

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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

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|---|---|--|
| <input type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> QUARTERLY STATEMENT | |
| <input checked="" type="checkbox"/> INSTRUCTIONS | <input 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, Quarterly 2011

IDENTIFICATION OF ITEM(S) TO CHANGE

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

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

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

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1

REPORT FOR: 1. CORPORATION

2.

(LOCATION)

NAIC Group Code _____ BUSINESS IN THE STATE OF _____

DURING THE YEAR _____

NAIC Company Code _____

	Comprehensive Health Coverage				8 Total
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Government Business (excluded by statute)	
1. Premium:					
1.1 Health premiums earned (From page X).....					
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 Net adjusted premiums earned after reinsurance (Lines 1.9 + 1.10 – 1.11).....					
2. Claims:					
2.1 Incurred claims excluding prescription drugs (From page X).....					
2.2 Prescription drugs.....					
2.3 Pharmaceutical rebates.....					
2.4 State stop loss, market stabilization and claims based assessments.....					
3. Incurred medical incentive pools and bonuses.....					
4. 4.0 Total Incurred Claims (Lines 2.1 + 2.2 – 2.3 + 3).....					
4.1 Assumed reinsurance claims incurred.....					
4.2 Ceded reinsurance claims incurred.....					
4.3 Rebates Paid.....					
4.4 Net incurred claims after reinsurance (Lines 4.0 + 4.1 – 4.2 – 4.3).....					
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 Type C. Other (TBD).....					
5.4 Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 5.1 + 5.2 + 5.3).....					
6. Medical Loss Ratio: MLR (Lines 4.0 + 5.4) / Line 1.9.....					
7. Claims Adjustment Expenses:					
7.1 Cost containment expenses not included in quality of care expenses in Line 5.4.....					
7.2 All other claims adjustment expenses.....					
7.3 Total claims adjustment expenses (Lines 7.1 + 7.2).....					
8. Claims Adjustment Expense Ratio (Line 7.3 / Line 1.9).....					
9. Sales, 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 other federal income taxes.....					
9.4 Other sales general and administrative expenses.....					
9.5 Total sales general and administrative (Lines 9.1 + 9.2 + 9.3 + 9.4).....					
10. Underwriting Gain/Loss (Lines 1.9 – 4.0 – 5.4 – 7.3 – 9.5).....					
11. Administering Self Insured Business:					
11.1 Income from fees to self insured groups.....					
11.2 Quality improvement, claims adjustment and G&A expenses to self insured groups.....					
11.3 Net gain from administering self insured groups (Lines 11.1 – 11.2).....					
12. Net investment and other gain/(loss).....					
13. Federal income taxes (excluding taxes on Line 1.5 above).....					
14. Net gain or (loss) (Lines 10 + 11.3 + 12 – 13).....					

	Comprehensive Health Coverage				8 Total
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Government Business (excluded by statute)	
OTHER INDICATORS:					
1. Number of certificates.....					
2. Number of Covered Lives.....					
3. Number of Plans.....					
4. Member Months.....					

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2

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	8
	Individual	Small Group Employer	Comprehensive Health Coverage	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

REPORT FOR: 1. CORPORATION _____ 2. _____

(LOCATION)

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

	Improving Health Care Quality Expenses					
	1 Care Coordination	2 Chronic Disease Management	3 Preventive Care and Wellness Programs	4 Other Approved Expenses	5 Other Approved HIT Expenses	6 Total
1. Individual Comprehensive Coverage Expenses: 1.1 Effective Case Management..... 1.2 Care Coordination..... 1.3 Chronic Disease Management..... 1.4 Medication and Care Compliance Initiatives..... 1.5 Prevention of Hospital Readmissions..... 1.6 Activities to Improve Patient Safety and Reduce Medical Errors by Using Best Clinical Practices..... 1.7 Activities to Encourage Evidence Based Medicine..... 1.8 Health Information Technology (HIT)..... 1.9 Wellness and Health Promotion Activities..... 1.10 24 Hour Nurse Hotline..... 1.11 Other (Placeholder)..... 1.12 Total.....						
2. Small Group Comprehensive Coverage Expenses: 2.1 Effective Case Management..... 2.2 Care Coordination..... 2.3 Chronic Disease Management..... 2.4 Medication and Care Compliance Initiatives..... 2.5 Prevention of Hospital Readmissions..... 2.6 Activities to Improve Patient Safety and Reduce Medical Errors by Using Best Clinical Practices..... 2.7 Activities to Encourage Evidence Based Medicine..... 2.8 Health Information Technology (HIT)..... 2.9 Wellness and Health Promotion Activities..... 2.10 24 Hour Nurse Hotline..... 2.11 Other (Placeholder)..... 2.12 Total.....						
3. Large Group Comprehensive Coverage Expenses: 3.1 Effective Case Management..... 3.2 Care Coordination..... 3.3 Chronic Disease Management..... 3.4 Medication and Care Compliance Initiatives..... 3.5 Prevention of Hospital Readmissions..... 3.6 Activities to Improve Patient Safety and Reduce Medical Errors by Using Best Clinical Practices..... 3.7 Activities to Encourage Evidence Based Medicine..... 3.8 Health Information Technology (HIT)..... 3.9 Wellness and Health Promotion Activities..... 3.10 24 Hour Nurse Hotline..... 3.11 Other (Placeholder)..... 3.12 Total.....						

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

SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1 AND 2

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. The allocation of premium between jurisdictions should be based upon situs of the contract. For purpose of this exhibit, situs of the contract is defined as “the jurisdiction in which the contract is issued or delivered as stated in the contract.” In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company.

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

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

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

Column 1	Individual
	Include: Health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes conversions from group policies.
	Associations
	Nonemployer Group Trusts
	Exclude: Policies reported in other columns.
Column 2	All policies issued to Small Group Employers
Column 3	All policies issued to Large Group Employer
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 similar government plans.
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 7	Other Health
	All other health care business not reported in columns 1 through 6 including the stand-alone dental, and vision coverages, long-term care, disability income, etc.

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1

- Line 1.1 – Health Premiums Earned
- Include: Direct written premium and other supplemental payments in lieu of dues (e.g. primarily co-payments, deductible payments and other fees) received by the health plan insurance issuer, due pursuant to a policy of insurance, 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 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 under State high risk pools
- Exclude: Items included on line 2.4.
- Line 1.5 – Federal Taxes and Federal Assessments
- Include federal income taxes allocated to premium and not related to other aspects of a company's operations (e.g., taxes on investment income and capital gains).
- Line 1.6 – State and Local Insurance Taxes
- Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the state.
- Guaranty fund assessments
- Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states. Canadian and other foreign taxes are to be included appropriately.
- Advertising required by law, regulation or ruling, except advertising associated with investments.
- State income taxes other than premium taxes.
- Exclude: State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.
- Line 1.7 – State and local Premium Taxes
- Include: State taxes based on policy reserves, if in lieu of premium taxes. Canadian and other foreign taxes should be included appropriately.
- 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: Assessments to defray operating expenses of any state insurance department.

Exclude: Fines and penalties of regulatory authorities.

Fees for examinations by state departments.

Line 1.10 – Assumed Reinsurance Premiums Earned

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.

Line 2.1 – Incurred Claims Excluding Prescription Drugs:

Hospital/Medical Benefits

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

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

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

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

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

The cost of utilizing skilled nursing and intermediate care facilities.

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

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

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

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

Other Professional Services

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

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

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.

Include: Direct Paid Claims during the Year

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

Change in Unpaid Claims

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

Change in Incurred but not Reported

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

Change in Contract & Other Reserves

Exclude: MLR rebates paid during the year.

Prescription drugs reported in line 2.2.

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

Medical incentive pools and bonuses.

- Line 2.2 – Prescription Drugs
- Include: Expenses for Prescription Drugs and other pharmacy benefits covered by the reporting entity.
- Exclude: Prescription drug charges that are included in a hospital billing which should be classified as Hospital/Medical Benefits on Line 2.1.

- Line 2.3 – Pharmaceutical Rebates
- Refer to SSAP 84.

Line 2.4 Aggregate Write ins for Other Hospital and Medical

Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 14 for Other Medical and Hospital

- Line 2.4.5 – State Stop Loss, Market Stabilization and Claims Based Assessments
- Any payments by insurers that are directly tied to claims paid by that insurer.
- State subsidies based on a stop-loss payment methodology.
- Unsubsidized State programs designed to address distribution of health risks across health insurers via charges to low risk carriers that are distributed to high risk carriers.

- Line 3 – Incurred Medical Incentive Pools and Bonuses
- Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.

- 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.

- 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.

- Line 4.3 – Rebates Paid
- MLR Rebates paid during the year.

- Line 5 – Improving Health Care Quality Expenses Incurred
- Expenses, other than those billed or allocated by a provider for care delivery (i.e., claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care. The following shown in lines 5.1 and 5.2 are the items that will be considered quality of care expenses if they are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care.

Exclude: Cost containment expenses that do not directly relate to the quality of health care. These are reported in line 7.1.

Line 5.1 – Type A: Expenses for Health Improvements other than Health Information Technology

Expenses, other than those billed or allocated by a provider for care delivery (i.e. claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care in ways that can be objectively measured and verified. The following are items that will included as quality of care expenses meeting these criteria:

- 1. Care coordination** (not just general care management) - the active hands on participation to coordinate a patient's care between multiple providers (such as making sure medical records are shared between all the patient's physicians, making/verifying appointments, and medication compliance) and arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center and prevention of hospital readmissions).
- 2. Chronic Disease Management** Hands on individually tailored programs for specific chronic conditions that interact with the insured (in person or via the phone) to (a) remind insured of doctor appointment, (b) check that insured is following a medically effective prescribed regimen for dealing with the specific disease/condition, (c) incorporating feedback from insured in the management program, (d) provide coaching on dealing with the disease/condition.
- 3. Preventive Care and Wellness Programs:** Hands on programs that interact with the insured (in person or via phone) related to: Wellness assessment, wellness / lifestyle coaching programs, coaching programs designed to educate individual members on clinically effective for dealing with a specific chronic disease, and coaching or education programs designed to change individual members behavior (e.g. smoking, obesity).
- 4. Other costs** approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

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

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

- Utilization Review
- Fraud Prevention activities
- Any function not expressly included in Type A items 1 through 4, above.

Line 5.2 – Type B: Health Information Technology Expenses Related to Health Improvement

Expenses for Health Information Technology (HIT), consistent with the purposes described in A, above, defined as depreciation on hardware and expenses for software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information and the personnel costs associated with implementing those technologies or licenses, but limited to the following expenses;

1. Monitoring or reporting clinical effectiveness;
2. Advancing the ability of providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
4. Other costs approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

Line 7.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 5.4

Include: Expenses that actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses which improve the quality of health care reported in line 5.4. The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services:

Post and concurrent claim case management activities associated with past or ongoing specific care;

Utilization review;

Detection and prevention of payment for fraudulent requests for reimbursement;

Expenses for internal and external appeals processes.

Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting

Line 7.2 – All Other Claims Adjustment Expenses

Include: Costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in subparagraphs 6 a. and 6 b. of SSAP No. 55. Further, Claim Adjustment Expenses for Managed Care Reporting Entities are those costs expected to be incurred in connection with the adjustment and recording of managed care claims defined in subparagraph 7 a. of SSAP No. 55.

Examples of other claim adjustment expenses are:

Estimating the amounts of losses and disbursing loss payments;

Maintaining records, general clerical, and secretarial;

Office maintenance, occupancy costs, utilities, and computer maintenance;

Supervisory and executive duties; and

Supplies and postage.

Line 9 – Sales General & Administrative Expenses

Line 9.1 – Direct Sales Salaries, Force Salaries and Benefits

Line 9.2 – Agents and Brokers Fees and Commissions

Line 9.3 – Other Taxes (Excluding Taxes on Lines 1.5 through 1.8 above and Federal Income Tax)

Include: Taxes of Canada or of any other foreign country not specifically provided for elsewhere.

Sales taxes, other than state sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Line 9.4 – Other Sales General & Administrative Expenses

OTHER INDIDCATORS

- Line 1 – Number of Certificates
- This is the number of 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 Plans
- This is the total number of insurance plans issued as of the end of the reporting period.
- Line 4 – Member Months
- The sum of total number of lives insured on a pre-specified day of each month of the reported period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Drafting note for discussion:

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

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2

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

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

This schedule provides more detailed reporting of the amounts reported in Part 1 as Improving Health Care Quality Expenses Incurred. Expenses that do not qualify for Improving Health Care Quality Expenses in Part 1 should not be included in this Exhibit.

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

Columns:

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

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

Lines:

Effective Case Management

Care Coordination

Chronic Disease Management

Medication and Care Compliance Initiatives

Prevention of Hospital Readmissions

Activities to Improve Patient Safety and Reduce Medical Errors by Using Best Clinical Practices

Activities to Encourage Evidence Based Medicine

Health Information Technology (HIT): Only those amounts that support the major expense type columns should be included.

Wellness and Health Promotion Activities

24 Hour Nurse Hotline: Only those amounts that support the major expense type columns should be included.

Other (Placeholder)

Total