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

Table of Contents

Section 1. Short Title
Section 2.

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(b) 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.

(c) 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 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 xhiberxhptefsson (er)-1.7 (s)-3.5 (A)-1.2 (s)-3.5 (s)-3.

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(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).

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

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.

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(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. If the 2012 experience is not fully credible, the experience rating refund for the plan year 2012 calculation shall a (l)-1.51.4 (l)Othe r-2.51 [(4 (l 5(m a)-e)1.g1t (f)-5.5 (.7 (r6 (n)-1.5)1.7

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(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. Notwithstanding the foregoing, rebates shall be reflected as specifically provided for in the instructions in Appendix A for Line 7 of the Rebate Calculation Supplemental Form.

Section 4. Applicability and Scope

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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

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(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 not credible for any aggregation as defined in Section 5, a credibility adjustment is not applicable.

(3)

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(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 f. (l)-1.5 (a)-8.3 lus i4 TD [(t)0.7 (t)0.7 (t)0.6 lutgteu ui(20.732(r)3

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

A. A rebate is not payable for any aggregation that is not 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 shall 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 (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.

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J. (1) If the result of I is greater than zero, this number is rounded to the nearer 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 not 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

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

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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

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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:

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L 6:

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Title - Please Type

Date

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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.

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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 7.

Line 15: Column 5:

If Line 14 Column 4 is equal to zero
Credibility Adjusted Medical Loss Ratio = Line 13 Col:na[t,0.6 (f)-1 (L)-0.8Tw 3.2 Tw 4.098 t-4DC 8Tw 3fs

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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 _____

s57.301 re W n BT 178. -0-0 0 10.98 T 0.238 (p)57 (itaTw 0.22l Tm [(L)-0.8 70 T5)Tj ET Q d [49.38 583.14 31.26 27.301 re W

1	2	3	4	5
Line	Description	2011	2012	

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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)

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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 7.

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 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

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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 Regulatory Fees				

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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 8B, 9B, and 10B 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 Exhibit1 (m)-5.7 (E)0.6 (xh)-0.6 (i)-6.9 (b)-0.6 (i)

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Line6: 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

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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 $5,000	1.164

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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 Section 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

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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.

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- 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 ;

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- 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)

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- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;
- Marketing expenses;
- Any accreditation fees that are not directly related to activities included in Columns 1 5,
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included incltcon (n)0.8 (n8 (e)l)-1.5.222i aTc 0 Tw28.9678 0 Td ( )Tj E

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medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.

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

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

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

Other Professional Services

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

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

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

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

Outside Referrals

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

Emergency Room and Out-of-Area

Include: Expenses for other health delivery services including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital.

In the event a member is admitted to the health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.

Aggregate Write-ins for Other Hospital and Medical

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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 related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the pom p((a)2.6 (n (t)3.7 (e)2)-3 (m)1.0.002 Tc .6 (h)1cT5mpB8 (d)-3.tgr5 Tw [(r)-6.2 (eo)-3

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