CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) MEDICAL LOSS RATIO (MLR) ANNUAL REPORTING FORM FILING INSTRUCTIONS FOR ALL PARTS

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INSTRUCTIONS FOR THE 2011 MLR REPORTING YEAR ONLY

This filing is the report to the Secretary required by section 2718 of the Public Health Service Act (PHS Act), including the elements that make up the medical loss ratio and calculation and provision of rebates to enrollees. The numbers included in this MLR Annual Reporting Form (MLR Form) are the exact numbers that will be used to calculate an issuer's medical loss ratio (MLR) and rebates, if any, under section 2718 of the PHS Act and the implementing regulation, codified at 45 CFR Part 158.

The MLR implementing regulations can be found at:

http://cciio.cms.gov/resources/regulations/index.html#mlr.

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011. Filing will require a one-time registration, by the issuer, with the CMS Health Insurance Oversight System (HIOS) to submit its report to the Secretary.

References are made in these instructions to the National Association of Insurance Commissioners (NAIC) Statements of Statutory Accounting Principles (SSAP) as of March 2011 and Supplemental Health Care Exhibit (SHCE) as adopted June 30, 2011, filed by many issuers with the NAIC. These references are solely for the convenience of the filer in identifying the information needed for this MLR Form.

These Filing Instructions are to be used in completing the MLR Form by all health insurance issuers (issuers) offering health insurance coverage subject to section 2718 of the PHS Act and the MLR implementing regulations. All terms used in these Filing Instructions that are not defined here have the meaning used in 45 CFR Part 158 and the PHS Act.

The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The definition includes any insurance product, such as drug, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, unless specifically identified as "excepted benefits" by the PHS Act.

An MLR Form must be prepared and submitted for each State in which the issuer has written direct health insurance coverage or has direct amounts paid, incurred or unpaid for the provision of health care services. (Note: The experience of expatriate plans is aggregated on a national basis and should be

reported on the "Grand Total" MLR Form for each issuer.) In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the issuer. An issuer required to file the MLR Form must complete Parts 1 and 2 for each State in which the issuer provides any health insurance coverage, even if a particular State will show $0 earned premium in Part 1 (see the 2% instruction below). Also, Parts 3 through 6 must be completed for any State in which there are non-zero amounts in Part 1.

Note: The MLR Form is an excel workbook that contains many calculated fields based on the information inputted into the data fields by the issuer. Calculated cells or cells not requiring any data input for the MLR Reporting Year, have been shaded and a key provided on each tab within the workbook for further clarification. This workbook includes calculations for any credibility adjustment based on an issuer's life-years and average deductible.

The various "Parts" of the MLR Form contain calculated fields, which will assist in reducing data input for the various elements required in the reporting form. Many of the fields within Part 1 of the MLR Form copy over calculated information from data that are entered into Part 2 and Part 3. (Recommendation: Begin inputting data into Part 2 and Part 3, prior to completing Part 1.) Once the information has been inputted into the cells not shaded in Part 2, Part 3, Part 1 and Part 5, the MLR and Rebate Calculation – Part 5 will automatically calculate the issuer's MLR and rebate for each market in each State.

Reinsurance

Experience under a 100% assumption reinsurance agreement (with a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.

Reporting of 100% indemnity reinsurance and administrative agreements is limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business. Experience under those indemnity reinsurance and administrative agreements must be reported by the assuming issuer and must not be reported by the ceding issuer.

Aggregate 2% Rule

If the issuer's total earned premium for health insurance coverage in the individual, small group and large group markets, including any active and credible "mini-med" policies for a particular State, is less than 2% of its total health earned premium for that State, the issuer may choose to not complete Columns 32 and 33 of Parts 1 and 2 for that State, and instead combine Government Program Plans and Other Health Business experience (Columns 32 and 33) in Column 34 of Parts 1 and 2.

Deferred Business

If, for any aggregation as defined in 45 CFR §158.120, 50% or more of the total earned premium for an MLR reporting year is attributable to newly issued policies with less than 12 months of experience in that MLR reporting year, then the experience of these policies may be deferred, at the option of the issuer. If an issuer defers the reporting of newer business as provided in this paragraph, then the experience of such policies must be excluded from the MLR reporting year in which it occurred and must be added to the experience reported in the following MLR reporting year.

Allocation of Expenses

Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between the two (or more) types of expenses. Expenditures that benefit more than one affiliate may be allocated, on a pro rata basis, between the affiliates that benefit from these expenditures. Expenditures that benefit all lines of business or products, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata basis.

Aggregation of Experience

An issuer's experience, aggregated by individual, small group and large group markets, with respect to each policy must be included on the report submitted with respect to the State where the policy was issued, except as specified below.

Group Coverage in Multiple States:

Group coverage issued by a single issuer to an employer that covers employees in multiple States must be reported for the State where the contract is situsted. Situs of the contract is the jurisdiction in which the contract is issued or delivered, as stated in the contract.

Dual-Contract Group Health Coverage:

If an issuer has a group health plan which provides coverage for in-network coverage only and an affiliate issuer provides only out-of-network coverage solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, the issuer may choose to treat the out-of-network experience of the affiliate that provides the out-of-network coverage as if it were related to the contract providing the in-network coverage. If an issuer chooses this method of aggregation, it must do so for a minimum of three consecutive reporting years and the affiliate that provides the out-of-network coverage must not report this experience. After an issuer applies

this method for the initial three consecutive reporting years, the issuer may either continue to apply this method for any number of additional consecutive reporting years, or may choose to discontinue applying this method. Affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates in the applicable State market.

Individual Business through an Association:

For individual business sold through an association, the issuer shall include the experience in the State report for the issue State of the certificate of coverage.

Employer Business through Group Trust, Association or MEWA:

For employer business issued through a group trust, the issuer shall include the experience in the State report for the State where the employer has its principal place of business or where the trust is located. For employer business issued through a multiple employer welfare association (MEWA), the issuer shall include the experience in the State report for the State where the employer or MEWA has its principal place of business. For employer business issued through an association, experience with respect to each employer shall be reported as large group or small group based on the size of each employer and be reported in each State based upon the aggregation rules for employer based insurance.

The large group and small group markets are defined as those where health insurance coverage is obtained by a large or small employer, respectively. Large employer and small employer are defined by the number of employees employed; a small employer has 1 to 100 employees, but a State may substitute "50" employees for "100" employees until 2016. A sole proprietor or a sole proprietor's spouse is not considered a group of one. An employer's number of employees is determined by averaging the total number of all employees employed on business days during the preceding calendar year. This includes each full-time, part-time and seasonal employee.

An issuer must report on this MLR Form only the business issued by the reporting entity. Business that is written by an unaffiliated entity as part of a package provided to the enrollee (e.g., inpatient coverage written by the reporting entity, outpatient coverage written by an unaffiliated separate entity) ***must not*** be included in this MLR Form.

Health Insurance Coverage:
Do not include health insurance coverage specifically not subject to section 2718 of the PHS Act, such as government-sponsored programs, (e.g., Medicare (Title XVIII, including Medicare Advantage), Medicaid (Title XIX), State Children's Health Insurance Program (SCHIP) (Title XXI), and other Federal or State government-sponsored coverage (other than the Federal Employees Health Benefits Program or State government sponsored coverage for State employees or retirees), or uninsured business. Stop (or excess) loss coverage for self insured groups should be reported in Parts 1 and 2 – Other Health Business (business excluded by statute).

COLUMN DEFINITIONS FOR MEDICAL LOSS RATIO ANNUAL REPORTING FORM– PARTS 1 AND 2

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

Health insurance coverage, Columns 1 through 31, includes policies that provide medical coverage, including office visits, hospital, surgical and major medical (illness and injury). Include risk contracts and the Federal Employees Health Benefit Plan (FEHBP). Exclude mini-med plans and expatriate plans from Columns 1 through 15, as they are reported separately (Columns 16-21 and 22-31, respectively).

Do not include in Columns 1-31 business specifically included in Columns 32-35 (e.g., uninsured or self-funded business, Medicare (Title XVIII, including Medicare Advantage), Medicaid (Title XIX), vision only, dental only, State Children's Health Insurance Program (SCHIP) (Title XXI), other Federal or State government-sponsored coverage (other than the Federal Employees Health Benefits Program or State government sponsored coverage for State employees or retirees), and short-term, limited duration insurance as further defined in the PHS Act). The experience for pharmacy, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, should be reported with the health insurance coverage for the applicable market, as these are not "excepted benefits" under the PHS Act.

The experience of stop loss or excess of loss coverage for self-funded groups should be reported in Parts 1 and 2, Column 33 – Other Health Business Plans (business excluded by statute). Column 33 includes information reported in Columns 9 and 10 of the SHCE.

Columns 1, 6, 11, 16, 18, 20, 22, 27, 32, 33, 34, and 35 – **Business as of 12/31 of the MLR reporting year**

Include: Experience of policies in each of the relevant markets (individual market, small group market, large group market, mini-med individual market, mini-med small group market, mini-med large group market, expatriate small group market, or expatriate large group market) for the MLR reporting year, as reported as of December 31, to the department of insurance in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year regardless of incurred date.

For any data element that is not separately reported in the NAIC SHCE or separately reported elsewhere to the department of insurance of the issuer's State of domicile, an issuer does not need to separately report that element in the "12/31" column of the MLR Reporting form. However, an

issuer still must separately report those data elements in the "03/31" column as provided in 45 CFR Part 158 and as instructed in the MLR Reporting Form Instructions.

Columns 2, 7, 12, 17, 19, 21, 23, and 28 – **Business as of 3/31 of subsequent MLR reporting year**

Include: Experience of policies in each market, incurred, paid or received relevant only to the MLR reporting year, reported as of March 31 of the subsequent MLR reporting year.

For purposes of actuarial elements related to claims, the 3/31 column items should generally follow the structure of amounts incurred in the MLR reporting year settled through 3/31 of the following year (traditionally described as incurred 12 paid 15), plus any provision remaining as of 3/31 for items properly allocable to the prior period but not yet paid as of 3/31.

Columns 3, 8, 13, 24, and 29 - **Deferred Newer Business from prior MLR reporting year**

(*Not applicable to the 2011 MLR Reporting Year*)

Include: Beginning with the 2012 MLR Reporting Year, experience from policies for the relevant market newly issued in the prior MLR reporting year, previously deferred, as provided in the Preliminary Instructions.

Columns 4, 9, 14, 25, and 30 - **Deferred Newer Business for the MLR reporting year**

Include: Policies for the relevant market newly issued in the MLR reporting year, as defined more specifically in the Preliminary Instructions, deferred for reporting purposes at the issuer's option.

Columns 1 – 5 **Individual Market**

Include: Health insurance where the policy is issued to an individual covering the individual and his or her dependents in the individual market.

Exclude: Policies reported in other columns

Column 1- 4 See instructions for these columns, above

Column 5 – Total for the MLR reporting year as of 3/31/YY. (Col 2 + Col 3 – Col 4)

Columns 6 – 10 **Small Group Market**

Include: All policies issued in the small group market (including fully insured State and local government policies)

Exclude: Policies reported in other columns

Columns 6 – 9 See instructions for these columns, above

Column 10 – Total for the MLR reporting year as of 3/31/YY. (Col 7 + Col 8 – Col 9)

Columns 11 – 15 **Large Group Market**

Include: All policies issued in the large group market (including the Federal Employees Health Benefit Program and fully insured State and local government policies)

Exclude: Policies reported in other columns

Columns 11 –14 See instructions for these columns, above

Column 15 – Total for the MLR reporting year as of 3/31/YY. (Col 12 + Col 13 – Col 14)

Columns 16 – 21 **Mini-med Plans**

Include: All policies that have a total annual limit of $250,000 or less for individual, small group and large group markets, in their respective columns.

Exclude: Policies reported in other columns

Columns 16 - 21 See instructions for these columns, above

Columns 22 - 31 **Expatriate Plans** (Report separately (on the 'Grand Total' page) from other health insurance coverage business)

Include: All group policies written in the United States that provide coverage for employees working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country. These policies are to be reported on a nationwide, aggregated basis, separately for the small group and the large group markets, in their respective columns for the MLR reporting year, as of March 31 of the subsequent year, on the Grand Total page of the MLR Form.

Exclude: Policies reported in other columns

Columns 22 – 25 See instructions for these columns, above

Column 26 – Total for the MLR reporting year as of 3/31/YY. (Col 23 + Col 24 – Col 25)

Columns 27 – 30 See instructions for these columns, above

Column 31 – Total for the MLR reporting year as of 3/31/YY. (Col 28 + Col 29 – Col 30)

Column 32 **Government Program Plans (Excluded by Statute)**

Include: Government sponsored programs that are not subject to section 2718 of the PHS Act, such as Medicare (Title XVIII, including Medicare Advantage), Medicaid (Title XIX), State Children's Health Insurance Program (SCHIP) (Title XXI), and other Federal or State government-sponsored coverage (other than the Federal Employees Health Benefits Program or State government sponsored coverage for State employees or retirees).

Report the experience of the issuer's government program plans for the MLR reporting year as of December 31, reported to the department of insurance in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year.

Column 33 **Other Health Business (Not Subject to Section 2718 of the PHS Act)**

Information reported here is similar to that reported in the SHCE Part 1 Columns 9 & 10.

Report health plan arrangements that are <u>not</u> group *or* individual health insurance coverage provided by a health insurance issuer. Report all other health care business that is not reported in Columns 1 through 32, including stand alone dental and vision coverage, long-term care, disability income, etc.

Include: Short-term, limited-duration insurance (as defined under 45 C.F.R. §144.103); supplemental coverage if offered as a separate policy, certificate, or contract of insurance (45 C.F.R §146.145), including Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided under a group health plan; hospital or other fixed indemnity insurance, and specified disease or illness coverage if offered under a separate policy, certificate, or contract of insurance (45 C.F.R. §146.145), and other "excepted benefits" as specified by regulations promulgated by HHS (45

C.F.R §146.145). The experience for pharmacy, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, should be reported with the health insurance coverage for the applicable market, as these are not "excepted benefits" under the PHS Act.

Report the experience of the issuer's Other Business for the MLR reporting year as of December 31, as reported to the department of insurance in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year.

Column 34 **2% Aggregate Rule**

Include: Experience otherwise reportable in Columns 32 – 33, if issuer's total earned premium on health insurance coverage and "mini-med" experience (Columns 1, 6, 11, 16, 18, and 20) for a particular State is less than 2% of its total health earned premium for that State (Columns 1, 6, 11, 16, 18, 20, 32, and 33). See Preliminary Instructions, above.

Column 35 **Uninsured (Self Funded) Plans**

Include: Plans for which a reporting entity, as an administrator, performs administrative services such as claims processing for an employer that is at risk, and accordingly, the administrator has not issued an insurance policy.

Report the experience of the issuer's Uninsured (Self Funded) Plans for the MLR reporting year as of December 31, as reported to the department of insurance in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year.

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 1
(Data Development – Summary)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

In addition to the instructions below, the Preliminary Instructions and Column Definitions at the beginning of these Filing Instructions also apply to this Part 1. The Preliminary Instructions and Column Definitions include instructions regarding reporting of reinsurance, assumed and ceded insurance, deferred business, individual business through an association, employer business through a group trust or MEWA, group coverage in multiple states, and dual contract group health coverage.

Please note that the MLR Form and Filing Instructions implement the requirements of 45 CFR Part 158 and are not identical to the definitions or instructions of the NAIC's SHCE.

Line 1 – Premium:

Line 1.1 – Total direct premium earned (from MLR Form, Part 2 Line 1.11)

Line 1.2 - Federal high risk pools

Enter subsidies received or (assessments paid) under Federal high risk pools

Line 1.3 – State high risk pools

Enter subsidies received or (assessments paid) under State high risk pools

Exclude: Amounts included in Part 1 Line 2.4.

Line 1.4 – Premium earned including State and Federal high risk programs

(Lines 1.1 + 1.2 + 1.3)

Line 1.5 – Net assumed less ceded reinsurance premiums earned

The amount to net against the assumed reinsurance premiums earned is: the ceded reinsurance premiums written; plus the change in unearned premium reserve that is transferred to the company assuming the risk; plus the change in reserve credit taken other than for unearned premiums.

Line 1.6 – Other adjustments due to MLR calculations – premiums

Include: Any amounts excluded from premium for MLR calculation purposes that are normally included in premiums for financial statement purposes.

Amounts for rate credits paid and the change in reserve for rate credits that were excluded from Line 1.1 Total Direct Premiums Earned.

Line 1.7 – Risk revenue

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

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

Line 1.8 – Premium earned including federal and state high risk programs net of reinsurance

(Lines 1.4 + 1.5 + 1.6 + 1.7)

Line 2 – Claims:

Line 2.1 – Adjusted incurred claims: (from MLR Form, Part 2, Lines 2.17 and 2.18)

Line 2.2 – Prescription drugs - (informational only; already included in line 2.1 above)

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 above.

Line 2.3 – Pharmaceutical rebates - (informational only; already excluded in line 2.1 above)

Line 2.4 – State stop loss, market stabilization and claim/census based assessments

(Informational only; already excluded in line 2.1 above)

Adjustments that must be included in incurred claims:

- Market stabilization payments or receipts by issuers that are directly tied to claims incurred and other claims-based or census-based assessments;
- State subsidies based on a stop-loss payment methodology.

Adjustments that must be either included in or deducted from incurred claims:

- Payment to and from unsubsidized State programs designed to address distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers must be included in or deducted from incurred claims, as applicable.

Line 2.5 – Net assumed less ceded claims incurred

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

Line 2.6 – Other adjustments due to MLR calculation – claims incurred

Any amounts excluded from claims for MLR calculation purposes that are normally included in claims for financial statement purposes. For example, premium deficiency reserves are excluded from contract reserves for MLR purposes in Part 2; thus, premium deficiency reserves would be included on this Line. Include the adjustment for multi-option coverage amounts (if offsetting Part 2, Line 2.15; report as a negative amount).

Line 2.7 – Rebates paid (*Not applicable to the 2011 MLR Reporting Year*)

MLR rebates paid during the MLR reporting year.

Line 2.8 – Estimated rebates unpaid at the end of the prior MLR reporting year.

Should equal Line 2.9 from the prior year.

Line 2.9 – Estimated rebates unpaid at the end of the MLR reporting year

MLR rebates estimated but unpaid as of the end of the MLR reporting year.

Line 2.10 – Fee-for-service and co-pay revenue (net of expenses)

Include: Revenue recognized by the issuer for collection of co-payments from members and revenue derived from health services rendered by reporting entity providers that are not included in member policies (generally only applicable to staff-model HMOs).

Deduct: Medical expenses associated with fee-for-service business.

Line 2.11 – Net incurred claims after reinsurance (Lines 2.1 + 2.5 + 2.6 + 2.7 – 2.8 + 2.9 – 2.10)

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

Line 3.1 – Federal taxes and assessments incurred by the reporting issuer during the MLR reporting year

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;
- Fines and penalties of regulatory authorities, and fees for examinations by any Federal departments other than as specified in 45 CFR §158.161(a) as other non-claims costs, that are not included as an adjustment to premium revenue.

Line 3.2 – State insurance, premium and other taxes incurred by the reporting issuer during the MLR reporting year.

Include:

3.2a – State income, excise, business, and other taxes that may be excluded from earned premium under 45 CFR §158.162(b)(1).

- 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, 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 employed 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

3.2b – State premium taxes

- State premium taxes or State taxes based on policy reserves if in lieu of premium taxes

3.2c – Community Benefit Expenditures

<u>For the 2011 MLR Reporting Year ONLY</u>: Not-for-profit health issuers report one of the following types of payments:

- Payments by a not-for-profit issuer to a State 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;

- Payments by a not-for-profit issuer for community benefit expenditures** (described below in these Filing Instructions) if made pursuant to a State-based requirement, 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;
- Payments by an issuer exempt from Federal income tax for community benefit expenditures** (described below in these Filing Instructions), 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: These expenditures may not be reported multiple times or in multiple categories; if reported in Line 3.2c, the Federal or State assessments may not be included in Lines 3.1, 3.2a, or 3.2b or in the Quality Improvement expenses reported in Lines 4.1 through 4.5.

**A deduction from premium for community benefit expenditures is available to a not-for-profit issuer who is exempt from Federal or State taxes and assessments but is required to make community benefit expenditures in lieu of taxes. Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;

- Reduce geographic, financial or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);

- Address federal, state or local public health priorities, such as advancing health care knowledge through education or research that benefits the public;

- Leverage or enhance public health department activities, such as childhood immunization efforts; or

- Otherwise would become the responsibility of government or another tax-exempt organization.

Line 3.3 – Regulatory authority licenses and fees incurred by the reporting issuer during the MLR reporting year.

Include: Statutory assessments to defray operating expenses of any State or Federal regulatory department, and examination fees in lieu of premium taxes as specified by State law.

Exclude: Fines and penalties of regulatory authorities, and any fees for examinations by any State or Federal regulatory departments other than as specifically included in this Line 3.3.

Line 3.4 – Total Federal and State taxes and fees to be excluded from Premium

(Lines 3.1 + 3.2a + Max (3.2b or 3.2c) + 3.3)

Line 4 - Health Care Quality Improvement Expenses Incurred

Line 4.1 – Improve Health Outcomes

Report the amount listed in the MLR Form, Part 3 Column 1 for each respective market.

Line 4.2 – Activities to Prevent Hospital Readmission

Report the amount listed in the MLR Form, Part 3 Column 2 for each respective market.

Line 4.3 – Improve Patient Safety and Reduce Medical Errors

Report the amount listed in the MLR Form, Part 3 Column 3 for each respective market.

Line 4.4 – Wellness and Health Promotion Activities

Report the amount listed in the MLR Form, Part 3 Column 4 for each respective market.

Line 4.5 – Health Information Technology (HIT) expenses related to improving health care quality

Report the amount listed in the MLR Form, Part 3 Column 5 for each respective market.

Line 4.6 – Total Health Care Quality Improvement Expenses Incurred (Lines 4.1 + 4.2 + 4.3 + 4.4 + 4.5)

Line 5 – Non-Claims Costs

Line 5.1 – Cost Containment expenses not included in quality improvement expenses on Line 4.6

Report the amount listed on the MLR Form, Part 3 Column 6 for each respective market.

Line 5.2 – All other claims adjustment expenses:

Report the amount listed on the MLR Form, Part 3 Column 7 for each respective market.

Line 5.3 – Direct sales salaries and benefits

Include compensation (including but not limited to salary and benefits) to employees engaged in soliciting and generating sales to policyholders for the issuer.

Line 5.4 – Agents and brokers fees and commissions

All expenses incurred by the issuer payable to a licensed agent, broker, or producer who is not an employee of the issuer in relation to the sale and solicitation of policies for the company.

Line 5.5 – Other taxes

Line 5.5a – State taxes and assessments not excluded from premium under 45 CFR §158.162(b)(2). (Not included in Line 3.2)

Include:

- State sales taxes if the issuer does not exercise the option of including such taxes with the cost of goods sold 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;

Line 5.5b – Report fines and penalties of regulatory authorities, and fees for examinations by any State or Federal departments other than those included in Line 3.3, above.

Line 5.6 – Other general and administrative expenses

General and Administrative Expenses not Included in Line 4.6, Line 5.1 or Line 5.2

Line 5.7 – Community benefit expenditures

Report all community benefit expenditures not including those reported in Line 3.2c.

Line 5.8 – Total non-claims costs (Lines 5.1 + 5.2 + 5.3 + 5.4 + 5.5a + 5.5b + 5.6 + 5.7)

Line 5.9 – ICD-10 Implementation expenses (already included in line 5.6; informational for 2011)

Line 6 – Pre-tax underwriting gain/(loss) as of 12/31/XX (Lines 1.8 – 2.11 – 4.6 – 5.8 + 5.5a + 5.5b – Part 2 Line 2.16)

Line 7 – Income from fees on uninsured plans

Line 8 – Net investment income and other gain/ (loss)

Line 9 – Other Federal income taxes not included on line 3.1 above.

Include:

Federal income taxes on investment income and capital gains

Line 10 – After-tax net gain/(loss) as of 12/31/XX (Lines 1.8 – 2.11 – 3.4 – 4.6 – 5.8 + 7 + 8 – 9)

OTHER INDICATORS OR INFORMATION

Data reported should be allocated to each State and market (e.g., individual, small group, large group) in the same manner as premium. See the MLR Form Filing Instructions, Preliminary Instructions.

Line 11.1 – Number of Policies / Certificates

This is the number of individual policies (for individual business) or certificates issued to individuals covered under a group policy in force as of the last day 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 available to the issuer for group business.

Line 11.2 – Number of Covered Lives

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

Line 11.3 – Number of Groups

This is the total number of groups insured as of the last day of the reporting period.

Line 11.4 – Member Months

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

Line 11.5 – Number of Life-Years

The number of member months divided by 12.

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 2

(Data Development - Premium and Claims)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

In addition to the instructions below, the Preliminary Instructions and Column Definitions at the beginning of these Filing Instructions also apply to this Part 2. The Preliminary Instructions and Column Definitions include instructions regarding reporting of reinsurance, assumed and ceded insurance, deferred business, individual business through an association, employer business through a group trust or MEWA, group coverage in multiple states, and dual contract group health coverage.

Please note that the MLR Form and Filing Instructions implement the requirements of 45 CFR Part 158 and are not identical to the definitions or instructions of the NAIC's SHCE.

Dual Contract Option: If an issuer has a group health plan which provides coverage for in-network coverage only and an affiliate issuer provides only out-of-network coverage solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, the issuer may choose to treat the out-of-network experience of the affiliate that provides the out-of-network coverage as if it were related to the contract providing the in-network coverage. If an issuer *chooses* this method of aggregation, it must do so for a minimum of three consecutive reporting years and the affiliate that provides the out-of-network coverage must not report this experience. After an issuer applies this method for the initial three consecutive reporting years, the issuer may either continue to apply this method for any number of additional consecutive reporting years, or may choose to discontinue applying this method. Affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates in the applicable State market.

SECTION 1 – HEALTH PREMIUMS EARNED

Earned premium means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan and reported on a direct basis.

*For line items in the "3/31" column that cannot be edited by the issuer and are based on the information entered in the corresponding "12/31" column, enter into the "12/31" column the experience as instructed by the "3/31" column instructions, where necessary, to ensure that the "3/31" column has accurate data and yields correct MLR and rebate calculations.

Line 1.1 – Direct premium written

Include:

- Premium assumed under a 100% assumption reinsurance agreement (treated as a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.

- Premium assumed under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business.

Exclude:

- Premium ceded under a 100% assumption reinsurance agreement (treated as a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.

- Premium ceded under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business.
- Assessments paid to or subsidies received from State and Federal high risk pools;
- Amounts for rate credits paid

Line 1.2 - Unearned premium (year preceding the MLR reporting 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 during the MLR reporting year.

Calculate reserves as of December 31 of the year preceding the MLR reporting year

Line 1.3 - Unearned premium (MLR reporting year)

Report reserves established to account for the portion of the premium paid in the MLR reporting year that was intended to provide coverage during the following MLR reporting year.

Calculate reserves as of December 31 of the MLR reporting year

Line 1.4 – Change in unearned premium (Lines 1.2 – 1.3)

Line 1.5 – Experience rating refunds paid

12/31 Columns - Based on all payments through 12/31 of the MLR reporting year.

3/31 Columns - Based on refunds incurred during the MLR reporting year and paid through 3/31 of the following MLR reporting year for those refunds incurred during the MLR reporting year

Experience rating refunds associated with premium earned during the MLR reporting year, including State premium refunds paid during the MLR reporting year. Experience rating refund is the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium.

Line 1.6 – Reserve for experience rating refunds (rate credits) (MLR reporting year)

12/31 Columns – based on all refunds unpaid as of 12/31 of the MLR reporting year.

3/31 Columns – based on refunds incurred only in the MLR reporting year and unpaid through 3/31 of the following year

Include:

- Reserves for the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, plus reserves for State premium refunds incurred during the MLR reporting year.

Exclude: Reserves for MLR rebates.

Deduct: Amounts receivable under retrospectively rated funding arrangements.

Line 1.7 – Reserve for experience rating refunds (rate credits) (year preceding the MLR reporting year)

12/31 Columns – As of 12/31 of the year preceding the MLR reporting year.

Include:

- Reserves for the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, plus reserves for State premium refunds incurred during the year preceding the MLR reporting year.

Exclude: Reserves for MLR rebates.

Deduct: Amounts receivable under retrospectively rated funding arrangements.

Line 1.9 – Premium write-offs

Include:

- Agents' or premium balances determined to be uncollectible and written off as losses;
- Recoveries made during the MLR reporting year on balances previously written off;
- Include actual write offs; not reserves for bad debt or statutory non-admitted amounts.

Line 1.10 – Group conversion charges

If the amount entered on 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.

If an issuer transfers portions of earned premium associated with group conversion privileges between group and individual lines of business in its Annual Statement, these amounts must be added to or subtracted from incurred claims. (See section 2 – Claims below)

Line 1.11 – Total direct premium earned (Lines 1.1 + 1.4 – 1.9 + 1.10)

Line 1.12 – Premium ceded under 100% reinsurance (informational only; excluded from Line 1.1)

Include:

- Premium ceded under a 100% assumption reinsurance agreement (treated as a novation).
- Premium ceded under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business..

Line 1.13 – Premium assumed under 100% reinsurance agreement (informational only; included in Line 1.1)

Include:

- Premium assumed under a 100% assumption reinsurance agreement (treated as a novation).

- Premium assumed under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business..

SECTION 2 - CLAIMS

Amounts reported in Section 2 must include direct claims paid to or received by physicians and other non-physician clinical providers, including under capitation contracts with those providers, whose services are covered by the policy for clinical services or supplies covered by the policy. Non-physician clinical providers must be licensed, accredited, or certified to perform clinical health services, consistent with State law, and engaged in the delivery of medical services to enrollees.

Reimbursement for clinical services to enrollees is also referred to as incurred claims.

*For line items in the "3/31" column that cannot be edited by the issuer and are based on the information entered in the corresponding "12/31" column, enter into the "12/31" column the experience as instructed by the "3/31" column instructions, where necessary, to ensure that the "3/31" column has accurate data and yields correct MLR and rebate calculations.

Line 2.1 – Claims paid

2.1a – 12/31 Column – Claims paid during the MLR reporting year regardless of incurred date.

Report payments net of risk share amount collected.

2.1b – 3/31 Column - Claims paid only on claims incurred during the MLR reporting year, and paid through 3/31 of the following year for those claims incurred during the MLR reporting year.

Include:

- Claims incurred during the MLR reporting year that were either paid during the MLR reporting year or paid through March 31 of the year following the MLR reporting year;
- Any overpayment that has not yet been recovered should be included in paid claims and included in health care receivables.
- Market stabilization payments or receipts by issuers that are directly tied to claims incurred and other claims based or census based assessments.
- State subsidies based on a stop-loss payment methodology.

- Claims assumed under a 100% assumption reinsurance agreement (treated as a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.

- Claims assumed under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into an effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business.
- Payment to unsubsidized State programs designed to address distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers must be included in incurred claims.

Exclude:

- Claims ceded under a 100% assumption reinsurance agreement (treated as a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.

- Claims ceded under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into an effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business.
- Amounts paid to third party vendors for secondary network savings;
- Amounts paid to third party vendors for network development, administrative fees and profit, claims processing, and concurrent or post-service utilization management or any other issuer function;
- Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee;
- Incentive and bonus payment made to providers (to be reported in Line 2.11).

Deduct:

- Any overpayment that has already been received from providers should not be reported as a paid claim;
- Prescription drug rebates, refunds, incentive payments, bonuses, discounts charge backs, coupons, grants, direct or indirect subsidies, direct or indirect remuneration, upfront payments, goods in kinds or similar benefits received by the issuer;
- Payment from unsubsidized State programs designed to address distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers must be deducted from incurred claims.

Line 2.2 – Direct claim liability (MLR reporting year)

12/31 Column – liability based on all claims unpaid as of 12/31 of the MLR reporting year

3/31 Column – liability based on claims incurred during the MLR reporting year, and unpaid as of 3/31 of the following year for those claims incurred during the MLR reporting year

For the 3/31 Column, calculate as of March 31 of the year following the MLR reporting year, based on claim payments made through March 31 of that year and report in the appropriate column.

Report the outstanding liabilities for healthcare services related to claims in the process of adjustment, incurred but not reported and amounts withheld from paid claims and capitation payments.

Include:

- Unpaid claims, 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 (including third party liability).
- Incurred but not reported - Report the claims incurred but not reported in the MLR reporting year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure.

Line 2.3 – Direct claim liability (year preceding the MLR reporting year)

12/31 Column – Amount reported as of 12/31 of the year preceding the MLR reporting year

Line 2.4 – Direct claim reserves (MLR reporting year)

12/31 Column – based on all claims regardless of the incurred date, calculated as of 12/31 of the MLR reporting year

3/31 Column – based on claims incurred only in the MLR reporting year, calculated as of 3/31 of the following year for those claims incurred during the MLR reporting year

For the 3/31 Column, calculate as of March 31 of the year following the MLR reporting year, based on claim payments made through March 31 of that year related to claims incurred for the MLR reporting year.

Report reserves related to healthcare services for present value of amounts not yet due on claims.

Line 2.5 – Direct claim reserve (year preceding the MLR reporting year)

12/31 Column – Amount reported as of 12/31 of the year preceding the MLR reporting year

Line 2.6 – Direct contract reserve (MLR reporting year)

Report the amount of reserves required when due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves. For policies issued prior to 2011, contract reserves may only be used in the MLR calculation if such reserves were held prior to 2011, and may include reserves used for the purpose of leveling policy duration-based variation in claims experience only if durational contract reserves were held for such policies prior to 2011. Reported contract reserves may not exceed contract reserves calculated using the applicable product pricing assumptions.

Include: Contract reserves and other claims related reserves.

Calculate as of December 31 of the MLR reporting year.

Exclude: Premium deficiency reserves.

Reserves for expected MLR rebates

Line 2.7 – Direct contract reserve (year preceding the MLR reporting year)

See instructions for line 2.6.

Calculate as of December 31 of the year preceding the MLR reporting year.

Line 2.8 – Experience rating refunds paid –

2.8a 12/31 Column – based on all payments through 12/31 of the MLR reporting year

2.8b 3/31 Column – based on refunds incurred during the MLR reporting year and paid through 3/31 of the following year for those refunds incurred during the MLR reporting year

Experience rating refunds associated with premium earned during the MLR reporting year, including State premium refunds paid during the MLR reporting year. Experience rating refund is the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium.

Line 2.9 – Reserve for experience rating refunds (rate credits) (MLR reporting year)

12/31 Column – based on all payments through 12/31 of the MLR reporting year

3/31 Column – based on refunds incurred during the MLR reporting year and unpaid through 3/31 of the following year for those refunds incurred during the MLR reporting year

Include:

- Reserves for the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, plus reserves for State premium refunds incurred during the MLR reporting year.

Exclude: Reserves for MLR rebates.

Deduct: Amounts receivable under retrospectively rated funding arrangements.

Line 2.10 – Reserve for experience rating refunds (rate credits) (year preceding the MLR reporting year)

12/31 Column – Amount reported as of 12/31 of the year preceding the MLR reporting year

Include:

- Reserves for the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, plus reserves for State premium refunds incurred during the year preceding the MLR reporting year.

Exclude: Reserves for MLR rebates.

Deduct: Amounts receivable under retrospectively rated funding arrangements.

Line 2.11 – Incurred medical incentive pools and bonuses

12/31 Column – based on all payments through 12/31 of the MLR reporting year

3/31 Column – payments based on amounts incurred during the MLR reporting year and paid through 3/31 of the following year for the amounts incurred during the MLR reporting year

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 – Paid medical incentive pools and bonuses for the MLR reporting year

2.11b – Accrued medical incentive pools and bonuses for the MLR reporting year. Exclude amounts recorded on line 2.11a, include only the amount of medical incentive and bonus pool payments that are estimated to be owed but not yet paid for the MLR reporting year.

2.11c – Accrued medical incentive pools and bonuses for the year preceding the MLR reporting year.

Line 2.12 – Net healthcare receivables

12/31 Column – receivables reported as of 12/31 of the MLR reporting year

3/31 Column – receivables incurred during the MLR reporting year and that remain outstanding as of 3/31 of the following year

2.12a – Healthcare receivables (MLR reporting year)

2.12b – Healthcare receivables (prior reporting year)

The amounts on these lines are the gross healthcare receivable assets, not just the admitted portion. These amounts should not include those healthcare receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Line 2.13 – Contingent benefit and lawsuit reserves for claims incurred in the MLR reporting year.

Include: The claims-related portion of reserves for contingent benefits and lawsuits.

Exclude: Reserves related to costs associated with claims lawsuits within Line 2.13; i.e. legal fees, court costs, pain and suffering damages, punitive damages, etc.

Line 2.14 – Group conversion charges

If there are any group conversion charges for a health plan, the conversion charges must be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount must be added to the incurred claims for the aggregation that provides coverage that is intended to be replaced by the conversion policies.

If an issuer transfers portions of earned premium associated with group conversion privileges between group and individual lines of business in its annual statement accounting, these amounts must be added to or subtracted from incurred claims.

Line 2.15 – Blended rate adjustment

Affiliated issuers that offer group coverage at a blended rate *may choose* whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer as a whole, according to an objective formula the issuer defined prior to January 1, 2011, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate. From the date an issuer ***chooses*** to use such an adjustment, it must be used for a minimum of three consecutive MLR reporting years. Affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates in the applicable State market.

Line 2.16 – Allowable fraud reduction recovery expenses

Report the amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses.

This amount is limited to the lesser of the total fraud reduction expenses reported on Line 2.16a and actual fraud recoveries collected on paid claims on Line 2.16b.

Line 2.16a – Total Fraud Reduction expense:

Line 2.16b – Total Fraud Reduction Recoveries that Reduced PAID claims.

Include collected fraud recoveries on paid claims only.

Line 2.17 – Total adjusted incurred claims - 12/31 Column (Lines 2.1a + 2.2 – 2.3 + 2.4 – 2.5 + 2.6 – 2.7 + 2.8a + 2.9 – 2.10 + 2.11a + 2.11b – 2.11c – 2.12a + 2.12b + 2.13 + 2.14 + 2.15 + 2.16)

Line 2.18 – Total adjusted incurred claims - 3/31 Column (Lines 2.1b + 2.2 + 2.4 + 2.6 – 2.7 + 2.8b + 2.9 + 2.11a + 2.11b – 2.12a + 2.13 + 2.14 + 2.15 + 2.16)

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 3
(Expense Allocation Report)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

In addition to the instructions below, refer to the Preliminary Instructions at the beginning of these Filing Instructions, as well as the Column Definitions which follow the Preliminary Instructions, for the definitions of various markets and business. The MLR Form and Filing Instructions implement the requirements of 45 CF R Part 158 and are not identical to the definitions or instructions of the NAIC's SHCE.

This Part 3 to the MLR Form is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for health insurance coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), and expatriate plans (small group and large group business). This exhibit also shows the amount of qualifying Health Insurance Technology (HIT) expenses, reported separately for each such group of business.

Affiliated issuers that offer group coverage at a blended rate *may choose* whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer that receives the blended rate as a whole, according to an objective formula that the issuer defined prior to January 1, 2011, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate. From the date an issuer that **chooses** to use such an adjustment must be used for a minimum of three consecutive MLR reporting years. Affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates in the applicable State market.

Improving Health Care Quality Expenses – General Definition:

Expenses for Quality Improvement (QI) activities are expenditures for activities conducted by an issuer that is designed to:

- improve health quality;
- increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

- be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees; and,
- be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

QI activities must be primarily designed to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;
- Prevent hospital readmissions through a comprehensive program for hospital discharge;
- Improve patient safety, reduce medical errors and lower infection and mortality rates;
- Implement, promote, and increase wellness and health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 CFR §158.151.

Expenditures and activities that must not be included in quality improving activities are:

- Those that are designed primarily to control or contain costs;
- The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;
- Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;
- Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
- Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements);
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
- All retrospective and concurrent utilization review;
- Fraud prevention activities;
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
- Provider credentialing;
- Marketing expenses;
- Costs associated with calculating and administering individual enrollee or employee incentives;
- That portion of prospective utilization that does not meet the definition of activities that improve health quality;

- Any function or activity not expressly included in Columns 1 through 5, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this Part or otherwise support monitoring, measuring or reporting health care quality improvement

NOTE: Expenses which otherwise meet the definition for QI activities but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI activities expenses.

Notes:

a. *Healthcare Professional Hotlines*: Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Prevent Hospital Readmissions, Improve Patient Safety, Reduce Medical Errors, and Lower Infection and Mortality Rates, and Implement, Promote, and Increase Wellness & Health Activities.

b. *Prospective Utilization Review*: Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Prevent Hospital Readmissions, Improve Patient Safety, Reduce Medical Errors, and Lower Infection and Mortality Rates, and Implement, Promote, and Increase Wellness & Health Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

Claim Adjustment Expenses for Accident and Health reporting entities and for managed care reporting entities are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims and managed care claims. Certain claim adjustment expenses reduce the number or cost of health services thereby resulting in lower premiums or lower premium increases. These claim adjustment expenses shall be classified as cost containment expenses.

Claim adjustment expenses, including legal expenses, can be subdivided into cost containment expenses and other claim adjustment expenses.

ROWS:

Health Insurance Coverage

Line 1.1a – Individual market

Line 1.1b – Deferred (PY)

Line 1.1c – Deferred (CY)

Line 1.2a – Small group market

Line 1.2b – Deferred (PY)

Line 1.2c – Deferred (CY)

Line 1.3a – Large group market

Line 1.3b – Deferred (PY)

Line 1.3c – Deferred (CY)

"Mini-med"

Line 2.1 – Individual market

Line 2.2 – Small group market

Line 2.3 – Large group market

Expatriate – (Grand Total Filing Only)

Line 3.1a – Small group market

Line 3.1b – Deferred (PY)

Line 3.1c – Deferred (CY)

Line 3.2a – Large group market

Line 3.2b – Deferred (PY)

Line 3.2c – Deferred (CY)

Other Business

Line 4.1 – Government program plans

Line 4.2 – Other health business

Line 4.3 – Aggregate 2% rule

Line 4.4 – Uninsured / Self-funded plans

COLUMNS:

Under each column for the initiatives noted below, the issuer must report the amount expended for each of the various markets (rows).

Column 1 – Improve Health Outcomes

Include expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes.

This category can include costs for associated activities such as:

- Effective case management, care coordination, and chronic disease management, including through the use of the medical homes model as defined in section 3606 of the Affordable Care Act.

- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1 through 5;

- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

- Quality reporting and documentation of care in non-electronic format; and

- Health information technology expenses to support these activities (report in Column 5 - see instructions)

Column 2 – Activities to Prevent Hospital Readmission

Include expenses for implementing activities to prevent hospital readmissions.

This category can include costs for associated activities such as:

- 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)

Column 3 – Improve Patient Safety and Reduce Medical Errors

Include expenses for activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates.

This category can include costs for associated activities such as:

- 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)

Column 4 – Wellness & Health Promotion Activities

Include expenses for activities primarily designed to implement, promote, and increase wellness and health activities.

This category can include costs for associated activities such as:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

- Public health education campaigns that are performed in conjunction with state or local health departments;

- Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI activities for the group market to the extent permitted by section 2705 of the PHS Act;

- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and

- Health information technology expenses to support these activities (Report in Column 5 – see instructions).

Column 5 – Health Information Technology (HIT) Expenses for Health Care Quality Improvement Activities

In Part 3 of the MLR Form, the issuer reports information technology expenses associated with the activities for which expenses are reported. (45 CFR §158.151 allows "Health Information Technology" expenses that are required to accomplish the activities allowed in 45 CFR §158.150.)

Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information as well as activities that are consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

1. Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their ‘‘meaningful use’’ as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in 45 CFR §158.140;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

4. Monitoring, measuring, or reporting clinical effectiveness, including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law);

5. Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic health records accessible by enrollees and appropriate providers to monitor and document an individual patient’s medical history and to support care management;

6. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

7. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; or

8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Exclude:

Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the

Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements.)

Column 6 – Cost Containment Expenses not included in quality improvement expenses

Include expenses that serve to actually reduce the number of health services provided or the cost of such services.

This category can include costs only if they result in reduced costs or services such as:

- Post- and concurrent- claim case management activities associated with past or ongoing care;
- Pre-Service Utilization review;
- Detection and prevention of payment for fraudulent requests for reimbursement;
- Expenses for internal and external appeals; and
- Network access fees to preferred provider organizations and other network-based health plans (including prescription drug networks) and allocated internal salaries and related costs associated with network development and/or provider contracting.

Exclude cost-containment expenses that improve the quality of health care (reported in Columns 1 through 5).

Column 7 – Other Claims Adjustment Expenses:

Other claims adjustment expenses are those expenses that are not cost containment expenses.

Include any expenses for administrative services that do not constitute adjustments to premium revenue, reimbursement for clinical services to enrollees or expenditures on quality improvement activities.

This category can include such costs as:

- Estimating the amount of losses and disbursing loss payments;
- Maintaining records, general clerical and secretarial costs;
- Office maintenance, occupancy costs, utilities and computer maintenance;
- Supervisory and executive duties; and
- Supplies and postage.

Column 8 – General and Administrative Expenses

General and Administrative Expenses not Included in Columns 1 through 7.

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 4
(Expense Allocation Methodology Report)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011. Complete Part 4 only within the Grand Total page of the submission.

Description of Methods to Allocate Expenses

A single (not State-by-State) Part 4 of the Grand Total MLR Form must be submitted by the issuer to describe the methods used to allocate expenses, as reported on the MLR Form, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, to each health insurance market (e.g., individual, small group, large group, mini-med plans, expatriate plans, government program plans, other health business, and uninsured plans, each as defined in the Column Definitions which follow the Preliminary Instructions at the beginning of these Filing Instructions) in each State.

A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

For a new initiative that otherwise meets the definition of quality improvement activities (QI) (see Filing Instructions for MLR Form, Part 3) but has not yet met the requirement that it be capable of being objectively measured and of producing verifiable results and achievements, note that it is "NEW" in the description of the QI and include the expected timeframe for the activity to meet this requirement.

Acceptable Bases for Allocation of Expenses

Allocation of each type of expense among health insurance markets should be based on a generally accepted accounting method that is expected to yield the most accurate results. If this is not feasible, the issuer should provide an explanation as to why it believes a more accurate result will be gained from its allocation of expenses, including pertinent factors or ratios, such as studies of employee activities, salary ratios or similar analyses.

Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management or administrative services contract, must be apportioned pro rata to the entities incurring the expense.

Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate to a specific entity or sub-set of entities, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by that specific entity or subset of entities and must not be apportioned to other entities within a group.

Line References

Line 1 – Incurred Claims (as reported on the MLR Form, Part 1, Line 2.1 and Part 2, Lines 2.1 through 2.18)

Line 2 – Federal and State Taxes and Licensing or Regulatory Fees (as reported on the MLR Form, Part 1, Lines 3.1 through 3.3)

Line 3 – Quality Improvement Expenses (as reported on the MLR Form, Part 3 or Part 1 Section 4)

Line 3.a – Improve health outcomes (as reported on the MLR Form, Part 3 Column 1)

Line 3.b – Activities to prevent hospital readmission (as reported on the MLR Form, Part 3 Column 2)

Line 3.c – Improve patient safety and reduce medical errors (as reported on the MLR Form, Part 3 Column 3)

Line 3.d – Wellness and health promotion activities (as reported on the MLR Form, Part 3 Column 4)

Line 3.e – Health Information Technology (HIT) expenses related to health improvement (as reported on the MLR Form, Part 3 Column 5)

Line 4 – Non-claims Costs (as reported on the MLR Form, Part 1, Lines 5.1 through 5.7)

Line 4.a – Cost containment expenses (as reported on the MLR Form, Part 1 Line 5.1)

Line 4.b – All other claims adjustment expenses (as reported on the MLR Form, Part 1 Line 5.2)

Line 4.c – Direct sales salaries and benefits (as reported on the MLR Form, Part 1 Line 5.3)

Line 4.d – Agents and brokers fees and commissions (as reported on the MLR Form, Part 1 Line 5.4)

Line 4.e – Other taxes (as reported on the MLR Form, Part 1 Line 5.5a and 5.5b)

Line 4.f – Other general and administrative expenses (as reported on the MLR Form, Part 1 Line 5.6)

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 5
(MLR and Rebate Calculation)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

Most fields on Part 5 of each State page are self calculating based on data elements entered on other Parts. No data need to be entered in any of the shaded cells.

COLUMN DEFINITIONS – PART 5

Prior years' MLR reporting information is to be reported as initially submitted to the Secretary in the MLR filing of the respective reporting year.

Columns 1, 5, 9, 13, 17, 21, 25 & 29 – **PY2** (*Not applicable to the 2011 MLR Reporting Year*)

Beginning in the 2013 MLR reporting year, report the information for the MLR reporting year that is 2 years prior to the MLR reporting year.

Columns 2, 6, 10, 14, 18, 22, 26 & 30 – **PY1** (*Not applicable to the 2011 MLR Reporting Year*)

Beginning in the 2012 MLR reporting year, report the information for the MLR reporting year that is 1 year prior to the MLR reporting year.

In the 2012 MLR reporting year only, if the issuer's experience is fully credible (as defined below in Part 5 Section 3), do not report the information for the 2011 MLR reporting year.

Columns 3, 7, 11, 15, 19, 23, 27 & 31 – **CY**

Report the information for the MLR reporting year.

Columns 4, 8, 12, 16, 20, 24, 28 & 32 – **Total** (Columns PY2 + PY1 + CY)

The information for PY2, PY1 and CY for each market (e.g., individual market, small group market, etc.) should be added together for the total. For the 2011 MLR Reporting year, this amount will be the same as the amount in the CY column. The amount in the Total column will be used to calculate the issuer's MLR and rebates owing, if any.

Column Groupings

For the definitions for each of the following markets, see the Column Definitions, which immediately follow the Preliminary Instructions in the Filing Instructions for the MLR Form.

Columns 1 – 4 – **Individual Market**

Columns 5 – 8 – **Small Group Market**

Columns 9 – 12 – **Large Group Market**

Columns 13 – 15 – **Mini-med plans – Individual Market**

Columns 17 – 20 – **Mini-med plans – Small Group Market**

Columns 21 – 24 – **Mini-med plans – Large Group Market**

Columns 25 – 28 – **Expatriate plans – Small Group Market**

Columns 29 – 32 – **Expatriate plans – Large Group Market**

LINE INSTRUCTIONS – PART 5

Section 1- Medical Loss Ratio Numerator

Line 1.1 – Adjusted incurred claims (report the amount listed on the MLR Form, Part 1 Line 2.1)

Line 1.2 – Adjusted incurred claims for the prior MLR reporting years, restated as of March 31 of the year following the MLR reporting year (*Not applicable to the 2011 MLR Reporting Year*)

Line 1.3 – Quality improving expenses (report the amount listed on the MLR Form, Part 1 Line 4.6)

Line 1.4 – MLR rebates paid based on experience for the two immediately preceding MLR reporting years. (*Not applicable to the 2011 MLR Reporting Year*)

Line 1.5 – MLR numerator (MLR Form, Part 5, Lines 1.2 + 1.3 + 1.4)

Line 1.6 – Mini-Med / Expatriate numerator after adjustment factor (Line 1.5 x adjustment factor)

For the 2011 MLR reporting year, the adjustment factor is 2.

Section 2 - Medical Loss Ratio Denominator

Line 2.1 – Adjusted earned premium (report the amount listed on the MLR Form, Part 1 Line 1.4)

Line 2.2 – Federal and State taxes and licensing or regulatory fees (report the amount listed on the MLR Form, Part 1 Line 3.4)

Line 2.3 – MLR denominator (MLR Form, Part 5, Lines 2.1 – 2.2)

Section 3 - Credibility Adjustment (*Not applicable to the Grand Total page*)

Line 3.1 – Life years to determine credibility (report the amount listed on the MLR Form, Part 1 Line 11.5)

Non-credible experience: Less than 1,000 life-years as reported in the Total Column for the relevant market. The issuer is presumed to meet or exceed the applicable MLR standard and does not receive a credibility adjustment.

Partially credible experience: 1,000 to 75,000 life-years as reported in the Total Column for the relevant market. Except as noted in the instructions for Line 3.5, below, the issuer receives a credibility adjustment, which is calculated using the data reported in Lines 3.1 through 3.4 of this Part 5.

Fully credible experience: More than 75,000 life-years as reported in the Total Column for the relevant market. The issuer does not receive a credibility adjustment.

Line 3.2 – Base credibility factor

This amount is automatically calculated on the MLR Form based upon the number of life-years reported in the Total Column for Line 3.1.

Issuers with non-credible or fully credible experience do not have a base credibility factor.

Line 3.3 – Average deductible

The per person deductible for a policy that covers a subscriber and the subscriber's dependents shall be calculated as follows:

The lesser of the sum of the deductible applicable to each of the individual family members; or the overall family deductible for the subscriber and subscriber's family divided by two (regardless of the total number of individuals covered through the subscriber).

Issuers may choose to leave this field blank if they wish to use a deductible factor of 1.0.

Issuers with non-credible or fully credible experience do not report an average deductible.

Line 3.4 – Deductible factor

This amount is automatically calculated on the MLR Form based upon the average deductible reported in the Total Column for Line 3.3. The deductible factor ranges from 1.0 to 1.736.

Issuers with non-credible or fully credible experience do not have a deductibility factor.

Line 3.5 – Credibility adjustment (MLR Form, Part 5, Lines 3.2 x 3.4)

This amount is automatically calculated on the MLR Form based upon the amounts reported on Lines 3.2 and 3.4.

Issuers with non-credible or fully credible experience do not receive a credibility adjustment.

Section 4 - Medical Loss Ratio Calculation (*Not applicable to Grand Total page*)

Line 4.1 – Is the experience considered partially or fully credible?

Line 4.2 – Preliminary Medical Loss Ratio

4.2a – Preliminary MLR (MLR Form for the applicable MLR reporting year, Part 5, Lines 1.5 / 2.3)

4.2b – Preliminary MLR: Mini-Med / Expatriate (MLR Form for the applicable MLR reporting year, Part 5, Lines 1.6/ 2.3)

Line 4.3 – Credibility adjustment (MLR Form, Part 5, Line 3.5)

Line 4.4 – MLR including credibility adjustment if applicable (Lines 4.2a or 4.2b + 4.3)

Section 5 - MLR Rebate Calculation

Line 5.1 – MLR Standard (*Not applicable to Grand Total page*)

The applicable MLR standard is automatically populated based on one of the following:

- The statutory MLR standard for the relevant market (i.e., 80% for the individual market and small group market; and 85% for the large group market);
- The HHS-approved adjusted MLR standard for a particular State's individual market; or
- The State MLR standard, if the State requires a higher percentage than the statutory MLR standard for the relevant market for rebate purposes.

Line 5.2 – Credibility-adjusted MLR (MLR Form, Part 5, Line 4.4)

(*Not applicable to Grand Total page*)

Line 5.3 – Adjusted earned premium, less Federal and State taxes and licensing or regulatory fees (MLR Form, Part 5, Line 2.3, Column CY) (*not applicable to Grand Total page*)

Line 5.4 – Rebate amount if credibility-adjusted MLR is less than the MLR standard (MLR Form, Part 5, Lines (5.1 – 5.2) x 5.3))

- On the Grand Total page, enter the sum of MLR rebates owed by the company for each State and market (individual, small group, large group, mini-med individual, mini-med small group, mini-med large group) and each market for expatriate plans (small group, large group) in the respective Total Columns.

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 6
(Rebate Report)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

The Column Definitions, which immediately follow the Preliminary Instructions at the beginning of these Filing Instructions, apply to the markets to be reported in Columns 1 through 8 of Part 6.

Column 1 – **Individual Market**

Column 2 – **Small Group Market**

Column 3 – **Large Group Market**

Column 4 – **Mini-med plans – Individual Market**

Column 5 – **Mini-med plans – Small Group Market**

Column 6 – **Mini-med plans – Large Group Market**

Column 7 – **Expatriate plans – Small Group Market**

Column 8 – **Expatriate plans – Large Group Market**

Additional definitions:

- **Policyholder** means any entity that has entered into a contract with an issuer to receive health insurance coverage.
- **Subscriber** refers to both the group market and the individual market. In the group market, subscriber means the individual, generally the employee, whose eligibility is the basis for the enrollment in the group health plan and who is responsible for the payment of premiums. In the individual market, subscriber means the individual who purchases an individual policy and who is responsible for the payment of premiums.

Line 1 – Is a rebate being paid?

This cell is automatically populated with a "Yes" if the amount on Part 5, Line 5.4, is greater than 0, otherwise it will populate with "No". If no rebate is owed, do not complete Lines 2 through 4.

If no rebate is being paid, do not complete Lines 2 through 5.

Line 2 – Number of policies and certificates (from Part 1, Line 11.1)

Line 3 - Number of policyholders/subscribers being paid rebates

Line 3.a – Number of group policyholders who are being paid a rebate

Include: All group policies within the respective group markets that are due a rebate and to whom the issuer is paying the rebate directly

Exclude: Rebates being paid in the individual market and rebates in group markets which the issuer is paying directly to the group's subscribers rather than to the group policyholder.

Line 3.b – Number of subscribers who are being paid a rebate.

Include: All subscribers under individual policies that are due a rebate;

All subscribers under small group and large group policies that are due a rebate and to whom the issuer is paying the rebate directly to the subscribers rather than to the group policyholder.

Line 3.c – Number of group policyholders whose calculated rebate is de minimis.

De Minimis –

- For a group policy for which the issuer distributes the rebate directly to the policyholder, if the total rebate owed to the policyholder and its subscribers combined is less than $20 for the MLR reporting year.

Line 3.d – Number of subscribers whose calculated rebate is de minimis.

Include the number of subscribers in the individual market and the number of subscribers of policyholders in the group markets whose calculated rebate is de minimis.

De Minimis –

- For a group policy for which the issuer distributes the rebate to the policyholder, if the total rebate owed to the policyholder and its subscribers combined is less than $20 for a given MLR reporting year.
- For a group policy for which the issuer distributes the rebate directly to the subscribers, if the total rebate owed to each subscriber is less than $5 for a given MLR reporting year.
- For an individual policy, if the total rebate owed to each subscriber is less than $5 for a given MLR reporting year.

Line 4 – Total amount of rebates

Line 4.a – Total amount of rebates (from Part 5, Line 5.4)

Line 4.b – Total amount of de minimis rebates

Report the total amount of rebates that are de minimis, as described above in Part 6 Section 3

Line 4.c – Amount of rebates being paid by premium credit

Line 4.d – Amount of rebates being paid by lump-sum reimbursement

Line 5 – Amount of unclaimed rebates from prior MLR reporting year

Report the amount of rebates owed based on the previous MLR reporting year which remain unpaid because the issuer was unable, after making a good faith effort, to locate a former enrollee or subscriber. (*Not applicable to the 2011 MLR Reporting Year*)

Line 5.a – Methods used to locate enrollees for unclaimed rebates

Describe the methods used to try to locate policyholders or subscribers to distribute the prior MLR reporting year's rebates which remain unclaimed. (*Not applicable to the 2011 MLR Reporting Year*)

Line 5.b – Disbursement method of prior MLR reporting year's unclaimed rebates

Describe the method used to disburse the prior MLR reporting year's unclaimed rebates. (*Not applicable to the 2011 MLR Reporting Year*)