this supplement is only for use if an insurer writes direct major medical business and also assumes and/or cedes such insurance. **If an insurer has direct business to include in Columns 1, 2 or 3 of Part 1 but also has some business in run off (major medical claims incurred for 2010 policy year and prior, with zero major medical earned premiums or no coverage in place), the run off claims and expenses results should be reported in Part 1, Columns 1, 2, or 3. (If an insurer files the supplement and has a state in which the only Columns 1, 2 and 3 business is run off business as defined above, the insurer can report the run off business for that state as if it was other accident and health business according to the 2% rule below – i.e., since the MLR is meaningless for that state, report zero for Columns 1, 2 and 3 and include the run off business along with any other accident and health insurance reported in the Total Columns of Parts 1 and 2.)** Additionally, if the insurer's business reported in Columns 1, 2 and 3 of Part 1 **for a particular state** is less than 2% of its total accident and health business **for that state**, only Columns 1, 2, 3, 8 (Uninsured) and 9 (Total) of Part 1 and Columns 1, 2, 3 and 7 of Part 2 need to be **completed for that state (this includes states for which there is \$0 business reported in Columns 1, 2 and 3).** 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 employer business issued through a group trust, the allocation shall be based on the location of the 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). **Exclude mini med plans and expatriate plans.**

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). **Stop loss coverage for self insured groups should be reported in Part 1, Column 5 (Other business excluded by statute).**

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
- Include small group health plans. “Small group health plan” means a health plan offered in the small group market as such term is defined in state law in accordance with the Public Health Service Act.
- 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 (including Medicare Advantage), Medicaid Title XIX, Insurance Program (SCHIP), Medicaid Program Title XXI risk contracts, and other Federal, or State government sponsored coverage.
- 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 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 included in the Accident and Health Experience Exhibit that is not reported in columns 1 through 5 including the stand-alone dental, and vision coverages, long-term care, disability income, etc. **Include mini med plans and expatriate plans.**
- For insurers who assume health business via aggregate stop loss reinsurance or other reinsurance that applied to a reinsured entity’s or group of entities’ entire business that would not be allocable to individual, small group and large group business in Columns 1, 2 and 3 of Parts 1 and 2 of the Supplement: report such assumed reinsurance on line 1.9 (premiums) and line 5.1 (claims) in Column 6 (Other Health) for the state page corresponding to the ceding insurer’s state of domicile.**

Column 7 – Subtotal

Sum of Columns 1 through 6. For Part 1, this is valid even for states where the insurer's Columns 1, 2 and 3 premiums are less than 2% of its total accident and health business in that state and the insurer opts to avoid reporting amounts in Columns 4, 5 and 6 (Columns 4, 5 and 6 will be zero since the other accident and health business will be reported in the Column 9 Total column).

For Part 2 for a particular state, Column 7 will not equal the sum of Columns 1 through 6 if the insurer's Columns 1, 2 and 3 premiums are less than 2% of its total accident and health business in that state and the insurer opts to avoid reporting amounts in Columns 4, 5 and 6.

For Part 2, the GT (Grand Total) page:

- Column 7, Line 1.13 (Net Premiums Earned) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 1, Line 6 (Total); and
- Column 7, Line 2.15 (Net Incurred Claims) minus Line 2.8 (Incurred medical incentive pools and bonuses) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 2 + 3, Line 6 (Total).

PART 1 ONLY:

Column 8 – Uninsured Plans

Refer to SSAP No. 47, Uninsured Plans for additional guidance.

Column 9 – Total

Sum of Columns 7 and 8.

For states where the insurer's Columns 1, 2 and 3 premiums are less than 2% of its total accident and health business in that state and the insurer opts to avoid reporting amounts in Columns 4, 5 and 6, this will equal any amounts reported in columns 1, 2 and 3 plus the total of all other insured health business written in that state that would have otherwise been reported in Columns 4, 5 and 6 if the 2% rule had not been triggered, plus Column 8.

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1

- Line 1.1 – Health Premiums Earned (From Part 2, Line 1.8)
- Include: Direct written premium plus the change in unearned premium reserves.
- 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
- Refer to SSAP No. 10R, Income Taxes—A Temporary Replacement of SSAP No. 10, for “current income taxes incurred.”
- 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 Insurance, Premium and Other Taxes and Assessments
- Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly; premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the state; or market stabilization redistributions, or cost transfers for the purpose of rate subsidies, not directly tied to claims and that are authorized by state law.
- 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 income, excise, and business taxes other than premium taxes.

State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes.

EITHER*:

- a. Payments to a state, by not-for-profit health plans, of premium tax exemption values in lieu of state premium taxes limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group;
- b. Payments by not-for-profit health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. These payments must be state-based requirements to qualify for inclusion in this line item;

OR

- c. Payments made by (federal income) tax exempt health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. (NOTE: If the instruction for Line 1.5 above excludes federal income taxes, then tax exempt health plans may NOT include community benefit expenditures in this line.)

Exclude: State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

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.

* These expenditures may not be double counted between this category; the federal or state assessments for similar purposes included in Lines 1.5, 1.6, or 2.4; or the Quality Improvement expenses reported in Line 6.1.

** Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);
- Address federal, state, or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
- Leverage or enhance public health department activities such as childhood immunization efforts; or
- Otherwise would become the responsibility of government or another tax-exempt organization.

- Line 1.7 – 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 1.9 – Net Assumed Less Ceded Reinsurance Premiums Earned
- The amount to net against the assumed reinsurance premiums earned is the 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 1.9 plus Line 1.10 less Line 1.11 for each column.
- Line 1.10 – Other Adjustments due to MLR Calculations - Premiums
- Any amounts excluded from premiums in Part 2 for MLR calculation purposes. Should agree with Supplemental Health Care Exhibit - Part 2, Line 1.12.
- Line 1.11 – 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 (including the Change in Reserve for Rate Credits).

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 No. 84, Certain Health Care. Receivables and Receivables Under Government Insured Plans

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 No. 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, Line 2.8, for each column.

Line 4 – Deductible Fraud and Abuse Detection/Recovery Expenses

This amount is the lesser of the expense reported in Part 3, Column 7, Line 1.11/2.11/3.11 and the fraud and abuse recoveries reported in Part 2, Line 3, Column 1/2/3, respectively.

Line 5.0 – 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 5.1 – Net Assumed Less Ceded Reinsurance Claims Incurred

Assumed reinsurance claims paid plus the change in the assumed reinsurance claims liability and aggregate assumed reinsurance claims reserve less the 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 2.11 plus Line 2.12, less Line 2.13, for each column.

- Line 5.2 – Other Adjustments Due to MLR Calculation - Claims
- Any amounts excluded from claims in Part 2 for MLR calculation purposes. Should agree to Supplemental Health Care Exhibit Part 2, Line 2.14.
- Line 5.3 – Rebates Paid
- MLR Rebates paid during the year.
- Line 5.4 – Estimated Rebates Unpaid at the end of the Prior Year
- Line 5.5 – Estimated Rebates Unpaid at the end of the Current Year
- MLR rebates estimated but unpaid as of reporting period.
- Line 5.6 – 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 6 – Expenses for Health Care Quality Improvements
- See the definitions included in Part 3 of this Exhibit.
- Line 6.1 – 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 6.1 for Individual, Small Group Employer and Large Group Employer should agree with the amounts reported in Part 3B, Column 5, Lines 1.2, 2.2 and 3.2, respectively.
- Line 6.2 – 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 6.2 for Individual, Small Group Employer and Large Group Employer should agree with the amounts reported in Part 3B, Column 5, Lines 1.1, 2.1 and 3.1, respectively.
- Line 8.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 6.3
- 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 6.3). The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services. (See the instructions for Part 3 of this Supplement for items that qualify for Quality Improvement instead of “cost containment”):
- 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 8.2 – All Other Claims Adjustment Expenses not Included in Quality of Care Expenses in Line 6.3.

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, Unpaid Claims, Losses and Loss Adjustment Expenses. 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, Unpaid Claims, Losses and Loss Adjustment Expenses.

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 10 – General & Administrative Expenses not Included in Line 6.3 or Line 8.3.

Line 10.1 – Direct Sales Salaries, Force Salaries and Benefits

Line 10.2 – Agents and Brokers Fees and Commissions

Line 10.3 – Other Taxes (Excluding Taxes on Lines 1.5 through 1.7 above and Line 14 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 10.4 – 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.

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2

- Lines 1.1 – Direct Premiums Written
- Exclude: Amounts for rate credits paid.
- Line 1.8 – Total Direct Health Premiums Earned (Lines 1.1 + 1.4 less \$_____ write offs)
- Include: Direct written premium plus the change in unearned premium reserves.
- For MLR purposes, Health Premiums Earned are reduced by actual write offs, not reserves for bad debt or statutory nonadmitted amounts.
- Line 1.12 – Other Adjustments Due to MLR Calculation - Premiums
- Include: Any amounts excluded from premium for MLR calculation purposes which are normally included in premiums for financial statement purposes, including the amount of write offs in Line 1.8.
- Amounts for rate credits paid and the change in reserve for rate credits that were excluded from Line 1.8, Total Direct Premiums Earned.
- 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.

Include: Amounts for rate credits paid that were deducted in Line 1.1, Direct Premiums Written.

- 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.
- Included 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.
- Include: Amounts for the reserve for rate credits for the current year.
- Lines 2.5 – Direct Claim Reserve Prior Year
- Include: Amounts for the reserve for rate credits from the prior year.
- 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 No. 54, Individual and Group Accident and Health Contracts, for guidance.
- Include: Contract reserves and other claims related reserves.
- Exclude: Premium deficiency 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 – Total Incurred Claims
- Should agree to Supplemental Health Care Exhibit - Part 1, Line 5.0.

Line 2.14 – Other Adjustments Due to MLR Calculation - Claims

Include: Any amounts excluded from claims for MLR calculation purposes which are normally included in claims for financial statement purposes. For example, premium deficiency reserves are excluded from contract reserves for MLR purposes in Part 2; thus, premium deficiency reserves would be included on this Line 2.14.

Exclude: Amounts for rate credits paid and the change in reserve for rate credits that were included in Line 2.10, Total Incurred Claims.

Line 3 – Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)

Include collected recoveries on paid claims only.

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

Part A of 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. Part B of this exhibit is intended to show the amount of qualifying HIT expenses, reported separately for the Individual, Small Group and Large Group amounts, broken down into the four categories of Quality Improvement expenses (see below); similarly, the Other than HIT qualifying Quality Improvement expenses are disclosed for each of the four categories of Quality Improvement expenses. The definitions of Individual, Small Group and Large Group are found in the instructions for Parts 1 and 2 of this supplement exhibit.

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), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- 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;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

PARTS 3A and 3B

COLUMNS:

Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined above. This category can include costs for associated activities such as:

- Effective 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),
 - Programs to support shared decision making with patients, their families and the patient's representatives; 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 or other support 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);
- Activities to prevent avoidable hospital admissions;
- Education and participation in self management programs; 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;
- Accreditation Fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1 through 5;
- 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 in non-electronic format; 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

Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions as defined above, 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;
- Personalized post discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; 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

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to avoid harm;
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; 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; or

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- Public health education campaigns that are performed in conjunction with state or local health departments;
- Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:
 - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and
- 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 enrollees for the electronic creation, maintenance, access, or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, 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 enrollees, 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 electronic Health Records accessible by enrollees 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;
4. Reformating, transmitting or reporting data to national or international government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; or
5. Provision of electronic health records and patient portals.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing 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

Expense Allocation
Supplemental Filing:

A single (not state-by-state), 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 Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing as well. For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an “X” in the “New” column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable results. Expenses for prospective Utilization Review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an “E” in the “New” column. 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.

Notes:

- a. *Healthcare Professional Hotlines:* Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.
- b. *Prospective Utilization Review:* Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent Utilization Review;
- Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;
- Marketing expenses;
- Any Accreditation Fees that are not directly related to activities included in Columns 1 through 5;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.

Note:

The NAIC will review requests to include expenses for broadly excluded activities and activities not described under Columns 1 through 5 above. Upon an adequate showing that the activity’s costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.

<u>Expense Type from Part 3</u>	<u>Line Number</u>
Improve Health Outcomes	1.0001 – 1.9999
Activities to Prevent Hospital Readmission.....	2.0001 – 2.9999
Improve Patient Safety and Reduce Medical Errors	3.0001 – 3.9999
Wellness & Health Promotion Activities.....	4.0001 – 4.9999
HIT Expenses for Health Care Quality Improvements	5.0001 – 5.9999

PART 3A – ALL EXPENSES

LINES:

The Sections for Individual, Small Group and Large Group are defined as per the Individual, Small Group Employer and Large Group Employer columns in Parts 1 and 2 of this supplement.

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

Lines 1.11, 2.11,
& 3.11 -

Total Fraud and Abuse Detection/Recovery Expenses Included in Column 7 (Informational Only)

Include: Fraud and abuse detection and recovery expenses as well as prevention expenses.

PART 3B – QUALITY IMPROVEMENT EXPENSES ONLY

This schedule includes the same amounts for Quality Improvement expenses as in Part 3A but presents the amounts consistent with the lines of Part 1 and across the major categories of Quality Improvement expenses defined in the instructions for Columns 1 through 4 of Parts 3A and 3B.

1. Individual Comprehensive Coverage Expenses:

Part 3B, Column 5, Line 1.1 should tie to Part 3A, Column 5, Line 1.10.

Part 3B, Column 5, Line 1.2 should tie to Part 3A, Columns 1 + 2 + 3 + 4, Line 1.10

2. Small Group Comprehensive Coverage Expenses:

Part 3B, Column 5, Line 2.1 should tie to Part 3A, Column 5, Line 2.10.

Part 3B, Column 5, Line 2.2 should tie to Part 3A, Columns 1 + 2 + 3 + 4, Line 2.10

3. Large Group Comprehensive Coverage Expenses:

Part 3B, Column 5, Line 3.1 should tie to Part 3A, Column 5, Line 3.10.

Part 3B, Column 5, Line 3.2 should tie to Part 3A, Columns 1 + 2 + 3 + 4, Line 3.10