Draft: 10/14/10

Health Insurance and Managed Care (B) Committee Chair Amendment to the Chair's Oct. 12 proposed amendment. Underlining and overstrikes show the changes from the Chair's Oct. 12 proposed amendment to the Oct. 5 draft. This Amendment reflects state stop loss, market stabilization and claims/census based assessments provisions that were inadvertently not included in the Oct. 5 draft. In addition, this proposed amendment also includes other technical corrections to the Oct. 5 draft.

REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF THE MEDICAL LOSS RATIO FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE ACT

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Section 1. Short Title

This Regulation shall be known and may be cited as the Patient Protection and Affordable Care Act Medical Loss Ratio Regulation.

Section 2. Purpose

The purpose and intent of this Regulation are to promulgate uniform definitions and a standardized methodology for calculating the medical loss ratio, as legislated by Section 2718 (b) of the Public Health Service Act and the Patient Protection and Affordable Care Act.

Section 3. Definitions

A. As used in this Regulation and directed by PPACA to be defined by the NAIC:

(1) "Affiliate" means the statutory accounting definition for affiliate as contained in the then current NAIC Accounting Practices and Procedures Manual.

(2) "Clinical services" means "incurred claims," as defined in 3.A.(8).

(3) "Earned premium" means the statutory accounting definition for premium for health insurance coverage on a direct basis as contained in the then current NAIC Accounting Practices and Procedures Manual, plus or minus any portions of premium associated with group conversion privileges the issuer transfers between Group and Individual lines of business in its Annual Statement accounting, plus or minus any experience rating refunds paid or received, except as follows: Earned premium for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct earned premium for the assuming entity's medical loss ratio rebate calculations and excluded from the ceding entity's medical loss ratio rebate calculations. If a block of business was subject to indemnity reinsurance

and administrative agreements, effective prior to the effective date of PPACA (March 23, 2010), such that the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block, then the assuming entity and not the ceding entity should report the reinsured earned premium as part of its medical loss ratio rebate calculations.

(4) "Expenses to improve health care quality" means those expenses as a defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(5) "Federal and State taxes and licensing or regulatory fees" means those taxes and licensing or regulatory fees, as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit, as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(6) "Health plan" means health insurance coverage offered by a health insurance issuer as such terms are defined in the Public Health Service Act (including a grandfathered health plan) unless such coverage is an excepted benefit as provided for in the Public Health Service Act.

(7) "Incurred loss" means "incurred claims," as defined in 3.A.(8).

(8) "Incurred claims" means the statutory accounting definition for claims for health insurance coverage on a direct basis as contained in the then current NAIC Accounting Practices and Procedures Manual incurred during the applicable plan year, plus unpaid claim reserves associated with claims incurred during the applicable plan year, plus the change in contract reserves, plus the claims-related portion of reserves for contingent benefits and lawsuits, plus any experience rating refunds paid or received, and reserves for experience rating refunds. If there are any group conversion charges for a health plan, the conversion charges should be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount should be added to the incurred claims for the aggregation that provides coverage that is intended to be replaced by the conversion policies. Additionally, if the issuer transfers portions of earned premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, these amounts should be added to or subtracted from incurred claims.

(9) "Individual health plan" means a health plan offered to individuals in the individual market as such term is defined in the Public Health Service Act, but does not include short-term limited duration insurance as defined in the Public Health Service Act.

(10) "Large group health plan" means a health plan offered in the large group market as such term is defined in the Public Health Service Act.

(11) "Medical loss ratio rebate" means the quantity specified in Section 2718 (b) (1) (A) of the Public Health Service Act.

(12) "Plan year" means "calendar year" as defined in Section 3. B. (4).

(13) "Small group health plan" means a health plan offered in the small group market as such term is defined in the Public Health Service Act.

B. As used in this Regulation:

(1) "Blended rates" means cross-subsidized rates charged for health insurance coverage provided by a single employer through two or more affiliates.

(2) "Business sold through an association" means a policy issued to an association or to a trust or to the trustees of a fund established, created or maintained for the benefit of members of one or more associations.

(3) "Calendar year" means the period of time from January 1, YYYY to December 31, YYYY.

(4) "Claims unpaid" means claims reported and in the process of adjustment, percentage withholds from payments made to contracted providers, incurred but not reported claims, and recoverables for anticipated coordination of benefits and subrogation.

(5) "Contract reserves" means reserves that are established which, due to the gross premium pricing structure at issue, account for the value of the future benefits at any time exceeding the value of any appropriate future valuation net premiums at that time. Contract reserves should not include premium deficiency reserves. Contract reserves should not include reserves for expected MLR rebates.

(6) "Credibility adjustment" means the adjustment to account for random statistical fluctuations in claims experience for smaller plans.

(7) "Direct paid claims" means claim payments before ceded reinsurance and excluding assumed reinsurance except as follows: Paid claims for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct paid claims for the assuming entity's medical loss ratio rebate calculations and excluded from the ceding entity's medical loss ratio rebate calculations. If a block of business was subject to indemnity reinsurance and administrative agreements, effective prior to the effective date of PPACA (March 23, 2010), such that the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block, then the assuming entity and not the ceding entity should report the reinsured claims as part of its medical loss ratio rebate calculations. Claims payments recovered through fraud reduction efforts can be added back to claims in the medical loss ratio calculation, up to the amount of expenses expended to reduce fraud.

(8) "Dual contract" means the case where a small or large group policyholder purchases in-network coverage from one issuer and out-of-network coverage from a different issuer that is an affiliate of the first issuer.

(9) "Dual option" means the case where a small or large group policyholder purchases two or more different health plans from two or more affiliates.

(10) "Experience rating refund" means retrospective premium adjustments arising from retrospectively rated contracts as determined by the Statements of Statutory Accounting Principles 66 plus any incurred state premium refunds.

(11) "Fully credible," as it relates to experience, means experience generated by 75,000 or more life years.

(12) "Group conversion charges" means the portion of earned premium allocated to providing the privilege for a certificate holder terminated from a group health plan to purchase individual health insurance without providing evidence of insurability.

(13) "Incurred medical pool incentives and bonuses" means arrangements with providers and other risk sharing arrangements as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(14) "Life years" means the number of member months divided by 12.

(15) "Minimum medical loss ratio standard" means the percentage determined in accordance with Section 2718 (b) (1) (A) (i) or (ii) of the PHSA. In the case of minimum medical loss ratio standards that are not constant over an averaging period, the minimum standard will be the average of the standards used in each year weighted by earned premium less Federal and State taxes and licensing or regulatory fees.

(16) "Net healthcare receivables" means the healthcare receivable assets as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010.

(17) "Non-credible," as it relates to experience, means experience generated by less than 1,000 life years.

(18) "Partially credible," as it relates to experience, means experience generated by at least 1,000 life years but less than 75,000 life years.

(19) "PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(20) "PHSA" means Public Health Service Act.

(21) "Policyholder" means any entity that has entered into a contract with a health insurance issuer to receive health insurance coverage as defined in Section 2791 (b) of the PHSA.

(22) "Reserves for experience rating refunds" means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement or due but unpaid for a state premium refund.

(23) "Situs of the contract" means the jurisdiction in which the contract is issued or delivered as stated in the contract.

(24) "State premium refund" means any rebate or refund of premium payable under state law as a result of state loss ratio requirements which need not be identical to the federal requirements in such matters as minimum percentage, definition of claim, definition of premium, aggregation, timing of calculation, etc.

(25) "Unearned premium reserves" means reserves that are established to account for that portion of the premium paid in the plan year that is intended to provide coverage during a period which extends beyond the plan year.

(26) "Unpaid Claim Reserves" means reserves and liabilities established to account for claims unpaid.

C. All terms defined in this Regulation, whether in this Section or elsewhere, shall be construed, and all calculations provided for by this Regulation shall be performed, as to exclude the financial impact of any of the rebates provided for in Sections 8, 9, and 10.

Section 4. Applicability and Scope

The provisions of this Regulation concerning the calculation and payment of medical loss ratio rebates shall apply to any health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) as provided for in Section 2718 of the PHSA for plan years 2011, 2012 and 2013.

Section 5. Levels of Aggregation for Medical Loss Ratio Rebate Calculations

A. Medical loss ratios shall be calculated at the licensed entity level within a state, with experience allocated to states based on the situs of the contract, except that for individual business sold through an association, the allocation shall be based on the issue state of the certificate of coverage and for employer business issued through a group trust, the allocation shall be based on the location of the employer. Experience shall be further subdivided into

(1) Individual health plans;

(2) Small group health plans;

(3) Large group health plans.

B. Pursuant to Section 1312(c) (3) of PPACA, a state may require the individual and small group insurance markets within a state to be merged if the state determines appropriate. In this case, rebates shall be calculated at the licensed entity level within a state, further subdivided into

(1) Individual and small group health plans;

(2) Large group health plans.

C. Plans classified as dual contract may be aggregated as follows:

(1) Experience may be treated as if it were all generated by the plan provided by the in-network issuer.

(2) An issuer that chooses this method of aggregation shall apply it for a minimum of three plan years.

(3) For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

Section 6. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Rebate Payments

A. Medical loss ratios shall be calculated annually by all health insurance issuers that provide coverage through one or more health plans that are subject to Section 2718 of the PHSA.

B. Medical loss ratios must be calculated using data as of December 31 of the plan year except for incurred claims which must be restated as of March 31 of the year following the plan year.

C. Medical loss ratios must be reported to the applicable state(s) by May 31 of the year following the plan year using the appropriate reporting format in Appendix A.

D. Rebates shall be paid annually by June 30 of the year following the plan year.

Section 7. Credibility Adjustments to Medical Loss Ratio

A. Plan year 2011

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is either non-credible or fully credible based on plan year 2011 life years.

(2) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on plan year 2011 life years is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using plan year 2011 life years for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the plan year 2011 average plan deductible, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

B. Plan year 2012

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is fully credible based on plan year 2012 life years or based on the sum of life years for plan years 2011 and 2012.

(2) If the sum of life years for plan years 2011 and 2012 is non-credible for any aggregation as defined in Section 5, a credibility adjustment is not applicable.

(3) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on the sum of life years for plan years 2011 and 2012 is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using the sum of plan year 2011 and plan year 2012 life years for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the average plan deductible for plan year 2011 and plan year 2012 combined, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

C. Plan year 2013

(1) A credibility adjustment is not applicable to any aggregation as defined in Section 5 that is either fully credible or non-credible based on the sum of life years for plan years 2011, 2012, and 2013.

(2) The credibility adjustment for any aggregation as defined in Section 5 that is partially credible based on the sum of life years for plan years 2011, 2012, and 2013 is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.

(a) The Table 1 factor is determined using the sum of life years for plan years 2011, 2012, and 2013 for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the average plan deductible for plan year 2011, plan year 2012 and plan year 2013 combined, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

Section 8. Medical Loss Ratio Rebate Calculation for Plan Year 2011

A. A rebate is not payable for any aggregation that is non-credible based on plan year 2011 life years.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2011 is attributable to policies newly issued in 2011 with less than 12 months of experience in 2011, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2011. The excluded experience must be added to the experience used to calculate the medical loss ratio for plan year 2012. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2011 to December 31, 2011, less any claims incurred in 2011 that are to be deferred to the plan year 2012 calculation.

(2) Expenses to improve health care quality are for the period from January 1, 2011 to December 31, 2011, less any expenses to improve health care quality from the 2011 plan year that are to be deferred to the plan year 2012 calculation .

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2011, and shall apply to all groups as described in D. (1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2011.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2011, and shall apply to all groups as described in E. (1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2011.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2011 to December 31, 2011, less any premiums earned in the 2011 plan year that are to be deferred to the plan year 2012 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2011, less any Federal and State taxes and licensing fees from the 2011 plan year that are to be deferred to the plan year 2012 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

I. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

J. (1) If the result of I is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for 2011. The resulting amount is the rebate to be paid.

(2) If the result of I is zero or less, no rebate is to be paid.

Section 9. Medical Loss Ratio Rebate Calculation for Plan Year 2012

A. A rebate is not payable for any aggregation that is non-credible based on the sum of life years for plan years 2011 and 2012.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2012 is attributable to policies newly issued in 2012 with less than 12 months of experience in 2012, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2012. The excluded experience must be added to the experience used to calculate the medical loss ratio for plan year 2013. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2012 to December 31, 2012, plus any incurred claims deferred from the plan year 2011 calculation, less any claims incurred in 2012 that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, incurred claims are those with incurral dates from January 1, 2011 to December 31, 2012, less any claims incurred in 2012 that are to be deferred to the plan year 2013 calculation.

(2) Expenses to improve health care quality are those expenses for the period from January 1, 2012 to December 31, 2012, plus any expenses to improve health care quality deferred from the plan year 2011 calculation, less any expenses to improve health care quality from the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, expenses to improve health care quality are those for the period from January 1, 2011 to December 31, 2012, less any expenses to improve health care quality from the 2012 plan year that are to be deferred to the plan year 2013 calculation.

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2012, and shall apply to all groups as described in D. (1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2012.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2012, and shall apply to all groups as described in E. (1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2012.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2012 to December 31, 2012, plus any earned premiums deferred from the plan year 2011 calculation, less any premiums earned in the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, earned premiums are for the period from January 1, 2011 to December 31, 2012, less any premiums earned in the 2012 plan year that are to be deferred to the plan year 2013 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2012 to December 31, 2012, plus any Federal and State taxes and licensing or regulatory fees deferred from the plan year 2011 calculation, less any Federal and State taxes and licensing or regulatory fees from the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2012, less any Federal and State taxes and licensing or regulatory fees from the 2012 plan year that are to be deferred to the plan year 2013 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

I. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

J. (1) If the result of I is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for the plan year. The resulting amount is the rebate to be paid.

(2) If the result of I is zero or less, no rebate is to be paid.

Section 10. Medical Loss Ratio Rebate Calculation for Plan Year 2013

A. A rebate is not payable for any aggregation that is non-credible based on the sum of life years for plan year 2011, plan year 2012 and plan year 2013.

B. If, for any level of aggregation as defined in Section 5, 50% or more of the total earned premium for 2013 is attributable to policies newly issued in 2013 with less than 12 months of experience in 2013, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2013. The excluded experience must be added to the experience used to calculate the medical loss ratio for plan year 2014. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

C. The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality.

(1) Incurred claims are those with incurral dates from January 1, 2011 to December 31, 2013, less any claims incurred from January 1, 2013 to December 31, 2013 that are to be deferred to the plan year 2014 calculation.

(2) Expenses to improve health care quality are those expenses for the period from January 1, 2011 to December 31, 2013, less any expenses to improve quality from the 2013 plan year that are to be deferred to the plan year 2014 calculation.

D. Numerator adjustment for insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2013, and shall apply to all groups as described in D. (1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2013.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

E. Numerator adjustment for dual option insurance coverage provided to a single employer at blended rates.

(1) An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(2) The decision whether to apply the adjustment shall be made prior to January 1, 2013, and shall apply to all groups as described in E. (1).

(3) The adjustment shall be an objective formula that is defined prior to January 1, 2013.

(4) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.

(5) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

F. The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less Federal and State taxes and licensing or regulatory fees.

(1) Earned premiums are for the period from January 1, 2011 to December 31, 2013, less any premiums earned in 2013 that are to be deferred to the plan year 2014 calculation.

(2) Federal and State taxes and licensing or regulatory fees are for the period from January 1, 2011 to December 31, 2013, less any Federal and State taxes and licensing or regulatory fees from the 2013 plan year that are to be deferred to the plan year 2014 calculation.

G. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D and E, to the denominator in F.

H. If both of the following conditions are met, no credibility adjustment will be applicable:

(1) Each of plan years 2011, 2012 and 2013 are partially credible based on the life years for each plan year, respectively, and;

(2) The medical loss ratio, before applying any credibility adjustments, for each of plan years 2011, 2012 and 2013 is less than the minimum medical loss ratio standard for each plan year, respectively.

(a) The plan year 2011 medical loss ratio is the quantity calculated in Section 8 G.

(b) The plan year 2012 medical loss ratio is calculated using the methodology given in Sections 9.B, C., D., E., F., and G., with the exception that only experience from January 1, 2012 through December 31, 2012 is to enter into the calculation.

(c) The plan year 2013 medical loss ratio is the quantity calculated using the methodology given in Sections 10.B., C., D., E., F., and G., with the exception that only experience from January 1, 2013 through December 31, 2013 is to enter into the calculation.

I. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in G and any applicable credibility adjustment.

J. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group or large group).

K. (1) If the result of J is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less Federal and State taxes and licensing or regulatory fees for the plan year. The resulting amount is the rebate to be paid.

(2) If the result of J is zero or less, no rebate is to be paid.

Appendix A. Formats for Reporting Rebate Calculations

This appendix contains formats to report rebate calculations for the 2011, 2012, and 2013 plan years. Each report will require a separate supplemental information form for each experience year in the calculation.

"Line of Business" is the applicable aggregation as defined in Section 5.

"Minimum medical loss ratio" is the loss ratio as defined in Section 3.B (16).

REBATE CALCULATION
FORM FOR PLAN YEAR 2011

Company _____ NAIC Company Code _____
For the State of_____ NAIC Group Code _____
Line of Business _____ Minimum Medical Loss Ratio_____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011
1.	Life Years	
2.	Earned Premium	
3.	Federal and State Taxes and Licensing or Regulatory Fees	
4.	Expenses to Improve Heath Care Quality	
5.	Paid Claims	
6.	Unpaid Claim Reserve	
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds	
8.	Change in Contract Reserves	
9.	Contingent Benefit and Lawsuit Reserve	
10.	Incurred Medical Pool Incentives and Bonuses	
11.	Net Healthcare Receivables	
12.	Incurred Claims	
13.	Medical Loss Ratio	
14.	Credibility Adjustment Factor	
15.	Credibility Adjusted Medical Loss Ratio	
16.	Rebate	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2011

Line 1: Life Years

Rebate Supplemental Form for experience year 2011

Line 2: Earned Premium

Rebate Supplemental Form for experience year 2011

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year 2011

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year 2011

Line 5: Paid Claims

Rebate Supplemental Form for experience year 2011

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year 2011

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year 2011

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year 2011

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year 2011

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year 2011

Line 11: Net Healthcare Receivables

Rebate Supplemental Form for experience year 2011

Line 12: Incurred Claims as of 3/31= Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 + Line 11

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3)

Line 14: Credibility Adjustment based on the number of life years in Line 1 and the methodology in Section 8.

Line 15: Credibility Adjusted Medical Loss Ratio = Line 13 + Line 14

Line 16: If 2011 experience is non-credible as determined by Line 1, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 15) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15) · (Line 2 – Line 3),where (Minimum Medical Loss Ratio - Line 15) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION FORM
FOR PLAN YEAR 2012

Company _____ NAIC Company Code _____
For the State of_____ NAIC Group Code _____
Line of Business _____ Minimum Medical Loss Ratio_____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011	4 2012	5 Total
1.	Life Years			
2.	Earned Premium			
3.	Federal and State Taxes and Licensing or Regulatory Fees			
4.	Expenses to Improve Heath Care Quality			
5.	Paid Claims			
6.	Unpaid Claim Reserve			
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds			
8.	Change in Contract Reserves			
9.	Contingent Benefit and Lawsuit Reserve			
10.	Incurred Medical Pool Incentives and Bonuses			
11.	Net Healthcare Receivables			
12.	Incurred Claims			
13.	Medical Loss Ratio	XXX		
14.	Credibility Adjustment Factor	XXX		
15.	Credibility Adjusted Medical Loss Ratio	XXX	XXX	
16.	Rebate	XXX	XXX	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2012

Line 1: Life Years

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 2: Earned Premium

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 5: Paid Claims

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 11: Net Healthcare Receivables

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 12: Incurred Claims as of 3/31 = Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 + Line 11.

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3) for Column 4 and Column 5.

Line 14: Credibility Adjustment based on the number of life years in Line 1 for Column 4 and Column 5 and the methodology in Section 8.

Line 15 Column 5:
If Line 14 Column 4 is equal to zero
Credibility Adjusted Medical Loss Ratio = Line 13 Column 4
If Line 14 Column 4 is not equal to zero
Credibility Adjusted Medical Loss Ratio = Line 13 Column 5 + Line 14 Column 5

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Line 16: If 2011 plus 2012 experience is non-credible as determined by Line 1 Column 5, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 15) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15 Column 5) · (Line 2 Column 4 – Line 3 Column 4), where (Minimum Medical Loss Ratio - Line 15 Column 5) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION FORM
FOR PLAN YEAR 2013

Company _____ NAIC Company Code _____
For the State of_____ NAIC Group Code _____
Line of Business _____ Minimum Medical Loss Ratio_____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 2011	4 2012	5 2013	6 Total
1.	Life Years				
2.	Earned Premium				
3.	Federal and State Taxes and Licensing or Regulatory Fees				
4.	Expenses to Improve Heath Care Quality				
5.	Paid Claims				
6.	Unpaid Claim Reserve				
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds				
8.	Change in Contract Reserves				
9.	Contingent Benefit and Lawsuit Reserve				
10.	Incurred Medical Pool Incentives and Bonuses				
11.	Net Healthcare Receivables				
12.	Incurred Claims				
13.	Medical Loss Ratio				
14.	Credibility Adjustment Factor	XXX	XXX	XXX	
15.	Credibility Adjusted Medical Loss Ratio	XXX	XXX	XXX	
16.	Rebate	XXX	XXX	XXX	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

INSTRUCTIONS
REBATE CALCULATION FORM FOR PLAN YEAR 2013

Line 1: Life Years

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 2: Earned Premiums

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 5: Paid Claims

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 6: Unpaid Claim Reserve

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 8: Change in Contract Reserves

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 9: Contingent Benefit and Lawsuit Reserve

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 10: Incurred Medical Pool Incentives and Bonuses

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 11: Net Healthcare Receivables
Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 12: Incurred Claims as of 3/31 = Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 + Line 11

Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3)

Line 14: Credibility Adjustment based on the number of life years in Line 1 for Column 6 and the methodology in Section 8.

Line 15: Credibility Adjusted Medical Loss Ratio = Line 13 + Line 14 for Column 6

Line 16: If the sum of 2011, 2012 and 2013 experience is non-credible as determined by Line 1 Column 6, Rebate = 0, else

If the experience of each of plan years 2011, 2012, and 2013 are partially credible as determined by Line 1 Columns 3, 4, and 5, respectively and the medical loss ratio for each of plan years 2011, 2012 and 2013 as determined by Line 13 Columns 3, 4, and 5, respectively is less than the Minimum Medical Loss Ratio for each plan year, respectively,

Rebate = (Minimum Medical Loss Ratio - Line 13 Column 6) · (Line 2 Column 5 – Line 3 Column 5), rounded to the nearer dollar, else,

If (Minimum Medical Loss Ratio - Line 15 Column 6) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 15 Column 6) · (Line 2 Column 5 – Line 3 Column 5), where (Minimum Medical Loss Ratio - Line 15 Column 6) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION SUPPLEMENTAL FORM
Plan Year ____
Experience Year ____

Company _____ NAIC Company Code _____
For the State of_____ NAIC Group Code_____
Line of Business _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

1 Line	2 Description	3 12/31	4 Deferred	5 Added	6 Total
1.	Life Years				
2.	Earned Premium				
3.	Federal and State Taxes and Licensing or Regulatory Fees				
4.	Expenses to Improve Heath Care Quality				
5.	Paid Claims				
6.	Unpaid Claim Reserve				
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds				
8.	Change in Contract Reserves				
9.	Contingent Benefit and Lawsuit Reserve				
10.	Incurred Medical Pool Incentives and Bonuses				
11.	Net Healthcare Receivables				
12.	Incurred Claims				

INSTRUCTIONS
REBATE CALCULATION SUPPLEMENTAL FORM

Column 3 is data from the Supplemental Health Care Exhibit in the NAIC Annual Statement for the experience year.

Column 4 is data for policies newly issued in the experience year with less than 12 months of experience in that year that are excluded from the medical loss ratio calculation for the plan year of issue and will be added back in the next plan year. Column 5 is data for policies newly issued in a prior experience year with less than 12 months of experience in that year that were excluded from the medical loss ratio calculation for a prior plan year and are added back in this plan year. See Sections 8.B., 9.B. , and 10.B. for additional details.

Note that quantities in Lines 2 through 9 should be allocated to represent only the experience associated with the deferred business using reasonable methods.

Line 1: Life Years

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1 Other Indicators, Column(s) for applicable line of business - Line 4 divided by 12 and rounded to zero decimal places.

Line 2: Earned Premium

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 2, Column(s) for applicable line of business – Line 1.8 – Line 1.7, plus Part 1, Column(s) for applicable line of business – Line 1.2 + Line 1.3, plus or minus any portions of premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, plus or minus any incurred experience rating refunds.

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 1.5 + Line 1.6 + Line 1.7

Line 4: Expenses to Improve Health Care Quality

Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 6.3

Line 5: Paid Claims

Amounts paid on claims incurred in the experience year as of March 31 of the year following the plan year, plus or minus any portions of premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, plus Deductible Fraud and Abuse Detection/Recovery Expenses from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 4, minus any state stop loss, market stabilization and claim/census based assessments from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 2.4, plus or minus any adjustment from paragraphs D.(4) and/or E.(4) in Section ~~9~~8, Section 9 or Section 10.

Line 6: Unpaid Claim Reserve

The reserve for amounts unpaid on claims incurred in the experience year as of March 31 of the year following the plan year.

Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds

Experience rating refunds incurred in the experience year and paid through March 31 of the year following the plan year, plus the estimate as of March 31 of the year following the plan year for any reserves experience rating refunds incurred in the experience year, plus any state premium refunds incurred in the experience year.

Line 8: Change in contract reserves

Change in contract reserves from December 31 of the year prior to the experience year to December 31 of the plan year after eliminating the effect of any valuation basis changes.

Line 9: Contingent Benefit and Lawsuit Reserve

Contingent Benefit and Lawsuit Reserve for claims incurred in the experience year as of March 31 of the year following plan year.

Line 10: Incurred Medical Pool Incentives and Bonuses

Medical Pool Incentives and Bonuses incurred in the experience year as of March 31 of the year following the plan year.

Line 11: Net Healthcare Receivables

Net Healthcare Receivables incurred in the experience year as of March 31 of the year following the plan year.

Line 12: Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 - Line 11

Appendix B. Credibility Tables

Table 1	
Base Credibility Additive Adjustment Factors	
Life Years	**Additive Adjustment**
< 1,000	No Credibility
1,000	8.3%
2,500	5.2%
5,000	3.7%
10,000	2.6%
25,000	1.6%
50,000	1.2%
75,000	0.0%

Table 2	
Plan Cost-Sharing Adjustment Factors by Deductible	
Deductible Range	**Adjustment Factor**
< $2,500	1.000
$2,500	1.164
$5,000	1.402
>= $10,000	1.736

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

Federal and State Taxes and Licensing or Regulatory Fees:

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1:

Line 1.5 – Federal Taxes and Federal Assessments

Refer to SSAP 10R 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, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the state.

Guaranty fund assessments

Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states.

Advertising required by law, regulation or ruling, except advertising associated with investments.

State 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.

Expenses to Improve Health Care Quality:

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3:

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;
- 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. Reformatting, 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;
- All Accreditation Fees;
- 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.

Incurred Medical Pool Incentives and Bonuses

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

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.

Net Healthcare Receivables

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

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.

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