Texas Department of Insurance

HMO SUPPLEMENT

for filing

2005 Quarterly and 2004 Annual Information

Financial Analysis & Examinations
333 Guadalupe St MC 303-1A
Austin TX 78701

TEXAS DEPARTMENT OF INSURANCE
2004 Annual
HMO SUPPLEMENT INSTRUCTIONS

1. HMO Supplement – Exhibits I – VII:

In addition to the NAIC annual statement blank, HMOs licensed in Texas are required to file HMO Supplemental Exhibits I through VII with the Texas Department of Insurance (the Department). Separate instructions for completing these pages are included on the reverse side of each exhibit. Please read carefully because some **exhibits and instructions have been amended**.

Exhibit I and II have been developed to closely compare to the 2004 NAIC quarterly statement blanks, but some deviation does exist. Please note that "Fee-for-service" revenues are to be reported on line 6, column 9 (for non-risk business) with the medical and hospital expenses associated with this fee-for-service income are to be reported on the appropriate lines 12 through 17 in column 9 and any administrative expense associated with "fee-for-service" revenues on line 22 in column 9. Please also note that line 28 in the NAIC's "Statement of Revenues and Expenses" has been combined with other expenses for the purposes of completing this Exhibit.

Exhibit I (Projected Revenues and Expenses For The Following Year), Exhibit III (Complaints – Business in the State of Texas), Exhibit IV (Contracts between Primary HMOs, Provider HMOs, and ANHCs), Exhibit V (Listing of Significant Capitated Providers), and Exhibit VII (Supplemental Information) are to be submitted **only with the annual statement**.

Exhibit II (Actual Revenues and Expenses by Major Specified Lines) and Exhibit VI (Supplemental Interrogatories) are required to be submitted with **both the annual and quarterly statements**.

2. Annual and Quarterly Statements – Exhibit of Premiums, Enrollment and Utilization & Schedule E – Part 2 - Special Deposits :

Exhibit of Premiums, Enrollment and Utilization:
Separate exhibits are ***required*** to be filed for ***each*** Texas and out-of-state division. A consolidated corporate exhibit is also required. Membership reflected in the primary Exhibit of Premiums, Enrollment and Utilization should include direct business only, and neither provider HMO business nor non-risk business. Before completing the Exhibit of Premiums, Enrollment and Utilization form, page 30, make copies of the form. A copy of this form shall be completed with Provider HMO business and filed as a supplemental exhibit labeled, "Provider HMO Premiums, Enrollment and Utilization Exhibit" under which the HMO shall report risk revenue, enrollment and utilization (relating to services under contract with Primary HMOs and ANHCs). Number the separate supplemental exhibit as Page 30 (a). At the HMO's option, a copy of the form may also be either fully or partially completed for non-risk business and labeled as such, numbered Page 30 (b). Divisional reports should be numbered Page 30 (1) or Page 30 (a)(1), depending if a breakdown of direct business or provider HMO business as indicated.

Schedule E – Part 2, Special Deposits
This schedule, which is included with the annual statement filing, must also be included with the quarterly statement filing as an additional supplemental schedule. Instructions on completing this schedule for the quarterly filing are the same instructions used for the annual filing. When reporting deposits in this schedule, a sufficient description should include under what line each deposit is reported on page 2 of the financial statement.

3. Annual Statement -General Interrogatories, Part 2- Health Interrogatories
Interrogatory #6:

Covered Expenses/Liabilities
If any liabilities or expenses are reported as covered in the annual statement, disclosure should include the basis or reason for such liabilities or expenses being considered covered.

Guarantees
If a guarantee of any debts or expenses of the HMO exists, disclosure and explanation in General Interrogatories, Part 2 - Health Interrogatory #6, and continuing on Overflow Page for Write-ins, page 54 if needed, shall include the following:

- the name of the guarantor;
- the number and amounts of other guarantees such guarantor has issued;

- the guarantee's fiscal year; and
- the period covered in the guarantor's most recent audited financial statement filed with the Department.

4. Annual and Quarterly Statement "Notes to Financial Statements" (Regarding Note #10 and Note #20 of the NAIC Annual Statement Instructions):

- List all subordinated and unsubordinated lines of credit with ***parent or affiliated*** companies in Note #10, including the following:

  - the total amount of each line of credit;
  - the name and affiliation of the lender;
  - whether the line of credit is subordinated or unsubordinated;
  - the total amount advanced to the HMO as of the statement date;
  - the remaining balance not advanced as of the statement date; and
  - the amount of any advances subsequent to the statement date, as of the statement filing date.

- List all subordinated and unsubordinated lines of credit with ***unaffiliated*** companies not listed elsewhere under Note #20 and including the following:

  - the total amount of each line of credit;
  - the name of the lender;
  - whether the line of credit is subordinated or unsubordinated;
  - the total amount advanced to the HMO as of the statement date;
  - the remaining balance not advanced as of the statement date; and
  - the amount of any advances subsequent to the statement date, as of the statement filing date.

5. Definition of Claims:

Amounts reported under the term "claims" include amounts paid or to be paid on a capitation, per diem, or fee-for-service basis for medical, hospital, and other health care services.

Reserves for capitation not paid, because a physician or other provider was not selected by an enrollee, shall be reported as Incurred but not Reported Claims (IBNR).

6. Electronic Data Filing:

- Pursuant to Title 28 of the Texas Administrative Code, §7.67, all HMOs licensed in Texas are required to file electronic data containing quarterly and annual statement data with the NAIC. Electronic data filed with the NAIC must be completed in accordance with the current NAIC Annual Statement Diskette Filing Specifications for HMOs.

- In addition, for annual and quarterly filings, the Department shall furnish each HMO formatted data forms and instructions for Texas-specific filings. These electronic forms shall be filed with the Department only. Instructions should be closely followed and no changes made to the forms except as instructed. For instructions related to such electronic data filing, contact Richard Dunlap at (512) 322-4365.

7. Other Instructions:

In addition to the guidance provided by these instructions, all HMOs licensed in Texas should follow the requirements of Title 28 of the Texas Administrative Code, §7.67, including the adoption of the NAIC Annual Statement Instructions, Health Maintenance Organizations. Also in completing the financial statements, please be aware that the NAIC Accounting Practices and Procedures Manual has been adopted effective March 2003, per Title 28, Texas Administrative Code, §7.18, and should be used as a reference.

STATEMENT FOR THE PERIOD ENDING _____ OF THE _____

(NAME OF COMPANY)

REPORT FOR: 1. CORPORATION / 2. DIVISION _____

(Location)

EXHIBIT I *(Filed Annually)*

PROJECTED REVENUES AND EXPENSES FOR THE FOLLOWING YEAR

Indicate Period of Projections:

Annual: ___ Quarter: 1st __2nd __3rd __ 4th __

	1. TOTAL	2. COMMERCIAL RISK (Omit Provider HMO Business)	3. MEDICARE (Omit Provider HMO Business) RISK	3. MEDICARE COST	4. MEDICAID (Omit Provider HMO Business) RISK	4. MEDICAID COST	5. POINT OF SERVICE RIDER COVERAGE	6. ASSUMED RISK (as a Provider HMO)	7. CHILDREN'S HEALTH INSURANCE PLAN	8. PUBLICLY SUPPORTED HEALTH CARE	9. NON-RISK
1. **ENROLLEES AT THE END OF REPORTING PERIOD**											
2. **MEMBER MONTHS**											
3. Direct Premium								XXXXX			XXXXXX
4. Net Premium								XXXXX			XXXXXX
5. Change in unearned premium reserve and reserve for rate credits											
6. Fee-for-Service (gross revenues)		XXXXXXXX	XXXX	XXXXX	XXXX	XXXXX	XXXXXX	XXXXXX	XXXXXXX		
7. Risk Revenue.		XXXXXXXX	XXXX	XXXXX	XXXX	XXXXX	XXXXXX		XXXXXXX	XXXXXX	XXXXXX
8. Other Health Related Revenues											
9. TOTAL HEALTHCARE RELATED REVENUE (Lines 4 to 8)											
10. Other Revenue (excluding investment income)											
11. TOTAL REVENUE (Lines 9 plus 10)											
MEDICAL AND HOSPITAL:											
12. Hospital/Medical Benefits											
13. Other Professional Services											
14. Outside Referrals											
15. Emergency Room and Out-of Area							XXXXXXX				
16. Other Medical & Hospital											
17. Incentive Pool and Withhold Adjustments											
18. SUBTOTAL MEDICAL AND HOSPITAL (Lines 12 to 17)											
19. Net Reinsurance Recoveries Incurred											
20. TOTAL MEDICAL AND HOSPITAL (Lines 18 minus 19)											
21. Claims Adjustment Expense											
22. General Administrative Expenses											
23. Increase in Reserves for Accident and Health contracts											
24. TOTAL UNDERWRITING DEDUCTIONS (Lines 20 to 23)											
25. NET UNDERWRITING GAIN/(LOSS) (Lines 9 minus 24)											
26. Net Investment Income Earned											
27. Net Realized Capital Gains/(Losses)											
28. NET INVESTMENT GAINS/(LOSSES) (Lines 26 to 27)											
29. Other Expenses											
30. **INCOME /(LOSS) BEFORE FIT & EXTR ITEMS** (Lines 10 + 25 + 28 - 29)											
31. Extraordinary Items & Federal Income Taxes											
32. **NET INCOME (LOSS)** (Lines 30 minus 31)											

INSTRUCTIONS FOR EXHIBIT I
PROJECTED REVENUES AND EXPENSES FOR THE FOLLOWING YEAR

Exhibit I has been developed to closely compare to the 2004 NAIC quarterly statement blanks, but please note there are some differences.

Please note that "Fee-for-service" revenues are to be reported on line 6, column 9 (for non-risk business) and the medical and hospital expenses associated with this fee-for-service income are to be reported on the appropriate lines 12 through 17, column 9. Any administrative and other expense associated with "Fee-for-service revenues are also to be reported under their respective line item in column 9. Please also note that line 28 in the NAIC's "Statement of Revenues and Expenses" has been combined with "other expenses" for the purposes of completing this Exhibit.

- **Exhibit I is used to indicate the HMO's projected revenues and expenses for calendar year 2005.** For the Corporation or entity as a whole, and for each Division, **five separate forms are required.** Projections must be submitted on an **annual** basis (i.e., one form projecting annual results and separate forms projecting 1st, 2nd, 3rd and 4th quarter results).

- Amounts budgeted for each Division's Exhibit I must add to the amounts reported in the Annual Exhibit I.

- **Exhibit I** must be completed on a **total dollar amount basis only**. Projected enrollees and projected member months must be reported on lines 1 and 2, respectively, of Exhibit I. Non-risk enrollees and member months are required only if a type of business represented lends itself to maintenance of an enrollee count. Examples of non-risk business are "Administrative Services Only" and "Fee-for-Service".

- The **definition of a division** is an operation that meets at least one of the following conditions:
  1. *A distinct and separate operation* of an HMO corporation as opposed to other operations of the corporation serving other distinct and separate geographical service areas;
  2. *A separate geographical area* whereby the geographical location of an enrollee or a group contract holder is used in determining charges or rates; or
  3. *A service area that crosses state lines* or international boundaries is considered to have a separate divisional operation in each state or country and requires separate cost centers and reports.

  HOWEVER, at a minimum, service areas for Dallas/Ft. Worth, Austin/San Antonio, Houston/Galveston/Beaumont, Corpus Christi/Rio Grande Valley, El Paso, and Lubbock/Amarillo shall each require separate divisional reporting. For HMOs writing Medicaid business, divisional reporting shall be, at a miniumum, according to service areas defined by the Texas Department of Health.

- **A Point-of-service rider** is coverage issued and offered by a HMO that meets the requirements of Texas Insurance Code, §843.108 [formerly, Art. 20A.06(c)], to its enrollees, which may be used, at the option of the enrollee, for self-referred health care services, benefits, and supplies, other than emergency services, from non-participating physicians and providers or services from participating physicians or providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining in-plan covered services.

TEXAS HMO SUPPLEMENT

STATEMENT FOR THE PERIOD ENDING_____ OF THE _____
(NAME OF COMPANY)

REPORT FOR: 1. CORPORATION ____ / 2. DIVISION _____
(Location)

EXHIBIT II (Quarter/Annual)

ACTUAL REVENUES AND EXPENSES BY MAJOR SPECIFIED LINES

Indicate Reporting Period:
Current Quarter: ____ Year-to-date: _____

	1. TOTAL	2. COMMERCIAL RISK (Omit Provider HMO Business)	3. MEDICARE (Omit Provider HMO Business) RISK	3. MEDICARE COST	4. MEDICAID (Omit Provider HMO Business) RISK	4. MEDICAID COST	5. POINT OF SERVICE RIDER COVERAGE	6. ASSUMED RISK (as a Provider HMO)	7. CHILDREN'S HEALTH INSURANCE PLAN	8. PUBLICLY SUPPORTED HEALTH CARE	9. NON-RISK
1. **ENROLLEES AT THE END OF REPORTING PERIOD**											
2. **MEMBER MONTHS**											
3. Direct Premium								XXXXX			XXXXXX
4. Net Premium								XXXXX			XXXXXX
5. Change in unearned premium reserve and reserve for rate credits											
6. Fee-for-Service (gross revenues)		XXXXXXXX	XXXX	XXXXX	XXXX	XXXXX	XXXXXX	XXXXXX	XXXXXXX		
7. Risk Revenue.		XXXXXXXX	XXXX	XXXXX	XXXX	XXXXX	XXXXXX		XXXXXXX	XXXXXX	XXXXXX
8. Other Health Related Revenues											
9. TOTAL HEALTHCARE RELATED REVENUE (Lines 4 to 8)											
10. Other Revenue (excluding investment income)											
11. TOTAL REVENUE (Lines 9 plus 10)											
MEDICAL AND HOSPITAL:											
12. Hospital/Medical Benefits											
13. Other Professional Services											
14. Outside Referrals											
15. Emergency Room and Out-of Area							XXXXXXX				
16. Other Medical & Hospital											
17. Incentive Pool and Withhold Adjustments											
18. SUBTOTAL MEDICAL AND HOSPITAL (Lines 12 to 17)											
19. Net Reinsurance Recoveries Incurred											
20. TOTAL MEDICAL AND HOSPITAL (Lines 18 minus 20)											
21. Claims Adjustment Expense											
22. General Administrative Expenses											
23. Increase in Reserves for Accident and Health contracts											
24. TOTAL UNDERWRITING DEDUCTIONS (Lines 20 to 23)											
25. NET UNDERWRITING GAIN/(LOSS) (Lines 9 minus 24)											
26. Net Investment Income Earned											
27. Net Realized Capital Gains/(Losses)											
28. NET INVESTMENT GAINS/(LOSSES) (Lines 26 to 27)											
29. Other Expenses											
30. **INCOME /(LOSS) BEFORE FIT & EX ITEMS** (Lines 10 + 25 + 28 - 29)											
31. Extraordinary Items & Federal Income Taxes											
32. **NET INCOME (LOSS)** (Lines 30 minus 31)											
33a. NON-TAXABLE COMMERCIAL RISK ENROLLEES											
33b. NON-TAXABLE COMMERCIAL RISK MEMBER MONTHS											

(Examples of non-taxable enrollees are State of Texas enrollees & Federal employees.)

TEXAS HMO SUPPLEMENT

EXHIBIT II IS FOR REPORTING *ACTUAL RESULTS* OF THE HMO FOR THE CURRENT QUARTER AND YEAR-TO-DATE BY GROUPINGS OF THE MAJOR LINES OF BUSINESS

A *SEPARATE FORM* IS REQUIRED FOR EACH OF THE FOLLOWING:

- Corporate operations, as a whole
- Each Division's operations, separately,
  HOWEVER, at a minimum, service areas for Dallas/Ft. Worth, Austin/San Antonio, Houston/Galveston/Beaumont, Corpus Christi/Rio Grande Valley, El Paso, and Lubbock/Amarillo shall each require separate divisional reporting. For HMOs writing Medicaid business, divisional reporting shall be, at a miniumum, according to service areas defined by the Texas Department of Health.
- Additional information, by specific type of business, may be requested at any time throughout the reporting year. The HMO should be prepared to report its financial condition at this level of detail when requested.
- **Separate pages** are required to break out **Current Period information from Year-to-Date information** for each exhibit submitted.
- Disclosure must be made in the **Management's Discussion & Analysis (MDA)** stating how ***indirect costs are apportioned among lines of business and divisional operations.*** The MDA must be filed annually.

HMO DEFINITIONS

A Division is an operation that meets one of the following conditions:

1. *A distinct and separate operation* of an HMO corporation as opposed to other operations of the corporation serving other distinct and separate geographical service areas;
2. *A service area that crosses state lines* or international boundaries is considered to have a separate divisional operation in each state or country and requires separate cost centers and reports; or
3. *A separate geographical area* whereby the geographical location of an enrollee or a group contract holder is used in determining charges or rates.

A Point-of-service rider is coverage issued by an HMO that meets the requirements of Texas Insurance Code §843.108 [formerly, Art. 20A.06(c)], which may be used, at the option of the enrollee, for self-referred health care services, benefits, and supplies (other than emergency services) from non-participating physicians and providers or for services from participating physicians and providers under circumstances in which the enrollee fails to comply with the HMO's requirements for obtaining in-plan covered services.

Assumed risk pertains to indirect business obtained from other HMOs (or Approved non-profit health corporations) for a set capitation and which places the reporting HMO at risk. In this instance, another HMO is the direct writer of business and the reporting HMO obtained this business as a provider. Assumed risk includes Medicare and Medicaid business obtained from another HMO.

Children's Health Insurance Plan is to include all business generated under the Children's Health Insurance Plan.

Commercial risk is defined as all business generated under HMO coverage contracts **directly** issued to individuals or groups, whether single service HMO coverage, limited service HMO coverage, or basic service HMO coverage, with the exception of Medicare and Medicaid premiums paid by the Federal Government or the State of Texas. Medicare supplement premiums paid by an individual or on that individual's behalf by an employer would be included in "Commercial risk business."

Medicare business to be reported in this exhibit pertains to premiums paid by the Federal Government for coverage under the Medicare program. This business is to include premiums paid directly to the HMO by the Federal Government and supplemental charges as allowed by the Federal Government to be charged to Medicare enrollees as a part of Medicare risk coverage, but is not to include indirect Medicare business obtained through another HMO.

Medicaid business pertains to premiums paid by the State of Texas for coverage under the Medicaid program. This business line is to include only premiums directly paid by the State of Texas to the HMO and is not to include indirect Medicaid business obtained through another HMO.

Publicly Supported Health Care pertains to premiums paid for indigent care and other publicly sponsored benefits. These benefits may be paid for by the State of Texas, the Federal Government, local hospital districts, local municipalities or local counties. This business excludes Medicare and Medicaid business. Also, indirect business of this nature that is received from another HMO or other carrier is not to be included in this column, but is to be included in assumed risk business.

Non-risk business pertains to business without underwriting risk. Examples of this type of business include "Administrative Services Only" agreements, fee-for-service revenues, whether directly from the public at large or from another carrier for services provided to beneficiaries of that carrier, and management or administrative fees received for managing or administering operations of another company. The reporting of non-risk enrollees and member months that lends itself to maintenance of an enrollee count is optional.

TEXAS DEPARTMENT OF INSURANCE
HMO SUPPLEMENT - ANNUAL

STATEMENT FOR THE PERIOD ENDING _____ OF THE _____
(NAME OF COMPANY)

EXHIBIT III
BUSINESS IN THE STATE OF TEXAS DURING THE YEAR

COMPLAINTS Complaint Category	1. TOTAL COMPLAINTS RECEIVED DURING YEAR	TOTAL COMPLAINTS RECEIVED FROM: (DURING YEAR)			5. NUMBER PENDING END OF PREVIOUS YR.	6. TOTAL NUMBER RESOLVED DURING YEAR	7. NUMBER PENDING END OF CURRENT YR.
		2. ENROLLEE	3. PHYSICIAN OR OTHER HEALTHCARE PROVIDER	4. OTHER			
1. Quality of care services							
2. Accessibility/Availability of services							
3. Utilization review or utilization management.....							
4. Complaint procedures							
5. Physician and provider contracts							
6. Group subscriber contracts							
7. Individual subscriber contracts							
8. Marketing							
9. Claims processing							
10. Miscellaneous/Other							
11. TOTAL							

TEXAS DEPARTMENT OF INSURANCE

HMO SUPPLEMENT – ANNUAL

INSTRUCTIONS FOR EXHIBIT III

COMPLAINTS

Business in the State of Texas During the Year

The manner of grouping complaints for annual statement reporting purposes has been changed to be consistent with the manner complaints are required to be catagorized by 28TAC §11.205(a)(4), as published for adoption on 11/12/04. The total amount of pending complaints at the end of 2003 reported on line 11, column 7, Texas Supplemental Exhibit III in the 2003 annual statement should agree with the total amount of pending complaints to be reported on line 5, column 5 of Texas Supplemental Exhibit III in this year's annual statement. If any difference is reported, an explanation should also be provided explaining the difference.

Complaints should include only complaints from persons or entities residing, receiving services, or located in Texas.

The term "Complaint" is defined by Texas Insurance Code, §843.002(6) [formerly, Art. 20A.02(f)].

TEXAS DEPARTMENT OF INSURANCE HMO SUPPLEMENT - ANNUAL

EXHIBIT IV

CONTRACTS BETWEEN PRIMARY HMOs/ANHCs AND PROVIDER HMOs/ANHCs

FOR THE PERIOD ENDING _____ **OF THE** _____

(Name of Company)

EXHIBIT IV - PART 1 (To be completed by: HMOs or ANHCs Acting as PROVIDER HMOs and ANHCs)

1. NAME OF PRIMARY HMO AND/OR ANHC	2. HEALTH CARE SERVICES TO BE PROVIDED	3. ENROLLEES AT YEAR END	4. MEMBER MONTHS FOR YEAR	5. RISK REVENUE RECEIVED DURING YEAR	6. RISK REVENUE EARNED DURING YEAR	7. COMPENSATION OTHER THAN RISK REVENUE RECEIVED DURING YEAR	8. COMPENSATION OTHER THAN RISK REVENUE EARNED DURING YEAR	9. AMOUNTS PAYABLE	10. AMOUNTS RECEIVABLE
9999999 TOTALS		XXXXX	XXXXX						

EXHIBIT IV - PART 2 (To be completed by: PRIMARY HMOs and ANHCs Contracting with Provider HMOs and/or ANHCs)

1. NAME OF PROVIDER HMO AND/OR ANHC	2. STATUS	3. HEALTH CARE SERVICES TO BE PROVIDED	4. ENROLLEES AT YEAR END	5. MEMBER MONTHS FOR YEAR	6. CAPITATION PAID DURING YEAR	7. CAPITATION ACCRUED DURING YEAR	8. COMPENSATION OTHER THAN CAPITATION PAID DURING YEAR	9. COMPENSATION OTHER THAN CAPITATION ACCRUED DURING YEAR	10. AMOUNTS PAYABLE	11. AMOUNTS RECEIVABLE
9999999 TOTALS			XXXXX	XXXXX						

TEXAS DEPARTMENT OF INSURANCE
HMO SUPPLEMENT - ANNUAL

INSTRUCTIONS FOR EXHIBIT IV

Exhibit IV – Part 1 For HMOs or ANHCs Acting as Provider HMOs and ANHCs:

1. List each and every Primary HMO and ANHC from which Risk Revenue (Capitation) was earned during the year. Also, list each and every Primary HMO and ANHC from or to which a receivable or payable is recorded, even if no risk revenue was earned during the year.

2. Under column 2, the type of health care service or lines of business which the Provider HMO is furnishing the Primary HMO must be listed. An example of health care service could be: Dental, Vision, Pediatric, or Therapeutic, etc. Lines of business could be: Medicare, Group business, Medicaid, or even all business within a smaller service area.

3. Column 3 is for reporting Primary HMO Enrollees covered under contract by the Provider HMO or ANHC. These enrollees are to be reported by the Primary HMO as well as the Provider HMO or ANHC.

Exhibit IV – Part 2 For Primary HMOs and ANHCs Contracting with Provider HMOs and/or ANHCs:

1. List each and every Provider HMO and ANHC to which Capitation was paid during the year. Also, list each and every Provider HMO and ANHC from or to which a receivable or payable is accrued, even if no capitation was paid during the year.

2. Under column 2, "Status", indicate "L" to represent an ANHC that is **licensed** and holds a Certificate of Authority in Texas under §844.051, formerly Article 21.52F, Texas Insurance Code. Indicate "U" to represent an ANHC which is **unlicensed** (does not hold a Certificate of Authority under §844.051, TIC) in Texas. Provider HMOs operating in Texas are assumed to hold licenses issued by the Texas Department of Insurance, but if one does not hold a license, please indicate with the initials UHMO. If the contracted responsibilities of the provider HMO/ANHC are exclusively for operations outside the state of Texas, please indicate by the initials F, or if the contracted responsibilities partially concern Texas enrollees and partially concern operations outside the state of Texas, please indicate with a P.

3. Under column 3, the type of health care service or lines of business for which the Provider HMO is furnishing the Primary HMO must be listed. An example of health care service could be: Dental, Vision, Pediatric, or Therapeutic, etc. Lines of business could be: Medicare, Group business, Medicaid, or even all business within a smaller service area.

TEXAS DEPARTMENT OF INSURANCE
HMO SUPPLEMENT - ANNUAL

EXHIBIT V

LISTING OF SIGNIFICANT PROVIDERS

FOR THE PERIOD ENDING _____ **OF THE** _____

(Name of Company)

1. INDIVIDUALLY LIST ALL MEDICAL AND HEALTHCARE PROVIDERS THAT RECEIVED MORE THAN THE GREATER OF $100,000 OR 2.0% OF THE HMO's TOTAL MEDICAL & HOSPITAL EXPENSE PAID DURING THE YEAR	2. STATUS	3. HEALTH CARE SERVICES TO BE PROVIDED	4. ENROLLEES AT YEAR END	5. MEMBER MONTHS FOR YEAR	6. CAPITATION PAID DURING YEAR	7. CAPITATION ACCRUED DURING YEAR	8. COMPENSATION OTHER THAN CAPITATION PAID	9. OTHER COMPENSATION ACCRUED	10. AMOUNTS PAYABLE	11. AMOUNTS RECEIVABLE
Capitated Providers:										
Non-capitated Providers:			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
			XXXXXXX	XXXXX						
8888888 Total: All Others Not Listed Above			XXXXXXX	XXXXX						
9999999 TOTALS			XXXXXXX	XXXXX						

TEXAS DEPARTMENT OF INSURANCE

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INSTRUCTIONS FOR EXHIBIT V

In Exhibit V, individually list all physicians, physician groups, IPAs, hospitals, and all other healthcare providers that rendered health care services with a cost of more than the **GREATER** of $100,000 or 2.0% of all of the HMO's total medical & hospital expense paid during the year. Please note that the criterion has **been changed** from the lesser of $250,000 or 2.5%**.** For those providers (including physicians) ***not*** individually listed, please include the requested information in the aggregate on line 8888888. **Do not include** in Texas Supplemental Exhibit V any providers listed in Part 2 of Exhibit IV.

In Column 1, the next-to-last line states "Total: All Others Not Listed Above". The amount shown on each column on this line should be the total of all medical and healthcare providers, both capitated and non-capitated, that are ***not*** individually listed as receiving compensation during the year in an amount more than the lesser of $250,000 or 2.5% of the total medical and hospital expense paid by the HMO during the year.

In Column 2, "Status", state whether the provider meets the definition of "delegated entity" or "delegated network" by including the initials "DE" or "DM" in this column for that provider. If the contracted responsibilities of the provider have to exclusively do with operations outside of the state of Texas, please indicate by the initials F, or if the contracted responsibilities partially include Texas operations and partially concern operations outside of the state of Texas, please indicate with a P.

Enrollee and member month information required in columns 3 and 4 are for capitated arrangements only. Membership may be assigned to more than one provider based upon different services they may receive. As such, totals for enrollment and member months are not required due to potential duplication. Also, enrollment and member month numbers are not required for Line 8888888 due to potential duplication.

STATEMENT FOR THE PERIOD ENDING _____, OF THE_____

EXHIBIT VI
Supplemental Interrogatories

1. Are any providers, within the HMO's Texas network, responsible for provision of health care services for which the provider, itself, is not licensed to directly furnish that particular service [§843.318, TIC, formerly Art. 20A.26(f)(8)]? **YES / NO**

   a. If answer is "yes", are the costs of these services less than 15% of the total costs of services provided by the contracting provider? **YES / NO / NA** (**Percentage**: _____%)

   b. Are the services being directly provided by licensed sub-contracting providers? **YES / NO / NA**

   c. Is documentation supporting the answers above being maintained at the HMO's home office or other designated administrative office, as approved by the Texas Dept. of Insurance? **YES / NO / NA**

2. Are you a Primary HMO contracting with Provider HMO(s) or ANHC(s), as defined in 28 TAC §11.2? **YES / NO**

3. If the answer to question number 2 is yes;

   a. Are there written agreements evidencing each Primary HMO / Provider HMO and Primary HMO / ANHC relationship? **YES / NO / NA**

      (If not, please attach a description of any such relationship including the identity of the parties involved.)

   b. Have all written agreements been filed with the Texas Department of Insurance in accordance with 28 TAC §11.1604(2). **YES / NO / NA**

      (If not please attach a schedule identifying those agreements that have not been filed.)

   c. Has a monitoring plan been submitted to the Texas Department of Insurance in accordance with 28 TAC §11.1604(1). **YES / NO / NA**

      (If not, please attach a schedule listing all relationships of which a monitoring plan has not been submitted to the Texas Department of Insurance.)

   d. If contracting with an ANHC,

      i. Has each ANHC provided a financial statement showing evidence of financial solvency and financial ability to perform under the contract in accordance with 28 TAC § 11.1604(2)(F)? **YES / NO / NA**

         (Attach a schedule identifying any ANHCs not providing a financial statement.)

      ii. List the "as of dates" and dates that the financial statements were received from each ANHC.

      _____

   e. Has the data required under 28 TAC §11.1604(2)(G) been received from the Provider HMO or ANHC? **YES / NO / NA**

   f. If so;

      i. Is utilization data received from Provider HMO or ANHC included on Page 35? **YES / NO / NA**

      ii. Is complaint data received from Provider HMO or ANHC included in Exhibit III? **YES / NO / NA**

   g. Has an on-site audit of each ANHC or Provider HMO been conducted in accordance with 28 TAC §11.1604(3)? **YES / NO / NA**

      List dates of last audit of each ANHC and Provider HMO: _____

      _____

4. Are you a Provider HMO or ANHC contracting with a Primary HMO as defined in 28 TAC §11.2? **YES / NO**

5. If answer to question number 4 is "yes", then;

   a. For services provided under the written agreement required to be filed under 28 TAC §11.1604(2), do all contracts and sub-contracts between the Provider HMO and physicians and providers contain enrollee hold harmless clauses? **YES / NO / NA**

   b. Has the information listed under 28 TAC §11.1604(G) been provided to the Primary HMO on a monthly basis? **YES / NO / NA**

STATEMENT FOR THE PERIOD ENDING _____, OF THE_____

EXHIBIT VI
Supplemental Interrogatories

6. For all operations, including out-of-state operations, please list the total amounts <u>paid</u> to physicians, hospitals, and other health care providers under the compensation methods listed:

COMPENSATION METHOD	CURRENT YEAR-TO-DATE AMOUNT	PERCENT OF TOTAL	PREVIOUS YEAR AMOUNT	PERCENT OF TOTAL
Fee for service	$	%	$	%
Discounted Fee For Service	$	%	$	%
Capitation	$	%	$	%
Per diem	$	%	$	%
Other	$	%	$	%
Total Paid	$	100%	$	100%

7. Within the next 12 months following the reporting date, does the HMO anticipate a change in compensation methods utilized (as reflected above) equal or exceeding 20%? (For example, if 70% of an HMO's medical and hospital expenses were paid on a capitation basis in the previous year and the HMO anticipates that for the next 12 months only 50% of the medical and hospital expenses will be paid on a capitation basis, then there is a change equal to 20%.) **YES / NO**

   a. If yes, please reflect the anticipated percentages below.

COMPENSATION METHODS	PERCENTAGE, CURRENT YEAR-TO-DATE	ANTICIPATED PERCENTAGES
Fee for service	%	%
Discounted Fee For Service	%	%
Capitation	%	%
Per diem	%	%
Other	%	%
Total Paid	100%	100%

8. Within the next 12 months, does the HMO anticipate any major changes in the manner by which health care services are provided? (for example, implementing or eliminating a "gatekeeper" system would constitute a major change in the manner by which health care services are provided.)

   YES / NO

9. Has there been any significant change in the manner of delivery of health care services during the current period that was not previously anticipated and disclosed in previous statement filings?

   YES / NO

10. If question 8 and/or 9 is answered "Yes", please describe.

    _____

    _____

11. If medical and hospital costs are expected to increase as a result in a change in utilization of compensation methods or changes in the manner that health care services are provided, have rates been adjusted to anticipate the additional costs? If yes, please furnish the date that these rates were filed.

    YES / NO **DATE:** _____

12. If the HMO is incurring medical and hospital expenses under a Point of Service Rider (POS) at any time during the previous 4 calendar quarters, the schedule below must be completed.

(1)	(2)	(3)	(4)
	TOTAL MEDICAL AND HOSPITAL EXPENSES INCURRED (*FOR THE LAST 4 CALENDAR QUARTERS*)	TOTAL MEDICAL AND HOSPITAL EXPENSES INCURRED UNDER POINT OF SERVICE RIDER (*FOR THE LAST 4 CALENDAR QUARTERS*)	PERCENT OF POS MEDICAL AND HOSPITAL EXPENSES TO TOTAL MEDICAL AND HOSPITAL EXPENSES (*COLUMN 3 ÷ COLUMN 2*)
Total business (including out-of-state)	$	$	%
Texas business, only	$	$	%

*Amounts reported above are on a gross basis (reinsurance recoveries are not excluded)

STATEMENT FOR THE PERIOD ENDING _____, OF THE_____

EXHIBIT VI - Supplemental Interrogatories (continued)

13. The primary purpose of this schedule is to determine if the HMO is subject to the requirement of setting up a premium deficiency reserve for Texas business under 28 TAC §11.706. Complete information below for each line of business. "Date Commenced Business" is defined as the date of the issuance of the first policy for each particular line of business listed below.

Direct Business:	**Date Commenced Business:**	**Premiums Earned**	**Medical & Hospital Expenses Incurred***	**Administrative & Other Expenses Incurred****	**Net Income/Loss**	**Current Period Premium Deficiency Reserve**
		(total for the last four calendar quarters)				
Medicare						
Medicaid						
CHIP						
Commercial:						
large group						
small group						
individual						

Assumed Risk:						
Medicare						
Medicaid						
CHIP						
Commercial:						
large group						
small group						
individual						

* Medical & Hospital Expense also means "benefit" expense.

** Administrative & Other Expenses include claim adjustment expenses as well as administrative and all other non-benefit expenses.

14. Information regarding 'end of period enrollment' and 'total member month for last four calendar quarters' for Texas business that corresponds to the information provided in question #13.

	Medicare	Medicaid	CHIP	Large Group Commercial	Small Group Commercial	Individual
Ending Enrollment (Direct Business)						
Ending Enrollment (Assumed Risk)						
Member Months (Direct Business)						
Member Months (Assumed Risk)						

15. Does the HMO participate in the State of Texas Employee Retirement System's Uniform Group Insurance Program (write coverage for Texas state employees)? **YES / NO**

16. If answer to question number 15 is "yes", then in relation to the Uniform Group Insurance Program coverage what are:

a. number of enrollees _____

b. number of member months _____

c. premium revenue _____

d. medical and hospital expense _____

e. loss ratio _____

f. net income/loss from business _____

g. major metropolitan area(s) covered _____

TEXAS DEPARTMENT OF INSURANCE

HMO Supplemental Information - Annual

EXHIBIT VII

ANNUAL STATEMENT FOR THE YEAR _____

OF _____
(Name of Organization)

1.	Texas premiums received from the Federal Government for Title XVIII (Medicare), Federal Social Security Act		_____
1a.	Texas enrollees that pertain to above premiums:		
	at 3/31/04	_____	
	at 6/30/04	_____	
	at 9/30/04	_____	
	at 12/31/04	_____	
1b.	Texas member months during year that pertain to Line 1 premiums.	_____	
2.	Premiums on HMO Contracts Applicable to the Texas Employees Uniform Group Insurance Program (State employees)		_____
2a.	Texas enrollees that pertain to above premiums:		
	at 3/31/04	_____	
	at 6/30/04	_____	
	at 9/30/04	_____	
	at 12/31/04	_____	
2b.	Texas member months during year that pertain to Line 2 premiums.	_____	
3.	Premiums on HMO Contracts Applicable to Federal Employees located in Texas.		_____
3a.	Texas enrollees that pertain to above premiums:		
	at 3/31/04	_____	
	at 6/30/04	_____	
	at 9/30/04	_____	
	at 12/31/04	_____	
3b.	Texas member months during year that pertain to Line 3 premiums.	_____	
4.	Other non-taxable premiums (specify source and reason):		
	_____		_____
	_____		_____
	_____		_____
4a.	Texas enrollees that pertain to other non-taxable premiums:		
	at 3/31/04	_____	
	at 6/30/04	_____	
	at 9/30/04	_____	
	at 12/31/04	_____	
4b.	Texas member months during year that pertain to Line 4 premiums.	_____	
5.	Total Non-taxable Premiums (1 to 4)		_____

TEXAS DEPARTMENT OF INSURANCE

HMO Supplemental Information - Annual

EXHIBIT VII-CONTINUED

ANNUAL STATEMENT FOR THE YEAR _____

OF _____
(Name of Organization)

6.	Texas premiums received from the State for Welfare Benefits		
6a.	Medicaid	_____	
6b.	CHIP	_____	
6c.	Total of both CHIP and Medicaid		_____
6d.	Texas enrollees that pertain to above premiums:	Medicaid	CHIP
	at 3/31/04	_____	_____
	at 6/30/04	_____	_____
	at 9/30/04	_____	_____
	at 12/31/04	_____	_____
6e.	Texas member months during year that pertain to Line 6 premiums.	_____	_____
7.	Texas Subscribers at Year End (A Subscriber is the holder of an individual policy. In the case of a group contract, a Subscriber is the holder of an individual certificate.)	_____	
8.	Gross Reinsurance Premiums Paid on all business (do not net reinsurance recoveries)	_____	
8a.	Gross Reinsurance Premiums Paid on Texas business only (do not net reinsurance recoveries)	_____	
9.	Net Premiums in Force*	_____	
9a.	Net Premiums in Force on Texas business*	_____	
10.	Uncovered Health Care Expenses Incurred in Texas	_____	
11.	Total Taxable Premiums written in Texas during year (include Medicaid & CHIP).		_____
11a.	Total Taxable Enrollees in Texas (include Medicaid & CHIP):		
	at 3/31/04	_____	
	at 6/30/04	_____	
	at 9/30/04	_____	
	at 12/31/04	_____	
11b.	Total Taxable Member Months in Texas during the year (include Medicaid & CHIP)	_____	

*Net premiums in force constitutes the premiums written which resulted in coverage being in force for the reporting date, net of any reinsurance expense evidencing the reduction/limitation of risk on the reporting date.