NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

	DATE: **June 18, 2010**	**FOR NAIC USE ONLY**
CONTACT PERSON:		Agenda Item # 2010 – 1X BWG
		Year 2010
TELEPHONE:		Changes to Existing Reporting [X]
		New Reporting Requirement [X]
EMAIL ADDRESS:		**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**
ON BEHALF OF:	**Health Reform Solvency Impact (E) Subgroup**	No Impact [X]
		Modifies Required Disclosure [ ]
NAME:	**Lou Felice**	**DISPOSITION**
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SUPPLEMENT HE YEAR 2010 OF THE SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

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

REPORT CORPORATION _____ 2. _____

(LOCATION)

NAIC Group Code ____ BUSINESS IN THE STATE OF_____ DURING THE YEAR _____ NAIC Company Code _____

3A		l Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
			1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)

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Column 5	Other Business (Excluded by Statute) Health

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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

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Line 1.10 – Other Adjustments due to MLR Calculations - Premiums

Any amounts excluded from premiums in Part 2 for MLR calculation purposes. Should agree with Supplemental Health Care Exhibit - Part 2, Line 1.12.

Line 1.11 – Risk Revenue

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

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

Line 2.1 – Incurred Claims Excluding Prescription Drugs

Include: Direct Paid Claims during the Year

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

Change in Unpaid Claims

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

Change in Incurred but not Reported

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

Change in Contract & Other Claims Related Reserves

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.

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

Any market stabilization payments or receipts by insurers that are directly tied to claims incurred and other claims based or census based assessments.

State subsidies based on a stop-loss payment methodology.

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

Refer to SSAP 35 (Guaranty Fund and Other Assessments).

Line 3 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers to promote quality improvements as defined in the PHSA (section 2717).

Should agree to Supplemental Health Care Exhibit – Part 2, Line 2.8, for each column.

Line 4 – Deductible Fraud and Abuse Detection/Recovery Expenses

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

Line 5.0 – Total Incurred Claims (Lines 2.1 + 2.2 – 2.3 – 2.4 + 3)

Should agree with Supplemental Health Care Exhibit – Part 2, Line 2.10.

Line 5.1 – Net Assumed Less Ceded Reinsurance Claims Incurred

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

Should agree with Supplemental Health Care Exhibit - Part 2, Line 2.11 plus Line 2.12, less Line 2.13, for each column.

Line 5.2 – Other Adjustments Due to MLR Calculation - Claims

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

Line 10.1 – Direct Sales Salaries, Force Salaries and Benefits

Line 10.2 – Agents and Brokers Fees and Commissions

Line 10.3 – Other Taxes (Excluding Taxes on Lines 1.5 through 1.7 above and Line 14 below)

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

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

Line 10.4 – Other General & Administrative Expenses

OTHER INDICATORS

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

Line 1 – Number of Certificates / Policies

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

Line 2 – Number of Covered Lives

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

Line 3 – Number of Groups

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

Line 4 – Member Months

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

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Line 1.8 – Total Direct Health Premiums Earned (Lines 1.1 + 1.4 + 1.7 less $_____ write offs)

Include: Direct written premium plus the change in unearned premium reserves and reserve for rate credits.

For MLR purposes, Health Premiums Earned are reduced by actual write offs, not reserves for bad debt or statutory nonadmitted amounts.

Line 1.12 – Other Adjustments Due to MLR Calculation - Premiums

Include: Any amounts excluded from premium for MLR calculation purposes which are normally included in premiums for financial statement purposes, including the amount of write offs in Line 1.8.

Line 2 – Direct Claims Incurred:

Hospital/Medical Benefits

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

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

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

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

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

The cost of utilizing skilled nursing and intermediate care facilities.

Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the

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

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

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

Outside Referrals

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

Emergency Room and Out-of-Area

Include: Expenses for other health delivery services including emergency room costs incurred by members for w.039 Tme(e)8(s) reporting entii5(n)-5(s)2(Tf-22.4(ers for)6(odv)-5(n ib]TJEM1)-

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Line 2.6 – Direct Contract Reserve Current Year

Report the amount of reserves required when due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves. Refer to *SSAP 54 – Individual and Group Accident and Health Contracts* for guidance.

Include: Contract reserves and other claims related reserves.

Exclude: Premium deficiency reserves.

Line 2.8 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.

Line 2.9 – Net Healthcare Receivables

Report the change between prior year healthcare receivables and current year healthcare receivables. The amounts on this line are the gross healthcare receivable assets, not just the admitted portion. This amount should not include those healthcare receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Line 2.10 – Should agree to Supplemental Health Care Exhibit - Part 1, Line 5.0.

Line 2.14 – Adjustments Due to MLR Calculation - Claims

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

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

Include collected recoveries on paid claims only.

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SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

Part A of this exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the Individual, Small Group and Large Group amounts. Part B of this exhibit is intended to show the amount of qualifying HIT expenses, reported separately for the Individual, Small Group and Large Group amounts, broken down into the four categories of Quality Improvement expenses (see below); similarly, the Other than HIT qualifying Quality Improvement expenses are disclosed for each of the four categories of Quality Improvement expenses. The definitions of Individual, Small Group and Large Group are found in the instructions for Parts 1 and 2 of this supplement exhibit.

Improving Health Care Quality Expenses – General Definition:

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

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

NOTE: Expenses which otherwise meet the definitihot thv(he)9(rwh( )6(o9(hs and)r)2(ee)8)5(i)d5(e)-1(s5(w(v)s and(h)-TJ0h5(e)-1(sgraes

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

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 accr

Life/Fraternal:

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

Health:

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

P/C:

Outsourced portion of U&I Part 3, Line 1.4 Net claim adjustment services

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Lines 1.6, 2.6, 3.6 - Other Expenses

Include: Any additional expenses not included in another category.

Life/Fraternal

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SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your annual statement filing. However, in the event that

SUPPLEMENTAL EXHIBITS AND SCHEDULES

SUPPLEMENTAL EXHIBITS AND SCHEDULES
INTERROGATORIES

Detail Eliminated To Conserve Space

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