STATE OF MINNESOTA

HMO MINNESOTA d/b/a BLUE PLUS

WORK ORDER CONTRACT NO: 47132

December 3, 2012
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Executive Summary

The Minnesota Department of Commerce (MNDOC) employed the services of Risk and Regulatory Consulting, LLC (RRC) to assist in evaluating the appropriateness of the managed care plans’ expense allocations to public programs, the appropriateness of established Premium Deficiency Reserves and the Retrospective Review of Reserves established for such public programs. This evaluation was conducted in accordance with Executive Order 11-06 Creating Public Disclosure for Minnesota’s Managed Care Health Care Programs issued March 21, 2011 (see Appendix 1) and information was also collected as provided in Minn. Statutes Section 256B.69, subd 9c (see Appendix 2). The public programs are provided by various Managed Care Organizations, including Blue Plus (hereinafter referred to as “the Company”). The public programs include: Prepaid Medical Assistance Program (PMAP), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), MinnesotaCare (MNCare) and Special Needs Basic Care (SNBC).

Expense Allocations – According to the NAIC Accounting Practices and Procedures Manual - Appendix A-440 – Insurance Holding Companies, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions. SSAP No. 70 “Allocation of Expenses” states that any basis adopted to apportion expenses shall be that which yields the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

Blue Plus expenses are allocated to the following cost/profit centers:
- Individual Portability-Blue Plus
- Blue Plus Small Group
- Blue Plus Large Group
- Closed Select (HCPP) – Medicare Supplement
- PMAP Prepaid Medicaid
- MSHO-SecureBlue
- MNCare
- Medical Management PPO

We observed instances where the Company does not appear to be allocating expenses in accordance with NAIC Accounting Practices and Procedures Manual - Appendix A-440 – Insurance Holding Companies (fair and reasonable). See the “Observations and Findings” section for specific examples.

Premium Deficiency Reserves – According to SSAP No. 54 “Individual and Group Accident and Health Contracts”, when the expected claims payments or incurred costs, claims adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent
with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started.

As of December 31, 2011 and 2010, Blue Plus had Premium Deficiency Reserves ("PDR") of $32,380,000 and $10,586,000, respectively, covering all lines of business.

A review of the PDR Calculation for the Company’s public programs as of December 31, 2011 was performed. The Company has two lines of business within the public program category - PMAP and MNCare. The PDR for these lines of business at December 31, 2011 amounted to $29,780,000.

The PDR calculations appear conservative and appropriate. The methodology used appears reasonable and appears to adhere to generally accepted actuarial principles. We did not review or otherwise audit the data included in the information provided, but only reviewed the methodology for reasonableness. Based on claims paid data as of May 31, 2012, the Company re-estimated its 2011 PDR to be approximately $5,140,000 million lower than originally booked.

**Reserves** – According to SSAP No. 54 “Individual and Group Accident and Health Contracts”, claim reserves shall be accrued for estimated costs of future health care services to be rendered that the reporting entity is currently obligated to provide or reimburse as a result of premiums earned to date that would be payable after the reporting date under the terms of the arrangements, regulatory requirements or other requirements if the insured’s illness were to continue.

According to the 2011 Annual Statement, the total claims activity related to prior years was $128,995,583, compared to $139,055,206 claim reserves accrued at year end 2010. The favorable development of unpaid claims has principally been experienced on the MNCare, Medicaid and MSHO blocks of business. Original estimates are modified as additional information becomes known regarding individual claims.

<table>
<thead>
<tr>
<th>Annual Statement Liability Line Item</th>
<th>Description</th>
<th>12/31/11 balance</th>
<th>12/31/10 balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Claims unpaid</td>
<td>$ 137,189,025</td>
<td>$ 139,055,206</td>
</tr>
<tr>
<td>2</td>
<td>Accrued medical incentive pool and bonus amounts</td>
<td>$ 739,661</td>
<td>$ 944,403</td>
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<tr>
<td>3</td>
<td>Unpaid claim adjustment expenses</td>
<td>$ 3,012,394</td>
<td>$ 2,849,669</td>
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<tr>
<td>4</td>
<td>Aggregate health policy reserves</td>
<td>$ 32,380,000</td>
<td>$ 10,586,000</td>
</tr>
</tbody>
</table>

The Company’s reserving methodology involves the use of the Developmental Method, also referred to as the Lag Factor Method. The Company utilizes an Oracle program which produces completion factors using 3-of-3, 6-of-6, and 12-of-12 averaging techniques. The Company indicated estimates do not incorporate implicit margins. The method substitutes per-member
per-month methodology for the most recent one, two, or three months. Estimates also incorporate a “days in a month” adjustment.

Best estimates are determined by the Company, and then an explicit margin for adverse claim deviation is applied to the best estimates. A 6.0% margin is used for Blue Plus business. The Company did not have a formal written policy on margin levels as of December 31, 2011. The Company has subsequently developed a formal written policy regarding margin levels. The Company has worked closely over time with their external auditors in selecting margin levels.

The methodology employed appears reasonable and appropriate. It follows generally accepted actuarial practice for coverages with a relatively short time-period between the incurral and payment of claims which includes most health care coverages.

Run-out
The Company provided the files submitted to DHS that show recasts of year-end reserve estimates using claim data through May of the ensuing year. Based upon the information provided, the December 31, 2010 estimates for MNCare appear very close to the eventual run-out. For the December 31, 2011, the original estimates are 2.0% and 3.5% higher for MNCare and PMAP, respectively, than the run-out for January 2012 through May 2012. The difference in total is 3.0%. The estimates appear reasonable.

Background
Blue Plus (hereinafter referred to as “Blue Plus” or “the Company”) is a Minnesota nonprofit health maintenance organization which offers health plans and networks throughout Minnesota to individuals and groups and promotes quality improvement.

Blue Plus is a controlled affiliate of Blue Cross and Blue Shield of Minnesota (BCBSM), a Minnesota non-profit corporation. BCBSM serves as the sole corporate member of Blue Plus and elects a majority of the Board of Directors.

Under the terms of management agreements, BCBSM supplies substantially all general and administrative services necessary to Blue Plus’ operations. Blue Plus was charged $64.4 million in 2011 and $63.0 million in 2010 for these services.

Blue Plus has an administrative services agreement under which BCBSM will provide funds to Blue Plus to enable it to maintain the statutory or regulatory net worth, deposit and capital and surplus requirements. In the event Blue Plus incurs operating deficits, BCBSM agrees to maintain Blue Plus’s capital and surplus for future care and contingencies to enable Blue Plus to meet statutory or regulatory reserve requirements, provided that BCBSM is not required to make reserve contributions if BCBSM does not meet its statutory reserve requirements or if the contributions would cause BCBSM to fall below 2.2 months of its statutory reserve requirements or as otherwise set forth in the terms of the administrative agreements. As of December 31, 2011 and 2010, Blue Plus’s statutory reserves exceeded minimum statutory requirements.
Blue Plus has contracted with the Minnesota Department of Human Services (DHS) to provide health care coverage to PMAP and MNCare recipients via a managed care model.

Since 2006, Blue Plus has contracted with the Centers for Medicare and Medicaid Services (CMS) as a Special Needs Plan under the Medicare Advantage program. The contract is part of a program sponsored by DHS called MSHO for beneficiaries age 65 and older who are eligible for DHS Medical Assistance and Medicare Parts A and B.

Public Programs administered by DHS and Minnesota Department of Health (MDH) provided by Blue Plus:

PMAP
PMAP, also known as Medical Assistance (MA), is a health care program for families, children, pregnant women, adults without children who meet certain income limits and people who have disabilities. PMAP is Minnesota’s Managed Care Medicaid program. There is no monthly fee, but enrollees may need to pay small co-pay for some services.

In 2011, Blue Plus provided coverage to PMAP members in 60 of the 65 counties that are available for prepaid health care contracting. Blue Plus has approximately 21% of the statewide PMAP market share. See Appendix 5 for the PMAP health plan choices by county.

Medicaid Expansion
Beginning in 2011, PMAP also includes Minnesota Medicaid Expansion. Starting March 1, 2011, additional low income adults became eligible for Medicaid benefits when Minnesota expanded the Medical Assistance program. The federal Affordable Care Act (ACA) requires states participating in Medicaid, known in Minnesota as MA, to expand coverage to certain adults who meet specific criteria effective January 1, 2014. The ACA permits states to implement this expansion beginning April 1, 2010.

The 2010 Minnesota Legislature amended state law allowing the governor to authorize coverage of this population by Jan. 15, 2011. Gov. Mark Dayton signed an executive order Jan. 5, for implementation of MA expansion by March 1. The CMS approved the state’s plan in February of 2011.

The expansion provides federal matching funds — $826 million for the 2012-2013 biennium — for health care previously funded with only state dollars through MNCare and General Assistance Medical Care (GAMC). The GAMC program ended February 28, 2011. Enrollees were automatically moved to MA, Minnesota's Medicaid program.

MSC+
MSC+ is a health care program for seniors 65 and older who qualify for Medical Assistance (Medicaid) and are not enrolled in Medicare. There is no monthly fee, but enrollee may need to pay small co-pay for some services. In 2011 Blue Plus provided coverage to approximately 25% of the statewide MSC+ enrollment. See Appendix 7 for the MSC+ health plan choices by county.
MNCare
MNCare is a program for children, adults and seniors who don’t have access to affordable health care coverage, but do not meet the eligibility requirements for Medical Assistance (Medicaid). Working adults who are unable to get health care coverage through an employer may qualify.

MNCare provides subsidized coverage for individuals and children who are not covered by group insurance and not eligible for Medical Assistance. In 2011 Blue Plus provided coverage to approximately 38% of the statewide MNCare enrollment and is available in 86 of Minnesota’s 87 counties. See Appendix 6 for the MNCare health plan choices by county.

Public Programs Integrated with Federal Programs provided by Blue Plus

MSHO
MSHO is a health care program that combines separate health programs and support systems into one health care package. It is for people ages 65 and older who are eligible for Medical Assistance (MA) and enrolled in Medicare Parts A and B. In 2011 Blue Plus had approximately 27% of the statewide MSHO enrollment. See Appendix 8 for the MSHO health plan choices by county.

SNBC Integrated
SNBC is a managed care program for individuals with disabilities. SNBC contracts include agreements for MCO’s to cover the cost of medical assistance co-pays and deductibles for SNBC. SNBC enrollees may have to pay Part D drug co-pays since Medicare does not allow waivers, unless the enrollee is in an institution. Blue Plus offers a SNBC plan which is integrated with Medicare Benefits for eligible enrollees (SNBC Integrated). See Appendix 9 for the SNBC health plan choices by county. Also, the Special Needs Basic Care (SNBC) contract between Blue Plus and DHS that is identified on page 6 ended on 12/31/10 (such that any 2011 activity is simply related to run out of the program).

Public Programs managed by CMS and provided by Blue Plus

Medicare + Choice
Medicare + Choice is a managed care plan for individuals who are over 65 years old and are eligible for Medicare Part A and Part B.

Private Programs provided by Blue Plus

Commercial
Commercial Programs are managed care plans for individuals, families, and groups.

Other
Blue Plus provides Medical Management and Administrative Service Contracts (ASC) for Self-Insured Groups.
Observations & Findings

Note, this review is not considered a statutory examination but a special review requested by the Governor. Therefore, observations and findings within this report are not necessarily violations of Statutory Accounting Principles or State law. The objective of the review is to report the facts as observed and make recommendations where deemed to be appropriate. The following represents our key observations and findings:

Observations:

1. Blue Plus made a $10 million cash contribution to the Blue Cross Blue Shield Foundation on December 29, 2011.

   The entire $10 million contribution was included in Column 13 “Med Mgmt” line 21 “general administrative expenses” of the MN Supplement Report #1. The Blue Plus Medical Management “Med Mgmt” program relates to services performed by Blue Plus for the Northern Plains Alliance, a group of six Blue plans covering the seven state region including NE, ND, MT, WY, MN, IA, and SD. These services include managing the business functions for the Northern Plains Alliance related to case management, utilization management, nurse phone line, disease management and select quality improvement functions.

2. RRC reviewed how salaries were allocated to the Company’s public and non public programs, including the salaries of its executives. Blue Plus allocates executive management expenses based on an “executive allocation statistic”. According to the Company, each executive's allocation rule is determined by collaboration between the Finance area and the executives. The allocation is based on member months and a weighting factor for each executive. The Company was not required to, and did not, cap executive salaries prior to allocating them to the public programs or any other programs administered by the Company.

3. Blue Plus was asked to perform a re-estimation of PDR using actual experience that was available. Based on claims paid data through August 31, 2012, the Company re-estimated its 2011 PDR to be approximately $5,140,000 million lower than originally booked at December 31, 2011.

4. The Company provided a listing of profit centers for Blue Plus and BCBSM that are considered “government programs”. Not all profit centers were allocated government-related expenses.

5. In reviewing the Company’s expenses and allocations, it was noted Blue Plus does not have a separate profit center established for MSC+.

6. There are three separate cost centers for IHM-GP. These include case management, disease management and utilization management. According to the Company, these cost
centers provide care management for government program members. This cost center also includes staff that performs access management for commercial business. Costs are allocated based on a fixed percentage determined from staffing. Blue Plus government programs PMAP, MSHO and MNCare are allocated approximately 99% of these costs. BCBSM government programs are allocated the remaining 1%.

7. PMAP & MNCare were allocated approximately $330,000 of expenses in 2011 for cost center 12600 “Virginia Commercial Claims”. PMAP & MNCare were allocated approximately $35,000 of expenses in 2011 for cost center 89300 “Commercial Accounts Large Group”. The Company indicated the naming convention for Cost center 12600 is “Virginia Commercial Claims” but staff in this cost center also work on government claims, including PMAP and MNCare. The different types of claims are identified within a claims tracking system. There also is a cost center “Virginia Government Claims” which is 100% dedicated to government claims. As claim volume fluctuates throughout the month, in addition to having individuals in the government claims cost center work overtime, individuals within the Commercial claims cost center are utilized when needed.

8. The Company allocates costs to the Printing & Postage cost center based on a total membership statistic. Blue Plus was allocated approximately $1.0 million of printing & postage expenses in 2011. Approximately $875,000 was allocated to PMAP and MNCare. This is in addition to cost center “Printing & Postage – Govt” 2011 expenses of $356,000, of which $330,000 was allocated to PMAP and MNCare. The Company indicated the Printing & Postage cost center contains the cost of transactional print and postage that is business critical. The Company indicated the Printing & Postage – Government cost center contains the cost of marketing print and postage. The Company indicated the membership statistic is utilized due to the volume of transactions.

Findings:

1. Marketing and Corporate Communications

Finding:
The Company allocates Marketing & Corporate Communications expenses based on total MN membership statistics. This includes all Blue Plus profit centers except Med Mgmt. Blue Plus was allocated $1.4 million of Marketing & Corporate Communications expenses in 2011. Of this amount, PMAP and MNCare were allocated approximately $1.2 million in 2011.

BCBSM runs a variety of ads including their “Do” campaign on local TV stations. These ads do not target Blue Plus or the public programs. The Company indicated the expenses within the Marketing and Corporate Communications cost center are not specific to any one segment but are for business overall. Blue Plus was allocated 11.4% (10% to PMAP and MNCare) of the following December 2011 expenses (partial listing):

- $1.0 million - Haworth (TV ads)
- $133,922 – Twins Ballpark Sponsorship
In addition to direct expenses, Blue Plus was also allocated a portion of "Tier 1" expenses for payroll, benefits, travel, rent, etc. within the "Marketing & Corporate Communications" account. "Tier 1" expenses spread overhead-type costs to the cost centers. These costs include human resources, payroll, benefits, travel, building services, rent, depreciation, mail services, voice/data systems and local area network.

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS section 3.2.4 "Marketing Materials":

(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

(2) Mailings to recipients. The MCO may make no more than two mailings per calendar year to Enrollees of the MCO covered under this Contract or potential Enrollees who reside in the MCO’s Service Area.

a) The MCO may distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO’s provider network...

b) The MCO may provide health education materials for Enrollees in Providers’ offices.

Recommendation:
The Company should allocate only those direct expenses allowed by the contract to PMAP and MNCare public programs.

2. Affiliated Medical Center Covenant

Finding:
Affiliated Medical Centers, P.A. (AMC) entered into an Affiliation and Capitalization agreement with BCBSM and Blue Plus on December 21, 1993. The agreement calls for total principal payments from BCBSM to AMC in the amount of $9,912,754. The amount is being amortized over a thirty year time period on a straight line basis; each year BCBSM allocates to Blue Plus $330,425 ($9,912,754 / 30) of amortization expense related to this agreement. Of this amount, 46% is allocated to PMAP, 27% to MNCare, 21% to MSHO and the remaining 6% to Blue Plus Commercial. BCBSM is not allocated any portion of the amortization expense. The amortization expense is included in general administrative expenses. The Company did not provide a complete copy of the agreement between the parties nor a description of the nature of the services or activities underlying the agreement. Based on the information provided by the Company, it is unclear how the agreement specifically relates to the public programs.
Recommendation:
The Company should only allocate expenses that can be shown to directly relate to the public programs. Any portion not allocable to the public programs should be allocated to other programs or entities, including BCBSM.

3. Mankato Covenant

Finding:
The Company entered into an agreement with Mankato Clinic. We were not provided the first 19 pages of the agreement or the last pages of the agreement. The agreement calls for total principal payments from BCBSM/Blue Plus to Mankato in the amount of $8,000,000. The amount is being amortized over a twenty year time period on a straight line basis; each year BCBSM allocates to Blue Plus $200,000 ($8,000,000 / 20) of amortization expense related to this agreement. Of this amount, 46% is allocated to PMAP, 27% to MNCare, 21% to MSHO and the remaining 6% to Blue Plus Commercial. BCBSM is also allocated $200,000 of the amortization expense. The amortization expense is included in general administrative expenses. The Company did not provide a complete copy of the agreement between the parties nor a description of the nature of the services or activities underlying the agreement. Based on the information provided by the Company, it is unclear how the agreement specifically relates to the public programs.

Recommendation:
The Company should only allocate expenses that can be shown to directly relate to the public programs. Any portion not allocable to the public programs should be allocated to other programs or entities, including BCBSM.

4. Government Program Management

Finding:
Allocation to this cost center is based on a fixed percentage statistic. The following costs were included in this cost center: payroll, benefits, car insurance allowance, meals, cell phones and travel. These were in addition to the Company’s allocation of “Tier 1” expenses. The Company also included various fees to attend exhibits & conferences in MN as expenses. These exhibits and conferences target the public programs. The Company indicated this cost center also includes sales promotion and travel related to the PMAP, MSHO and MNCare programs. This appears to be in violation of the PMAP and MNCare contract between the Company and DHS.

Expenses in 2011 for this account were approximately $720,000. There were no allocations to the BCBSM government programs. Expenses were allocated entirely to the following Blue Plus profit centers:

- 150100 PMAP
- 150200 MSHO
- 160100 MNCare

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS section 3.2.4 “Marketing Materials”: 
(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

Recommendation:
The Company should allocate only those expenses allowed by the contract to PMAP and MNCare programs.

5. Gov’t Prog Business Strategy & Development

Finding:
Costs are allocated based on a fixed percentage statistic. Blue Plus profit centers (PMAP, MSHO and MNCare) are allocated approximately 74% and BCBSM profit centers are allocated 26%.

Blue Plus was allocated $1.1 million of costs in 2011. It was noted Blue Plus was allocated 74% of a $37,000 Medicare Parts C&D audit. PMAP and MNCare were allocated approximately $10,000 of the Medicare Parts C&D audit. Medicare Parts C&D do not involve PMAP and MNCare.

Recommendation:
The Company should allocate only those government expenses that directly relate to the public programs.

6. Lobbying Expenses

Finding:
PMAP & MNCare were allocated approximately $67,000 of expenses in 2011 for cost center 80503 “MN Lobbying”.

PMAP & MNCare were allocated approximately $21,000 of expenses in 2011 for cost center 80504 “Federal Lobbying”.

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS Article 15 “Lobbying Disclosure”:

The MCO certifies, that, to the best of its knowledge, understanding, and belief, that:

(A) No Federal Funds Used. No Federal appropriated funds have been paid or will be paid in what the undersigned believes to be a violation of 31 U.S.C. § 1352, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, Member of Congress, an officer or employee of Congress...
(B) Other Funds Used. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(C) Certification. The undersigned will require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontractors, sub-grants and contracts under grants, loans, and cooperative agreements) and will required that all sub-Recipients certify and disclose accordingly. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. § 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Recommendation:
The Company should allocate only those lobbying expenses that directly relate to the public programs and report them in accordance with the contract.

Scope and Procedures Performed

In accordance with Work Order Contract No. 47132, the specific tasks for which RRC was charged with are listed below.

1. Compare the PMAP detail which is provided to the Department of Human Services to the Minnesota Supplement Report filed with the Minnesota Department of Health.

   RRC obtained the Minnesota Supplement Report #1 filed with the MDH and compared this to the PMAP detail provided to the DHS. An example of the Minnesota Supplement Report #1 can be found in Appendix 3. The following PMAP detail was obtained directly from the Minnesota Supplement Report #1.
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<tr>
<th>NAIC Description</th>
<th>2010</th>
<th>2011</th>
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<td></td>
<td>Prepaid Medical Assistance Program (PMAP)</td>
<td>Prepaid Medical Assistance Program (PMAP)</td>
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<tr>
<td>REVENUES:</td>
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<tr>
<td>1 Member Months</td>
<td>818,258</td>
<td>960,181</td>
</tr>
<tr>
<td>2 Net Premium Income</td>
<td>367,274,272</td>
<td>431,682,131</td>
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<tr>
<td>3 Change in unearned premium reserves and serve for rate credits</td>
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<td></td>
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<tr>
<td>4 Fee-for-service</td>
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<tr>
<td>5 Risk revenue</td>
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</tr>
<tr>
<td>6 Aggregate write-ins for other health care related revenues (Line 699)</td>
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<td></td>
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<tr>
<td>7 Aggregate write-ins for other non-health revenues (Line 799)</td>
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<tr>
<td>8 TOTAL REVENUES (Lines 2 through 7)</td>
<td>367,274,272</td>
<td>431,682,131</td>
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<td>EXPENSES:</td>
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<tr>
<td>9 Hospital/medical benefits</td>
<td>250,584,703</td>
<td>306,005,530</td>
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<td>10 Other professional services</td>
<td>11,341,827</td>
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<td>11 Outside referrals</td>
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<td>12 Emergency room and out-of-area</td>
<td>9,305,909</td>
<td>12,208,849</td>
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<td>13 Prescription drugs</td>
<td>27,584,606</td>
<td>41,801,169</td>
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<td>14 Aggregate write-ins for other hospital and medical expenses (Line 1499)</td>
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<td>15 Incentive Pool and Withhold Adjustments</td>
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<td>16 TOTAL EXPENSES (Lines 9 through 15)</td>
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<td>375,035,801</td>
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<td>LESS:</td>
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<tr>
<td>17 Net reinsurance recoveries</td>
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<tr>
<td>18 Total hospital and medical (Lines 16 minus 17)</td>
<td>296,116,822</td>
<td>375,035,801</td>
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<tr>
<td>19 Non-health claims</td>
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<tr>
<td>20 Claims adjustment expenses</td>
<td>17,230,940</td>
<td>18,017,149</td>
</tr>
<tr>
<td>21 General administrative expenses</td>
<td>14,694,082</td>
<td>16,258,785</td>
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<tr>
<td>22 Increase in reserves for life, accident and health contracts.</td>
<td>-</td>
<td>10,729,060</td>
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<tr>
<td>23 Total underwriting deductions (Lines 18 through 22)</td>
<td>331,041,844</td>
<td>429,040,545</td>
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<tr>
<td>24 Net underwriting gain or (loss)(Lines 8 minus 23)</td>
<td>36,232,428</td>
<td>2,641,686</td>
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<td>25 Net investment income earned</td>
<td>5,096,126</td>
<td>8,113,955</td>
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<tr>
<td>26 Net realized capital gains or (losses)</td>
<td></td>
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</tr>
<tr>
<td>27 Net investment gains or (losses)(Lines 25 plus 26)</td>
<td>5,096,126</td>
<td>6,113,955</td>
</tr>
<tr>
<td>28 Net gain or (loss) from agents’ or premium balances charged off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Aggregate write-ins for other income or expenses (Line 2999)</td>
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<td></td>
</tr>
<tr>
<td>30 Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)</td>
<td>41,328,554</td>
<td>8,755,541</td>
</tr>
<tr>
<td>31 Federal and foreign income taxes incurred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Net income (loss) (Lines 30 minus 31)</td>
<td>41,328,554</td>
<td>8,755,541</td>
</tr>
</tbody>
</table>

The 2011 PMAP detail provided agreed to the 2011 Blue Plus MN Supplemental Report #1. RRC noted the programs reported in the PMAP columns varied from 2010 to 2011.
The PMAP column consisted of the following programs in the 2011 MN Supplement Report #1:
- PMAP (Non seniors)
- Medical Assistance
- GAMC run-out
- Medicaid Expansion

The PMAP column consisted of the following programs in the 2010 MN Supplement Report #1:
- PMAP (Non seniors)
- MSC+

The 2011 PMAP member months, revenues and expenses are higher in 2011 for various reasons. According to the Minnesota Department of Human Services website, the GAMC program ended February 28, 2011. Enrollees were automatically moved to Medical Assistance (MA), Minnesota's Medicaid program. In 2010, the GAMC program information was reflected in a column separate from PMAP. In 2011, Minnesota participated in the Medicaid Expansion, as explained earlier in this report.

2. Verify the Minnesota Supplement Report #1 was completed in accordance with all instructions currently effective set forth by the Minnesota Department of Health.

RRC obtained the Minnesota Supplement Report #1 instructions. An example of the Minnesota Supplement Report #1 can be found in Appendix 3 and the instructions can be found in Appendix 4.

The instructions state: "All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing." The Minnesota Supplement Report #1 reconciles to the annual statement.

The instructions also state the primary MN Statute reference for MN Supplement Report #1 is §62D.08. See Appendix 2 for §62D.08.

3. Perform an analytical review comparing the 2010 and 2011 MN Supplement Reports and research any significant fluctuations.

An analytical review was performed comparing the 2010 and 2011 MN Supplement Report #1. Any fluctuations greater than 20% and the individual program's materiality were identified and sent to Blue Plus for an explanation. Materiality was calculated for the individual programs based on 5% of the individual programs' 2011 net income (rounded), i.e. materiality for MSHO = $34,173,338 (2011 net income) * 5% = $1,708,667 rounded to $1,709,000.

The Company provided a response to the significant fluctuations. The majority of the Company's responses appeared reasonable. The following fluctuations were noted as unusual:
Reserves
According to the 2011 Notes to the Financial Statement, reserves for claims attributable to the events of prior years have decreased from $139,055,277 in 2010 to $128,995,583 in 2011 as a result of re-estimation of unpaid claims and provider settlement liabilities. The favorable development of unpaid claims has principally been experienced on the MNCare, Medicaid (PMAP) and MSHO blocks of business. This development is the result of ongoing analysis of the reserves based on recent claim trends. Original estimates are modified as additional information becomes known regarding the block of business.

According to the MN Supplement Report #1, the PMAP PDR went from $0 in 2010 to $19.7 million in 2011. The Company indicated the deficiency reserve shown on this line for PMAP is the value of the expected loss in the following year for this line of business. As of December 31, 2010, Blue Plus did not anticipate a loss in 2011 for the PMAP line of business, and therefore did not hold a deficiency reserve. However, as of December 31, 2011 Blue Plus anticipated a $19.7 million loss.

According to the MN Supplement Report #1, the MNCare PDR increased $6.6 million in 2010 and $3.5 million in 2011. The Company indicated that as of December 31, 2010, Blue Plus anticipated a $6.6 million loss in 2011 for the MNCare line of business. As of December 31, 2011 Blue Plus anticipated a $10.1 million loss in 2012 resulting in an increase in the deficiency reserve of $3.5 million.

Med Management Expenses
The general administrative expenses in Column 13 "Other: Med Management" of the MN Supplement Report #1 increased from $764,000 in 2010 to $10.3 million in 2011. The large increase in administrative expenses was due to a $10,000,000 contribution from Blue Plus to the Blue Cross and Blue Shield of Minnesota Foundation made in 2011.

Capital Gains
In 2011 Blue Plus had net realized capital gains of $10.3 million. All of the capital gains were included in the "Med Management" column. The Company indicated they did not allocate capital gains but rather included the entire balance as "Med Management/Other" in column 13 of the MN Supplement.

4. Review (by total) the MN Supplement Report to the Expense page of the Statutory Annual Statement. Review the expense categories in terms of:

- Expense allocation between legal entities is consistent with the Statement of Statutory Accounting Principles Appendix A-440 (fair and reasonable) and SSAP No. 70 "Allocation of Expenses".

- Identify expense allocation between public and private programs.
- Perform analytical review and/or testing by sampling various expense categories to determine if expenses were accounted for in accordance with the entity's expense allocation agreements and guidelines.

We obtained the 2011 expense detail from Blue Plus. The $92,225,977 expense detail provided was agreed to the Underwriting and Investment Exhibit Part 3 - Analysis of Expenses in the 2011 annual statement for completeness. We sorted the allocated expense amounts from largest to smallest and chose the 10 largest allocated expenses. In addition to these 10 largest expenses, 4 additional expenses were chosen judgmentally consisting of 2 PMAP expenses in addition to an IT expense and a government program expense. These were chosen to specifically review the Company's allocation process. For all of the expenses, we chose the smallest and largest month to review.

In addition to the allocated expenses, Blue Plus has expenses they do not allocate across programs. All of these expenses were chosen to review the Company's criteria and documentation.

**Blue Plus Cost Allocation Process**

Administrative expenses are recorded in organizational cost centers where the costs are incurred. At the end of each month, these costs are allocated out in a series of stages called "tiers". When all of the allocation tiers are complete, all administrative expenses have been allocated to customer/products cost centers.

Tier 1 allocations spread overhead-type costs to other organizational cost centers. Cost centers such as human resources, benefits, building services, mail services, voice/data systems and local area network are allocated in Tier 1. Allocations statistics used in Tier 1 include headcount, square feet and others.

Tier 2 allocations are performed mainly on cost centers with multiple functions. An example is a dedicated cost center that provides membership, claims processing and customer service functions. Tier 2 allocations are based on fixed percentages determined through information obtained from cost center managers. In many instances, time reporting or staffing levels are used to validate the cost allocations.

Tier 3 allocates administrative expenses to customer/product cost centers. The allocations from each of the cost centers are determined from information received from cost center managers. Each cost center is allocated to the appropriate receiver customer/product cost centers based on a cost allocation method. Cost allocation methods include fixed percentages and variable statistic allocations. Allocation statistics used in Tier 3 include membership counts, claim counts, contract counts and others.

In addition to the cost center allocation process, there are two other methods used to allocate expenses. If a cost center incurs an expense that should not follow the allocation method used for the cost center as a whole, the expense may be allocated via a special general ledger account or a real internal order. Special general ledger accounts are established to allocate an expense to a company or a select group of customer/product cost centers. Real internal
orders are set up to allocate an expense to a single customer/product cost center. The expense is coded to the real internal order and then allocated directly to the appropriate customer/product cost center.

In reviewing the Company’s expenses and allocations, it was noted Blue Plus does not have a separate cost/profit center set up for MSC+ business.

See the “Observations and Findings” section for details on specific expense accounts that did not appear to be accounted for in accordance with the Company’s expense allocation agreements and guidelines and in accordance with Appendix A-440 (fair and reasonable) and SSAP No. 70 “Allocation of Expenses”.

5. Verify appropriateness with regards to the establishment of any PDR allocated to the public programs.

As of December 31, 2011 and 2010, Blue Plus had PDR of $32,380,000 and $10,586,000, respectively.

A review of the PDR Calculation for the Company’s public programs as of December 31, 2011 was performed. The Company has two lines of business within the public program category - PMAP and MNCare.

The PDR calculation develops a contribution margin for each market segment based on forecasted results in each entity’s business plan.

Premiums
minus Claims
minus Taxes & Assessments
minus Administrative Expenses

Policy reserves are subtracted, if applicable, from the amount calculated above to arrive at the PDR.

The Company does not include investment income in the PDR calculations. Blue Plus received permission from the Minnesota Department of Commerce to exclude investment income from the PDR calculation.

The original calculation results in a PDR of $29,780,000 as of December 31, 2011.

The PDR calculations appear reasonable and appropriate. The methodology used appears reasonable and appears to adhere to generally accepted actuarial principles. We did not review or otherwise audit the data included in the information provided, but only reviewed the methodology.
The Company combines PMAP and MNCare (i.e., Public Programs) for the purpose of determining a need for a PDR. Statement of Statutory Accounting Principle ("SSAP") No. 54, paragraph 18 states:

“For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured."

The Company has a single contract with the State of Minnesota, acting through its Department of Human Services for PMAP and MNCare. Further, the Company represented to us that its grouping is a result of the residing Company of the business, underwriting methodology and marketing method. It is an approach consistent with that seen during the Financial Examination as of December 31, 2010. As of December 31, 2011, combining results for these two lines of business did not impact the need for or magnitude of a PDR. The Company projected negative operating income for both programs for the calendar year 2012. In the December 31, 2010 Financial Examination, the Company had projected an operating loss for MNCare and an operating gain for PMAP. These results were combined and the resulting PDR was less as opposed to viewing the line of business independently since the PMAP operating gain partially offset a portion of the MNCare operating loss.

From the information provided, it appears that the grouping PMAP and MNCare appears reasonable and appears to follow SSAP No. 54.

Blue Plus was asked to perform a re-estimation using actual experience that was available. It is noted that the original estimates include an expense item titled “Additional Administrative Allocation for 2012 Strategic Spend”. The “Additional Administrative Allocation for 2012 Strategic Spend” amounts were $861,000 and $511,000 for PMAP and MNCare, respectively. The revised estimates do not include an amount for “Additional Administrative Allocation for 2012 Strategic Spend”. The following page shows the original estimates, revised estimates, and the differences. It appears that experience is emerging better than the original estimates. Based on claims paid data as of May 31, 2012, the Company re-estimated its 2011 PDR to be approximately $5,140,000 lower than originally booked.


The Company’s reserving methodology involves the use of the Developmental Method, also referred to as the Lag Factor Method. The Company utilizes an Oracle program which produces completion factors using 3-of-3, 6-of-6, and 12-of-12 averaging techniques. The Company indicated the estimates do not incorporate implicit margins. The method substitutes per-member per-month methodology for the most recent one, two, or three months. Estimates also incorporate a “days in a month” adjustment.

Best estimates are determined by the Company, and then an explicit margin for adverse claim deviation is applied to the best estimates. A 6.0% margin is used for Blue Plus
business. The Company does not have a formal written policy on margin levels. The Company has worked closely over time with their external auditors and MNDOC in selecting reasonable margin levels. The explicit margin is the same as applied for 2010. It is considered reasonable by the Company’s auditors, a similar conclusion as drawn during the 2010 Examination by MNDOC.

The methodology employed appears reasonable and appropriate. It follows generally accepted actuarial practice for coverages with a relatively short time-period between the incurring and payment of claims which includes most health care coverages.

7. Compare the 2010 run-out provided to the Department of Human Services in 2011 to the retrospective review of reserves.

The Company provided the files submitted to DHS that show recasts of year-end reserve estimates using claim data through May 31, 2012. The following tables summarize these results. Initial estimates do not include margin for adverse claim deviation.

<table>
<thead>
<tr>
<th>Blue Plus</th>
<th>Unpaid Claim Liabilities as of December 31, 2010</th>
<th>Data Through May 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial Estimate</td>
<td>Paid-on-Incurred</td>
</tr>
<tr>
<td>MNCare Adults w/o Children</td>
<td>$12,007,518</td>
<td>$12,007,310</td>
</tr>
<tr>
<td>MNCare Families and Children</td>
<td>9,368,257</td>
<td>9,367,959</td>
</tr>
<tr>
<td>MNCare Total</td>
<td>$21,375,775</td>
<td>$21,375,269</td>
</tr>
<tr>
<td>PMAP Expansion*</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PMAP F&amp;C</td>
<td>27,691,866</td>
<td>27,661,186</td>
</tr>
<tr>
<td>PMAP Total</td>
<td>$27,691,866</td>
<td>$27,661,186</td>
</tr>
</tbody>
</table>

* Starting March 1, 2011, additional low income adults became eligible for Medicaid benefits when Minnesota expanded the Medical Assistance program (PMAP Expansion).
<table>
<thead>
<tr>
<th></th>
<th>Initial Estimate</th>
<th>Paid-on-Incurred</th>
<th>Remaining Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNCare Adults w/o Children</td>
<td>$6,523,676</td>
<td>$6,399,392</td>
<td>$124,284</td>
</tr>
<tr>
<td>MNCare Families and Children</td>
<td>10,172,552</td>
<td>9,977,054</td>
<td>195,497</td>
</tr>
<tr>
<td>MNCare Total</td>
<td>$16,696,228</td>
<td>$16,376,446</td>
<td>$319,782</td>
</tr>
<tr>
<td>PMAP Expansion</td>
<td>$11,607,203</td>
<td>$11,064,170</td>
<td>$543,033</td>
</tr>
<tr>
<td>PMAP F&amp;C</td>
<td>31,846,126</td>
<td>30,934,634</td>
<td>911,492</td>
</tr>
<tr>
<td>PMAP Total</td>
<td>$43,453,329</td>
<td>$41,998,804</td>
<td>$1,454,525</td>
</tr>
</tbody>
</table>

Based upon the information provided, the December 31, 2010 estimates for MNCare appear very close to the eventual run-out. For the December 31, 2011, the original estimates are 2.0% and 3.5% higher for MNCare and PMAP, respectively, than the run-out for January 2012 through May 2012. The difference in total is 3.0%. It was concluded that a majority of run-out has emerged in the first five months of 2012, with a small amount of run-out expected yet to be incurred. The estimates as of December 31, 2011 appear reasonable.

Beginning in 2008, the Company began to slow claim payment speed as a cash flow management technique while still abiding by appropriate prompt payment rules and regulations. A reserve is held for these held claims, which are referred to as Special Reserves. With this approach, the Company has partitioned the Unpaid Claim Liability into 2 components: (1) Incurred But Not Reported Liability, and (2) Reported But Not Paid Liability. Special Reserves fall into category (2). The Company removes "held claims" when developing the claim lag reports which are used to develop the IBNR liability estimates. The change in the Company’s claims payment speed was reviewed in detail during the 2010 examination by MNDOC and no specific concerns were noted.
Appendix 1 – Executive Order 11-06

STATE OF MINNESOTA
EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 11-06
Creating Public Disclosure for
Minnesota’s Managed Care Health Care Programs

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, over 500,000 Minnesotans receiving public health insurance coverage are enrolled in managed care; and

Whereas, the State spends approximately $3 billion annually on purchasing health care from managed care plans for state public programs; and

Whereas, it is critical for public trust that Minnesota’s taxpayers understand how public dollars for health care are being used; and

Whereas, the State needs greater disclosure and accountability of managed care plan spending on health care and long-term care services and administrative expenses for state public programs;

Now, Therefore, I hereby order the Commissioner of Human Services to:

1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.

2. Develop an annual comprehensive managed care report in consultation with the Commissioners of Health and Commerce that includes detailed information on administrative expenses, premium revenues, provider payments and reimbursement.
rates, contributions to reserves, enrollee quality measures, service costs and utilization, enrollee access to services, capitation rate-setting and risk adjustment methods, and managed care procurement and contracting processes.

3. Submit data from the managed care plans for state public programs to the Commissioner of Commerce so that regular financial audits of data will be conducted.

Under Minnesota Statutes, section 4.035, subdivision 2, this Executive Order is effective 15 days after publication in the State Register and filing with the Secretary of State.

In Testimony Whereof, I have set my hand on March 23, 2011.

Mark Dayton
Governor

Filed According to Law:

Mark Ritchie
Secretary of State
Appendix 2 – Minnesota Statutes §62D.08 and 256B.69, subd 9c

62D.08 ANNUAL REPORT.

Subdivision 1. Notice of changes.

A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q), (r), (s), and (t) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 60 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Subd. 2. Annual report required.

Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health covering the preceding calendar year. However, utilization data required under subdivision 3, clause (e), shall be filed on or before July 1.

Subd. 3. Report requirements.

Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of health;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (e), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization,
including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(c) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; and

(f) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Subd. 4. Penalty; extension for good cause.

Any health maintenance organization which fails to file a verified report with the commissioner on or before April 1 of the year due shall be subject to the levy of a fine up to $500 for each day the report is past due. This failure will serve as a basis for other disciplinary action against the organization, including suspension or revocation, in accordance with sections 62D.15 to 62D.17. The commissioner may grant an extension of the reporting deadline upon good cause shown by the health maintenance organization. Any fine levied or disciplinary action taken against the organization under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 to 14.69.

Subd. 5. Changes in participating entities; penalty.

Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner 120 days before the effective date. When the health maintenance organization terminates a provider for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within ten working days of the date the health maintenance organization sends out or receives the notice of cancellation, discontinuance, or termination. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $200 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Subd. 6. Financial statements.

A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization for the first three quarters of the year on forms prescribed by the commissioner. The statements are due 30 days after the end of the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.
Subd. 7. Consistent administrative expenses and investment income reporting.

(a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

256B.69 PREPAID HEALTH PLANS.

Subd. 9c. Managed care financial reporting.

(a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

1. administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;
2. revenues by program, including investment income;
3. nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:
   i. individual-level provider payment and reimbursement rate data;
(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.
## Appendix 3 – Minnesota Supplement Report #1

**Minnesota Supplement Report #1**

**STATEMENT OF REVENUE, EXPENSES AND NET INCOME**

For the year ending December 31, 2011

Public Information, Minnesota Statutes § 62D.08

### Revenue

<table>
<thead>
<tr>
<th>Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Monitor Months</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>An found on page 4 of the Annual Statement</td>
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<tr>
<td><strong>REVENUES:</strong></td>
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<td></td>
</tr>
<tr>
<td>2 Net Premium income (including $ non-health premium income)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>3 Change in unearned premiums reserves and reserve for rate credits</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4 Fee-for-service (net of $ medical expenses)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5 Risk revenue</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6 Aggregate write-offs for other health care related revenues (Line 58)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>7 Aggregate write-offs for other non-health revenues (Line 75)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>8 TOTAL REVENUES (Lines 2 through 7)</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>9 Inpatient and outpatient services</td>
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<td>12 Emergency rooms and out-patient</td>
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<td>13 Prescription drugs</td>
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<td>14 Aggregate write-offs for other hospital and medical expenses (Line 149)</td>
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<tr>
<td>15 Miscellaneous and other adjustments</td>
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<td>16 TOTAL EXPENSES (Lines 9 through 15)</td>
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<td>17 Net emoluments recoveries</td>
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<td>18 Total hospital and medical (Lines 16 minus 17)</td>
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<td>19 Net health costs</td>
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<td>20 Claim adjustment expenses</td>
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<td>21 General administrative expenses</td>
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<td>22 Interest in reserves for life, accident and health contracts</td>
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<td>23 Total unused int (Lines 18 through 22)</td>
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<td>24 Net underwriting gains or (loss) (Line 8 minus 23)</td>
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<td>25 Net investment income earned</td>
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<td>26 Net realized capital gains or (losses)</td>
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<td>27 Net investment income earned</td>
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<td>28 Aggregate write-offs for other income or expenses (Line 250)</td>
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<td>29 Net income or (loss) from federal income taxes (Lines 24 plus 25)</td>
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<td>30 Net income or (loss) from federal income taxes</td>
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<td>31 Federal and foreign income taxes</td>
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<tr>
<td>32 Net income (loss) (Lines 30 minus 31)</td>
<td>NR</td>
<td>NR</td>
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Appendix 4 – MN HMO Instructions

Date: December 1, 2011

To: Minnesota Domiciled Health Maintenance Organizations and County Based Purchasers

From: Mike Rothman, Commissioner
Minnesota Department of Commerce

Subject: Filing of Annual Statement, Supplements, Exhibits, Certificates and Reports

Contacts: Minnesota Department of Commerce
Constance Peterson, Constance.Peterson@state.mn.us (651)297-8943
Robert Rivera, Robert.Rivera@state.mn.us (651)296-4523 (Questions about Medical Necessity Evaluation Filing Only)

Minnesota Department of Health
MaryAnn (Fena) Benke, MaryAnn.Benke@state.mn.us (651)201-5164

NAIC Instructions and Blanks

The National Association of Insurance Commissioners (NAIC) Annual Statement health blank is required to be filed with the Department of Commerce no later than 4/1/12 per Minnesota Statutes §62D.08. Refer to the following table for details regarding the Annual Statement filing and other required filings for the year 2012:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Copies</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Statement (hard copy)</td>
<td>5</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 2 &amp; 3</td>
<td></td>
</tr>
<tr>
<td>Annual Statement (electronic filing)</td>
<td>1</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 2 &amp; 3</td>
<td>Those organizations not filing electronically with the NAIC are required to file the Annual Statement in PDF format in addition to the required hard copies.</td>
</tr>
<tr>
<td>Investment Policy Certification</td>
<td>5</td>
<td>4/1/12</td>
<td>§62D.045, Subd. 2 and §60A.112</td>
<td>Not required for County Based Purchasers.</td>
</tr>
<tr>
<td>Audited Financial Statement</td>
<td>3</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 3(a)</td>
<td></td>
</tr>
<tr>
<td>Risk Based Capital Report</td>
<td>3</td>
<td>4/1/12</td>
<td>§62D.04, Subd. 1(e)</td>
<td></td>
</tr>
</tbody>
</table>
| Notification of Change in Appointed Actuary      | 1                | Within 5 business days | §62D.08, Subd. 2 & 3 | According to the NAIC Annual Statement Instructions, documentation for a newly appointed actuary needs to include the following:  
  • The insurer shall provide the Commissioner with a letter within 10 business days stating whether, in the preceding 24 months, there were any disagreements with the former actuary.  
  • The insurer shall request the former actuary to furnish a letter addressed to the insurer stating whether the actuary |
Filing Address:  Department of Commerce
Financial Institutions - Insurance
85 Seventh Place East, Suite 500
St. Paul, MN  55101-2198

Filing Fees:  Health Maintenance Organizations: Send the filing fee of $400 for the Annual Statement and $200 for each Quarterly Statement, payable to the Minnesota Department of Health (not the Minnesota Department of Commerce), to: Managed Care Systems Section, Minnesota Department of Health, P.O. Box 64882, St. Paul, MN  55164-0882 by the filing due dates.  County Based Purchasers:  Filing fees not required.

Minnesota Supplemental Reports (excluding HEDIS)

Pursuant to applicable Minnesota law, complete the following reports.  These report forms, with the exception of the HEDIS 2012 Data Submission Tool, can be downloaded from the “HMO Annual Report Forms” link at the bottom of the following Department of Health Web page: www.health.state.mn.us/divs/hspec/mes/forms.htm

<table>
<thead>
<tr>
<th>Report</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>4/1/12</td>
<td>§62D.08</td>
<td>Statement of Revenue, Expenses and Net Income</td>
</tr>
<tr>
<td>2.</td>
<td>4/1/12</td>
<td>§4685.2000</td>
<td>Summary of Complaints and Grievances</td>
</tr>
<tr>
<td>3.</td>
<td>4/1/12</td>
<td>§72A.201, Subd. 8(7)</td>
<td>Summary of Chemical Dependency Claims and Appeals</td>
</tr>
<tr>
<td>4.</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 3(d) and 4685.210D</td>
<td>Participating Providers Listing</td>
</tr>
<tr>
<td>5.</td>
<td>4/1/12</td>
<td>§62M.09, Subd. 9</td>
<td>Medical Necessity Evaluation</td>
</tr>
<tr>
<td>6.</td>
<td>7/1/12</td>
<td>§62D.04(1)(c),(5) &amp; 62D.08</td>
<td>Enrollment Statistics By Products and County</td>
</tr>
<tr>
<td>7.</td>
<td>7/1/12</td>
<td>§62D.04(1)(c),(5) &amp; 62D.08</td>
<td>HEDIS 2012 (For Calendar Year 2011) Data Submission Tool (through NCQA), Separate Instructions To Follow.</td>
</tr>
</tbody>
</table>

Instructions for filing the HEDIS data (through NCQA) will be sent from the Minnesota Department of Health under separate cover.

In addition to the electronic copy of the Medical Necessity Evaluation Form filing (Supplemental Report #5) with the Department of Health, e-mail a copy of the filing to Robert Rivera at the Department of Commerce: Robert.Rivera@state.mn.us.

All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.
Minnesota Supplements Filing Instructions: It is not necessary to send a paper copy in addition to the electronic submission; none of these reports require a signature. Send the completed Minnesota Supplement forms on a CD to:

Mailing Address: Dedra Johnson
Managed Care Systems Section
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Courier Address: Managed Care Systems Section
Minnesota Department of Health
85 Seventh Place East, Suite 220
St. Paul, MN 55101
Appendix 5 - Prepaid Medical Assistance Program (PMAP) map
Health Plan Choices by County Effective April 1, 2011

One Plan Choice  Two Plan Choices  Three Plan Choices  Four Plan Choices  Five Plan Choices
BP = Blue Plus  HP = HealthPartners  IMC = Itasca Medical Care  MED = Medica  MHP = Metropolitan Health Plan  PW = PrimeWest Health  SC = South Country Health Alliance  UC = UCare

www.dhs.state.mn.us/healthcare  or  www.dhs.state.mn.us/maps
Appendix 9 - Special Needs Basic Care (SNBC) map
Health Plan Choices by County Effective Jan. 1, 2011

MED = Medica*
MHP = Metropolitan Health Plan
PW = PrimeWest Health System
SC = South Country Health Alliance
UC = UCare

*SNBC through Medica no longer integrates Medicare. People with Medicare will need a separate Medicare Part D plan.

**Effective Sept. 1, 2009 SNBC - PINS (Preferred Integrated Network) in Dakota County only through Medica.

www.dhs.state.mn.us/SNBC
Addendum to Report

Blue Plus Comment Letter
The Minnesota Department of Commerce (MNDOC) employed the services of Risk and Regulatory Consulting, LLC (RRC) in order to assist it in evaluating the appropriateness of managed care plans' expense allocations to public programs, the appropriateness of established Premium Deficiency Reserves and the Retrospective Review of Reserves established for such public programs. This evaluation was conducted in accordance with Executive Order 11-06 Creating Public Disclosure for Minnesota's Managed Care Health Care Programs issued March 21, 2011 and information was also collected as provided in Minn. Statutes Section 256B.69, subd 9c. The public programs are provided by various Managed Care Organizations, including Blue Plus.

Below are HMO Minnesota's (Blue Plus or the Company) responses to the observations and findings noted in the final report labeled:

STATE OF MINNESOTA
HMO MINNESOTA d/b/a BLUE PLUS
WORK ORDER CONTRACT NO: 47132
December 04, 2012

Within the scope and procedures of the review, there were limited exceptions and Blue Plus' responses to those items are contained herein. This document should be read in conjunction with the final report to give a complete and comprehensive understanding of the observations and findings.

As stated by RRC, the observations and findings are not in violations of Statutory Accounting Principles and State Law.

The recommendations in each finding below are that the Company should allocate only those expenses that are directly related to the public programs. The Company follows Statutory Accounting Principles and its internal corporate allocation policies. When possible specific identification of expenses is recorded and in all cases a reasonable methodology is employed. The Company disagrees with each of the findings below, with the exception of one in which the Company acknowledges an error of $10,000.

Observations & Blue Plus Responses:

1. Blue Plus made a $10 million cash contribution to the BCBSM Foundation on December 29, 2011.
   The entire $10 million contribution was included in Column 13 “Med Mgmt” line 21 “general administrative expenses” of the MN Supplement Report #1. The Blue Plus Medical Management “Med Mgmt” program relates to services performed by Blue Plus for the Northern Plains Alliance, a group of six Blue plans covering the seven state region including NE, ND, MT, WY, MN, IA, and SD. These services include managing the business functions for the Northern Plains Alliance related to case management, utilization management, nurse phone line, disease management and select quality improvement functions.
   bluecrossmn.com

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.
Blue Plus Response:

Column 13 of the Minnesota Supplement Report #1 is for “Other” activities that do not fit into the other predetermined columns. For Blue Plus the majority of this column is for its Medical Management activities. In 2011 this column also included the $10 million contribution to the Blue Cross Blue Shield Foundation such that this expense would not be allocated to/or included in any public program or government business results.

The contribution to the foundation is being utilized to fund charitable initiatives benefiting populations eligible for state public programs and to improve community conditions affecting the health and well-being of low income children and families in Minnesota.

2. RRC reviewed how salaries were allocated to the Company’s public and non-public programs, including the salaries of its executives. Blue Plus was allocated approximately $1.8 million of “Executive Management” expenses in 2011. Blue Plus allocates executive management expenses based on an “executive allocation statistic”. According to the Company, each executive’s allocation rule is determined by collaboration between the Finance area and the executives. The allocation is based on member months and a weighting factor for each executive. The Company was not required to, and did not, cap executive salaries prior to allocating them to the public programs or any other programs administered by the Company.

Blue Plus Response:

It is not clear to Blue Plus why this is included as an observation, when it states in the observation that there is no requirement to cap executive salaries. The allocation methodology for executive salaries is appropriate, reasonable and in accordance with our policies.

3. Blue Plus was asked to perform a re-estimation of PDR using actual experience that was available. Based on claims paid data through May 31, 2012, the Company re-estimated its 2011 PDR to be approximately $5,140,000 million lower than originally booked at December 31, 2011.

Blue Plus Response:

The premium deficiency reserve (PDR) is an estimate required to be made under accounting principles based on the best information available at year end. This liability will develop favorably or unfavorably as actual experience occurs in the following year. The $5,140,000 difference that is currently estimated is 0.76% of 2011 public program revenue and is before taking into account the $11.2 million that was required to be paid to the State under the 2011 1% operating margin cap. If this were to be taken into account, the PDR developed unfavorably by $6.2 million. Within the
report RRC states that the PDR is conservative, appropriate and adheres to generally accepted actuarial principles.

4. The Company provided a listing of profit centers for Blue Plus and BCBSM that are considered “government programs”. Not all profit centers were allocated government-related expenses.

**Blue Plus Response:**

Government related expenses are allocated to the appropriate profit centers based on activities that are performed and to which programs they relate.

5. In reviewing the Company’s expenses and allocations, it was noted Blue Plus does not have a separate profit center established for MSC+.

**Blue Plus Response:**

MSC+ was originally part of the PMAP contract and therefore was combined with and accounted for as part of that profit center. In order to separate MSC+ from the PMAP column on the 2011 Minnesota Supplement Report the revenue and claims were specifically identified and administrative costs were allocated based on the ratio of member months. A separate MSC+ profit center has been set up for 2012 and beyond.

6. There are three separate cost centers for IHM-GP. These include case management, disease management and utilization management. According to the Company, these cost centers provide care management for government program members. This cost center also includes staff that performs access management for commercial business. Costs are allocated based on a fixed percentage determined from staffing. Blue Plus government programs PMAP, MSHO and MNCare are allocated approximately 99% of these costs. BCBSM government programs are allocated the remaining 1%.

**Blue Plus Response:**

The three cost centers for IHM-GP are allocated to government programs and do not include staff that perform access management for commercial business. The commercial staff are included in a separate cost center and are not allocated to any government program business.

7. PMAP & MNCare were allocated approximately $330,000 of expenses in 2011 for cost center 12600 “Virginia Commercial Claims”. PMAP & MNCare were allocated approximately $35,000 of expenses in 2011 for cost center 89300 “Commercial Accounts Large Group”. The
Company indicated the naming convention for cost center 12600 is “Virginia Commercial Claims” but staff in this cost center also works on government claims, including PMAP & MNCare. The different types of claims are identified within a claims tracking system. There also is a cost center “Virginia Government Claims” which is 100% dedicated to government claims. As claim volume fluctuates throughout the month, in addition to having individuals in the government claims cost center work overtime, individuals within the Commercial claims cost center are utilized when needed.

Blue Plus Response:

The allocation methodology is appropriate, reasonable and in accordance with our policies.

8. The Company allocates costs to the Printing & Postage cost center based on a total membership statistic. Blue Plus was allocated approximately $1.0 million of printing & postage expenses in 2011. Approximately $875,000 was allocated to PMAP and MNCare. This is in addition to cost center “Printing & Postage - Govt” 2011 expenses of $356,000, of which $330,000 was allocated to PMAP and MNCare. The Company indicated the Printing & Postage cost center contains the cost of transactional print and postage that is business critical. The Company indicated the Printing & Postage – Government cost center contains the cost of marketing print and postage. The Company indicated the membership statistic is utilized due to the volume of transactions.

Blue Plus Response:

The allocation methodology is appropriate, reasonable and in accordance with our policies.

Findings & Blue Plus Responses:

1. Marketing and Corporate Communications

Finding:
The Company allocates Marketing & Corporate Communications expenses based on total MN membership statistics. This includes all Blue Plus profit centers except Med Mgmt. Blue Plus was allocated $1.4 million of Marketing & Corporate Communications expenses in 2011. Of this amount, PMAP and MNCare were allocated approximately $1.2 million in 2011.

BCBSM runs a variety of ads including their “Do” campaign on local TV stations. These ads do not target Blue Plus or the public programs. The Company indicated the expenses within the Marketing and Corporate Communications cost center are not specific to any one segment but are for business overall. Blue Plus was allocated 11.4% (10% to PMAP and MNCare) of the following December 2011 expenses (partial listing):
$1.0 million - Haworth (TV ads)
$133,922 – Twins Ballpark Sponsorship

In addition to direct expenses, Blue Plus was also allocated a portion of “Tier 1” expenses for payroll, benefits, travel, rent, etc. within the “Marketing & Corporate Communications” account. “Tier 1” expenses spread overhead-type costs to the cost centers. These costs include human resources, payroll, benefits, travel, building services, rent, depreciation, mail services, voice/data systems and local area network.

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS section 3.2.4 “Marketing Materials”:

(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

(2) Mailings to recipients. The MCO may make no more than two mailings per calendar year to Enrollees of the MCO covered under this Contract or potential Enrollees who reside in the MCO’s Service Area.

a) The MCO may distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO’s provider network...

b) The MCO may provide health education materials for Enrollees in Providers’ offices.

Recommendation:
The Company should allocate only those direct expenses allowed by the contract to PMAP and MNCare public programs.

Blue Plus Response:

The expenses accounted for in the marketing and communications cost center are not for the expenses addressed in the contract section above but rather are corporate business expenses that promote recognition of the organization in the wider community and are a normal cost of doing business. The expenses noted are not targeted to a specific population and do not promote any specific products but are related to health awareness and brand. Of the specific expenses identified above, PMAP and MNCare were allocated 11.4% or $129,267.
2. Affiliated Medical Center Covenant

Finding:
Affiliated Medical Centers, P.A. (AMC) entered into an Affiliation and Capitalization agreement with BCBSM and Blue Plus on December 21, 1993. The agreement calls for total principal payments from BCBSM to AMC in the amount of $9,912,754. The amount is being amortized over a thirty year time period on a straight line basis; each year BCBSM allocates to Blue Plus $330,425 ($9,912,754 / 30) of amortization expense related to this agreement. Of this amount, 46% is allocated to PMAP, 27% to MNCare, 21% to MSHO and the remaining 6% to Blue Plus Commercial. BCBSM is not allocating any portion of the amortization expense. The amortization expense is included in general administrative expenses. The Company did not provide a complete copy of the agreement between the parties nor a description of the nature of the services or activities underlying the agreement. Based on the information provided by the Company, it is unclear how the agreement specifically relates to the public programs.

Recommendation:
The Company should only allocate expenses that can be shown to directly relate to the public programs. Any portion not allocable to the public programs should be allocated to other programs or entities, including BCBSM.

Blue Plus Response:

The Affiliation and Capitalization Agreement was originally filed, reviewed and approved in its entirety by the Minnesota Department of Health. Affiliated Medical Centers, P.A. (now known as Affiliated Community Medical Centers, P.A.) (ACMC), BCBSM, Inc. dba Blue Cross and Blue Shield of Minnesota (Blue Cross) and Blue Plus are parties to an Affiliation and Capitalization Agreement entered into in 1993. A primary purpose of the agreement was to assure the long term independence of ACMC and to ensure continued access to quality and cost effective health services for Blue Plus’ managed care members in ACMC’s service area. ACMC continues to be the primary service provider for Blue Plus public programs members in ACMC’s service area. All payments made pursuant to a promissory note signed by Blue Plus were allocated to Blue Plus business.

3. Mankato Covenant

Finding:
The Company entered into an agreement with Mankato Clinic. We were not provided the first 19 pages of the agreement or the last pages of the agreement. The agreement calls for total principal payments from BCBSM/Blue Plus to Mankato in the amount of $8,000,000. The amount is being amortized over a twenty year time period on a straight line basis; each year BCBSM allocates to Blue Plus $200,000 ($8,000,000 / 20) of amortization expense related to this agreement. Of this
amount, 46% is allocated to PMAP, 27% to MNCare, 21% to MSHO and the remaining 6% to Blue Plus Commercial. BCBSM is also allocated $200,000 of the amortization expense. The amortization expense is included in general administrative expenses. The Company did not provide a complete copy of the agreement between the parties nor a description of the nature of the services or activities underlying the agreement. Based on the information provided by the Company, it is unclear how the agreement specifically relates to the public programs.

Recommendation:
The Company should only allocate expenses that can be shown to directly relate to the public programs. Any portion not allocable to the public programs should be allocated to other programs or entities, including BCBSM.

Blue Plus Response:

The Joint Venture and Affiliation Agreement was originally filed, reviewed and approved in its entirety by the Minnesota Department of Health. A Joint Venture and Affiliation Agreement was entered into by Mankato Clinic, Ltd, BCBSM, Inc. dba Blue Cross and Blue Shield of Minnesota (Blue Cross) and Blue Plus in 1995. A primary purpose of the agreement was to assure the long term independence of Mankato Clinic and to ensure continued access to quality and cost effective health services for our members in Mankato Clinic’s service area. Mankato Clinic continues to be a significant service provider for Blue Plus public programs members in Mankato Clinic’s service area. Pursuant to the agreement, Blue Cross and Blue Plus jointly agreed to pay Mankato Clinic the sum of $8.0 million per a payment schedule ending in 2014.

4. Government Program Management

Finding:
Allocation to this cost center is based on a fixed percentage statistic. The following costs were included in this cost center: payroll, benefits, car insurance allowance, meals, cell phones and travel. These were in addition to the Company’s allocation of “Tier 1” expenses. The Company also included various fees to attend exhibits & conferences in MN as expenses. These exhibits and conferences target the public programs. The Company indicated this cost center also includes sales promotion and travel related to the PMAP, MSHO and MNCare programs. This appears to be in violation of the PMAP and MNCare contract between the Company and DHS.

Expenses in 2011 for this account were approximately $720,000. There were no allocations to the BCBSM government programs. Expenses were allocated entirely to the following Blue Plus profit centers:
150100 PMAP
150200 MSHO
160100 MNCare
According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS section 3.2.4 “Marketing Materials”:

(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

Recommendation:
The Company should allocate only those expenses allowed by the contract to PMAP and MNCare programs.

Blue Plus Response:

The expenses allocated to this cost center are not related to the marketing mailings and promotional activities targeted to enrollees or potential enrollees as described in Section 3.2.4 (C) of the Contract quoted in the report. This cost center has responsibility for business partnerships statewide that support government programs. This responsibility includes education, problem solving, regulatory adherence, training Care Coordinators for the Counties and Clinics, auditing case files and ensuring that assessments, CMS and DHS requirements are met.

Of the $720,000 allocated to Blue Plus, $144,011 was allocated to PMAP and MNCare. These costs are for the purpose of managing the business and developing and maintaining relationships with stakeholders, delegates and counties. There are also state-wide travel expenses included in this amount related to providing Child and Teen Check Up/Blood Lead Screening clinic training, Home Care Association Provider Training, attending C&TC Coordinator meetings, Public Health Conferences and collaborative meetings; DHS work group meetings, etc. Activities related to lead screening and C & TC activities are specifically referenced in the contract. Blue Plus staff attend and exhibit at numerous state-wide conferences to connect with its provider and county partners. These expenses were reasonable, allowed under the contract and appropriately allocated in accordance with our policies.

5. Gov’t Prog Business Strategy & Development

Finding:
Costs are allocated based on a fixed percentage statistic. Blue Plus profit centers (PMAP, MSHO and MNCare) are allocated approximately 74% and BCBSM profit centers are allocated 26%.

Blue Plus was allocated $1.1 million of costs in 2011. It was noted Blue Plus was allocated 74% of a $37,000 Medicare Parts C&D audit. PMAP and MNCare were allocated approximately $10,000 of the Medicare Parts C&D audit. Medicare Parts C&D do not involve PMAP and MNCare.
Recommendation:
The Company should allocate only those government expenses that directly relate to the public programs.

**Blue Plus Response:**

Blue Plus agrees with the above finding. The audit costs were inadvertently allocated across programs rather than being directly allocated 100% to MSHO.

6. Lobbying Expenses

Finding:

PMAP & MNCare were allocated approximately $67,000 of expenses in 2011 for cost center 80503 “MN Lobbying”.

PMAP & MNCare were allocated approximately $21,000 of expenses in 2011 for cost center 80505 “Federal Lobbying”.

According to the Medical Assistance (PMAP) and MNCare contract between Blue Plus and DHS Article 15 “Lobbying Disclosure”:

The MCO certifies, that, to the best of its knowledge, understanding, and belief, that:

(A) No Federal Funds Used. No Federal appropriated funds have been paid or will be paid in
what the undersigned believes to be a violation of 31 U.S.C. § 1352, by or on behalf of the
undersigned, to any person for influencing or attempting to influence an officer or employee
of an agency, Member of Congress, an officer or employee of Congress...

(B) Other Funds Used. If any funds other than Federal appropriated funds have been paid or
will be paid to any person for influencing or attempting to influence an officer or employee of
any agency, a Member of Congress, an officer or employee of Congress or an employee of a
Member of Congress in connection with this Federal contract, grant, loan or cooperative
agreement., the undersigned shall complete and submit Standard Form-LLL, “Disclosure
Form to Report Lobbying,” in accordance with its instructions.

(C) Certification. The undersigned will require that the language of this certification be included
in the award documents for all sub-awards at all tiers (including subcontractors, sub-grants
and contracts under grants, loans, and cooperative agreements) and will required that all
sub-Recipients certify and disclose accordingly. Submission of this certification is a
prerequisite for making or entering into this transaction imposed by 31 U.S.C. § 1352. Any
person who fails to file the required certification shall be subject to a civil penalty of not less
than $10,000 and not more than $100,000 for each such failure.

Recommendation:
The Company should allocate only those lobbying expenses that directly relate to the public programs and report them in accordance with the contract.

**Blue Plus Response:**

These expenses are not specific to a contract, but represent an allocation of overall lobbying expenses including expenses at the State and Federal level, relating to health care reform, review of legislative proposals and the impact of health care reform on all health care programs including the Medicaid program. These expenses were reasonable and appropriately allocated in accordance with our policies.

**Blue Plus’ Summary Comments**

RRC performed specific tasks under the Scope and Procedures in accordance with the Executive Order. There were no exceptions with respect to the reporting and accuracy of the Minnesota Supplement Report #1 and its PDR and claim reserve methodologies were found to be appropriate and the amounts recorded reasonable. The allocation methodology followed by Blue Plus was in accordance with Statutory Accounting Principles.
STATE OF MINNESOTA

HealthPartners, Inc.

WORK ORDER CONTRACT NO: 50693

December 3, 2012
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Executive Summary

The Minnesota Department of Commerce (MNDOC) employed the services of Risk and Regulatory Consulting, LLC (RRC) in order to assist it in evaluating the appropriateness of the managed care plans’ expense allocations to public programs, the appropriateness of established Premium Deficiency Reserves and the Retrospective Review of Reserves established for such public programs. This evaluation was conducted in accordance with Executive Order 11-06 Creating Public Disclosure for Minnesota’s Managed Care Health Care Programs issued March 21, 2011 (see Appendix 1) and information was also collected as provided in Minn. Statutes Section 256B.69, subd 9c (see Appendix 2). The public programs are provided by various Managed Care Organizations, including HealthPartners, Inc. (hereinafter referred to as “HPI” or “the Company”). The public programs include: Prepaid Medical Assistance Program (PMAP), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), MinnesotaCare (MNcare) and Special Needs Basic Care (SNBC).

Expense Allocations – According to the NAIC Accounting Practices and Procedures Manual - Appendix A-440 – Insurance Holding Companies, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions. SSAP No. 70 “Allocation of Expenses” states that any basis adopted to apportion expenses shall be that which yields the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

The HealthPartners family of Companies consists of approximately 30 different legal entities. These companies are supported centrally by administrative departments that are expensed through the Group Health Plan, Inc. (GHI) corporation. GHI uses an administrative model to allocate these administrative expenses across companies, divisions and at a product or line of business level. HPI’s businesses are organized by corporation (Health Plan, Hospital and Foundations) and by divisions within each corporation. Examples of these divisions are the HealthPartners Medical Group, HealthPartners Pharmacy Division, HealthPartners Dental Group, Foundations, Health Plans and Administration Divisions. Each of these divisions consists of accounting units which accumulate the expenses for each business unit within HPI companies.

The expense allocation model was developed in the late 1980’s and is updated each year. HPI Finance staff interviews each accounting unit owner to determine if the current allocation methodology used is still the best method and properly reflects changes in the business.

The results of our analytical review and testing of samples of various expense categories show that HPI appears to be allocating expenses in a manner consistent with their expense allocation methodology and model, in accordance with the NAIC Accounting Practices and Procedures Manual - Appendix A-440 and in a manner consistent with SSAP No. 70 "Allocation of Expenses".
**Premium Deficiency Reserves** – According to SSAP No. 54 “Individual and Group Accident and Health Contracts”, when the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started.

HPI assesses the need for a PDR by reviewing internal Product Line Reports. If the Medical Loss Ratio (MLR) for the current year, excluding administration expenses for the selected grouping is less than 100%, then a PDR is deemed unnecessary. This review is supplemented by discussions amongst the Finance, Actuarial and Underwriting Departments. HPI determined that a PDR was not necessary as of December 31, 2011. The Appointed Actuary, Steven H. Mahan, FSA, MAAA, confirmed the Company’s conclusion in his “Actuarial Memorandum in Support of the Actuarial Statement of Opinion” as of December 31, 2011. RRC was provided with the Product Line Reports as of December 31, 2011 as well as the Actuarial Memorandum.

The Company’s decision that a PDR was not necessary as of December 31, 2011 appears reasonable from a financial perspective. However, it was concluded that the Company lacks a formal PDR analysis process, lacks any formal documentation of its process and its analysis relies on retrospective results of operations rather than prospective projections or forecast of its operations in the coming year. In addition, the Company did not provide supporting documentation of its rationale for combining all public programs in one group for the purpose of assessing the need for a premium deficiency or how its grouping methodology was in compliance with SSAP No. 54. SSAP No. 54 requires policies to be grouped in a manner consistent with how they are marketed, serviced and measured, for purposes of determining if a premium deficiency exists.

**Reserves** – According to SSAP No. 54 “Individual and Group Accident and Health Contracts”, claim reserves shall be accrued for estimated costs of future health care services to be rendered that the reporting entity is currently obligated to provide or reimburse as a result of premiums earned to date that would be payable after the reporting date under the terms of the arrangements, regulatory requirements or other requirements if the insured’s illness were to continue.
The Company’s reserving methodology involves the use of the Developmental Method, also referred to as the Lag Factor Method, developed on a Generally Accepted Accounting Principles (GAAP) basis, with adjustments to convert to a statutory basis of accounting. A variety of data sources and supplementary information are reviewed to determine the adjustments necessary for conversion to Statutory basis of accounting. Best estimates are made, with an explicit load representing both a margin for adverse claim deviation and Loss Adjustment Expense (“LAE”) applied. As represented to RRC’s actuary, the Company’s estimates do not incorporate implicit margins.

For the initial GAAP unpaid claims liability (UCL) estimates, reserving cells are service types within each related legal entity (Group Health Plan, Inc.; HealthPartners, Inc.; HealthPartners Insurance Company). The splits differ for Statutory UCL estimates. The Statutory UCL estimates are adjusted to match the GAAP amounts. The adjustment is typically small and immaterial. The methodology employed appears reasonable and appropriate. It follows generally accepted actuarial practice for coverage with a relatively short time period between the incurred date and payment of claims. Further, the methodology is consistent with that seen during the Financial Examination as of December 31, 2009 performed by MNDOC.

Run-out
For HPI, claim lag data is summarized on an incurred-and-processed basis, as opposed to an incurred-and-paid basis. Claim lag date includes both claims processed but not yet paid as well as claims incurred and paid. The lag period between claim processing and claim payment is extremely small, and does not appear to materially impact the reserve estimation.

For GHI and HPI, the Company applies a 12.5% load to their Best Estimates consisting of a 10.0% margin for adverse claim deviation and a 2.5% Loss Adjustment Expense (LAE). We concluded that the margin was overly conservative compared when considering historic redundancies and profitability analysis of the company’s public programs.

Based upon the information provided, the December 31, 2010 estimates in total were redundant by 13.0%, which can be viewed as almost entirely related to the 12.5% explicit margin.

Utilizing May 31, 2012 claims paid data, indications are that estimates as of December 31, 2011 were deficient by 5.1%. There are wide variations within the public product line reserves
established as of 2011 and the subsequent year run-off of related claims. The Company indicated that within the PMAP MA program, exceptionally high ranges of completion factors were incurred during 2012 for claims with 2011 dates of service. These types of payments are not picked up in the Company’s normal completion factors when setting IBNR; the margins built into their reserves serve to mitigate such variations. In collaboration with its consideration of appropriate margin level, the Company should review its reserving methodology for public programs as it relates to improving precision.

Background

HealthPartners, Inc. is a nonprofit corporation licensed as a health maintenance organization (HMO) in Minnesota. HPI provides health care services and coverage to approximately 237,000 members throughout Minnesota. It provides these services through a network of contracted medical and dental centers, physician groups, hospitals and related health care providers located primarily in the Minneapolis – Saint Paul metropolitan area. HPI is exempt from taxation under Section 501(c) (4) of the Internal Revenue Code.

HPI has contracted with the Minnesota Department of Human Services (DHS) to provide health care coverage to Prepaid Medical Assistance Program (PMAP) and prepaid MinnesotaCare (MNCare) recipients via a managed care model.

HPI contracts with the Centers for Medicare and Medicaid Services (CMS) as a Special Needs Plan under the Medicare Advantage program. The contract is part of a program sponsored by DHS called Minnesota Senior Health Options (MSHO) for beneficiaries age 65 and older who are eligible for DHS Medical Assistance and Medicare Parts A and B.

Group Health Plan, Inc. (GHI), a subsidiary of HPI, provides management, administrative and healthcare services to HPI, its affiliates, as well as their respective members through the Management and Administration Expense Allocation Agreement and the HealthCare Expense Allocation Agreements. Under these agreements, HPI paid GHI $79 million and $73 million in 2011 and 2010, respectively, for management and administrative services and $64 million and $111 million in 2011 and 2010, respectively, for healthcare services.

Public Programs administered by DHS and Minnesota Department of Health (MDH) provided by HPI:

PMAP
PMAP, also known as Medical Assistance (MA), is a health care program for families, children, pregnant women, adults without children who meet certain income limits and people who have disabilities. PMAP is Minnesota’s Managed Care Medicaid program. There is no monthly fee, but enrollees may need to pay small co-pay for some services.

In 2011, HPI provided coverage to PMAP members in 12 of the 65 counties that are available for prepaid health care contracting. HPI has approximately 12% of the statewide PMAP market share. See Appendix 5 for the PMAP health plan choices by county.
Medicaid Expansion

Beginning in 2011, PMAP also includes Minnesota Medicaid Expansion. Starting March 1, 2011, additional low income adults became eligible for Medicaid benefits when Minnesota expanded the Medical Assistance program. The federal Affordable Care Act (ACA) requires states participating in Medicaid, known in Minnesota as MA, to expand coverage to certain adults who meet specific criteria effective January 1, 2014. The ACA permits states to implement this expansion beginning April 1, 2010.

The 2010 Minnesota Legislature amended state law allowing the governor to authorize coverage of this population by Jan. 15, 2011. Gov. Mark Dayton signed an executive order Jan. 5, for implementation of MA expansion by March 1. The CMS approved the state’s plan in February.

The expansion provides federal matching funds — $826 million for the 2012-2013 biennium — for health care previously funded with only state dollars through MinnesotaCare and General Assistance Medical Care (GAMC). The GAMC program ended February 28, 2011. Enrollees were automatically moved to MA, Minnesota's Medicaid program.

MSC+
Minnesota Senior Care Plus is a health care program for seniors 65 and older who qualify for Medical Assistance (Medicaid) and are not enrolled in Medicare. There is no monthly fee, but enrollee may need to pay small co-pay for some services. In 2011 HPI provided coverage to approximately 10% of the statewide MSC+ enrollment.

See Appendix 7 for the MSC+ health plan choices by county.

MNCare
This program provides coverage to children, adults and seniors who don’t have access to affordable health care coverage, but do not meet the eligibility requirements for Medical Assistance (Medicaid). Working adults who are unable to get health care coverage through an employer may also qualify.

MNCare provides subsidized coverage for individuals and children who are not covered by group insurance and not eligible for Medical Assistance.

In 2011, HPI provided coverage to approximately 13% of the statewide MNCare enrollment and is available in 14 of Minnesota’s 87 counties.

See Appendix 6 for the MNCare health plan choices by county.
Public Programs Integrated with Federal Programs provided by HPI

MSHO
MSHO is a health care program that combines separate health programs and support systems into one health care package. It is for people ages 65 and older who are eligible for Medical Assistance (MA) and enrolled in Medicare Parts A and B. In 2011 HPI provided coverage to approximately 8% of the statewide MSHO enrollment.

See Appendix 8 for the MSHO health plan choices by county.

Public Programs managed by CMS and provided by HPI

Medicare + Choice
Medicare + Choice is a managed care plan for individuals who are over 65 years old and are eligible for Medicare Part A and Part B.

Private Programs provided by HPI

Commercial
Commercial Programs are managed care plans for individuals, families, and groups.

HPI does not offer the Special Needs Basic Care (SNBC) program to its members.

Observations & Findings

Note, this review is not considered a statutory examination but a special review requested by the Governor. Therefore, observations and findings within this report are not necessarily violations of Statutory Accounting Principles or State law. The objective of the review is to report the facts as observed and make recommendations where deemed to be appropriate. The following represents our key observations and findings:

Observations:

1. RRC reviewed how salaries were allocated to the Company’s public and non-public programs, including the salaries of its executives. HPI is allocated salaries based on membership, first by corporation, then by operating divisions, then by product/program.

   The Company was not required to, and did not, cap executive salaries prior to allocating them to the Public Programs or any other programs administered by the Company.

2. In 2011, HPI changed the way they reported allocations to claims adjustment expenses and general administrative expenses to be consistent with the new Medical Loss Ratio (MLR) reporting requirements stemming from the Affordable Care Act. The changes
were related to those expenses considered by the Affordable Care Act MLR reporting requirements as “Improving Health Care Quality Expenses”, which are considered claims adjustment expenses for purposes of the MLR calculation.

In 2010 (as in prior years), HPI applied the NAIC definition to determine which expenses to categorize as general administration expenses and claims adjustment expenses, respectively. In 2011, HPI modified its allocation process to consider the expense categories related to “Improving Health Care Quality Expenses” as defined in the Affordable Care Act MLR reporting criteria. This had the impact of an increase in claims adjustment costs across all Medicare and Medicaid products. However, that increase had a corresponding decrease in general administrative expenses and no impact for the financial results as a whole of the Medicaid programs, or the administrative expenses that were reported for the Medicaid program. This change had no impact on the financial performance of the public programs or the total general administrative and claims adjustment expenses of the public programs. HPI total claims adjustment expenses were $28,935,000 in 2011 and were $28,736,000 in 2010.

3. Total administrative expenses for MSHO decreased from $7,588,000 in 2010 to $6,571,000 in 2011. In 2011 and prior years, the financial results of MSHO have been correctly reported in the MSHO column of the Minnesota Supplement Report #1 submitted to the Minnesota Department of Health and within the Title XIX Medicaid column of the Analysis of Operations by Lines of Business on its Statutory Annual Report. The primary reason for the decrease in administrative expenses for MHSO during 2011 was a change in the way that HPI allocated taxes and assessments to the program. From a tax perspective only, the MSHO program is considered by the Company to be a Medicare Advantage program even though it is reported as a Medicaid program on HPI’s Annual Report and the Minnesota Supplement Report #1. The Company’s justification for this position is that the contract for MSHO is with the Centers for Medicare and Medicaid Services (CMS) and is considered a Medicare Advantage program by CMS. Because it is treated as a Medicare Advantage program, MSHO is exempt from all State of Minnesota assessed taxes. Prior to 2011, the MSHO program was allocated certain State of Minnesota assessment taxes on HPI’s internal product line financial statements. MSHO showed improved financials in 2011 due to the removal of taxes as described above as well as improved claim trends during 2011 and a resulting improved Medical Loss Ratio.

4. As of December 31, 2011, the Company determined that it did not require accrual of a PDR liability, which we agree is a reasonable conclusion. However, the manner in which the Company made this determination does not appear reasonable. The Company’s process includes analyzing current year product line financial statements to determine if any product line grouping (Commercial, Medicare, and Medicaid) is in a loss position. The Company’s analysis was not documented and appeared to be informal in nature. We also note that the approach taken by the Company is retrospective in nature. The reports on the prior year are reviewed and are supplemented by subjective insights. It can be argued that a prospective view, such as that found in forecasts, would be more appropriate and precise as well as adhering to generally accepted actuarial principles. The
current approach relies heavily on judgment as well as the idea that results for the previous year is an accurate predictor of the next year’s results.

The Company should consider formalizing its analysis related to determining the need for a premium deficiency, including documentation of the analysis for future review by auditors, its actuary as well as regulators. The analysis should include both retrospective and prospective analysis, including the use of financial projections of the profitability of its public programs.

**Findings:**

1. **Finding:**
   The Company combines all public programs for the purpose of assessing the need for a premium deficiency. The Company did not provide supporting documentation for its rationale for this grouping or how this grouping methodology was in compliance with SSAP No. 54, which requires policies to be grouped in a manner consistent with how they are marketed, serviced and measured, for purposes of determining if a premium deficiency exists. The Company’s approach is consistent with that seen during the Financial Examination as of December 31, 2009, performed by MNDOC. The Company has a separate contract with the State of Minnesota, acting through its Department of Human Services covering PMAP and MNCare services. In addition, the Company has a separate contract covering MSHO and MSC+ services together. We concluded that grouping the programs in accordance with the contracts entered into with the State for purposes of determining if a premium deficiency exists would be a reasonable approach to comply with SSAP No.54. If the Company had grouped its public programs during 2011 according to the contracts with the State covering these services under each program, a determination would have still been that no PDR was necessary at 2011. However, the current grouping practice of including all programs could have an impact on the adequacy of the Company’s PDR calculation in subsequent years, if certain programs incurred significant underwriting losses.

**Recommendation:**
We recommend that the Company develop documentation supporting its rationale that all public programs should be combined for purposes of determining if a premium deficiency exists and how this methodology is consistent with how policies are marketed, serviced and measured, as required in accordance with SSAP No. 54.
2. Finding:
HPI applies a 12.5% load to their best estimates for its Unpaid Claims Liability (UCL) consisting of a 10.0% margin for adverse claim deviation and a 2.5% Loss Adjustment Expense (LAE). The Company has not changed these percentages from the levels applied during 2009, as noted during the most recent Financial Examination by MNDOC. According to the Company, it had reached an agreement with its prior auditor regarding margins, which was a draw-down of the margin level over a five year period culminating at current levels. HPI feels that the margins it has established in their UCL calculations are consistent with industry averages and provides a reasonable level of comfort that adverse claims run-out experience will not impact future year financial performance. We concluded that while the margins have been reduced significantly since the 2006 Financial Examination by MNDOC, the margins are overly conservative compared to historic redundancies and the varying magnitude of such by reserving category.

Based upon the information provided, the December 31, 2010 UCL for the Company’s public programs in total were redundant by 13.0%. It can be concluded that the majority of the redundancies in the December 31, 2010 UCL is almost entirely related to the 12.5% explicit margin carried by the Company. The UCL for the Company’s public programs as of December 31, 2011 were shown to be deficient by 5.1%, as of May 31, 2012, the date specific information was requested by MNDOC. There are wide variations within the public product line reserves. For example the PMAP program December 31, 2011 UCL was deficient by $2,223,848, or 15.9%, utilizing data available as of May 31, 2012. The Company indicated that within the PMAP MA program, exceptionally high ranges of completion factors were incurred during 2012 for claims with 2011 dates of service. These types of payments are not picked up in the Company’s normal completion factors when setting IBNR; the margins built into their reserves serve to mitigate such variations.

Recommendation:
We recommend that the Company consider varying the margin level for particular blocks of business based upon historic estimation accuracy and anticipated estimation risk. We also recommend that in collaboration with its consideration of an appropriate margin level, the Company review its reserving methodology for public programs as it relates to precision. These suggestions further support the previous recommendation that the Company consider its financial projections of profitability at each public program when determining the need for a premium deficiency.

Scope and Procedures Performed
In accordance with Work Order Contract No. 50693, the specific tasks for which RRC was charged with are listed below.

1. Compare the PMAP detail which is provided to the Department of Human Services to the Minnesota Supplement Report filed with the Minnesota Department of Health.
For HPI there was no PMAP detail exhibit for HealthPartners (splitting PMAP Non Seniors to MSC+ Seniors data). This is because HPI reported MSC+ separately in the Minnesota Supplement Report #1 in Column 14 for both years. The PMAP results reported to DHS matched what was reported in the Minnesota Supplement #1 Report for both 2010 and 2011.

According to the Minnesota Department of Human Services website, the GAMC program ended February 28, 2011. Enrollees were automatically moved to Medical Assistance (MA) Minnesota's Medicaid Program. MA is reflected in the 2011 PMAP numbers (as run-off). HealthPartners provided us with a breakout of the GAMC component of PMAP. In 2011 PMAP total expenses reported on line 16 of the Minnesota Supplement Report #1 were $216,519,000 of which $143,000 were attributed to GAMC run-off.

The following PMAP detail was obtained directly from the HPI Amended 2011 and 2010 Minnesota Supplement Report #1.
<table>
<thead>
<tr>
<th>NAC Description</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prepaid Medical Assistance Program (PMAP)</td>
<td>Prepaid Medical Assistance Program (PMAP)</td>
</tr>
<tr>
<td>REVENUES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Member Months</td>
<td>459,739</td>
<td>552,308</td>
</tr>
<tr>
<td>2 Net Premium Income</td>
<td>183,312,000</td>
<td>235,728,000</td>
</tr>
<tr>
<td>3 Change in unearned premium reserves and serve for rate credits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Fee-for-service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Risk revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Aggregate write-ins for other health care related revenues (Line 699)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Aggregate write-ins for other non-health revenues (Line 799)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 TOTAL REVENUES (Lines 2 through 7)</td>
<td>183,312,000</td>
<td>235,728,000</td>
</tr>
<tr>
<td>EXPENSES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Hospital/medical benefits</td>
<td>142,304,000</td>
<td>178,857,000</td>
</tr>
<tr>
<td>10 Other professional services</td>
<td></td>
<td>16,820,000</td>
</tr>
<tr>
<td>11 Outside referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Emergency room and out-of-area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Prescription drugs</td>
<td>13,058,000</td>
<td>20,832,000</td>
</tr>
<tr>
<td>14 Aggregate write-ins for other hospital and medical expenses (Line 1499)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Incentive Pool and Withhold Adjustments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 TOTAL EXPENSES (Lines 9 through 15)</td>
<td>155,362,000</td>
<td>216,519,000</td>
</tr>
<tr>
<td>LESS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Net reinsurance recoveries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Total hospital and medical (Lines 16 minus 17)</td>
<td>155,362,000</td>
<td>216,519,000</td>
</tr>
<tr>
<td>19 Non-health claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Claims adjustment expenses</td>
<td>2,623,000</td>
<td>5,360,000</td>
</tr>
<tr>
<td>21 General administrative expenses</td>
<td>9,381,000</td>
<td>12,921,000</td>
</tr>
<tr>
<td>22 Increase in reserves for life, accident and health contracts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Total underwritings deductions (Lines 18 through 22)</td>
<td>167,366,000</td>
<td>234,806,000</td>
</tr>
<tr>
<td>24 Net underwritings gain or (loss) (Lines 8 minus 23)</td>
<td>15,948,000</td>
<td>922,000</td>
</tr>
<tr>
<td>25 Net investment income earned</td>
<td>57,000</td>
<td>(129,000)</td>
</tr>
<tr>
<td>26 Net realized capital gains or (losses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Net investment gains or (losses) (Lines 25 plus 26)</td>
<td>57,000</td>
<td>(129,000)</td>
</tr>
<tr>
<td>28 Net gain or (loss) from agents’ or premium balances charged off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Aggregate write-ins for other income or expenses (Line 2996)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Net income or (loss) before federal income taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Lines 24 plus 27 plus 28 plus 29)</td>
<td>16,003,000</td>
<td>793,000</td>
</tr>
<tr>
<td>31 Federal and foreign income taxes incurred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Net income (loss) (Lines 30 minus 31)</td>
<td>16,003,000</td>
<td>793,000</td>
</tr>
</tbody>
</table>

RRC noted the programs reported in column 10 (PMAP) of the Minnesota Supplement Report #1 varied significantly from 2010 to 2011.

The 2011 PMAP member months, revenues and expenses are higher in 2011 for various reasons. According to the Minnesota Department of Human Services website, the GAMC program ended February 28, 2011. Enrollees were automatically moved to Medical
Assistance (MA), Minnesota's Medicaid program. In 2010, the GAMC program information was reflected in a separate column. In 2011, Minnesota participated in the Medicaid Expansion. The majority of the increases can be attributed to Medicaid Expansion.

In 2011, Column 10 contained PMAP results (which included Medicaid Expansion) plus GAMC run-off expenses and was labeled "PMAP". In 2010, Column 10 contained PMAP results only and was labeled "PMAP".

2. Verify the Minnesota Supplement Report #1 was completed in accordance with all instructions currently effective set forth by the Minnesota Department of Health.

See Appendix 3 & 4.

RRC obtained the Minnesota Supplement Report #1 instructions. An example of the Minnesota Supplement Report #1 can be found in Appendix 3 and the instructions can be found in Appendix 4.

The instructions state: “All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.” The Minnesota Supplement Report #1 reconciles to the annual statement.

The instructions also state the primary MN Statute reference for MN Supplement Report #1 is §62D.08. See Appendix 2 for §62D.08.

According to §62D.08 Subd. 7(b) “Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health”.

HPI completed the Amended 2011 MN Supplement Report #1 in accordance with the instructions. "All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing”.

HPI also completed the instructions according to MN Statute §62D.08 Subd. 7(b) in regards to the reporting and allocation of investment income.

3. Perform an analytical review comparing the 2010 and 2011 MN Supplement Reports and research any significant fluctuations.

An analytical review was performed comparing the 2010 and Amended MN Supplement Report #1. Any fluctuations greater than 20% AND the individual programs materiality were identified and sent to HPI for explanation. Materiality was calculated for the individual programs based on 5% of the individual programs' net income (rounded). i.e. materiality for MN Senior Health Options (MSHO) = $9,237,000 (2011 net income) * 5% = $461,850 rounded to $461,900.
In 2011, HPI changed the way they reported allocations to claims adjustment expenses and general administrative expenses to be consistent with the new Medical Loss Ratio (MLR) reporting requirements stemming from the Affordable Care Act. The changes were related to those expenses considered by the Affordable Care Act MLR reporting requirements, related to “Improving Health Care Quality Expenses”.

In 2010 (as in prior years), HPI used its own internal definitions to determine what expense categories were considered to be related to “Improving Health Care Quality Expenses”. In 2011, HPI modified what expense categories were considered to be related to “Improving Health Care Quality Expenses” to those categories defined in the Affordable Care Act MLR reporting criteria. This had the impact of an increase in claims adjustment costs across all Medicare and Medicaid products. However, that increase had a corresponding decrease in general administrative expenses and no impact for the financial results of the Medicaid programs, or on the administrative expenses that were reported for the Medicaid program. When a variance analysis is performed where claims adjustment expenses are combined with general administrative expenses and looked at as a total claims expense figure, the variances are mitigated. HPI total claims adjustment expenses were $28,935,000 in 2011 and were $28,736,000 in 2010. According to the Company, the reason for this increase, coupled with the change in methodology of allocating claims adjustment expenses, was related to HPI's continued investment in Health Improvement costs such as Disease Management, Case Management and Quality and Utilization Management.

For the most part the Company's responses to the questions related to the significant fluctuations appeared reasonable. Significant differences of note include:

**Medicare + Choice (Medicare Advantage):**
In 2011, HPI eliminated this Medicare Advantage product. All members in this program were given the opportunity to move to the HPI Medicare Cost products. The elimination of this program significantly reduced premium revenue in the MSC+ Column (Column 5) of the Amended 2011 Minnesota Supplement Report #1 from $12,629,000 in 2010 to $1,270,000 in 2011. In 2011 all that remained in the MSC+ Column was the stand alone Medicare Part D program whereas in 2011 this column contained results for both the stand alone Medicare Part D program and the Medicare Advantage program.

**MSHO:**
In 2011 there were large fluctuations (increases in claim adjustment expenses and decreases in general administration expenses) in the MSHO program. MSHO claims adjustment expenses increased from $1,658,000 in 2010 to $2,335,000 in 2011. MSHO general administrative expenses decreased from $8,930,000 in 2010 to $4,236,000 in 2011. This was attributed to the change in the way the Company reported allocations to these two expense categories, as previously noted.

Total administrative expenses for MSHO decreased from $7,588,000 in 2010 to $6,571,000 in 2011. The primary reason for this decrease was that HPI did not allocate taxes and assessments to MSHO in 2011 as it is a Medicare Advantage program and there should not be any taxes allocated to it. In previous years (2010 and prior) HPI allocated MSHO a
portion of taxes. The decrease was $1,300,000 in MSHO administrative expenses in 2011 due to this tax treatment change.

MSHO showed improved financials in 2011 due to the removal of taxes as described above as well as claim trends from 2010 were only .63% where as revenue increased 3.15%. The low claim trends improved the Medical Loss Ratio for 2011.

PMAP
In 2011 there were large fluctuations (large percentage increases in claim adjustment expenses and lesser percentage increases in general administration expenses) in the PMAP program. PMAP claims adjustment expenses increased from $2,623,000 in 2010 to $5,366,000 (49% increase) in 2011. PMAP general administrative expenses increased from $9,381,000 in 2010 to $12,921,000 in 2011 (27% increase). This was primarily because HPI changed the way they reported allocations to these two expense categories (as previously noted) plus the increases driven by the addition of the Medicaid Expansion population to PMAP in 2011.

The PMAP prescription drug expenses increased 60% from $13 million in 2010 to $20.1 million in 2011. The increase in expenses for pharmacy in 2011 is also attributable to the new Medicaid Expansion program. The Pharmacy PMPM's for the Medicaid Expansion population was $98.40 PMPM compared to HP Care MA which is only $27.65. Most of the Medicaid Expansion population is coming from the General Assistance Medicaid program (GAMC) which also had high Pharmacy PMPM's. In 2011 the PMAP column included Medicaid Expansion, HP Care MA, and some GAMC run-off expenses where in 2010 it only included HP Care MA.

Total administrative expenses for PMAP increased from $12,004,000 in 2010 to $18,287,000 in 2011. The primary reason for this increase was the addition of the Medicaid Expansion program.

MNCare
In 2011 there were large fluctuations (increases in claim adjustment expenses and decreases in general administration expenses) in the MNCare program. MNCare claims adjustment expenses increased from $1,258,000 in 2010 to $2,034,000 in 2011. MNCare general administrative expenses decreased from $4,501,000 in 2010 to $4,164,000 in 2011. This was because HPI changed the way they reported allocations to these two expense categories (as previously noted).

The MNCare program had a net underwriting loss $215,000 in 2010 and a net underwriting loss of $627,000 in 2011. In 2011 the MNCare product was impacted by membership moving to the new Medicaid Expansion product. As a result premium revenue PMPM's decreased 9.31% where as underwriting expenses PMPM only decreased 8.84%. This difference contributed to the MNCare program decreased earnings in 2011.
MSC+
In 2011 there were large fluctuations (increases in claim adjustment expenses and decreases in general administration expenses) in the MSC+ program. MSC+ claims adjustment expenses increased from $293,000 in 2010 to $397,000 in 2011. MSC+ general administrative expenses decreased from $1,050,000 in 2010 to $998,000 in 2011. As previously noted, this was caused by the changes implemented by HPI in the way it allocates various items between claims adjustment expenses and administrative expenses.

The reason for the increased underwriting gain in 2011 in the MSC+ program was due to claim trends actually decreasing 1.58% from 2010. Coupled with an increase in premium revenue of 3.73%, the underwriting gain for this program increased significantly in 2011. According to the Company, in 2011, claim trends across all HPI product lines were around 1% from 2010. This contributed to the significant underwriting gain that all HPI products saw in 2011.

Commercial
HPI Commercial net reinsurance recoveries decreased from $1.0 million in 2010 to $46K in 2011. This was caused by the low claim trends for 2011. HPI only had one reinsurance recovery in 2011. In addition HPI increased its reinsurance limits from $2,250,000 to $2,500,000 from 2010 to 2011.

The primary reason for the financial improvement was the positive claim trends that HPI saw in 2011. According to the Company, the overall claim trends were around 1% in 2011 compared to premium trends around 2%. This difference contributed significantly to HPI’s positive financial performance for its Commercial insurance line of business.

4. Review (by total) the MN Supplement Report to the Expense page of the Statutory Annual Statement. Review the expense categories in terms of:

- Expense allocation between legal entities is consistent with the Statement of Statutory Accounting Principles Appendix A-440 (fair and reasonable) and SSAP No. 70 "Allocation of Expenses".

- Identify expense allocation between public and private programs.

- Perform analytical review and/or testing by sampling various expense categories to determine if expenses were accounted for in accordance with the entity’s expense allocation agreements and guidelines.

We obtained the 2011 expense detail from HPI. The $122,400,000 expense detail provided was tied to the Underwriting and Investment Income Exhibit Part 3 – Analysis of Expenses in the 2011 annual statement for completeness.

The HealthPartners family of Companies (HPI) consists of approximately 30 different legal entities. These companies are supported centrally by administrative departments that are
expensed through the Group Health Plan, Inc. (GHI) corporation. GHI uses an administrative model to allocate these administrative expenses across companies, divisions and at a product or line of business level. HPI's businesses are organized by corporation (Health Plan, Hospital and Foundations) and by divisions within each corporation. Examples of these divisions are the HealthPartners Medical Group, HealthPartners Pharmacy Division, HealthPartners Dental Group, Foundations, Health Plans and Administration Divisions. Each of these divisions consists of accounting units (A/Us) which accumulate the revenue and each business unit within HPI companies. A/Us are expensed centrally through GHI and then used in the HPI administration allocation model. Each A/U is given an attribute within the HPI financial system to determine whether it is either an administrative expense or a hospital medical expense. A/Us can only be an administrative expenses type or a medical expense type, but not both.

A/Us include the following areas:
- Presidents Division
- Chief Health Officer Division
- Health Plan Administration Division
- Finance Division
- Health Plan Operations Division
- Information Services Division
- Marketing/Sales and Member Communications Division
- Health Plan Medical Management and Contracting Division
- Taxes and Assessments (include: Minnesota Comprehensive Health Association, Medical Care Surcharge, Premium Taxes and Income Taxes)

Once an A/U has been identified as an administrative expense type it is included in the HPI administration model which allocates those costs across corporations, operating divisions and across product lines that are disclosed in the HPI statutory filings. The model allocates based on a number of methods depending on the function of the A/U. The allocation methods include:

- Direct allocation to a product line
- Member Months
- Weighted Member Months
- Claim Counts Employee Counts – Full Time Equivalents (FTEs)
- Square Footage
- Annual Interviews with A/U owners to determine best allocation method

The HPI expense allocation model is broken into three sections.

- Section I of the model allocates administrative costs by corporations from GHI to HPI, HealthPartners Administrators, Inc., HealthPartners Insurance Company, HealthPartners Services, Inc. and HealthPartners Associates, Inc. Each A/U is reviewed each year to determine the best allocation methodology to allocate across corporations.
• Section 2 of the model allocates administrative costs that remain in GHI, after allocating administrative costs to the various corporations, by operating division within GHI. These divisions include the HealthPartners Medical Group, HealthPartners Dental Group and Pharmacy Operations. Each A/U is reviewed each year to determine the best allocation methodology to allocate across operating Division.

• Section 3 of the model allocates all administrative costs that are allocated to HPI and the remaining administrative costs on GHI, after allocating to corporations and operating divisions, by the products that HPI and GHI sell. These products include Commercial, Medicare and Medicaid products (by program: PMAP, MNCare, MSHO, MSC+, etc.). Each A/u is reviewed each year to determine the best allocation methodology to allocate across each product/program that HPI and GHI offers.

The expense allocation model was developed in the late 1980’s and is updated each year HPI Finance staff interviews each A/U owner to determine if the current allocation methodology used is still the best method and to reflect changes in the business.

The results of our analytical review and testing of samples of various expense categories show that HPI appears to be allocating expenses in a manner consistent with their expense allocation methodology and model, according to the NAIC Accounting Practices and Procedures Manual - Appendix A-440 and in a manner consistent with SSAP No. 70 "Allocation of Expenses" and Minnesota Statute §62D.08.

The results of our analytical review show HPI appears to be allocating expenses between public and private programs appropriately.

RRC performed an analytical review and tested by sampling various expense categories to determine if expenses were accounted for in accordance with the entity’s expense agreements and guidelines.

The description below is the process we used to meet this objective of our review.

• We obtained and reviewed copies of the Intercompany Agreements from HPI, the 2012 Master Intercompany Agreement and the MNDOC Non-Disapproval Letter re: Form D dated 3.7.12.

• We also obtained and reviewed HPI Admin Model Description document and notes from an August 23, 2012 meeting attended by members of the RRC team and HPI representatives where the Admin Model was discussed in detail.

• We also obtained and reviewed the HPI Administrative Allocation EXCEL Workbook that contains 10 tabs.

• From Tab one of the HPI Administrative Allocation Workbook we selected a sample of 12 allocated expense items and requested supporting detail for each item for
testing purposes for the months of June and December 2011. The selection was done by judgmentally selecting large dollar items in various key Operating Divisions.

- For each sample selected HPI provided an Excel workbook containing the expense account totals for each Accounting Unit selected with the selected accounts highlighted, the GL detail for each selected account and the AP detail for each selected account for the months of June and December.

- HPI also provided another workbook that is a cross walk table for each of the sample selection. The first tab shows how the entire amount of the Accounting Unit (A/U) (e.g. Legal, Underwriting, Government Programs, etc.) is allocated to the various corporations and then the summary level products. The second tab shows how the expense totals for each A/U selected are allocated to just the HPI corporations’ products. The expense account totals for each A/U selected on tab 1 of each workbook for the twelve samples tied to the 2011 expense totals for each A/U on this spreadsheet. And the GL and AP detail for each A/U for the months of June and December tied to each other.

- HPI uses various methods to allocate administrative expenses. For the twelve samples tested most were allocated based on member months or claim counts. For Underwriting, the method of allocation is based on input directly from the Underwriting Department on an annual basis and is based on the mix of business HPI underwrites in a given year. For Government programs, allocations are based on direct input from the Director of Government programs who established an allocation percentage for Medicare and for Medicaid programs as they staff in this group works on both. The Allocation methodology for member months had many variations and we sent a request to HPI to elaborate on the differences between the types on member month allocation methodologies and to explain why they are used for specific A/Us. Their answers to our questions appeared reasonable.

- For all twelve samples tested the allocation methodology was applied correctly and the percentages of each A/U total expenses by program and product calculated to the correct percentages per the HPI Allocation Model.

The only difference that was noted was an immaterial difference in the member months used in the model versus the member months used on the Minnesota Supplement Report #1 for 2011. The Company explained the difference was due to the fact that HPI’s administrative allocation model uses a snapshot of membership counts at exactly midnight on December 31, 2011. For the HPI Minnesota Supplement Report #1, the Company uses a membership count from the Sales and Marketing department which takes into consideration any retro membership changes that occur in January and are added to the number from the 12/31/2011 snap shot membership count. We concluded the explanation was reasonable.
In addition to requesting samples for 12 Allocated Expense A/Us we selected in our expense sample request, we selected three additional expense categories for unallocated expenses. We checked the amounts in these A/Us and confirmed they were not allocated.

From this analysis and testing we concluded it appears HPI expenses were accounted for in accordance with the entity's expense allocation agreements and guidelines.

5. Verify appropriateness with regards to the establishment of any Premium Deficiency Reserves allocated to the public programs.

RRC conducted a review to verify the appropriateness with regards to HPI's establishment of any Premium Deficiency Reserve (PDR) allocated to public programs.

HPI assesses the need for a PDR by reviewing internal Product Line Reports. If the Medical Loss Ratio (MLR) for the current year, excluding administration expenses for the selected grouping is less than 100%, then a PDR is deemed unnecessary. This review is supplemented by discussions amongst the Finance, Actuarial and Underwriting Departments. HPI determined that a PDR was not necessary as of December 31, 2011. The Appointed Actuary, Steven H. Mahan, FSA, MAAA, confirmed the Company's conclusion in his "Actuarial Memorandum in Support of the Actuarial Statement of Opinion" as of December 31, 2011. RRC was provided with the Product Line Reports as of December 31, 2011 as well as the Actuarial Memorandum.

As of December 31, 2011, the Company determined that it did not require accrual of a PDR liability, which we agree is a reasonable conclusion. However, the manner in which the Company made this determination is not reasonable. The Company's analysis was not documented and appeared to be informal in nature. We also note that the approach taken by the Company is retrospective in nature. The reports on the prior year are reviewed and are supplemented by subjective insights. It can be argued that a prospective view, such as that found in forecasts, would be more appropriate and precise as well as adhering to generally accepted actuarial principles. The current approach relies heavily on judgment as well as the idea that results for the previous year is an accurate predictor of the next year's results.

We recommend that the Company formalize its analysis related to determining the need for a premium deficiency, including documentation of the analysis for future review by auditors, its actuary as well as regulators. We also recommend that the analysis include both retrospective and prospective analysis, including the use of financial projections of the profitability of its public programs.
The following is a summary of the Profitability Analysis provided by the Company.

<table>
<thead>
<tr>
<th>HealthPartners, Inc.</th>
<th>Net Income / (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Program Product Profitability</td>
<td></td>
</tr>
<tr>
<td>Calendar Year 2011</td>
<td></td>
</tr>
<tr>
<td>HP Care Medical Assistance</td>
<td>$4,106,957</td>
</tr>
<tr>
<td>HP MSC</td>
<td>2,819,020</td>
</tr>
<tr>
<td>HP Care General Assistance Medical Care</td>
<td>(142,579)</td>
</tr>
<tr>
<td>HP Medicaid Expansion</td>
<td>866,092</td>
</tr>
<tr>
<td>HP MinnesotaCare</td>
<td>(626,658)</td>
</tr>
<tr>
<td>HP Minnesota Senior Health Options</td>
<td>9,144,129</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$16,166,961</strong></td>
</tr>
</tbody>
</table>

Statement of Standard Accountancy Practice ("SSAP") No. 54, paragraph 18 states:

“For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured.”

The Company combines all public programs for the purpose of assessing the need for a premium deficiency. SSAP No. 54 requires policies to be grouped in a manner consistent with how policies are marketed, serviced and measured, for purposes of determining if a premium deficiency exists. The above approach is consistent with that seen during the Financial Examination as of December 31, 2009, performed by MNDOC. The Company has a separate contract with the State of Minnesota, acting through its Department of Human Services covering PMAP and MNCare services. In addition, the Company has a separate contract covering MSHO and MSC+ services together. Grouping the premium deficiency analysis according to this grouping would be a more transparent approach to comply with SSAP No.54. Grouping all public programs together under the assumption that they are marketed, serviced and measured consistently is not reasonable. If the Company had grouped its public programs according to the contracts with the State covering these services, a determination would have still been that no PDR was necessary at 2011. However, this conclusion of whether or not to accrue a premium deficiency could be different in subsequent years depending on the grouping implemented by the Company.
We recommend that the Company work with the Department to determine an appropriate grouping of its public programs in determining whether a premium deficiency is required in accordance with SSAP No. 54.


RRC conducted a retrospective review of the Incurred But Not Reported (IBNR) Claim Reserves for HPI.

The Company's reserving methodology involves the use of the Developmental Method, also referred to as the Lag Factor Method, developed on a Generally Accepted Accounting Principles (GAAP) basis, with adjustments to convert to a statutory basis of accounting. A variety of data sources and supplementary information are reviewed to determine the adjustments necessary for conversion to Statutory basis of accounting. Best estimates are made, with explicit load, representing both a margin for adverse claim deviation and Loss Adjustment Expense ("LAE"), is applied. As represented to RRC's actuary, the Company's estimates do not incorporate implicit margins.

For the initial GAAP unpaid claims liability (UCL) estimates, reserving cells are service types within each related legal entity (Group Health Plan, Inc.; HealthPartners, Inc.; HealthPartners Insurance Company). The splits differ for Statutory UCL estimates. The Statutory UCL estimates are adjusted to match the GAAP amounts. The adjustment is typically small and immaterial. The methodology employed appears reasonable and appropriate. It follows generally accepted actuarial practice for coverages with a relatively short time period between the incurred date and payment of claims. Further, it is consistent with that seen during the Financial Examination as of December 31, 2009 performed by MNDOC.

7. Compare the 2010 run-out provided to the Department of Human Services in 2011 to the retrospective review of reserves.

RRC conducted a review of the HPI Unpaid Claim Liabilities (UCL) as of December 31, 2010 using data through May 2012.

For HPI, claim lag data is summarized on an incurred-and-processed basis, as opposed to an incurred-and-paid basis. The Company treats processed claims as paid claims and the lag period between a processed and paid claim is very small.

For GHI and HPI, the Company applies a 12.5% load to their Best Estimates consisting of a 10.0% margin for adverse claim deviation and a 2.5% Loss Adjustment Expense (LAE). We concluded that these margins were abnormally high when considering historic redundancies and profitability analysis of the company's public programs.
### HealthPartners, Inc.
Unpaid Claim Liabilities as of December 31, 2010
Data Through May 2012

<table>
<thead>
<tr>
<th></th>
<th>Initial Estimate</th>
<th>Restated Liability</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNCare Total*</td>
<td>$4,459,429</td>
<td>$3,389,207</td>
<td>(24.0%)</td>
</tr>
<tr>
<td>HP MSC</td>
<td>1,273,604</td>
<td>1,525,854</td>
<td>19.8%</td>
</tr>
<tr>
<td>HP Care General Assistance Medical Care</td>
<td>120,500</td>
<td>(25,589)</td>
<td>-----</td>
</tr>
<tr>
<td>PMAP Adults w/o Children</td>
<td>$0</td>
<td>$0</td>
<td>-----</td>
</tr>
<tr>
<td>PMAP Families and Children</td>
<td>12,195,437</td>
<td>9,776,075</td>
<td>(19.8%)</td>
</tr>
<tr>
<td>PMAP Total</td>
<td>$12,195,437</td>
<td>$9,776,075</td>
<td>(19.8%)</td>
</tr>
<tr>
<td>HP Minnesota Senior Health Options</td>
<td>5,591,526</td>
<td>5,912,097</td>
<td>5.7%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$23,640,496</strong></td>
<td><strong>$20,577,644</strong></td>
<td><strong>(13.0%)</strong></td>
</tr>
</tbody>
</table>

* Prior to 2011, data was submitted for Total MNCare (MNCare Families & Children and MNCare Adults without Children)

### HealthPartners, Inc.
Unpaid Claim Liabilities as of December 31, 2011
Data Through May 2012

<table>
<thead>
<tr>
<th></th>
<th>Initial Estimate</th>
<th>Restated Liability</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNCare Adults w/o Children</td>
<td>$1,000,000</td>
<td>$1,007,003</td>
<td>0.7%</td>
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<tr>
<td>MNCare Families and Children</td>
<td>2,385,767</td>
<td>1,524,825</td>
<td>(36.1%)</td>
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<tr>
<td>MNCare Total</td>
<td>$3,385,767</td>
<td>$2,531,828</td>
<td>(25.2%)</td>
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<tr>
<td>HP MSC</td>
<td>$1,401,936</td>
<td>$1,512,597</td>
<td>7.9%</td>
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<tr>
<td>HP Care General Assistance Medical Care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>PMAP Adults w/o Children</td>
<td>$4,740,000</td>
<td>$4,856,947</td>
<td>2.5%</td>
</tr>
<tr>
<td>PMAP Families and Children</td>
<td>9,235,290</td>
<td>11,342,191</td>
<td>22.8%</td>
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<tr>
<td>PMAP Total</td>
<td>$13,975,290</td>
<td>$16,199,138</td>
<td>15.9%</td>
</tr>
<tr>
<td>HP Minnesota Senior Health Options</td>
<td>6,250,344</td>
<td>6,046,408</td>
<td>(3.3%)</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$25,013,337</strong></td>
<td><strong>$26,289,971</strong></td>
<td><strong>5.1%</strong></td>
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</table>

Based upon the information provided, the December 31, 2010 estimates in total were redundant by 13.0%, which can be viewed as almost entirely related to the 12.5% explicit margin. Estimates as of December 31, 2011 were deficient by 5.1%. There are wide
variations with respect to accuracy within the public product line reserve established as of 2011 and the subsequent year run-off of related claims.
Appendix 1 – Executive Order 11-06
STATE OF MINNESOTA
EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 11-06
Creating Public Disclosure for
Minnesota's Managed Care Health Care Programs

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, over 500,000 Minnesotans receiving public health insurance coverage are enrolled in managed care; and

Whereas, the State spends approximately $3 billion annually on purchasing health care from managed care plans for state public programs; and

Whereas, it is critical for public trust that Minnesota's taxpayers understand how public dollars for health care are being used; and

Whereas, the State needs greater disclosure and accountability of managed care plan spending on health care and long-term care services and administrative expenses for state public programs;

Now, Therefore, I hereby order the Commissioner of Human Services to:

1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.

2. Develop an annual comprehensive managed care report in consultation with the Commissioners of Health and Commerce that includes detailed information on administrative expenses, premium revenues, provider payments and reimbursement
rates, contributions to reserves, enrollee quality measures, service costs and utilization, enrollee access to services, capitation rate-setting and risk adjustment methods, and managed care procurement and contracting processes.

3. Submit data from the managed care plans for state public programs to the Commissioner of Commerce so that regular financial audits of data will be conducted.

Under Minnesota Statutes, section 4.035, subdivision 2, this Executive Order is effective 15 days after publication in the State Register and filing with the Secretary of State.

In Testimony Whereof, I have set my hand on March 23, 2011.

Mark Dayton
Governor

Filed According to Law:

Mark Ritchie
Secretary of State
Appendix 2 – Minnesota Statutes §62D.08 and 256B.69, subd 9c

62D.08 ANNUAL REPORT.

Subdivision 1. Notice of changes.

A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q), (r), (s), and (t) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 60 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Subd. 2. Annual report required.

Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health covering the preceding calendar year. However, utilization data required under subdivision 3, clause (c), shall be filed on or before July 1.

Subd. 3. Report requirements.

Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of health;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization,
including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(c) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; and

(f) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Subd. 4. Penalty; extension for good cause.

Any health maintenance organization which fails to file a verified report with the commissioner on or before April 1 of the year due shall be subject to the levy of a fine up to $500 for each day the report is past due. This failure will serve as a basis for other disciplinary action against the organization, including suspension or revocation, in accordance with sections 62D.15 to 62D.17. The commissioner may grant an extension of the reporting deadline upon good cause shown by the health maintenance organization. Any fine levied or disciplinary action taken against the organization under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 to 14.69.

Subd. 5. Changes in participating entities; penalty.

Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner 120 days before the effective date. When the health maintenance organization terminates a provider for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within ten working days of the date the health maintenance organization sends out or receives the notice of cancellation, discontinuance, or termination. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $200 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Subd. 6. Financial statements.

A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization for the first three quarters of the year on forms prescribed by the commissioner. The statements are due 30 days after the end of the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.
Subd. 7. Consistent administrative expenses and investment income reporting.

(a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

256B.69 PREPAID HEALTH PLANS.

Subd. 9c. Managed care financial reporting.

(a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

1. administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;
2. revenues by program, including investment income;
3. nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:
   (i) individual-level provider payment and reimbursement rate data;
(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and
(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.
### Appendix 3 – Minnesota Supplement Report #1

**Minnesota Supplement Report #1**

**STATEMENT OF REVENUE, EXPENSES AND NET INCOME**

For the year ending December 31, 2011

Public Information, Minnesota Statutes § 62C.05

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<th>NAIC Description</th>
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<th>Cost</th>
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<td>2 Net Premium Income (including $non-health premium income)</td>
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<td>3 Change in unpaid premium reserves and reserve for late credits</td>
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<td>5 Risk revenue</td>
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<td>6 Aggregate activities for other health care related revenues (Line 699)</td>
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<td>7 Aggregate activities for other non-health revenues (Line 799)</td>
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<td>9 Hospital/medical benefits</td>
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<td>10 Other professional services</td>
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<td>11 Medical services</td>
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<td>12 Ambulance and out-of-area</td>
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<td>13 Prescription drugs</td>
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<td>15 Aggregate Paid and Written Adjustments</td>
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<td>16 TOTAL EXPENSES (Lines 9 through 15)</td>
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<td>18 Net investment gains (Line 14 minus 17)</td>
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<td>26 Net investment gains or losses (Line 25 minus 26)</td>
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</tr>
<tr>
<td>27 Net investment gains or losses (Line 25 plus 26)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>28 Net income or loss before federal income taxes (Line 27 minus 25 plus 26)</td>
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<td>NR</td>
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<tr>
<td>29 Federal income taxes</td>
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</tr>
<tr>
<td>30 Net income or loss before federal income taxes (Line 28 plus 29 minus 30)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>31 Net income (loss) (Line 30 minus 31)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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</tr>
</tbody>
</table>

31
Appendix 4 – MN HMO Instructions

Date: December 1, 2011

To: Minnesota Domiciled Health Maintenance Organizations and County Based Purchasers

From: Mike Rothman, Commissioner
Minnesota Department of Commerce

Subject: Filing of Annual Statement, Supplements, Exhibits, Certificates and Reports

Contacts: Minnesota Department of Commerce
Constance Peterson, Constance Peterson@state.mn.us (651)297-8943
Robert Rivera, Robert Rivera@state.mn.us (651)296-4523 (Questions about Medical Necessity Evaluation Filing Only)

Minnesota Department of Health
MaryAnn (Fena) Benke, MaryAnn.Benke@state.mn.us (651)201-5164

NAIC Instructions and Blanks

The National Association of Insurance Commissioners (NAIC) Annual Statement health blank is required to be filed with the Department of Commerce no later than 4/1/12 per Minnesota Statutes §62D.08. Refer to the following table for details regarding the Annual Statement filing and other required filings for the year 2012:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Copies</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Statement (hard copy)</td>
<td>5</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 2 &amp; 3</td>
<td></td>
</tr>
<tr>
<td>Annual Statement (electronic filing)</td>
<td>1</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 2 &amp; 3</td>
<td>Those organizations not filing electronically with the NAIC are required to file the Annual Statement in PDF format in addition to the required hard copies.</td>
</tr>
<tr>
<td>Investment Policy Certification</td>
<td>5</td>
<td>4/1/12</td>
<td>§62D.045, Subd. 2 and §60A.112</td>
<td>Not required for County Based Purchasers.</td>
</tr>
<tr>
<td>Audited Financial Statement</td>
<td>3</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 3(a)</td>
<td></td>
</tr>
<tr>
<td>Risk Based Capital Report</td>
<td>3</td>
<td>4/1/12</td>
<td>§62D.04, Subd. 1(e)</td>
<td></td>
</tr>
</tbody>
</table>
| Notification of Change in Appointed Actuary | 1                | Within 5 business days | §62D.08, Subd. 2 & 3 | According to the NAIC Annual Statement Instructions, documentation for a newly appointed actuary needs to include the following:
  - The insurer shall provide the Commissioner with a letter within 10 business days stating whether, in the preceding 24 months, there were any disagreements with the former actuary.
  - The insurer shall request the former actuary to furnish a letter addressed to the insurer stating whether the actuary |
<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Copies</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Additional Notes</th>
</tr>
</thead>
</table>
| Quarterly Financial Statements (hard copy)       | 4                | 4/30, 7/30 and 10/30      | $62D.08, Subd. 6            | agrees or disagrees with the statements contained in the insurer’s letter, to be forwarded to the Commissioner.  
- Please provide the requested information electronically by emailing it to a special email box we have established for these appointments (and illustration actuary filings): insurance.actuary@state.mn.us |
| Quarterly Financial Statements (electronic filing) | 1                | 4/30, 7/30 and 10/30      | $62D.08, Subd. 6            | Those organizations not filing electronically with the NAIC are required to file the Quarterly Statements in PDF format in addition to the required hard copies. |

**Filing Address:** Department of Commerce  
Financial Institutions - Insurance  
85 Seventh Place East, Suite 500  
St. Paul, MN 55101-2198

**Filing Fees:** Health Maintenance Organizations: Send the filing fee of $400 for the Annual Statement and $200 for each Quarterly Statement, payable to the Minnesota Department of Health (not the Minnesota Department of Commerce), to: Managed Care Systems Section, Minnesota Department of Health, P.O. Box 64882, St. Paul, MN 55164-0882 by the filing due dates. County Based Purchasers: Filing fees not required.

**Minnesota Supplemental Reports (excluding HEDIS)**

Pursuant to applicable Minnesota law, complete the following reports. These report forms, with the exception of the HEDIS 2012 Data Submission Tool, can be downloaded from the “HMO Annual Report Forms” link at the bottom of the following Department of Health Web page: www.health.state.mn.us/divs/hpsc/mcs/forms.htm

<table>
<thead>
<tr>
<th>Report</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>4/1/12</td>
<td>$62D.08</td>
<td>Statement of Revenue, Expenses and Net Income</td>
</tr>
<tr>
<td>2.</td>
<td>4/1/12</td>
<td>$4685.2000</td>
<td>Summary of Complaints and Grievances</td>
</tr>
<tr>
<td>3.</td>
<td>4/1/12</td>
<td>§72A.201, Subd. 8(7)</td>
<td>Summary of Chemical Dependency Claims and Appeals</td>
</tr>
<tr>
<td>4.</td>
<td>4/1/12</td>
<td>$62D.08, Subd. 3(d) and 4685.2100D</td>
<td>Participating Providers Listing</td>
</tr>
<tr>
<td>5.</td>
<td>4/1/12</td>
<td>$62M.09, Subd. 9</td>
<td>Medical Necessity Evaluation</td>
</tr>
<tr>
<td>6.</td>
<td>7/1/12</td>
<td>$62D.04(1)(c),(5) &amp; 62D.08</td>
<td>Enrollment Statistics ByProducts and County</td>
</tr>
<tr>
<td>7.</td>
<td>7/1/12</td>
<td>$62D.04(1)(c),(5) &amp; 62D.08</td>
<td>HEDIS 2012 (For Calendar Year 2011) Data Submission Tool (through NCQA). Separate Instructions to Follow.</td>
</tr>
</tbody>
</table>

Instructions for filing the HEDIS data (through NCQA) will be sent from the Minnesota Department of Health under separate cover.

In addition to the electronic copy of the Medical Necessity Evaluation Form filing (Supplemental Report #5) with the Department of Health, e-mail a copy of the filing to Robert Rivera at the Department of Commerce: Robert.Rivera@state.mn.us.
All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.

**Minnesota Supplements Filing Instructions:** It is not necessary to send a paper copy in addition to the electronic submission; none of these reports require a signature. Send the completed Minnesota Supplement forms on a CD to:

**Mailing Address:**
Dedra Johnson  
Managed Care Systems Section  
Minnesota Department of Health  
P.O. Box 64882  
St. Paul, MN  55164-0882

**Courier Address:**
Managed Care Systems Section  
Minnesota Department of Health  
85 Seventh Place East, Suite 220  
St. Paul, MN  55101
Appendix 7 – Minnesota Senior Care Plus (MSC+) Map
Health Plan Choices by County Effective April 1, 2011

[Map of Minnesota showing health plan choices by county]

Legend:
- One Plan Choice
- Two Plan Choices
- Three Plan Choices
- Four Plan Choices
- Five Plan Choices

BP = Blue Plus
HP = HealthPartners
IMC = Itasca Medical Care
MED = Medica
MHP = Metropolitan Health Plan
PW = PrimeWest Health
SC = South Country Health Alliance
UC = UCare

www.dhs.state.mn.us/healthcare
or
www.dhs.state.mn.us/meds
Addendum to Report

Health Partners Comment Letter
HealthPartners, Inc. (HPI) has reviewed the final audit report related to WORK ORDER CONTRACT NO: 50693 and is providing the following formal public comment letter in response to the two findings included in the final audit report.

Findings #1:

“The Company combines all public programs for the purpose of assessing the need for a premium deficiency. The Company did not provide supporting documentation for its rationale for this grouping or how this grouping methodology was in compliance with SSAP No. 54, which requires policies to be grouped in a manner consistent with how they are marketed, serviced and measured, for purposes of determining if a premium deficiency exists. The Company’s approach is consistent with that seen during the Financial Examination as of December 31, 2009, performed by MNDOC. The Company has a separate contract with the State of Minnesota, acting through its Department of Human Services covering PMPA and MNCare services. In addition, the Company has a separate contract covering MSHO and MSC+ services together. We concluded that grouping the programs in accordance with the contracts entered into with the State for purposes of determining if a premium deficiency exists would be a reasonable approach to comply with SSAP No 54. If the Company had grouped its public programs during 2011 according to the contracts with the State covering these services under each program, a determination would have still been that no PDR was necessary at 2011. However, the current grouping practice of including all programs could have an impact on the adequacy of the Company’s PDR calculation in subsequent years, if certain programs incurred significant underwriting losses.

We recommend that the Company develop documentation supporting its rationale that all public programs should be combined for purposes of determining if a premium deficiency exists and how this methodology is consistent with how policies are marketed, serviced and measured, as required in accordance with SSAP No. 54.”

Comment to Findings #1:

HealthPartners disagrees with this finding. HealthPartners has provided adequate and appropriate documentation to Risk and Regulatory Consulting, LLC (RRC) supporting our position that grouping all Medicaid products together is reasonable for purposes of determining premium deficiency reserves. Specifically, we provided the following information. Marketing of these products is strictly limited by the Minnesota Department of Human Services and any marketing of them is as one group. We have dedicated member services, claims, appeals and grievances, and membership departments specifically supporting these programs. We measure these programs together not separately in our product line reporting, board financial presentations and monthly, quarterly and annual financial statements and have done so historically. Our combining these products for purposes of assessing the need for premium deficiency reserves is therefore consistent with SSAP No. 54.
Findings #2:

"HPI applies a 12.5% load to their best estimates for its Unpaid Claims Liability (UCL) consisting of a 10.0% margin for adverse claim deviation and a 2.5% Loss Adjustment Expense (LAE). The Company has not changed these percentages form the levels applied during the 2009, as noted during the most recent Financial Examination by MNDOC. According to the Company, it had reached an agreement with its prior auditor regarding margins, which was a draw-down of the margin level over a five year period culminating at current levels. HPI feels that the margins it has established in their UCL calculations are consistent with industry averages and provides a reasonable level of comfort that adverse claims run-out experience will not impact future year financial performance. We concluded that while the margins have been reduced significantly since the 2006 Financial Examination by MNDOC, the margins are overly conservative compared to historic redundancies and the varying magnitude of such by reserving category.

Based upon the information provided, the December 31, 2010 UCL for the Company’s public programs in total were redundant by 13.0%. It can be concluded that the majority of the redundancies in the December 31, 2010 UCL is almost entirely related to the 12.5% explicit margin carried by the Company. The UCL for the Company’s public programs as of December 31, 2011 were shown to be a deficient by 5.1%, as of May 31, 2012, the date specific information was requested by MNDOC. There are wide variations within the public product line reserves. For example the PMAP program December 31, 2011 UCL was deficient by $2,223,848, or 15.9%, utilizing data available as of May 31, 2012. The Company indicated that with the PMAP MA program, exceptionally high ranges of completion factors were incurred during 2012 for claims with 2011 dates of service. These types of payments are not picked up in the Company’s normal completion factors with setting IBNR; the margins built into their reserves serve to mitigate such variations.

We recommend that the Company consider varying the margin level for particular blocks of business based upon historic estimation accuracy and anticipated estimation risks. We also recommend that in collaboration with its consideration of an appropriate margin level, the Company review its reserving methodology for public programs as it relates to precision. These suggestions further support the previous recommendation that the Company consider its financial projections of profitability at each public program when determining the need for premium deficiency."

Comment to Findings #2:

HealthPartners disagrees with the statement that our margin for adverse claims deviation is too conservative. HealthPartner’s margins for adverse claims deviation are consistent with industry
standards and are independently certified both by an outside actuary and our independent auditor KPMG. The analysis prepared by RRC shows using claims run-out with perfect hindsight that we missed our initial estimate of unpaid claims by 13% one year and 5% the other direction the following year. This type of change in estimate is the reason for a margin for adverse claims deviation in the calculation of unpaid claims. At December 31 each year we use the best data available to us at that time and determine our best point estimate for unpaid claims liability. We do not believe varying the margin level at a higher level of granularity will add value and improve the estimation of unpaid claims. It actually could have just the opposite effect.
STATE OF MINNESOTA

MEDICA HEALTH PLANS

PROJECT NO: 50686

November 26, 2012
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<td>Appendix 6 - MinnesotaCare (MNCare) map</td>
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<td>Addendum to Report – Medica Comment Letter</td>
<td>29</td>
</tr>
</tbody>
</table>
Executive Summary

The Minnesota Department of Commerce (MNDOC) employed the services of INS Regulatory Services, Inc. (InsRis) to assist it in a review of the Medica Health Plans (MHP, Company). The review included the appropriateness of the Company’s expense allocations to public programs, the appropriateness of established premium deficiency reserves and the retrospective review of reserves established for such public programs. This evaluation was conducted in accordance with Executive Order 11-06 Creating Public Disclosure for Minnesota’s Managed Care Health Care programs issued march 21, 2011 (see Appendix 1), information was also collected as provided in Minn. Statutes Section 256B.69, subd 9c (see Appendix 2). These public programs are provided throughout the State of Minnesota by various Managed Care Organizations (MCO) in Minnesota, including MHP.

Expense Allocations

Appendix A440 of SSAP No. 70, titled Allocation of Expenses, states that any basis adopted to apportion expenses shall be that which yields the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

MHP employs a comprehensive administrative expense allocation process that is documented. The process allocates administrative expense to product, state and legal entity. There are four main components of the allocation to each product:

- Per Member Per Month fees (PMPM)
- Cost center allocations
- Allocation of expense to Medica Insurance Company (MIC) Stop Loss
- Intercompany fees

PMPM Fees

• United Health Group (UHG) Base Fees: MHP pays a fee to UHG for services which include billing and enrollment, claims processing, and accounting. The base fee to UHG is a PMPM fee, which varies by product and is adjusted annually with an indexed increase and an annual deflator specified in the contract. The base fee is adjusted for retroactive membership changes during the current year and for 3 months after year end. See a detail of UHG fees below.

• UHG SLA Withhold: A percentage of the base fee (currently 6.25%) is withheld subject to annual review of UHG’s performance under the service level agreement (SLA). Medica monitors SLA performance throughout the year and adjusts the withhold accrual to reflect the anticipated payout, but the amount is not finalized until March of the following year. The withhold forfeited is allocated to all products based on the base fees.

• UHG Incentive Pool: The UHG contract also provides for an incentive pool (up to 3% of base fees). The incentive payment is based on UHG’s performance on the SLA. Medica accrues for
the estimated incentive pool earnings, but the amount is not finalized until March of the following year. The incentive pool is allocated by product based on the base fees.

• Passport Out of Area Fee: Medica pays UHG an additional per subscriber fee for certain out of area (OOA) members. These fees are charged to the MIC Passport and Large Group Self-Insured products.

• Large Group Call Center Fee: UHG provides call center services to a large group’s members in the Medica service area. Medica pays UHG a monthly fee for these services. This fee is charged to the Large Group Self-Insured product.

• Private Fee for Service (PFFS) Support Fee: Medica pays an additional fee to UHG for support of the Medicare Private Fee for Service product. This fee is allocated among the PFFS products based on membership.

• Prior Year Adjustments: Adjustments to the prior year’s fees due to membership retroactivity are calculated for 3 months following year end. Prior year adjustments may also include adjustments for over or under accrual of prior year SLA withhold and incentive pool. Prior year adjustments of base fees are product-specific. Adjustments to the SLA withhold or incentive pool accruals are allocated in the same manner as current year expenses.

• MIC Stop Loss: Medica pays UHG a fee for the MIC Stop Loss product. The fee is calculated as a percent of revenue.

• Dental Fees: Medica also pays UHG a PMPM fee for dental product members. Fees for all products except State Public Programs and MSHO (products for which Medica has full risk) are billed back to Delta Dental. Since the net expense for these products is zero, the fees are not shown in the allocation schedule.

• Re-pricing Fee: Fee paid to a third party service provider for re-pricing of SelectCare and LaborCare claims. Fees are allocated to the SelectCare and LaborCare products based on member months.

• DHS TPA Fee: Fee paid to Minnesota DHS for MSHO and SNBC members per contractual agreement. Fees are allocated to the MSHO and SNBC products based on PMPM.

• Medicare Part D fee: Medica pays for UHG an additional PMPM fee for Medicare Part D members.

Cost Center Allocations

With the exception of regulatory costs and most Medica Health Management (MHM) costs, the remaining administrative expenses originate in MHP. They are allocated to market business segments or product groups to determine a PMPM which is then used to further distribute costs to a product and state level. The majority of costs originating in MHP are allocated to all of the Medica entities; however, there are a few costs which are not allocated to all entities, as well as
regulatory costs which are charged directly to the appropriate entity. This can result in several PMPMs which are combined to determine the total cost for a product.

The allocation of these expenses is done at the cost center level, using various methods. Some support cost centers (Human Resources, Facilities and a portion of Information Technology and Finance) are allocated to all of the other cost centers. Other methods include time-based allocations and allocations based on member months, claims volume or call volume. MHP finance staff meets annually with a representative of each cost center to review the allocation method.

The majority of MHM costs are captured in specific cost centers which are charged directly to MHM. However, they are allocated their share of the support cost centers listed above.

MIC Stop Loss Expense: After the cost center allocation is completed, a portion of the MSI Large Group expense is reallocated to the MIC Stop Loss product. The Stop Loss expense is calculated based on fully insured cost center allocations as a percentage of revenue. This percentage is applied to Stop Loss revenue to determine the Stop Loss administrative expense.

Intercompany Fees

Medica Insurance Company (MIC), Medica Self-Insured (MSI), Medica Health Plans of Wisconsin (MHPW) and Medica Health Management (MHM) are each charged a fee for their allocated share of MHP’s expense (“cost center allocations” and MIC stop loss allocation).

The results of our analytical review and testing of samples of various expense categories show that MHP appears to be allocating expenses in a manner consistent with their expense allocation methodology and model, in accordance with the *NAIC Accounting Practices and Procedures Manual - Appendix A-440* and in a manner consistent with SSAP No. 70 "Allocation of Expenses".

**Premium Deficiency Reserves**

According to SSAP No. 54 *Individual and Group Accident and Health Contracts*, when the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started.

As of December 31, 2011 and 2010, MHP had premium deficiency reserves for all lines of business of $37.2 million and $19.9 million, respectively. The breakdown of the 2011 deficiency reserves is as follows:
<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Total 2011 Premium Deficiency Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepaid Medical Assistance Program (PMAP)</td>
<td>$ 4,500,000</td>
</tr>
<tr>
<td>MNCare</td>
<td>14,000,000</td>
</tr>
<tr>
<td>CompleteSolutions (Commercial)</td>
<td>475,000</td>
</tr>
<tr>
<td>Special Needs Basic Care (SNBC)</td>
<td>17,800,000</td>
</tr>
<tr>
<td>Medicare Fee For Service (FSS)</td>
<td>425,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 37,200,000</strong></td>
</tr>
</tbody>
</table>

**Reserves** – According to SSAP No. 54 “Individual and Group Accident and Health Contracts”, claim reserves shall be accrued for estimated costs of future health care services to be rendered that the reporting entity is currently obligated to provide or reimburse as a result of premiums earned to date that would be payable after the reporting date under the terms of the arrangements, regulatory requirements or other requirements if the insured’s illness were to continue.

According to the 2011 Annual Statement, reserves for claims attributable to the events of prior years have decreased from $151.5 million in 2010 to $144.9 in 2011.

<table>
<thead>
<tr>
<th>Annual Statement Liability Line Item</th>
<th>Description</th>
<th>12/31/2011 balance (000)</th>
<th>12/31/2010 balance (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Claims unpaid</td>
<td>$ 133,558</td>
<td>$ 148,653</td>
</tr>
<tr>
<td>2</td>
<td>Accrued medical incentive pool and bonus amounts</td>
<td>$ 11,388</td>
<td>$ 2,903</td>
</tr>
<tr>
<td>1, 2</td>
<td>Total claims payable</td>
<td>$ 144,946</td>
<td>$ 151,557</td>
</tr>
<tr>
<td>3</td>
<td>Unpaid claim adjustment expenses</td>
<td>$ 4,208</td>
<td>$ 3,932</td>
</tr>
<tr>
<td>4</td>
<td>Aggregate health policy reserves</td>
<td>$ 37,643</td>
<td>$ 14,073</td>
</tr>
<tr>
<td>9</td>
<td>Aggregate health claim reserves</td>
<td>$ 29,908</td>
<td>$ 28,979</td>
</tr>
</tbody>
</table>

The Company reported redundancies in the reserves for prior years of $45.4 million as of 2011 and $30.1 million as of 2010. This favorable development is the result of lower than expected medical costs and utilization.
<table>
<thead>
<tr>
<th>Description</th>
<th>12/31/2011 (000)</th>
<th>12/31/2010 (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims payable at the beginning of the year</td>
<td>$151,557</td>
<td>$135,151</td>
</tr>
<tr>
<td>Add provision for claims occurring in the current year</td>
<td>$1,519,406</td>
<td>$1,595,963</td>
</tr>
<tr>
<td>Add provision for claims occurring in the prior years</td>
<td>$(45,400)</td>
<td>$(30,125)</td>
</tr>
<tr>
<td>Net incurred losses during the year</td>
<td>$1,474,006</td>
<td>$1,565,838</td>
</tr>
<tr>
<td>Deduct payment for claims occurring in the current year</td>
<td>$1,377,901</td>
<td>$1,446,288</td>
</tr>
<tr>
<td>Deduct payments for claims made in the prior years</td>
<td>$102,716</td>
<td>$103,144</td>
</tr>
<tr>
<td>Net claim payments made during the year</td>
<td>$1,480,617</td>
<td>$1,549,432</td>
</tr>
<tr>
<td>Claims reserve payable at the end of the year</td>
<td>$144,946</td>
<td>$151,557</td>
</tr>
</tbody>
</table>

**Background**

MHP is a Minnesota nonprofit health maintenance organization which offers health plans and networks throughout Minnesota to insured individuals and groups. MHP is authorized to provide prepaid comprehensive health maintenance services in the State of Minnesota under the provisions of the Minnesota Health Maintenance Act of 1973. MHP is a subsidiary of the Medica Holding Company (MHC).

In addition to MHP, MHC also includes the following subsidiary insurers:

- Medica Insurance Company (MIC)
- Medica Self Insured (MSI)
- Medica Health Plans of Wisconsin (MHPW)
- Medica Health Management (MHM)

The group is collectively referred to as Medica.

The Company is required to participate in certain Minnesota programs in all counties where the Company sells its commercial products. Under Minnesota's Prepaid Medical Assistance Program (PMAP), General Assistance Medical Care (GAMC) and MinnesotaCare contracts, government program revenue is subject to a 5% withhold, which is returned to the Company if certain contract provisions are met.

The Company participates in Medicaid programs in the state of Minnesota. The Company agreed to limit its operating margin for certain programs to one percent for 2011. The Company
exceeded the one percent operating margin by $25.3 million and returned this amount to Minnesota.

The Company allocates expenses to affiliated companies under written management agreements and service contracts. The allocated expenses amounts are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>12/31/2011 (000)</th>
<th>12/31/2010 (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHP expenses</td>
<td>$ 251,962</td>
<td>$ 255,336</td>
</tr>
<tr>
<td>Allocated to Medica Insurance Company</td>
<td>$  79,635</td>
<td>$  69,985</td>
</tr>
<tr>
<td>Allocated to Medica Self Insured</td>
<td>$  46,215</td>
<td>$  44,720</td>
</tr>
<tr>
<td>Allocated to Medica Health Management</td>
<td>$   9,357</td>
<td>$  10,126</td>
</tr>
<tr>
<td>MHP expenses after allocations</td>
<td>$ 116,756</td>
<td>$ 130,505</td>
</tr>
</tbody>
</table>

The Company has an administrative service agreement with United HealthCare Services (UHC), which provides the Company with system dependent services including billing, enrollment, claims processing, and accounting. The fees paid to UHC for 2011 and 2010 were $17.7 million and $21.1 million, respectively. These fees are based on a predetermined amount per member, per month.

The Company has third party agreements for dental and pharmacy claims processing. The fees paid under these agreements are based on a predetermined amount per member, per month.

Under the terms of administrative agreements, MHP provides personnel and administrative services for all the operations of each affiliated entity. MHP is compensated for the services provided primarily a direct cost basis. Other appropriate allocation methods are used in the case where direct costs are not available. The allocation methods do not include any provision for profit to MHP.

MHP has contracted with the Minnesota Department of Human Services (DHS) to provide health care coverage to Prepaid Medical Assistance Program (PMAP) and prepaid MinnesotaCare (MNCare) recipients via a managed care model.

MHP has contracted with the Centers for Medicare and Medicaid Services (CMS) as a Special Needs Plan under the Medicare Advantage program. The contract is part of a program sponsored by DHS called Minnesota Senior Health Options (MSHO) for beneficiaries age 65 and older who are eligible for DHS Medical Assistance and Medicare Parts A and B.

MHP also contracts with CMS for Private Fee for Service and Medicare Supplement products.
Minnesota Public Programs

MHP provides coverage for several public programs administered by DHS and Minnesota Department of Health (MDH).

Prepaid Medical Assistance Program (PMAP)

Medical Assistance, also called MA or PMAP, is a program that provides medical care for low-income persons, families, children, and pregnant women. State and federal governments jointly fund this program. MHP contracts with the Minnesota Department of Human Services to offer this program in Minnesota. There is no monthly fee, but enrollees may need to pay a small copay for some services. The MHP product name for Medical Assistance is Medica Choice Care.

In 2011, MHP provided coverage to PMAP members in 30 of the 65 counties that are available for prepaid health care contracting. MHP has 29% of the statewide PMAP market share. See Appendix 5 for the PMAP health plan choices by county.

Effective in 2011, PMAP was included in the Minnesota Medicaid Expansion where additional low income adults became eligible for Medicaid benefits when Minnesota expanded the Medical Assistance program. This program expansion covers eligible individuals that were previously included in MinnesotaCare and General Assistance Medical Care (GAMC). The GAMC program ended February 28, 2011.

Minnesota Senior Care Plus (MSC)

Minnesota Senior Care (MSC) Plus is a health care program that pays for medical services for low-income individuals in Minnesota who are age 65 or older and are not enrolled in Medicare. MSC Plus members may also be eligible for Elderly Waiver services, home and community based services, and case management. There is no monthly fee, but the enrollee may need to pay a small co-pay for some services. The MHP product name for MSC Plus is Medica ChoiceCare. See Appendix 7 for the MSC Plus health plan choices by county.

MinnesotaCare (MNCare)

MinnesotaCare is a state-subsidized health care program for individuals and children who live in Minnesota and do not have access to health insurance. These individuals and children also do not meet the eligibility requirements for Medical Assistance (Medicaid). Working adults who are unable to get health care coverage through an employer may qualify.

In 2011, MHP provided coverage to approximately 27% of the statewide MNCare enrollment. The MHP product name for MinnesotaCare program is Medica MinnesotaCare. See Appendix 6 for the MNCare health plan choices by county.
Public Programs Integrated with Federal Programs provided by MHP

Minnesota Senior Health Options (MSHO)

Minnesota Senior Health Care Options (MSHO) provides coverage to seniors in Minnesota who are age 65 and older who are eligible for Medical Assistance (MA) and enrolled in Medicare Parts A and B. The plan combines the benefits and services of Medicare and Medicaid. The MHP product name for Minnesota Senior Health Care Options is Medica Dual Solution. See Appendix 8 for the MSHO health plan choices by county.

SNBC

Minnesota Special Needs Basic Care (SNBC) provides coverage for individuals age 18 to 65 with all types of disabilities who have Medical Assistance. SNBC contracts include agreements for MHP to cover the cost of medical assistance co-pays and deductibles for SNBC. Resource identification, organization and coordination are provided. MHP’s product name for Minnesota Special Needs Basic Care is Medica AccessAbility Solution. See Appendix 9 for the SNBC health plan choices by county.

Public Programs managed by CMS and provided by MHP

Medicare Part D Prescription Program

MHP is a plan sponsor offering Medicare Part D prescription drug insurance coverage under a contract with CMS. MHP shares insurance risk in a portion of the program. The coverage is incorporated with MHP products written with CMS.

Private Programs provided by MHP

Commercial

MHP offers commercial managed care plans for groups.

Observations & Findings

Note, this review is not considered a statutory examination but a special review requested by the Governor. Therefore, observations and findings within this report are not necessarily violations of Statutory Accounting Principles or State law. The objective of the review is to report the facts as observed and make recommendations where deemed to be appropriate. The following represents our key observations and findings:

1. It was observed that the allocation of salaries within the Medica group and in MHP’s public and non-public programs is performed through a comprehensive cost center allocation
process. MHP did not limit the salary or other compensation amounts that are allocated in the cost center process prior to allocating them to the Public Programs or any other programs administered by the Company.

2. It was observed that MHP contributed $3.5 million to the Medica Foundation in both 2011 and 2010. The Medica Foundation is an affiliated charitable organization with the stated mission to fund community-based initiatives and programs that support the needs of Medica's customers and the greater community by improving their health and removing barriers to health care services.

3. It was observed that MHP contributed $6.5 million to the Medica Research Institute in both 2011 and 2010. The Medica Research Institute is an affiliate nonprofit organization with the stated mission to conduct research that generates valid and meaningful evidence-based information for timely translation into activities that promote health and improve lives.

No recommendations were identified during the procedures performed.

Scope and Procedures Performed

In accordance with Work Order Contract No. 50686, the specific tasks which InsRis was charged with are listed below.

1. Compare the PMAP detail which is provided to the Department of Human Services to the Minnesota Supplement Report filed with the Minnesota Department of Health.

The 2011 PMAP detail which was provided to the Department of Human Services was agreed without exception to the Minnesota Supplement Report filed with the Minnesota Department of Health. A summary of the Minnesota Supplement Report is included below.
<table>
<thead>
<tr>
<th>NAIC Description</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prepaid Medical Assistance Program (PMAP)</td>
<td>Prepaid Medical Assistance Program (PMAP)</td>
</tr>
<tr>
<td>REVENUES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Member Months</td>
<td>1,232,513</td>
<td>1,378,029</td>
</tr>
<tr>
<td>2 Net Premium Income</td>
<td>$565,131,341</td>
<td>$637,483,545</td>
</tr>
<tr>
<td>3 Change in unearned premium reserves and serve for rate credits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Fee-for-service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Risk revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Aggregate write-ins for other health care related revenues (Line 699)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Aggregate write-ins for other non-health revenues (Line 799)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 TOTAL REVENUES (Lines 2 through 7)</td>
<td>$565,131,341</td>
<td>$637,483,545</td>
</tr>
<tr>
<td>EXPENSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Hospital/medical benefits</td>
<td>373,236,700</td>
<td>453,724,306</td>
</tr>
<tr>
<td>10 Other professional services</td>
<td>15,096,237</td>
<td>14,675,113</td>
</tr>
<tr>
<td>11 Outside referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Emergency room and out-of-area</td>
<td>31,293,226</td>
<td>50,637,407</td>
</tr>
<tr>
<td>13 Prescription drugs</td>
<td>45,620,054</td>
<td>61,717,644</td>
</tr>
<tr>
<td>14 Aggregate write-ins for other hospital and medical expenses (Line 1499)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Incentive Pool and Withhold Adjustments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 TOTAL EXPENSES (Lines 9 through 15)</td>
<td>$465,246,217</td>
<td>$580,754,470</td>
</tr>
<tr>
<td>LESS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Net reinsurance recoveries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Total hospital and medical (Lines 16 minus 17)</td>
<td>465,246,217</td>
<td>580,754,470</td>
</tr>
<tr>
<td>19 Non-health claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Claims adjustment expenses</td>
<td>11,150,925</td>
<td>12,635,329</td>
</tr>
<tr>
<td>21 General administrative expenses</td>
<td>28,022,922</td>
<td>34,223,018</td>
</tr>
<tr>
<td>22 Increase in reserves for life, accident and health contracts</td>
<td></td>
<td>4,500,000</td>
</tr>
<tr>
<td>23 Total underwriting deductions (Lines 18 through 22)</td>
<td>504,420,064</td>
<td>632,112,817</td>
</tr>
<tr>
<td>24 Net underwriting gain or (loss)(Lines 8 minus 23)</td>
<td>60,711,277</td>
<td>5,370,728</td>
</tr>
<tr>
<td>25 Net investment income earned</td>
<td>3,203,018</td>
<td>3,045,193</td>
</tr>
<tr>
<td>26 Net realized capital gains or (losses)</td>
<td>971,123</td>
<td>2,297,516</td>
</tr>
<tr>
<td>27 Net investment gains or (losses)(Lines 25 plus 26)</td>
<td>4,174,141</td>
<td>5,342,709</td>
</tr>
<tr>
<td>28 Net gain or (loss) from agents' or premium balances charged off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Aggregate write-ins for other income or expenses (Line 2999)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Net income or (loss) before federal income taxes (Lines 24, 27, 28, 29)</td>
<td>64,885,418</td>
<td>10,713,437</td>
</tr>
<tr>
<td>31 Federal and foreign income taxes incurred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Net income (loss) (Lines 30 minus 31)</td>
<td>$64,885,418</td>
<td>$10,713,437</td>
</tr>
</tbody>
</table>
2. Verify the Minnesota Supplement Report was completed in accordance with the instructions set forth by the Minnesota Department of Health.

The Minnesota Supplement Report was completed in accordance with the instructions set forth by the Minnesota Department of Health. The instructions provided to MHP can be found in Appendix 4.

3. Perform an analytical review comparing the 2010 and 2011 Minnesota Supplement Reports and research any significant fluctuations.

An analytical review comparing the 2010 and 2011 Minnesota Supplement Reports was performed. Significant fluctuations were noted and the business reasons for the fluctuations were obtained, reviewed and determined to adequately explain the fluctuations.

4. Review (by total) the Minnesota Supplement Report to the expense page of the Statutory Annual Statement. Review the expense categories in terms of:

- Expense allocation between legal entities is consistent with the Statement of Statutory Accounting Principles No. 25 (fair and reasonable).
- Identify expense allocation between public and private programs.
- Perform analytical review and/or testing by sampling various expense categories to determine if expenses were accounted for in accordance with the entity’s expense allocation agreements and guidelines.

The total amounts contained in the 2011 MHP Minnesota Supplement Report were agreed to the expense page of the Statutory Annual Statement. The expense categories were reviewed and the following information was noted:

MHP is in compliance with SSAP No. 25 regarding expense allocation between legal entities and that the allocation is fair and reasonable.

MHP provided documentation that identified the expense allocation between public and private programs. The allocation method used was determined to be reasonable.

Based on an analytical review and a sampling of various expense categories it was determined that the expenses reported for the year ending December 31, 2011, were accounted for and reported in accordance with the entity’s expense allocation agreements and guidelines.
5. Verify appropriateness with regards to the establishment of any Premium Deficiency Reserves allocated to the public programs.

MHP is in compliance with SSAP No. 54 regarding Premium Deficiency Reserves. It was noted that the basis of the calculation of the 2011 Premium Deficiency Reserve had changed from the 2010 basis but that the changes in the basis were appropriate and in compliance with SSAP No. 54.


A retrospective review of reserves established for public programs was performed for the years ending 2009, 2010 and 2011. The table indicates consistent redundancies for public programs with the exception of the 2009 development of MSC.

<table>
<thead>
<tr>
<th></th>
<th>PMAP (000)</th>
<th>MNCare (000)</th>
<th>MSC (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBNR as of December 2009</td>
<td>$ 34,065</td>
<td>$ 11,212</td>
<td>$ 7,041</td>
</tr>
<tr>
<td>Restated IBNR as of July 2012</td>
<td>28,933</td>
<td>7,987</td>
<td>10,722</td>
</tr>
<tr>
<td>Favorable (Unfavorable) Restatement</td>
<td>5,131</td>
<td>3,225</td>
<td>(3,680)</td>
</tr>
<tr>
<td>Favorable (Unfavorable) Percent</td>
<td>15%</td>
<td>29%</td>
<td>-52%</td>
</tr>
<tr>
<td>Outstanding IBNR as of July 2012</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IBNR as of December 2010</td>
<td>$ 34,316</td>
<td>$ 16,079</td>
<td>$ 6,847</td>
</tr>
<tr>
<td>Restated IBNR as of July 2012</td>
<td>29,605</td>
<td>11,420</td>
<td>8,298</td>
</tr>
<tr>
<td>Favorable (Unfavorable) Restatement</td>
<td>4,710</td>
<td>4,659</td>
<td>(1,450)</td>
</tr>
<tr>
<td>Favorable (Unfavorable) Percent</td>
<td>14%</td>
<td>29%</td>
<td>-21%</td>
</tr>
<tr>
<td>Outstanding IBNR as of July 2012</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IBNR as of December 2011</td>
<td>$ 44,239</td>
<td>$ 10,774</td>
<td>$ 6,281</td>
</tr>
<tr>
<td>Restated IBNR as of July 2012</td>
<td>42,561</td>
<td>8,660</td>
<td>7,788</td>
</tr>
<tr>
<td>Favorable (Unfavorable) Restatement</td>
<td>1,678,</td>
<td>2,113</td>
<td>(1,506)</td>
</tr>
<tr>
<td>Favorable (Unfavorable) Percent</td>
<td>4%</td>
<td>20%</td>
<td>-24%</td>
</tr>
<tr>
<td>Outstanding IBNR as of July 2012</td>
<td>$ 685</td>
<td>$ 45</td>
<td>$ 69</td>
</tr>
</tbody>
</table>

7. Compare the 2010 run-out provided to the Department of Human Services in 2011 to the retrospective review of reserves.

The 2010 run-out provided to the Department of Human Services in 2011 agreed to the retrospective review of reserves reported above.
STATE OF MINNESOTA
EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 11-06

Creating Public Disclosure for
Minnesota’s Managed Care Health Care Programs

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, over 500,000 Minnesotans receiving public health insurance coverage are enrolled in managed care; and

Whereas, the State spends approximately $3 billion annually on purchasing health care from managed care plans for state public programs; and

Whereas, it is critical for public trust that Minnesota’s taxpayers understand how public dollars for health care are being used; and

Whereas, the State needs greater disclosure and accountability of managed care plan spending on health care and long-term care services and administrative expenses for state public programs;

Now, Therefore, I hereby order the Commissioner of Human Services to:

1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.

2. Develop an annual comprehensive managed care report in consultation with the Commissioners of Health and Commerce that includes detailed information on administrative expenses, premium revenues, provider payments and reimbursement.
rates, contributions to reserves, enrollee quality measures, service costs and
utilization, enrollee access to services, capitation rate-setting and risk adjustment
methods, and managed care procurement and contracting processes.

3. Submit data from the managed care plans for state public programs to the
Commissioner of Commerce so that regular financial audits of data will be
conducted.

Under Minnesota Statutes, section 4.035, subdivision 2, this Executive Order is effective
15 days after publication in the State Register and filing with the Secretary of State.

In Testimony Whereof, I have set my hand on March 23, 2011.

[Signature]
Mark Dayton
Governor

Filed According to Law:

[Signature]
Mark Ritchie
Secretary of State
Appendix 2 – Minnesota Statutes §62D.08 and 256B.69, subd 9c

62D.08 ANNUAL REPORT.

Subdivision 1. Notice of changes.

A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q), (r), (s), and (t) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 60 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Subd. 2. Annual report required.

Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health covering the preceding calendar year. However, utilization data required under subdivision 3, clause (c), shall be filed on or before July 1.

Subd. 3. Report requirements.

Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of health;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization,
including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(e) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; and

(f) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Subd. 4. Penalty; extension for good cause.

Any health maintenance organization which fails to file a verified report with the commissioner on or before April 1 of the year due shall be subject to the levy of a fine up to $500 for each day the report is past due. This failure will serve as a basis for other disciplinary action against the organization, including suspension or revocation, in accordance with sections 62D.15 to 62D.17. The commissioner may grant an extension of the reporting deadline upon good cause shown by the health maintenance organization. Any fine levied or disciplinary action taken against the organization under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 to 14.69.

Subd. 5. Changes in participating entities; penalty.

Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner 120 days before the effective date. When the health maintenance organization terminates a provider for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within ten working days of the date the health maintenance organization sends out or receives the notice of cancellation, discontinuance, or termination. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $200 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Subd. 6. Financial statements.

A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization for the first three quarters of the year on forms prescribed by the commissioner. The statements are due 30 days after the end of the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.
Subd. 7. Consistent administrative expenses and investment income reporting.

(a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

256B.69 PREPAID HEALTH PLANS.

Subd. 9c. Managed care financial reporting.

(a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

1) administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;
2) revenues by program, including investment income;
3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:
   (i) individual-level provider payment and reimbursement rate data;
(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;
(iii) data on implementation of legislatively mandated provider rate changes; and
(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.
### Minnesota Supplement Report #1

**STATEMENT OF REVENUE, EXPENSES AND NET INCOME**

For the year ending December 31, 2011

Public Information, Minnesota Statutes § 61D.08

<table>
<thead>
<tr>
<th>NAC #</th>
<th>NAC Description</th>
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<td>NAC Total Non-Minnesota Products (Eliminations)</td>
<td>Total Minnesota Products</td>
<td>Commercial</td>
<td>Medicare + Child</td>
<td>Medicare DENT</td>
<td>Minnesota Senior Health Options (MNSHO)</td>
<td>SNIC (MA Only)</td>
<td>SNIC (Integrated)</td>
<td>Prepaid Medical Assistance Program (PMAP)</td>
<td>MNCare</td>
<td>Dental</td>
<td>Please Specify</td>
<td>Administrative Services Only</td>
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<td>REVENUES:</td>
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<td>2 Net Premium Income (including $ non-health premium income)</td>
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<td>3 Change in unrealized premium reserves and fund for rate costs</td>
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<td>4 Flexible-savings (net of $ medical expenses)</td>
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<td>6 Aggregate reserves for other health care related reserves (Line 659)</td>
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<td>7 Aggregate reserves for other non-health reserves (Line 759)</td>
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<td>8 TOTAL REVENUES (Lines 2 through 7)</td>
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<td>12 Emergency room and out-of-area</td>
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<td>13 Prescription drugs</td>
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<td>14 Aggregate expenses for other hospital and medical expenses (Line 14256)</td>
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<td>15 Aggregate PPO and SNP Adjustments</td>
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<td>16 TOTAL EXPENSES (Lines 9 through 15)</td>
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<td>18 Total hospital and medical (Lines 16 minus 17)</td>
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<td>20 Claim adjustment expenses</td>
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<td>21 General administrative expenses</td>
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<td>22 Increase in reserves for life, accident and health contracts (including $ increase in reserves for life only)</td>
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<td>23 Total undistributed dividends (Lines 18 through 22)</td>
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<td>24 Net underwriting gain or loss (Line 6 minus 23)</td>
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<td>25 Net underwriting income, earned</td>
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<td>26 Net realized capital gains or losses</td>
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<td>27 Net investment gain or loss (Lines 25 plus 26)</td>
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<td>28 Net investment income, earned</td>
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<td>29 Aggregate expenses for other income or expenses (Line 29555)</td>
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<td>30 Net income or (loss) before federal income taxes</td>
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<td>31 Federal and foreign income taxes incurred</td>
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<td>32 Net income (loss) (Lines 30 minus 31)</td>
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</tbody>
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20
Appendix 4 – MN HMO Instructions

Date: December 1, 2011
To: Minnesota Domiciled Health Maintenance Organizations and County Based Purchasers
From: Mike Rothman, Commissioner
       Minnesota Department of Commerce
Subject: Filing of Annual Statement, Supplements, Exhibits, Certificates and Reports
Contacts: Minnesota Department of Commerce
          Constance Peterson, Constance.Peterson@state.mn.us (651)297-8943
          Robert Rivera, Robert.Rivera@state.mn.us (651)296-4523 (Questions about Medical Necessity Evaluation Filing Only)

Minnesota Department of Health
MaryAnn (Fena) Benke, Maryann.Benke@state.mn.us (651)201-5164

NAIC Instructions and Blanks

The National Association of Insurance Commissioners (NAIC) Annual Statement health blank is required to be filed with the Department of Commerce no later than 4/1/12 per Minnesota Statutes §62D.08. Refer to the following table for details regarding the Annual Statement filing and other required filings for the year 2012:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Copies</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Statement (hard copy)</td>
<td>5</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 2 &amp; 3</td>
<td></td>
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<tr>
<td>Annual Statement (electronic filing)</td>
<td>1</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 2 &amp; 3</td>
<td>Those organizations not filing electronically with the NAIC are required to file the Annual Statement in PDF format in addition to the required hard copies.</td>
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<tr>
<td>Investment Policy Certification</td>
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<td>4/1/12</td>
<td>§62D.045, Subd. 2 and §60A.112</td>
<td>Not required for County Based Purchasers.</td>
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<td>Audited Financial Statement</td>
<td>3</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 3(a)</td>
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<tr>
<td>Risk Based Capital Report</td>
<td>3</td>
<td>4/1/12</td>
<td>§62D.04, Subd. 1(e)</td>
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</tbody>
</table>
| Notification of Change in Appointed Actuary       | 1                | Within 5 business days | §62D.08, Subd. 2 & 3          | According to the NAIC Annual Statement Instructions, documentation for a newly appointed actuary needs to include the following:
  • The insurer shall provide the Commissioner with a letter within 10 business days stating whether, in the preceding 24 months, there were any disagreements with the former actuary.
  • The insurer shall request the former actuary to furnish a letter addressed to the insurer stating whether the actuary
| Quarterly Financial Statements (hard copy) | 4 | 4/30, 7/30 and 10/30 | §62D.08, Subd. 6 |
| Quarterly Financial Statements (electronic filing) | 1 | 4/30, 7/30 and 10/30 | §62D.08, Subd. 6 |

Those organizations not filing electronically with the NAIC are required to file the Quarterly Statements in PDF format in addition to the required hard copies.

**Filing Address:** Department of Commerce
Financial Institutions - Insurance
85 Seventh Place East, Suite 500
St. Paul, MN 55101-2198

**Filing Fees:** Health Maintenance Organizations: Send the filing fee of $400 for the Annual Statement and $200 for each Quarterly Statement, payable to the Minnesota Department of Health (not the Minnesota Department of Commerce), to: Managed Care Systems Section, Minnesota Department of Health, P.O. Box 64882, St. Paul, MN 55164-0882 by the filing due dates. County Based Purchasers: Filing fees not required.

**Minnesota Supplemental Reports (excluding HEDIS)**

Pursuant to applicable Minnesota law, complete the following reports. These report forms, with the exception of the HEDIS 2012 Data Submission Tool, can be downloaded from the “HMO Annual Report Forms” link at the bottom of the following Department of Health Web page: www.health.state.mn.us/divs/hpsc/mcs/forms.htm

<table>
<thead>
<tr>
<th>Report</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>4/1/12</td>
<td>§62D.08</td>
<td>Statement of Revenue, Expenses and Net Income</td>
</tr>
<tr>
<td>2.</td>
<td>4/1/12</td>
<td>§4685.2000</td>
<td>Summary of Complaints and Grievances</td>
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<tr>
<td>3.</td>
<td>4/1/12</td>
<td>§72A.201, Subd. 8(7)</td>
<td>Summary of Chemical Dependency Claims and Appeals</td>
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<tr>
<td>4.</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 3(d) and 4685.2100D</td>
<td>Participating Providers Listing</td>
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<tr>
<td>5.</td>
<td>4/1/12</td>
<td>§62M.09, Subd. 9</td>
<td>Medical Necessity Evaluation</td>
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<tr>
<td>6.</td>
<td>7/1/12</td>
<td>§62D.04(1)(c),(5) &amp; 62D.08</td>
<td>Enrollment Statistics By Products and County</td>
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<td>7.</td>
<td>7/1/12</td>
<td>§62D.04(1)(c),(5) &amp; 62D.08</td>
<td>HEDIS 2012 (For Calendar Year 2011) Data Submission Tool (through NCQA), Separate Instructions to Follow.</td>
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</table>

Instructions for filing the HEDIS data (through NCQA) will be sent from the Minnesota Department of Health under separate cover.

In addition to the electronic copy of the Medical Necessity Evaluation Form filing (Supplemental Report #5) with the Department of Health, e-mail a copy of the filing to Robert Rivera at the Department of Commerce: Robert.Rivera@state.mn.us.

All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.
**Minnesota Supplements Filing Instructions:** It is not necessary to send a paper copy in addition to the electronic submission; none of these reports require a signature. Send the completed Minnesota Supplement forms on a CD to:

**Mailing Address:**
Dedra Johnson  
Managed Care Systems Section  
Minnesota Department of Health  
P.O. Box 64882  
St. Paul, MN  55164-0882

**Courier Address:**
Managed Care Systems Section  
Minnesota Department of Health  
85 Seventh Place East, Suite 220  
St. Paul, MN  55101
Appendix 6 - MinnesotaCare (MNCare) map
Health Plan Choices by County Effective April 1, 2011

www.MinnesotaCare411.com
or www.dhs.state.mn.us/Maps
Appendix 9 - Special Needs Basic Care (SNBC) map
Health Plan Choices by County Effective Jan. 1, 2011

MED = Medica*
MHP = Metropolitan Health Plan
PW = PrimeWest Health System
SC = South Country Health Alliance
UC = UCare

*SNBC through Medica no longer integrates Medicare. People with Medicare will need a separate Medicare Part D plan.

**Effective Sept. 1, 2009 SNBC—PINS (Preferred Integrated Network) in Dakota County only through Medica.

www.dhs.state.mn.us/SNBC
Addendum to Report

Medica Comment Letter
December 4, 2012

Mr. Rick Theisen
Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

Dear Mr. Theisen:

This letter is to formally acknowledge that the final draft report of Medica Health Plans dated November 26, 2012 is acceptable to Medica.

Sincerely,

[Signature]

Aaron Reynolds
Chief Administrative Officer
STATE OF MINNESOTA

UCare Minnesota

WORK ORDER CONTRACT NO: 50691

December 3, 2012
Executive Summary

The Minnesota Department of Commerce (MNDOC) employed the services of Risk and Regulatory Consulting, LLC (RRC) in order to assist it in evaluating the appropriateness of the managed care plans’ expense allocations to public programs, the appropriateness of established Premium Deficiency Reserves and the Retrospective Review of Reserves established for such public programs. This evaluation was conducted in accordance with Executive Order 11-06 Creating Public Disclosure for Minnesota’s Managed Care Health Care Programs issued March 21, 2011 (see Appendix 1) and information was also collected as provided in Minn. Statutes Section 256B.69, subd 9c (see Appendix 2). The public programs are provided by various Managed Care Organizations, including UCare Minnesota (hereinafter referred to as “UCare” or “the Company”). The public programs include: Prepaid Medical Assistance Program (PMAP), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), MinnesotaCare (MNCare) and Special Needs Basic Care (SNBC).

Expense Allocations – According to the NAIC Accounting Practices and Procedures Manual - Appendix A-440 – Insurance Holding Companies, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions. SSAP No. 70 “Allocation of Expenses” states that any basis adopted to apportion expenses shall be that which yields the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

UCare allocates expenses at a product and program level each month for reporting purposes. If a particular expense is determined to be directly related to a particular product line (based on the nature and/or purpose of the expense), it is coded and recorded directly to the specific product code in the month that it is processed. Administrative related expenses that are not specifically attributable to a product code flow into UCare’s overall indirect expense allocation process. This process is performed on a monthly basis and allocates cumulative indirect costs to a product line for reporting purposes proportional to a respective product’s premium revenue. Management indicates this process has been in place from 2005 through 2011; however, in 2012 due to significant growth the process for allocating indirect expenses has slightly changed.

The results of our analytical review and testing of samples of various expense categories show that UCare appears to be allocating expenses in a manner consistent with their expense allocation methodology and model, in accordance with the NAIC Accounting Practices and Procedures Manual - Appendix A-440 and in a manner consistent with SSAP No. 70 "Allocation of Expenses”.

Premium Deficiency Reserves – According to SSAP No. 54 “Individual and Group Accident and Health Contracts”, when the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent
with how policies are marketed, serviced and measured. A liability shall be recognized for each
grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated
profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the
contract period has not yet started.

UCare evaluates the need for a Premium Deficiency Reserve ("PDR") at the contract level based
on projected earnings determined through the annual budget process. The policy groupings for
PDR assessment purposes follow this approach. The Company determined that a PDR was not
necessary as of December 31, 2011. From the information provided, it appears that the groupings
are reasonable and are in compliance with SSAP No. 54.

Reserves – According to SSAP No. 54 “Individual and Group Accident and Health Contracts”,
claim reserves shall be accrued for estimated costs of future health care services to be rendered
that the reporting entity is currently obligated to provide or reimburse as a result of premiums
carried to date that would be payable after the reporting date under the terms of the arrangements,
regulatory requirements or other requirements if the insured’s illness were to continue.

UCare’s reserving methodology involves the use of the Developmental Method. Unpaid claim
liability estimates are made and then an explicit margin of 10% for adverse claim deviation is
applied to the estimates. The reserving methodology employed appears reasonable and
appropriate. It follows generally accepted actuarial practices. The margin level used appears to
be consistent from year-to-year. However, we concluded that these margins were overly
conservative when considering historic redundancies and profitability analysis of the company’s
public programs.

Based upon the information provided, the unpaid claim liabilities as of December 31, 2010 and
December 31, 2011 contain large redundancies in total. In addition, each product line also
contains redundancies. Using claim data through May 31, 2012 the magnitude of the
redundancies is approximately 24.3% and 19.0%, for claims incurred as of December 31, 2010
and December 31, 2011, respectively. The redundancies noted include the 10% explicit margin
and are greater than the margin levels established by the Company.
<table>
<thead>
<tr>
<th>Annual Statement Liability Line Item</th>
<th>Description</th>
<th>12/31/11 balance</th>
<th>12/31/10 balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Claims unpaid</td>
<td>$213,240,820</td>
<td>$168,846,694</td>
</tr>
<tr>
<td>2</td>
<td>Accrued medical incentive pool and bonus amounts</td>
<td>$14,534,656</td>
<td>$16,709,450</td>
</tr>
<tr>
<td>3</td>
<td>Unpaid claims adjustment expenses</td>
<td>$4,701,343</td>
<td>$3,679,098</td>
</tr>
<tr>
<td>4</td>
<td>Aggregate health policy reserves</td>
<td>$8,223,685</td>
<td>$490,393</td>
</tr>
</tbody>
</table>

**Background**

UCare Minnesota (UCare) is a nonprofit corporation licensed as a health maintenance organization (HMO) in Minnesota and provides health care services and coverage to approximately 218,000 enrollees throughout Minnesota. UCare is a tax-exempt organization under Section 501(c) (3) of the Internal Revenue Code and is not generally subject to federal or state income on related business income.

UCare has contracted with the Minnesota Department of Human Services (DHS) to provide health care coverage to Prepaid Medical Assistance Program (PMAP) and prepaid MinnesotaCare (MNCare) recipients via a managed care model.

UCare contracts with the Centers for Medicare and Medicaid Services (CMS) as a Special Needs Plan under the Medicare Advantage program. The contract is part of a program sponsored by DHS called Minnesota Senior Health Options (MSHO) for beneficiaries age 65 and older who are eligible for DHS Medical Assistance and Medicare Parts A and B.

UCare has an administrative service agreement with its subsidiary, UCare Wisconsin to provide overall management and administration of UCare Wisconsin’s business. UCare Wisconsin reimburses UCare for all costs and expenses directly and indirectly incurred and associated with the business and operations of UCare of Wisconsin. UCare Wisconsin incurred expenses under this management agreement of $5,347,000 and $7,902,000 for 2011 and 2010, respectively.

**Public Programs administered by DHS and Minnesota Department of Health (MDH) provided by UCare:**

Prepaid Medical Assistance Program (PMAP)

PMAP, also known as Medical Assistance (MA), is a health care program for families, children, pregnant women, adults without children who meet certain income limits and people who have disabilities. PMAP is Minnesota’s Managed Care Medicaid program. There is no monthly fee, but enrollees may need to pay small co-pay for some services.
In 2011, UCare provided coverage to PMAP members in 59 of the 65 counties that are available for prepaid health care contracting. UCare has 24% of the statewide PMAP market share. See Appendix 5 for the PMAP health plan choices by county.

**Medicaid Expansion**

Beginning in 2011, PMAP also includes Minnesota Medicaid Expansion. Starting March 1, 2011, additional low income adults became eligible for Medicaid benefits when Minnesota expanded the Medical Assistance program. The Federal Affordable Care Act (ACA) allows states participating in Medicaid, known in Minnesota as MA, to expand coverage to certain adults who meet specific criteria effective January 1, 2014. The ACA permits states to implement this expansion beginning April 1, 2010.

The 2010 Minnesota Legislature amended state law allowing the governor to authorize coverage of this population by Jan. 15, 2011. Gov. Mark Dayton signed an executive order Jan. 5, for implementation of MA expansion by March 1. The CMS approved the state’s plan in February.

The expansion provides federal matching funds — $826 million for the 2012-2013 biennium — for health care previously funded with only state dollars through MinnesotaCare and General Assistance Medical Care (GAMC). The GAMC program ended February 28, 2011. Enrollees were automatically moved to MA, Minnesota’s Medicaid program.

**Minnesota Senior Care Plus (MSC+)**

Minnesota Senior Care Plus is a health care program for seniors 65 and older who qualify for Medical Assistance (Medicaid) and are not enrolled in Medicare. There is no monthly fee, but enrollee may need to pay small co-pay for some services. In 2011 UCare provided coverage to approximately 22% of the statewide MSC+ enrollment. See Appendix 7 for the MSC+ health plan choices by county.

**MinnesotaCare (MNCare)**

MNCare is a health care program for children, adults and seniors who don’t have access to affordable health care coverage, but do not meet the eligibility requirements for Medical Assistance (Medicaid). Working adults who are unable to get health care coverage through an employer may qualify.

MNCare provides subsidized coverage for individuals and children who are not covered by group insurance and not eligible for Medical Assistance. In 2011 UCare provided coverage to approximately 18% of the statewide MNCare enrollment and is available in 80 of Minnesota’s 87 counties. See Appendix 6 for the MNCare health plan choices by county.

**Public Programs Integrated with Federal Programs provided by UCare**

**Minnesota Senior Health Options (MSHO)**

The Minnesota Senior Health Options (MSHO) is a health care program that combines separate health programs and support systems into one health care package. It is for people ages 65 and older who are eligible for MA and enrolled in Medicare Parts A and B. In 2011 UCare provided
coverage to approximately 25% of the statewide MSHO enrollment. See Appendix 8 for the MSHO health plan choices by county.

SNBC Integrated
Special Needs Basic Care (SNBC) is a managed care program for individuals with disabilities. SNBC contracts include agreements for MCO’s to cover the cost of medical assistance co-pays and deductibles for SNBC. SNBC enrollees may have to pay Part D drug co-pays since Medicare does not allow waivers, unless the enrollee is in an institution. UCare offers an SNBC plan which is integrated with Medicare Benefits for eligible enrollees (SNBC Integrated). In 2011 UCare provided coverage to approximately 42% of the statewide SNBC enrollment. See Appendix 9 for the SNBC health plan choices by county.

Public Programs managed by CMS and provided by UCare

Medicare + Choice
Medicare + Choice represents a Medicare Advantage managed care plan for individuals who are over 65 years old and are eligible for Medicare Part A and Part B.

Other
UCare provides administrative services through Administrative Service Only (ASO) contracts with two independent Health Plans.

Observations & Findings

Note, this review is not considered a statutory examination but a special review requested by the Governor. Therefore, observations and findings within this report are not necessarily violations of Statutory Accounting Principles or State law. The objective of the review is to report the facts as observed and make recommendations where deemed to be appropriate. The following represents our key observations and findings:

Observations:

1. UCare made charitable contributions of $37.8 million in 2011, including a $30 million voluntary contribution to the State of Minnesota. UCare also made a contribution of $1 million to the UCare Minnesota Fund of the Minnesota Medical Foundation.

Contributions specifically allocated to the Medical Assistance product line totaled $7,358,784; over $6 million of this was made to the Department of Family Medicine and Community Health (the Department) of the University of Minnesota Medical School. Eight of fifteen UCare Board members have an affiliation with the University.

Contributions of $341,000 were specifically allocated to the Medicare product line, the largest of which was a $150,000 contribution to the City of Minneapolis.
2. UCare’s salaries and wages, including executive salaries, are allocated on an indirect allocation basis to all products based upon premium revenue. The Company was not required to, and did not, cap executive salaries prior to allocating them to the public programs or any other programs administered by the Company.

Findings:

1. **Marketing and Advertising**

Finding:
In 2011 UCare allocated advertising and media expenses of $137,700 on an indirect basis to all products based upon premium revenue.

Expenses in this account represent the actual cost of advertising placed by UCare in the market for television, radio and other media advertisements. Expenses indirectly allocated to all lines of business represent general brand advertising of UCare. Management indicated that this brand awareness advertising is intended to promote general market awareness of UCare as a health plan, and it is allocated to all product lines as it supports all UCare products.

According to the Medical Assistance (PMAP) and MNCare contract between UCare and DHS section 3.2.4 “Marketing Materials”:

(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.

(2) Mailings to recipients. The MCO may make no more than two mailings per calendar year to Enrollees of the MCO covered under this Contract or potential Enrollees who reside in the MCO’s Service Area.

Recommendation:
The Company should allocate only those indirect expenses allowed by the contract to PMAP and MNCare public programs.

2. **Error in Supplemental Report #1**

Finding:
In the course of our review, UCare management discovered and disclosed to us that a spreadsheet formula used to allocate indirect administrative costs for reporting of administrative expenses in the 2011 Minnesota Supplement Report #1 contained an error. We were informed that the reported total administrative costs were accurate, but the allocation to state program products was inconsistent with UCare’s internal policy. This error resulted in an overstatement
of indirect costs allocated to UCare’s Prepaid Medical Assistance Plan (PMAP) product and a corresponding, identical understatement to UCare’s other products, including MinnesotaCare.

The overall effect on UCare’s reported financial information for Minnesota state public program products was that net operating income reported on Minnesota Supplement Report #1 for these products was approximately $1 million less than the corrected amount, representing approximately 0.1% of related revenue. UCare informed us, after consultation with their external financial auditors, that 2011 financial reports were not required to be restated, including Minnesota Supplement Report #1, due to the immaterial impact on the financial statements as a whole.

In addition, UCare determined that the error also impacted the amount UCare owed to the Department of Human Services (DHHS) under the 2011 voluntary agreement which capped net operating income for the PMAP and MinnesotaCare products at one percent. After addressing the error, the revised net operating income would have been greater for PMAP and slightly lower for MinnesotaCare, resulting in an additional $1.57 million of combined net operating income for these products. UCare proactively disclosed the error to the DHHS and has since paid an additional $1.57 million under the agreement. This additional payment will be reported in UCare’s 2012 financial statement reports. This is the reporting, disclosure, and remediation process agreed to by UCare and the Minnesota Department of Health, Department of Human Services, and Department of Commerce. See Exhibit 1 at the end of this report for a schedule showing the impact of the allocation calculation error.

Recommendation:
UCare management should perform a thorough review of Supplemental Report #1 and any schedules associated with its preparation to ensure they are accurately filed.

3. Explicit Margin for Adverse Claim Deviation

Finding:
The Company applies an explicit margin for adverse claim deviation of 10% to the unpaid claim liability estimates. According to the management this has been consistently applied since at least 2001. We concluded that the margin applied by the Company appears to be overly conservative when considering historic redundancies and profitability analysis of its public programs.

Recommendation:
We recommend that the Company consider varying the margin level for particular blocks of business based upon historic estimation accuracy and anticipated estimation risk. While estimating unpaid claim liabilities involves random variation and difficult-to-predict events, we also recommend that the Company review its reserving methodology for public programs to refine estimation precision, given the relatively large historical redundancies.
Scope and Procedures Performed

In accordance with Work Order Contract No. 50691, the specific tasks for which RRC was charged with are listed below.

1. Compare the PMAP detail which is provided to the Department of Human Services (DHS) to the Minnesota Supplement Report filed with the Minnesota Department of Health (MDH).

   RRC obtained the Minnesota Supplement Report #1 filed with the DOH and compared this to the PMAP detail provided to RRC. An example of the Minnesota Supplement Report #1 can be found in Appendix 3. The following PMAP detail was obtained directly from the Minnesota Supplement Report #1.
<table>
<thead>
<tr>
<th>NAIC Description</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prepaid Medical Assistance Program (PMAF)</td>
<td>Prepaid Medical Assistance Program (PMAF)</td>
</tr>
<tr>
<td><strong>REVENUES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Member Months</td>
<td>964,415</td>
<td>1,120,886</td>
</tr>
<tr>
<td>2 Net Premium Income</td>
<td>408,617,336</td>
<td>479,624,600</td>
</tr>
<tr>
<td>3 Change in unearned premium reserves and serve for rate credits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Fee-for-service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Risk revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Aggregate write-ins for other healthcare related revenues (Line 699)</td>
<td>57,996</td>
<td>(7,943,116)</td>
</tr>
<tr>
<td>7 Aggregate write-ins for other non-health revenues (Line 799)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 TOTAL REVENUES (Lines 2 through 7)</td>
<td>408,675,332</td>
<td>471,681,574</td>
</tr>
<tr>
<td><strong>EXPENSES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Hospital/medical benefits</td>
<td>162,613,861</td>
<td>198,352,167</td>
</tr>
<tr>
<td>10 Other professional services</td>
<td>119,628,996</td>
<td>115,788,527</td>
</tr>
<tr>
<td>11 Outside referrals</td>
<td>3,270,370</td>
<td>2,671,625</td>
</tr>
<tr>
<td>12 Emergency room and out-of-area</td>
<td>21,198,362</td>
<td>30,305,125</td>
</tr>
<tr>
<td>13 Prescription drugs</td>
<td>31,136,816</td>
<td>46,919,215</td>
</tr>
<tr>
<td>14 Aggregate write-ins for other hospital and medical expenses (Line 1499)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Incentive Pool and Withhold Adjustments</td>
<td>1,752,551</td>
<td>3,107,071</td>
</tr>
<tr>
<td>16 TOTAL EXPENSES (Lines 9 through 15)</td>
<td>339,600,956</td>
<td>397,143,730</td>
</tr>
<tr>
<td><strong>LESS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Net reinsurance recoveries</td>
<td>870,483</td>
<td>1,612,840</td>
</tr>
<tr>
<td>18 Total hospital and medical (Lines 16 minus 17)</td>
<td>338,730,472</td>
<td>395,530,890</td>
</tr>
<tr>
<td>19 Non-health claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Claims adjustment expenses</td>
<td>8,699,100</td>
<td>14,791,747</td>
</tr>
<tr>
<td>21 General administrative expenses</td>
<td>31,117,576</td>
<td>55,734,197</td>
</tr>
<tr>
<td>22 Increase in reserves for life, accident and health contracts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Total underwriting deductions (Lines 18 through 22)</td>
<td>378,547,150</td>
<td>466,066,834</td>
</tr>
<tr>
<td>24 Net underwriting gain or (loss) (Lines 8 minus 23)</td>
<td>30,128,182</td>
<td>5,624,740</td>
</tr>
<tr>
<td>25 Net Investment Income earned</td>
<td>2,832,188</td>
<td>2,815,311</td>
</tr>
<tr>
<td>26 Net realized capital gains or (losses)</td>
<td>2,462,311</td>
<td>3,667,755</td>
</tr>
<tr>
<td>27 Net Investment gains or (losses) (Lines 25 plus 26)</td>
<td>5,294,469</td>
<td>6,483,056</td>
</tr>
<tr>
<td>28 Net gain or (loss) from agents' or premium balances charged off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Aggregate write-ins for other income or expenses (Line 2999)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Net Income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)</td>
<td>35,422,681</td>
<td>12,107,806</td>
</tr>
<tr>
<td>31 Federal and foreign Income taxes incurred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Net Income (loss) (Lines 30 minus 31)</td>
<td>35,422,681</td>
<td>12,107,806</td>
</tr>
</tbody>
</table>

The 2011 PMAP detail provided to RRC agreed to the 2011 UCare MN Supplemental Report #1. RRC noted the programs reported in the PMAP columns (column 10) varied from 2010 to 2011.
The PMAP column consisted of the following programs in the 2011 MN Supplement Report #1:

- PMAP (Non seniors)
- GAMC run-out
- Medicaid Expansion

The PMAP column consisted of the following programs in the 2010 MN Supplement Report #1:

- PMAP (Non seniors)
- MSC+

For analysis purposes UCare provided RRC with a breakout of what other program data was included along with PMAP in Column 10 for each year.

The 2011 PMAP member months, revenues and expenses are higher in 2011 for various reasons. According to the Minnesota Department of Human Services website, the GAMC program ended February 28, 2011. Enrollees were automatically moved to Medical Assistance, Minnesota's Medicaid program. In 2010, the GAMC program information was reflected in a separate column. In 2011, Minnesota participated in the Medicaid Expansion. In connection with this expansion, an increasing number of adults without children became eligible for the program. Many of these individuals transitioned from MNCare or represent the former General Assistance type of enrollees. This population which was the primary driver of the PMAP enrollment growth in 2011 generally has more extensive mental health and chemical dependency issues and often first present in an Emergency Room setting. This changing cost mix associated with Medicaid Expansion had the following impacts on PMAP results between 2010 and 2011:

- Emergency Room and Out of Area claim costs increased 43% from $21,198,362 in 2010 to $30,305,125 in 2011 compared to a 16 % increase in member months, a 17% increase in net premium income and 22% increase in hospital/medical benefits.

- The prescription drug expenses increased 51% from $31,136,815 in 2010 to $46,919,215 in 2011 compared to a 16% increase in member months, a 17% increase in net premium income and 22% increase in hospital/medical benefits.

The PMAP claims adjustment expenses increased 70% (from $8,699,100 to $14,791,747) and general administration expenses increased 79% (from $31,117,578 to $55,734,197) between 2010 and 2011. The driving factor for the overall increase in both categories relates to the impact of including UCare's $30 million contribution to the State of Minnesota in the overall allocation of administrative expenses. The $30 million contribution was directly attributed primarily to the PMAP product line with a small portion included in MnCare. These amounts were included in the overall pro-rata product ratio to ensure that the proper total expense was allocated to each product. Removing the impact of the $30 million contribution to the state, PMAP 2011 expenses on a per-member basis would be $36.65 compared to $41.29 Per-member-per-month (pmpm) in 2010.
PMAF total underwriting deductions increased 23% (from $378,547,150 to $466,056,834) between 2010 and 2011. Total underwriting deductions in 2011, includes $29,550,000 of the voluntary UCare contribution to the State of Minnesota. Without this expense, the increase in total underwriting deductions falls to only 15% which is in line with the overall growth in enrollment between years of 16% and an increase in revenue of 17%.

PMAF had an 81% decrease in underwriting gain from $30,128,182 in 2010 to $5,624,740 in 2011.

<table>
<thead>
<tr>
<th>PMAP</th>
<th>2010 Amount</th>
<th>2011 Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Underwriting Gain</td>
<td>$30,128,182</td>
<td>$5,624,740</td>
</tr>
<tr>
<td>% of Revenue</td>
<td>7.37%</td>
<td>1.19%</td>
</tr>
<tr>
<td>MSC+ Loss</td>
<td>6,751,441</td>
<td></td>
</tr>
<tr>
<td>State Contribution</td>
<td></td>
<td>29,550,000</td>
</tr>
<tr>
<td>1% Earnings Cap</td>
<td></td>
<td>7,977,270</td>
</tr>
<tr>
<td>Adjusted Earnings</td>
<td>36,879,623</td>
<td>43,152,010</td>
</tr>
<tr>
<td>% of Revenue</td>
<td>9.0%</td>
<td>9.00%</td>
</tr>
</tbody>
</table>

As illustrated above, the significant decrease in earnings from 2010 to 2011 reflects the inclusion of two unique transactions in 2011 as well as a change in product line reporting. In MN Supplement Report #1, there is no separate column in which to report results for the MSC+ product line. For consistency purposes, UCare combined the results of this product with the PMAF product line results in 2010. However, the DHHS contract amendment relating to the 1% earnings cap excluded MSC+ from the application of the cap. In light of the fact that the cap was based on Supplement Report #1, UCare moved reporting of 2011 results for the MSC+ product to column 13, to ensure alignment with the purpose of the amendment. In 2010, the MSC+ product incurred a net underwriting loss of $6.7 million. Adding back this loss to 2010’s results creates adjusted earnings of $36.9 million (9% of revenue). Reported results for 2011 also include two unique transactions which make the overall net underwriting gain not comparable to 2010. 2011 results, as noted above, include both the impact of UCare’s voluntary contribution to the State as well as a reduction in earnings for the estimated amount owed under the 1% cap on earnings. Removing the impact of these two transactions, adjusted earnings is $43 million (also 9% of revenue) which is in line with the overall earnings level in 2010.

2. Verify the Minnesota Supplement Report #1 was completed in accordance with all instructions currently effective set forth by the Minnesota Department of Health.

RRC obtained the Minnesota Supplement Report #1 instructions. An example of the Minnesota Supplement Report #1 can be found in Appendix 3 and the instructions can be found in Appendix 4.

The instructions state: “All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.” The Minnesota Supplement Report #1 reconciles to the annual statement.
The instructions also state the primary MN Statute reference for MN Supplement Report #1 is §62D.08. See Appendix 2 for §62D.08.

3. Perform an analytical review comparing the 2010 and 2011 MN Supplement Reports and research any significant fluctuations.

In addition to the detailed breakout of what was included in Column 10 (PMAP Column) on the 2010 and 2011 MN Supplement Report #1 reports (discussed above in item 1.), UCare provided RRC with a breakout of what programs were included in other report columns in which there were differences between 2010 and 2011.

The differences are described below:

**Column 8**

In 2011, the State redefined Column 8 to be SNBC (MA Only) in the standard template dropping Minnesota Disability Health Options (MnDho) as a stand-alone column. In 2011 no values were reported in Column 8.

In 2010 Column 8 was used to report Minnesota Disability health options program (MnDho) program values only.

**Column 9**

In 2011, the State redefined Column 9 to be SNBC (Integrated) in the standard template dropping GAMC as a stand-alone column. In 2011 Column 9 was used to report SNBC (Connect) values and $172,000 in run-off revenue from the MnDho program that was discontinued as of 12/31/2010.

In 2010 Column 9 was used to report GAMC values only.

**Column 13**

In 2011 Column 13 was used to report MSC+, Medicare Supplement (Select) and ASO values.

In 2010 Column 13 was used to report SNBC (Connect), Medicare Supplement (Select) and ASO values.

Due to these significant format changes in what was reported in which columns in the 2010 and 2011 Minnesota Supplement #1 Report reports, RRC performed an analytical review comparing, where possible, data as presented in the 2010 and 2011 MN Supplement Report #1 (for Medicare + Choice, MSHO, and MNCare). Since the Minnesota Supplement Report #1 did not provide separately product level detail for the other product lines for 2010 and 2011, RRC requested and received this detail from UCare and used this information to perform the analytical review for the MSC+, SNBC, MnDho and GAMC programs. Any
fluctuations greater than 20% and the individual program's materiality were identified and sent to UCare for an explanation. Materiality was calculated for the individual programs based on 5% of the individual programs' 2011 net income (rounded), i.e. materiality for MN Senior Health Options (MSHO) = $11,275,119 (2011 net income) * 5% = $563,755 rounded to $564,000.

The Company provided responses to the significant fluctuations identified. Although the explanations appeared reasonable, the following fluctuations were noted as unusual:

The PMAP specific observations are reported in item 1 above. Other observations include:

For UCare's overall book of business, net realized capital gains increased by 44% from $6,752,401 in 2010 to $9,749,666 in 2011. This change was due to a change, in early 2011, in UCare's investment management strategy of equity securities in their investment portfolio. UCare liquidated and realized gains on the sale of actively managed equity securities and reinvested the proceeds into an equity index fund. The increase in the amount reported in each product line reflects its share of this increased company-wide amount under UCare's overall investment income allocation method, which remains unchanged from 2010 to 2011.

**MN Senior Health Options (MSHO)**

The MSHO prescription drug expenses decreased 15% between 2010 and 2011 (from $13,583,631 to $11,551,027). This is not consistent with the increase in other medical expenses and increase in member months between 2010 and 2011. There are a number of factors contributing to the decrease in prescription drug expenses for the MSHO product from 2010 to 2011. This decrease represents a pmpm decrease of approximately $23. In an effort to offset the first year phase-in of revenue reductions under the Affordable Care Act (ACA), UCare initiated a number of strategies to manage medical related costs, most notably pharmacy expenses. In the course of this effort, UCare initiated several cost savings strategies in 2011 including formulary and utilization strategies that resulted in approximately $14 pmpm of cost savings on an annual basis. In addition, prescription rebates earned related to this product increased by just over $9 pmpm, representing an overall reduction in the net prescription drug costs reported. The actual rebates received were greater than the estimated amounts originally reported and accrued in the prior year based on UCare's contract with its pharmacy benefits manager.

The MSHO program had a 935% net increase in underwriting gain (from $801,195 to $8,295,599) between 2010 and 2011. The table below summarizes the high level calculation of the net underwriting gain for UCare's MSHO product in 2010 and 2011.
While the increase in dollar amount of the net underwriting gain is significant from 2010 to 2011, as a percentage of the related premium revenue it represents a 2.7% improvement. As illustrated above, the improved net underwriting gain is attributable to both increased overall revenue per member in 2011 as well as reduced medical expenses. Revenue for 2010 is reduced by an accrual for potential payments to CMS as a result of risk adjustment data validation audits, undertaken by CMS, of Medicare Advantage plans and which have resulted in significant contract recoveries. Because MSHO is a dual Medicare and Medicaid product, this risk would apply only to the Medicare component of MSHO payment managed by CMS. UCare did not make such an accrual for the MSHO product in 2011, and therefore accounts for the majority of the revenue variance. With respect to cost reductions in 2011, UCare initiated several strategies to reduce prescription drug costs, which contributed to the overall decrease in medical expense. In addition, through other strategies, the MSHO product realized volume adjusted utilization reductions in high cost areas such as skilled nursing days per thousand (15% decrease) and reduced therapy visits per thousand (22% decrease). Finally, improvement in the administrative expense per member primarily represents efficiencies gained in the spread of fixed costs due to growth.

MinnesotaCare (MNCare)

MNCare had a 95% decrease in underwriting gain from $6,327,976 in 2010 to $339,528 in 2011. The reduction is the result of a number of factors including the transfer of enrollment to PMAP with the early expansion of Medicaid in spring of 2011. In addition to the reduction in enrollees from which to generate earnings, the remaining enrollees were subject to a full year impact of legislative rate reductions passed in 2010. These reductions included a 3% ratable reduction plus a 15% ratable reduction on single adult enrollees without children over 75% of poverty. These legislative percentages reduced revenue and directly impacted the overall net underwriting gain as medical and administrative costs were not able to be reduced enough to offset the effect on revenue.

MSC+

The MSC+ program had a 37% favorable movement in underwriting loss from ($6,751,441) in 2010 to ($4,262,206) in 2011. This was due to several factors. For UCare the MSC+ members are highly concentrated in the metro area and ethnically diverse. Much of the cost of care is home health care based (using Personal Care Assistants (PCAs) in the member’s homes and a lower frequency of the use of Assisted Living and Skilled Nursing Facilities (SNFs)). Between 2010 and 2011 UCare’s cost for PCA services decreased 10% and SNF utilization levels measured in days per thousand members decreased 43%. In addition, in late 2010 UCare implemented a more rigorous precertification program from physical
therapy, speech therapy and occupational therapy services that resulted in a utilization decrease of 62% in visits per thousand members from 2010 to 2011. This new precertification program/protocol decreased therapy costs for MSC+ significantly.

**SNBC (Connect)**

Membership in the SNBC (Connect) program increased 307% from 6,924 member months in 2010 to 28,168 member’s months in 2011. This increase was primarily driven by UCare’s discontinuation of the Minnesota Disability Health Options program (MnDho) as of 12/31/2010. Many of the MnDho members moved to the SNBC (Connect) program. A 385% increase in SNBC (Connect) revenues from $10,055,174 in 2010 to $48,721,320 in 2011 was primarily the result of this increase in membership.

Hospital and medical expenses increased 415% between 2010 and 2011 from $9,619,647 to $49,575,399 and general administration and claims administration expenses (combined) increased 271% between 2010 and 2011 from $833,134 to $3,091,225. This increase was driven by the increased membership but also because the MnDho members who shifted to SNBC (Connect) in 2011 tended to need more costly medical services due to their physical disabilities.

4. Review (by total) the MN Supplement Report to the Expense page of the Statutory Annual Statement. Review the expense categories in terms of:

- Expense allocation between legal entities is consistent with the Statement of Statutory Accounting Principles No. 25 (fair and reasonable).

- Identify expense allocation between public and private programs.

- Perform analytical review and/or testing by sampling various expense categories to determine if expenses were accounted for in accordance with the entity’s expense allocation agreements and guidelines.

We obtained the 2011 expense detail from UCare. The $117,567,844 general expense detail provided was agreed to the Underwriting and Investment Exhibit Part 3 - Analysis of Expenses in the 2011 annual statement for completeness. UCare’s general expense detail is separated into 25 categories of accounts. Ten categories were selected for further testing. We selected all categories over $1 million for testing, excluding premium taxes and payroll taxes as they are a function of premiums and salaries. Within each category, we judgmentally selected large accounts for a total selection of 15 accounts for expense review. Expenses were judgmentally reviewed for these accounts for the months of June and December 2011, with the exception of Audits (Account 710010) and Advertising Media (Account 820220). These two accounts did not have activity in June or December, and had little activity overall, so the entire year was reviewed.
**UCare Allocation Process**

UCare allocates expenses at a product and program level each month for reporting purposes. If a particular expense is determined to be directly related to a particular product line (based on the nature and/or purpose of the expense), it is coded and recorded directly to the specific product code in the month that it is processed. Administrative related expenses that are not specifically attributable to a product code flow into UCare's overall indirect expense allocation process. This process is performed on a monthly basis and allocates cumulative indirect costs to a product line for reporting purposes proportional to a respective product's premium revenue. Management indicates this process has been in place from 2005 through 2011; however, in 2012 due to significant growth the process for allocating indirect expenses has slightly changed.

5. Verify appropriateness with regards to the establishment of any Premium Deficiency Reserves allocated to public programs.

**Premium Deficiency Reserve**

UCare evaluates the need for a Premium Deficiency Reserve ("PDR") at the contract level based on projected earnings determined through the annual budget process. A contribution margin is determined based on budgeted results for the following year.

\[
\text{Premium Revenue} - \text{minus Medical Costs} - \text{minus Administrative Expenses}
\]

The Company noted that selling and other related costs are excluded in determining if a loss on the contract is expected.

The Company determined that a PDR was not necessary as of December 31, 2011. The following table shows the Company's results.

<table>
<thead>
<tr>
<th>UCare Public Programs</th>
<th>Contribution Margins as of 12/31/11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contract B48619</strong></td>
<td></td>
</tr>
<tr>
<td>PMAP</td>
<td>$10,100,000</td>
</tr>
<tr>
<td>MNCare</td>
<td>3,900,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$14,000,000</td>
</tr>
<tr>
<td><strong>Contract B48627</strong></td>
<td></td>
</tr>
<tr>
<td>MSHO</td>
<td>$4,600,000</td>
</tr>
<tr>
<td>MSC+</td>
<td>(2,600,000)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$2,000,000</td>
</tr>
<tr>
<td><strong>Contract B48636</strong></td>
<td></td>
</tr>
<tr>
<td>SNBC</td>
<td>$600,000</td>
</tr>
</tbody>
</table>
It is noted that neither Investment Income nor Taxes are included in the calculation. Taxes are excluded as UCare is a non-profit and not subject to income tax. Per above, since the related contracts did not appear to be in a loss position, excluding investment income from the calculation is reasonable.

Statement of Standard Accountancy Practice ("SSAP") No. 54, paragraph 18 states:
“For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured.”

As noted, the Company performs calculations at the contract level. They noted that PMAP and MNCare are combined based on the fact these two products are covered under the same Department of Human Services contract. For Contract B48627, the operating loss for MSC+ is offset by the gain for MSHO. Other methods of groupings may result in a need for a PDR. From the information provided, it appears that the groupings appear reasonable and appear to follow SSAP No. 54.


**Inurred But Not Reported Claim Liability**

UCare’s reserving methodology involves the use of the Developmental Method. Completion Factors are developed using 18-month historical claim lag triangles. They use software called “Incurred Claims Builder” developed by an outside vendor to compute lag factors. The calculations are supplemented by reviews of utilization statistics, claims inventory information and other pertinent provider and operational information. Estimates are reviewed by an external actuary for reasonableness.

UCare applies an explicit margin for adverse claim deviation of 10% to the unpaid claim liability estimates. This margin load is considered within an acceptable range of reasonableness by the Company’s external actuary. According to the Company, the margin percentage has remained unchanged since at least 2001.

We concluded that the margin applied by the Company is overly conservative when considering historic redundancies and profitability analysis of the company’s public programs.

The methodology employed appears reasonable and appropriate. It follows generally accepted actuarial practice for coverages with a relatively short time-period between the incurreal and payment of claims which includes most health care coverages.

7. Compare the 2010 run-out provided to the Department of Human Services in 2011 to the retrospective review of reserves.
The Company provided a file which was provided to the Department showing recasts of year-end reserve estimates using claim data through May 2012. The following tables summarize these results.
<table>
<thead>
<tr>
<th>UCare</th>
<th>Unpaid Claim Liabilities as of December 31, 2010</th>
<th>Data Through May 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial Estimate</td>
<td>Restated Liability</td>
</tr>
<tr>
<td>Medical Assistance - Families and Children</td>
<td>$41,947,969</td>
<td>$30,241,143</td>
</tr>
<tr>
<td>Medical Assistance - Adults Only</td>
<td>$41,947,969</td>
<td>$30,241,143</td>
</tr>
<tr>
<td>Medical Assistance Total</td>
<td>$1,099,210</td>
<td>$1,027,931</td>
</tr>
<tr>
<td>General Assistance</td>
<td>$9,887,668</td>
<td>$8,368,884</td>
</tr>
<tr>
<td>MNCare Adults w/o Children</td>
<td>4,580,863</td>
<td>3,877,225</td>
</tr>
<tr>
<td>MNCare Adults &amp; Children</td>
<td>$14,468,531</td>
<td>$12,246,108</td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td><strong>$57,515,710</strong></td>
<td><strong>$43,515,183</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UCare</th>
<th>Unpaid Claim Liabilities as of December 31, 2011</th>
<th>Data Through May 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial Estimate</td>
<td>Restated Liability</td>
</tr>
<tr>
<td>Medical Assistance - Families and Children</td>
<td>$55,544,450</td>
<td>$44,084,271</td>
</tr>
<tr>
<td>Medical Assistance - Adults Only</td>
<td>12,290,656</td>
<td>9,754,794</td>
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<tr>
<td>Medical Assistance Total</td>
<td>$67,835,107</td>
<td>$53,839,065</td>
</tr>
<tr>
<td>General Assistance</td>
<td>$0</td>
<td>$134,106</td>
</tr>
<tr>
<td>MNCare Adults w/o Children</td>
<td>$7,670,026</td>
<td>$6,745,643</td>
</tr>
<tr>
<td>MNCare Adults &amp; Children</td>
<td>5,774,491</td>
<td>5,078,556</td>
</tr>
<tr>
<td>MNCare Total</td>
<td>$13,444,517</td>
<td>$11,824,199</td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td><strong>$81,279,624</strong></td>
<td><strong>$65,797,369</strong></td>
</tr>
</tbody>
</table>

Based upon the information provided, the December 31, 2010 estimates in total were redundant by 24.3%. Estimates as of December 31, 2011 were redundant by 19.0%. Every product line is redundant and the magnitude is over-and-above the margin level. Original estimates include the 10% margin for adverse claim deviation whereas the Recasts do not. It is recommended that the reserving methodology for Public Programs as it relates to precision be reviewed.
STATE OF MINNESOTA
EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 11-06

Creating Public Disclosure for
Minnesota's Managed Care Health Care Programs

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, over 500,000 Minnesotans receiving public health insurance coverage are enrolled in managed care; and

Whereas, the State spends approximately $3 billion annually on purchasing health care from managed care plans for state public programs; and

Whereas, it is critical for public trust that Minnesota's taxpayers understand how public dollars for health care are being used; and

Whereas, the State needs greater disclosure and accountability of managed care plan spending on health care and long-term care services and administrative expenses for state public programs;

Now, Therefore, I hereby order the Commissioner of Human Services to:

1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.

2. Develop an annual comprehensive managed care report in consultation with the Commissioners of Health and Commerce that includes detailed information on administrative expenses, premium revenues, provider payments and reimbursement

1
rates, contributions to reserves, enrollee quality measures, service costs and utilization, enrollee access to services, capitation rate-setting and risk adjustment methods, and managed care procurement and contracting processes.

3. Submit data from the managed care plans for state public programs to the Commissioner of Commerce so that regular financial audits of data will be conducted.

Under Minnesota Statutes, section 4.035, subdivision 2, this Executive Order is effective 15 days after publication in the State Register and filing with the Secretary of State.

In Testimony Whereof, I have set my hand on March 23, 2011.

Mark Dayton
Governor

Filed According to Law:

Mark Ritchie
Secretary of State
Appendix 2 – Minnesota Statutes §62D.08 and 256B.69, subd 9c

62D.08 ANNUAL REPORT.

Subdivision 1. Notice of changes.

A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q), (r), (s), and (t) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 60 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Subd. 2. Annual report required.

Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health covering the preceding calendar year. However, utilization data required under subdivision 3, clause (e), shall be filed on or before July 1.

Subd. 3. Report requirements.

Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of health;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization,
including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(e) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; and

(f) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Subd. 4. Penalty; extension for good cause.

Any health maintenance organization which fails to file a verified report with the commissioner on or before April 1 of the year due shall be subject to the levy of a fine up to $500 for each day the report is past due. This failure will serve as a basis for other disciplinary action against the organization, including suspension or revocation, in accordance with sections 62D.15 to 62D.17. The commissioner may grant an extension of the reporting deadline upon good cause shown by the health maintenance organization. Any fine levied or disciplinary action taken against the organization under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 to 14.69.

Subd. 5. Changes in participating entities; penalty.

Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner 120 days before the effective date. When the health maintenance organization terminates a provider for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within ten working days of the date the health maintenance organization sends out or receives the notice of cancellation, discontinuance, or termination. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $200 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Subd. 6. Financial statements.

A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization for the first three quarters of the year on forms prescribed by the commissioner. The statements are due 30 days after the end of the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.
Subd. 7. Consistent administrative expenses and investment income reporting.

(a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

256B.69 PREPAID HEALTH PLANS.

Subd. 9c. Managed care financial reporting.

(a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

1. administrative expenses by category and subcategory consistent with administrative expense reporting to other state and federal regulatory agencies, by program;
2. revenues by program, including investment income;
3. nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:
   i. individual-level provider payment and reimbursement rate data;
(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 30 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 30 days to review the report and provide comment to the commissioner.
## Appendix 3 – Minnesota Supplement Report #1

### Minnesota Supplement Report #1

**STATEMENT OF REVENUE, EXPENSES AND NET INCOME**

For the year ending December 31, 2011

Public Information, Minnesota Statutes § 62D.08

<table>
<thead>
<tr>
<th>NAIC #</th>
<th>NAIC Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>As found on page 4 of the Annual Statement</td>
<td></td>
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<tr>
<td></td>
<td>NAIC Totals</td>
<td>Non-Minnesota Products (Eliminations)</td>
<td>Total Minnesota Products</td>
<td>Commercial</td>
<td>Medicare + Choice</td>
<td>Medicare Cost</td>
<td>Minnesota Sector Health Options (MSHO)</td>
<td>SMBG (MA Only)</td>
<td>SMBG (Integrated)</td>
<td>Prepaid Medical Assistance Program (PMAP)</td>
<td>MNCare</td>
<td>Dental</td>
<td>Other</td>
<td>Please Specify</td>
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<td>1 Member States</td>
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<tr>
<td></td>
<td><strong>REVENUES:</strong></td>
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<tr>
<td>2</td>
<td>Net Premium Income (including § 1.01 nonhealth premium income)</td>
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<tr>
<td>3</td>
<td>Change in unearned premium reserves and same for intercreditor adjustments</td>
<td>[</td>
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<td></td>
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<tr>
<td>4</td>
<td>Fee-for-service (net of § 4.02 medical expenses)</td>
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<td></td>
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<tr>
<td>5</td>
<td>Risk revenue</td>
<td>[</td>
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</tr>
<tr>
<td>6</td>
<td>Aggregate revenues for other health care related revenues (Line 6B)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>7</td>
<td>Aggregate revenues for other non-health related revenues (Line 7B)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>8</td>
<td>TOTAL REVENUES (Lines 2 through 7)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td></td>
<td><strong>EXPENSES:</strong></td>
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<td>9</td>
<td>Hospital/medical benefits</td>
<td>[</td>
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<tr>
<td>10</td>
<td>Other professional services</td>
<td>[</td>
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<tr>
<td>11</td>
<td>Office visits</td>
<td>[</td>
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<tr>
<td>12</td>
<td>Emergency room and out-patient</td>
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<td>13</td>
<td>Prescription drugs</td>
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<tr>
<td>14</td>
<td>Aggregate expenses for other hospital and medical expenses (Line 14B)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>15</td>
<td>Issuance Pools and Withhold Adjustments</td>
<td>[</td>
<td></td>
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<tr>
<td>16</td>
<td>TOTAL EXPENSES (Lines 9 through 15)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td></td>
<td><strong>LEBS:</strong></td>
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<tr>
<td>17</td>
<td>Net miscellaneous recoveries</td>
<td>[</td>
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<tr>
<td>18</td>
<td>Total hospital and medical (Lines 16 minus 17)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
<td>NR</td>
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<tr>
<td>19</td>
<td>Non-health claims</td>
<td>[</td>
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<tr>
<td>20</td>
<td>Claim adjustment expenses</td>
<td>[</td>
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<tr>
<td>21</td>
<td>General administrative expenses</td>
<td>[</td>
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<tr>
<td>22</td>
<td>Increase in reserves for life, accident and health contracts (including § 22.01 increase in reserves for life only)</td>
<td>[</td>
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<tr>
<td>23</td>
<td>Total underwriting deductions (Lines 18 through 22)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
<td>NR</td>
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<td>NR</td>
</tr>
<tr>
<td>24</td>
<td>Net underwriting gain or (loss) (Lines 8 minus 23)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
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<tr>
<td>25</td>
<td>Net investment income earned</td>
<td>[</td>
<td></td>
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<tr>
<td>26</td>
<td>Net realized capital gains or (losses)</td>
<td>[</td>
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<tr>
<td>27</td>
<td>Net investment gain or (losses) (Line 25 plus 26)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>28</td>
<td>Aggregate write-in for other income or expenses (Line 28A)</td>
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<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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</tr>
<tr>
<td>29</td>
<td>Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 minus 29)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
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<tr>
<td>30</td>
<td>Federal and foreign income taxes imposed</td>
<td>[</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>31</td>
<td>Net income (loss) (Line 20 minus 30)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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</tr>
</tbody>
</table>

27
Appendix 4 – MN HMO Instructions

Date: December 1, 2011

To: Minnesota Domiciled Health Maintenance Organizations and County Based Purchasers

From: Mike Rothman, Commissioner
Minnesota Department of Commerce

Subject: Filing of Annual Statement, Supplements, Exhibits, Certificates and Reports

Contacts: Minnesota Department of Commerce
Constance Peterson, Constance.Peterson@state.mn.us (651)297-8943
Robert Rivera, Robert.Rivera@state.mn.us (651)296-4523 (Questions about Medical Necessity Evaluation Filing Only)

Minnesota Department of Health
MaryAnn (Fena) Benke, Maryann.Benke@state.mn.us (651)201-5164

NAIC Instructions and Blanks

The National Association of Insurance Commissioners (NAIC) Annual Statement health blank is required to be filed with the Department of Commerce no later than 4/1/12 per Minnesota Statutes §62D.08. Refer to the following table for details regarding the Annual Statement filing and other required filings for the year 2012:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Copies</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Statement (hard copy)</td>
<td>5</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 2 &amp; 3</td>
<td></td>
</tr>
<tr>
<td>Annual Statement (electronic filing)</td>
<td>1</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 2 &amp; 3</td>
<td>Those organizations not filing electronically with the NAIC are required to file the Annual Statement in PDF format in addition to the required hard copies.</td>
</tr>
<tr>
<td>Investment Policy Certification</td>
<td>5</td>
<td>4/1/12</td>
<td>§62D.045, Subd. 2 and §60A.112</td>
<td>Not required for County Based Purchasers.</td>
</tr>
<tr>
<td>Audited Financial Statement</td>
<td>3</td>
<td>4/1/12</td>
<td>§62D.08, Subd. 3(a)</td>
<td></td>
</tr>
<tr>
<td>Risk Based Capital Report</td>
<td>3</td>
<td>4/1/12</td>
<td>§62D.04, Subd. 1(c)</td>
<td></td>
</tr>
</tbody>
</table>
| Notification of Change in Appointed Actuary | 1               | Within 5 business days | §62D.08, Subd. 2 & 3         | According to the NAIC Annual Statement Instructions, documentation for a newly appointed actuary needs to include the following:
  - The insurer shall provide the Commissioner with a letter within 10 business days stating whether, in the preceding 24 months, there were any disagreements with the former actuary.
  - The insurer shall request the former actuary to furnish a letter addressed to the insurer stating whether the actuary
agrees or disagrees with the statements contained in the insurer's letter, to be forwarded to the Commissioner.

- Please provide the requested information electronically by emailing it to a special email box we have established for these appointments (and illustration actuary filings):
  insurance.actuary@state.mn.us

<table>
<thead>
<tr>
<th>Quarterly Financial Statements (hard copy)</th>
<th>4</th>
<th>4/30, 7/30 and 10/30</th>
<th>§62D.08, Subd. 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Financial Statements (electronic filing)</td>
<td>1</td>
<td>4/30, 7/30 and 10/30</td>
<td>§62D.08, Subd. 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Those organizations not filing electronically with the NAIC are required to file the Quarterly Statements in PDF format in addition to the required hard copies.</td>
</tr>
</tbody>
</table>

**Filing Address:** Department of Commerce
Financial Institutions - Insurance
85 Seventh Place East, Suite 500
St. Paul, MN 55101-2198

**Filing Fees:** Health Maintenance Organizations: Send the filing fee of $400 for the Annual Statement and $200 for each Quarterly Statement, payable to the Minnesota Department of Health (not the Minnesota Department of Commerce), to: Managed Care Systems Section, Minnesota Department of Health, P.O. Box 64882, St. Paul, MN 55164-0882 by the filing due dates. **County Based Purchasers:** Filing fees not required.

**Minnesota Supplemental Reports (excluding HEDIS)**

Pursuant to applicable Minnesota law, complete the following reports. These report forms, with the exception of the HEDIS 2012 Data Submission Tool, can be downloaded from the “HMO Annual Report Forms” link at the bottom of the following Department of Health Web page:
www.health.state.mn.us/divs/hpse/mcs/forms.htm

<table>
<thead>
<tr>
<th>Report</th>
<th>Due Date</th>
<th>Primary MN Statute Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>4/12</td>
<td>§62D.08</td>
<td>Statement of Revenue, Expenses and Net Income</td>
</tr>
<tr>
<td>2.</td>
<td>4/12</td>
<td>§4685.2000</td>
<td>Summary of Complaints and Grievances</td>
</tr>
<tr>
<td>3.</td>
<td>4/12</td>
<td>§72A.201, Subd. 8(7)</td>
<td>Summary of Chemical Dependency Claims and Appeals</td>
</tr>
<tr>
<td>4.</td>
<td>4/12</td>
<td>§62D.08, Subd. 3(d) and 4685.2100D</td>
<td>Participating Providers Listing</td>
</tr>
<tr>
<td>5.</td>
<td>4/12</td>
<td>§62M.09, Subd. 9</td>
<td>Medical Necessity Evaluation</td>
</tr>
<tr>
<td>6.</td>
<td>7/12</td>
<td>§62D.04(1) &amp; §62D.08</td>
<td>Enrollment Statistics By Products and County</td>
</tr>
<tr>
<td>7.</td>
<td>7/12</td>
<td>§62D.04(1) &amp; §62D.08</td>
<td>HEDIS 2012 (For Calendar Year 2011) Data Submission Tool (through NCQA). Separate Instructions to Follow.</td>
</tr>
</tbody>
</table>

Instructions for filing the HEDIS data (through NCQA) will be sent from the Minnesota Department of Health under separate cover.

In addition to the electronic copy of the Medical Necessity Evaluation Form filing (Supplemental Report #5) with the Department of Health, e-mail a copy of the filing to Robert Rivera at the Department of Commerce: Robert.Rivera@state.mn.us.

All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.
**Minnesota Supplements Filing Instructions:** It is not necessary to send a paper copy in addition to the electronic submission; none of these reports require a signature. Send the completed Minnesota Supplement forms on a CD to:

**Mailing Address:** Dedra Johnson  
Managed Care Systems Section  
Minnesota Department of Health  
P.O. Box 64882  
St. Paul, MN  55164-0882

**Courier Address:** Managed Care Systems Section  
Minnesota Department of Health  
85 Seventh Place East, Suite 220  
St. Paul, MN  55101
Appendix 5 - Prepaid Medical Assistance Program (PMAP) map
Health Plan Choices by County Effective April 1, 2011

www.dhs.state.mn.us/healthcare
or
www.dhs.state.mn.us/maps
Appendix 6 - MinnesotaCare (MNCare) map
Health Plan Choices by County Effective April 1, 2011

www.MinnesotaCare411.com
or
www.dhs.state.mn.us/Maps
Appendix 7 - Minnesota Senior Care Plus (MSC+) map
Health Plan Choices by County Effective April 1, 2011

www.dhs.state.mn.us/
healthcare
or
www.dhs.state.mn.us/mcps
Appendix 10 – Organization Chart

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER
MEMBERS OF A HOLDING COMPANY GROUP
PART 1 - ORGANIZATIONAL CHART

UCare Minnesota
Federal ID # 36-3573805
NAIC Company Code 52629
NAIC Group Code 4380
State of Domicile -- MN

UCare Wisconsin, Inc.
Federal ID # 20-6265943
NAIC Company Code 12524
NAIC Group Code 4380
State of Domicile -- WI
Exhibit 1 – Impact of Allocation Calculation Error on Administrative Expenses Reported

The following Exhibit was provided to the review team to show the impact of the Allocation Calculation Error

UCare Minnesota
2011 Minnesota Supplement Report #1
Impact of Allocation Calculation Error on Administrative Expenses Reported

<table>
<thead>
<tr>
<th>Product Name - Per Supplement Report #1</th>
<th>Originally</th>
<th>Revised</th>
<th>Difference Over (Under)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reported</td>
<td>Revised</td>
<td></td>
</tr>
<tr>
<td>Prepaid Medical Assistance Program (PMAP)</td>
<td>70,525,940</td>
<td>68,794,681</td>
<td>1,731,259</td>
</tr>
<tr>
<td>MnCare</td>
<td>8,170,421</td>
<td>8,325,313</td>
<td>(154,892)</td>
</tr>
<tr>
<td>Minnesota Senior Health Options (MSHO)</td>
<td>14,789,823</td>
<td>15,161,572</td>
<td>(371,749)</td>
</tr>
<tr>
<td>Medicare + Choice</td>
<td>49,157,811</td>
<td>50,215,692</td>
<td>(1,057,881)</td>
</tr>
<tr>
<td>SNBC (Integrated)</td>
<td>3,019,494</td>
<td>3,091,225</td>
<td>(71,731)</td>
</tr>
<tr>
<td>Medicare Supplement and MSC+</td>
<td>3,215,300</td>
<td>3,290,306</td>
<td>(75,006)</td>
</tr>
<tr>
<td>Administrative Services Only</td>
<td>(85,877)</td>
<td>(85,877)</td>
<td>-</td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>148,792,912</td>
<td>148,792,912</td>
<td>-</td>
</tr>
</tbody>
</table>

Impact on 1% PMAP and MnCare Earnings Cap

1,576,367
Addendum to Report

UCare Minnesota Comment Letter
December 3, 2012

Rick Thielman
Chief Examiner
Minnesota Department of Commerce, Insurance Division
83 Suyanto Place East, Suite 500
St. Paul, MN 55101-2198

Dear Mr. Thielman:

UCare appreciates the opportunity to provide comments on the report dated December 3, 2012 in which Risk and Regulatory Consulting, LLC retained by the Minnesota Department of Commerce (DOC) made certain observations, findings, recommendations and conclusions regarding its evaluation, performed under Work Order Contract No. 50691, of information contained in various financial reports and cost allocations by UCare.

We strongly support the State’s interest in understanding and potentially clarifying how health plans report financial information. In 2011, we participated in a workgroup under the auspices of the Minnesota Department of Health, which developed recommendations to strengthen consistency and clarity of reporting across health plans. If this DOC report helps advance the goal of improving reporting standards for the benefit of regulators and the public, we believe it will serve as a valuable contribution to the important discussion about health plan reporting.

However, we believe we must respond to certain parts of the report, as set forth below, to ensure that any resulting policy action is based on an accurate understanding of UCare’s financial reporting practices. Our responses are intended to provide additional information that would be critical for a reader to consider for a full and complete evaluation of these complex policy areas.

Before moving to our specific comments, we would offer a general point for consideration. UCare completes and files Minnesota Supplement 41 and other financial reports for the purpose of fulfilling our obligation as a condition of our license — to the Minnesota Department of Health (MDH). This evaluation appeared to analyze such reports in the context of Minnesota Department of Human Services (DHS) payment policy. We believe any further discussion should make clear that financial reporting for MDH licensure and any reporting for use by DHS in determining payments are two distinct purposes that should not be confused. UCare supports efforts to ensure that DHS payments are appropriate and based on transparent information, but cautions that terms and information requirements for this purpose — and for licensing oversight — should be designed more specifically to achieve the respective goals of each of these different but equally important government purposes.

Charitable Contributions Observation — As a non-profit health plan required to have a community benefit program, UCare takes seriously our obligation to share funds to improve the health of our community, including supporting the education of family medicine physicians at the University of Minnesota. This observation regarding UCare’s charitable contributions is accurate and consistent with other public filings that have described our community benefit efforts.

500 Sutson Blvd NE Minneapolis MN 55413-5615 • P.O. Box 52 Minneapolis MN 55448-9493
612-676-6900 • 1-866-457-7144 • TTY 1-800-648-2594 • Fax 612-676-6500 • www.uche.org
December 3, 2012

Rick Theisen
Chief Examiner
Minnesota Department of Commerce, Insurance Division
85 Seventh Place East, Suite 500
St Paul, MN 55101-2198

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However, we believe we must repond to certain parts of the report, as set forth below, to ensure that any resulting policy action is based on an accurate understanding of UCare’s financial reporting practices. Our responses are intended to provide additional information that would be critical for a reader to consider for a fair and complete evaluation of these complex policy areas.

Before moving to our specific comments, we would offer a general point for consideration. UCare completes and files Minnesota Supplement #1 and other financial reports for the purpose of fulfilling our obligation as a condition of our license to the Minnesota Department of Health (MDH). This evaluation appeared to review such reports in the context of Minnesota Department of Human Services (DHS) payment policy. We believe any further discussion should make clear that financial reporting for MDH licensure and any reporting for use by DHS in determining payments are two distinct purposes that should not be confused. UCare supports efforts to ensure that DHS payments are appropriate and based on transparent information, but caution is needed as forms and information requirements for this purpose and for licensing oversight should be designed more specifically to achieve the respective goals of these different but equally important government purposes.

Charitable Contributions Observation – As a non-profit health plan required to have a community benefit program, UCare takes seriously our obligation to share funds to improve the health of our community, including supporting the education of family medicine physicians at the University of Minnesota. This observation regarding UCare’s charitable contributions is accurate and consistent with other public filings that have described our community benefit efforts.
Wages and Salaries Observation - The report accurately describes that we allocated wages and salaries, including executive compensation, as indirect costs across all of our products based on premium revenue, that health plans are not required to cap allocation of executive salaries to any product, and that we did not apply any such cap. However, we do not understand why the report highlights these facts as a noteworthy observation.

Marketing and Advertising Finding - Although UCare agrees that we allocated general brand advertising as an indirect cost to all of our products (including our Medicare products), we disagree with the report’s assertion that such activity is inconsistent with the DHS contract and should not be partially allocated as an indirect expense to our state public program products. The type of “Marketing” that is restricted under the contract section referenced in the finding is further defined in Section 2.52 of the contract as:

any communication from a MCO, or any of its agents or independent contractors, with an Enrollee or Recipient that can reasonably be interpreted as intended to influence that individual to enroll or reenroll in the MCO’s product(s) under this Contract.

In our discussions and years of experience working with DHS, the interpretation of “marketing” has focused on whether the communication describes our state public program plans, including benefits, or otherwise is designed to promote the plans with enrollees and potential enrollees. It is our understanding that general brand advertising that does not describe our plans and is intended to increase general knowledge of the UCare brand is not the kind of marketing regulated and prohibited by the DHS contract. Certainly, DHS has never suggested any concerns about such general brand advertising. Furthermore, with respect to how the costs of such advertising should be allocated for purposes of financial reporting, general brand advertising supports broad market awareness of UCare as an entity and is part of the general overhead cost of doing business. As a stand-alone non-profit organization, UCare’s general overhead expenses are allocated proportionally across all UCare product lines. There is no separate corporate parent or holding company to which these expenses could be applied. In addition, UCare believes it would be improper to allocate these types of expenses only to UCare’s non-state programs as suggested by the recommendation, when all products receive an indirect benefit.

Explicit Margin for Adverse Claim Deviation Finding - The process for estimating unpaid claims liabilities is subject to significant variation and judgment. We believe our current approach for estimating claims liabilities – while conservative -- appropriately falls within the bounds of actuarial standards. UCare’s claims reserves are independently reviewed and opined on annually by an actuary as required by the National Association of Insurance Commissioners (NAIC). In addition, in conjunction with UCare’s most recent financial solvency audit conducted by DOC for the period through 2010, the DOC’s actuary did not express concern about our estimation of unpaid claim liability, including our margin for adverse claim deviation, and the examination report concludes that “the claims liabilities appear to be reasonably stated.” It also should be recognized that maintaining a consistent level of conservatism in these type of accruals is important, because fluctuating the level from year to year can have a significant influence on the reported financial results. UCare has strived to maintain a consistent level of overall margin in unpaid claims liabilities from year to year to avoid significantly impacting reported financial results.

Even if our margin for adverse claim deviation was more conservative than desired, it did not have a material impact on our financial statements, and to our knowledge should not have affected the DHS rate setting process. The amount of explicit margin and redundant claims liability included in UCare financial statement balances reported in any one year is removed from the cost information provided to DHS for purposes of rate setting.
Finally, the report recommends that UCare consider varying the margin level for particular blocks of business. However, UCare maintains a single claims processing system and department that handles claims processing for all product lines. In addition, provider claims submission patterns and processes generally do not vary by product line. Therefore, UCare does not believe there are significant differences in estimation risk between the various blocks of business to warrant the need to vary margin levels by product line.

UCare appreciates the opportunity to provide additional insight and context for the information contained in this DOC report and looks forward to working with government agencies and others to find ways to improve the clarity and transparency of state public program financial reporting.

Sincerely,

Beth Monsrud
Chief Financial Officer

Cc: Jan Moenek, RRC