Department of Health and Human Services, Centers for Medicare and Medicaid Services
Medical Loss Ratio Quarterly Reporting Form Instructions

The following instructions apply to both the “mini-med” and expatriate plan quarterly filings.

When reporting quarterly, all data should be reported on a year-to-date basis for the 2011 MLR reporting year, except where explicitly noted in the instructions.

For “mini-med” business, data for each State may be reported either in separate Excel files or on separate Excel tabs combined within a single Excel file. You may include the State abbreviation in the Excel file and/or tab names to avoid overwriting existing files or tabs.

Column Instructions

"NAIC SHCE Cross Reference” Column - This column provides a quick cross reference point to the NAIC model regulation and Supplemental Health Care Exhibit. It is included for reference, and is not intended to provide an actual cross check.

- "Pt 1," “Pt 2,” and “Pt 3” refer to Part 1, Part 2, and Part 3, respectively, of the Supplemental Health Care Exhibit to the 2010 Annual Statement as adopted and amended by the NAIC through February 2011.

- "Pt 1 Other" refers to the Other Indicators section of Part 1 of the Supplemental Health Care Exhibit to the 2010 Annual Statement as adopted and amended by the NAIC through February 2011.

- "Supp Form" refers to the Rebate Calculation Supplemental Form of the NAIC model regulation adopted by the NAIC on October 21, 2010.

For “mini-med” business, all data should be aggregated by State and by individual, small group, and large group market, as required by 45 CFR §158.120(d)(3).

For expatriate business, all data should be aggregated nationally, by small group and large group market, as required by 45 CFR §158.120(d)(4).

Include:

- Premiums earned and claims incurred on novated policies.

- Premiums earned and claims incurred under 100% assumption reinsurance or for a block of business that was subject to 100% indemnity reinsurance and administrative agreements effective prior to March 23, 2010 should be reported by the assuming entity, and should not be reported by the ceding entity.

- Dual-contract group health coverage: if the reporting entity had group health plan(s) providing in-network coverage only in affiliation with another issuer that provided out-of-network coverage only solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, the reporting entity may choose to include the experience of the affiliate that provided out-of-network coverage for a minimum of three years. If the reporting entity chooses this method of aggregation, the affiliate that provided out-of-network coverage should not report this experience.

Line Instructions

Part 1

1.1 Adjusted direct premiums earned: from Part 2, Line 1.6.

1.2 Federal high risk pools. Enter subsidies received under Federal High Risk Pools as a positive number, and assessments paid as a negative number.

1.3 State high risk pools. Enter subsidies received under State High Risk Pools as a positive number, and assessments paid as a negative number. Exclude State stop loss, market stabilization and claim/census based assessments (which are included in claims).

1.4 Federal taxes and federal assessments. Provide your best estimate of the federal taxes and assessments allocated to the expatriate or "mini-med" business reported on this form. 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.

1.5 State insurance, premium and other taxes. Provide your best estimate of the state taxes allocated to the expatriate or "mini-med" business reported on this form.

Include:

- 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, or market stabilization redistributions, or cost transfers for the purpose of rate subsidies, not directly tied to claims and that are authorized by state law;

- Guaranty fund assessments;

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

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

- State income, excise, and business taxes other than premium taxes;

- State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes;

EITHER:*

a) Payments to a state, by not-for-profit health plans, of premium tax exemption values in lieu of state premium taxes limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group;

b) Payments by not-for-profit health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. These payments must be state-based requirements to qualify for inclusion in this line item; OR

c) Payments made by (federal income) tax exempt health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. (NOTE: If Line 1.4 of Part 1 excludes federal income taxes, then tax exempt health plans may NOT include community benefit expenditures in this line).

*These expenditures may not be double counted between this category; the federal or state assessments for similar purposes included in Lines 1.4 or 1.5; State stop loss, market stabilization and claim/census based assessments (included in claims) reported on Line 2.4; or the Quality Improvement expenses reported on Line 6.3.

** Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);
- Address federal, state, or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
- Leverage or enhance public health department activities such as childhood immunization efforts; or
- Otherwise would become the responsibility of government or another tax-exempt organization.

1.6 Regulatory authority licenses and fees. Provide your best estimate of the licenses and fees allocated to the expatriate or “mini-med” business reported on this form. Include statutory assessments to defray operating expenses of any state insurance department. Include examination fees in lieu of premium taxes as specified by state law. Exclude fines and penalties of regulatory authorities; fees for examinations by state departments other than as referenced above.

1.7 Adjusted premium: Line 1.1 + 1.2 + 1.3 – 1.4 – 1.5 – 1.6

2.1 Incurred claims excluding prescription drugs

Include:

- Direct Paid Claims Year-to-date.

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

- Change in Unpaid Claims.

  Report the change between prior year and current quarter 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 quarter. 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 (including the Change in Reserve for Rate Credits).

Exclude:

- MLR rebates paid year-to-date.
- Prescription drugs reported on Line 2.2.
- Pharmaceutical rebates received year-to-date, reported on Line 2.3.
- Medical incentive pools and bonuses.

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.

2.3 Pharmaceutical Rebates

Refer to SSAP No. 84, Certain Health Care. Receivables and Receivables Under Government Insured Plans.

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 No. 35, Guaranty Fund and Other Assessments.

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.

Should agree to Part 2, Line 2.11 for each column.

4. Deductible Fraud and Abuse recovery expense: from Part 2, Line 3.3.

5. Total Incurred Claims (Lines 2.1 + 2.2 – 2.3 – 2.4 + 3)

Should agree to Part 2, Line 2.16 for each column.

6.1 Type A. Expenses other than HIT. Refer to the NAIC Supplemental Health Care Exhibit instructions for Part 3, Columns 1 through 4. Provide your best estimate of these expenses allocated to the expatriate or "mini-med" business reported on this form.

6.2 Type B. HIT expenses. Refer to the NAIC Supplemental Health Care Exhibit instructions for Part 3, Column 5. Provide your best estimate of these expenses allocated to the expatriate or "mini-med" business reported on this form.

8.1 Cost Containment expenses not included in Line 6.3. Refer to the NAIC Supplemental Health Care Exhibit instructions for Part 1, Line 8.1.

8.2 All other claims adjustment expenses. Refer to the NAIC Supplemental Health Care Exhibit instructions for Part 1, Line 8.2.

8.5 Other taxes not included in Lines 1.4 through 1.6. Provide your best estimate of these taxes allocated to the expatriate or "mini-med" business reported on this form.

Include:

- taxes of Canada or of any other foreign country not specifically provided for elsewhere;
- state sales taxes if the issuer does not exercise options of including such taxes with the cost of goods and services purchased;
- any portion of commissions or allowances on reinsurance assumed that represent specific reimbursement of premium taxes;
- any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

Exclude:

- Federal income taxes on investment income and capital gains.

8.8 ICD-10 Implementation expenses: informational only, already included in general expenses in Line 8.7.

Part 1: Other Indicators

1. Number of certificates/policies: 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.

2. Number of covered lives: the total number of months of coverage for enrollees whose premiums and claims experience is included in this report, divided by 12.

3. Number of groups: the total number of insurance groups issued as of the end of the reporting period.

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.

Part 2

1.1 Direct premium written. Report all monies paid by a policyholder or subscriber year-to-date from the start of the current MLR reporting year through the end of the current reporting quarter, as a condition of receiving current year coverage from the issuer (exclude advance premiums for coverage beyond the current reporting quarter), including any fees or other contributions associated with the health plan.

Exclude:

- Amounts for rate credits paid.

1.2 Unearned premium, as of end of prior year. Report reserves established to account for the portion of the premium paid in the prior MLR reporting year that was intended to provide coverage through the end of the current reporting quarter.

1.3 Unearned premium, as of end of current quarter. Report reserves established to account for the portion of the premium paid from the start of the current MLR reporting year through the end of the current reporting quarter, that was intended to provide coverage beyond the current reporting quarter. Calculate reserves as of the end of the current reporting quarter.

1.4 Premium write-offs. Include agents' or premium balances determined to be uncollectible and written off as losses. Also include recoveries year-to-date on balances previously written off. Include actual write offs, not reserves for bad debt or statutory nonadmitted amounts.

1.5 Group conversion charges: if Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between Group and Individual lines of business in your Annual Statement accounting, enter the reverse of these charges on this line in the appropriate columns.

1.6 Adjusted direct premiums earned (Lines 1.1 + 1.2 – 1.3 – 1.4 + 1.5)

2. Refer to NAIC Supplemental Exhibit - Part 2, Line 2 instructions for components of direct incurred claims

2.1 Claims paid year-to-date. Any overpayment that has already been received from providers should not be reported as a paid claim, and any overpayment that has not yet been recovered should be included in paid claims but excluded from health care receivables.

2.2 Direct claim liability, as of the end of the current reporting quarter.

Include:

- Unpaid Claims.

  Report 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 claims recoveries received as a result of subrogation.

— Incurred but not Reported Claims.

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

2.3 Direct claim liability, as of the end of the prior year. Refer to instructions for Line 2.2.

2.4 Direct claim reserves, as of the end of the current reporting quarter. Report reserves for amounts not yet due on claims.

2.5 Direct claims reserves, as of the end of the prior year. Refer to instructions for Line 2.4.

2.6 Direct contract reserves, as of the end of the current reporting quarter. Report the amount of reserves required when due to the gross premium structure, the future benefits exceed the future net premium. Refer to SSAP No. 54, Individual and Group Accident and Health Contracts, for guidance.

Include:

— Contract reserves and other claims related reserves.

Exclude:

— Premium deficiency reserves and reserves for MLR rebates.

2.7 Direct contract reserves, as of the end of the prior year. Refer to instructions for Line 2.6.

2.8 Paid rate credits. Report the return of a portion of premiums pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, as determined by SSAP 66, plus any state premium refunds. If the employer will owe the issuer a refund, record a negative amount; if the issuer will owe the employer a refund, record a positive amount.

Exclude:

— Any MLR rebates paid.

2.9 Reserve for rate credits, as of end of current quarter. Exclude reserves for MLR rebates.

2.10 Reserve for rate credits, as of end of prior year. Exclude reserves for MLR rebates.

2.11 Incurred medical incentive pools and bonuses (Lines 2.11a + 2.11b – 2.11c). Include arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers.

2.11a Medical incentive pools and bonuses paid year-to-date.

2.11b Accrued medical incentive pools and bonuses, as of the end of the current reporting quarter.

2.11c Accrued medical incentive pools and bonuses, as of the end of the prior year.

2.12 Healthcare receivables (Lines 2.12a – 2.12b). Report the change between prior year and current quarter 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.

2.13 Contingent benefit reserves for claims incurred in the current MLR reporting year, as of the end of the current reporting quarter. Include the claims-related portion of reserves for future contingent benefits and lawsuits.

2.14 Group conversion charges: if Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between Group and Individual lines of business in your Annual Statement accounting, enter the reverse of these charges on this line. Else, if you reported group conversion charges separately from premiums and claims on your Annual Statement, enter these charges on this line in the appropriate columns.

2.15 Multi-option coverage blend rate adjustment. If multi-option coverage is provided to a single employer at blended rates, which are defined as cross-subsidized rates charged for coverage provided by a single employer through two or more affiliates, the reporting entity may make an adjustment to bring each affiliate's ratio of incurred claims to earned premium to equal the ratio calculated for that employer group in aggregate for the MLR reporting year. If the reporting entity chooses to make this adjustment, it must be made for a minimum of three years.

2.16 Total incurred claims (Lines 2.1 + 2.2 – 2.3 + 2.4 – 2.5 + 2.6 – 2.7 + 2.8 + 2.9 – 2.10 + 2.11 – 2.12 + 2.13 + 2.14 + 2.15)

3.1 Total Fraud and Abuse recoveries expense: informational only, included in general expenses on Part 1, Line 8.7.

3.2 Total Fraud and Abuse recoveries of paid claims (informational only): include collected recoveries that reduced paid claims on Line 2.1.

3.3 Deductible Fraud and Abuse recovery expense: the lesser of the amounts shown on Line 3.1 or 3.2.

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