STATE OF MINNESOTA

ITASCA MEDICAL CARE

WORK ORDER CONTRACT NO: 55012

APRIL 15, 2013

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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. 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 Itasca Medical Care (hereinafter referred to as "IMCare" 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* - 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.

In 2011, IMCare allocated expenses in the following manner:

- Member months were summarized from the enrollment files received from DHS.
- Revenue was estimated by using rates for the North Central region provided by DHS. Rates were adjusted for the impact of IMCare's withhold return.
- Claims totals were developed from a report as part of IBNR analysis, adjusted by allocated reserves.
- Administrative expenses were allocated on the same percentage for both MA Under 65 and MSC+. The allocation percent was based on PMAP column.
- Investment income was allocated as percent of revenue.
- Other healthcare revenues (prescription drug rebates, DHS incentives, etc.) were reviewed and assumed to be attributable only to MA Under 65.
- Other medical expenses (Stop Loss and Provider Settlements) were allocated for MA Under 65 and MSC+ based on PMAP claims.

The 2011 allocation was a change from how expenses were allocated in 2010. In 2010 expenses were allocated by percentage of medical expense.

Background

IMCare is a County Based Health Care Program administered by Itasca County Health & Human Service (ICHHS) that provides health care coverage for people who are eligible for Minnesota Health Care Programs and live within the Itasca County.

County Based Purchasing (CBP) is a purchasing system operated by a county or group of counties. The CBP entity purchases health care services for certain residents enrolled in Medical Assistance, General Assistance Medical Care, and MinnesotaCare. These residents would otherwise be enrolled in public programs where the State of Minnesota purchases services through contracts with HMOs. The participating counties are primarily rural.

Generally, counties propose arrangements that add value to public programs by:

- Assuring improved access to providers and community resources
- Improving coordination of health and human services
- Stabilizing and supporting existing community provider networks

CBP is authorized by Minnesota Statutes, section 256B.692, permitting counties to elect this purchasing system. CBP entities must meet the same requirements as HMOs or Community Integrated Service Networks (CISNs), as provided for under Minnesota Statutes, chapters 62D and 62N. Requirements are also set out in portions of Minnesota Statutes, chapters 62A, 62J, 62M, 62Q, and 72A.; and in Minn. Rules Part 4685.These requirements include standards for access, quality and financial solvency.

IMCare 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.

IMCare 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.

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

<u>Prepaid Medical Assistance Program (PMAP)</u>
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, IMCare provided coverage to PMAP members in Itasca County. IMCare has 1% 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). There is no monthly fee, but enrollee may need to pay small co-pay for some services. In 2011 IMCare provided coverage to approximately 1% 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 IMCare provided coverage to approximately 1% of the statewide MNCare enrollment and is available in Itasca County. See Appendix 6 for the MNCare health plan choices by county.

Public Programs Integrated with Federal Programs provided by IMCare

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 IMCare provided coverage to approximately 1% of the statewide MSHO enrollment. See Appendix 8 for the MSHO health plan choices by county.

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. Our review resulted in no observations or findings.

Scope and Procedures Performed

In accordance with Work Order Contract No. 55011, 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.

		Prepaid Medical Assistance Program (PMAP)	Prepaid Medical Assistance Program (PMAP)
REVENUES:			
1	Member Months	52,154	46,540
2	Net Premium Income	26,578,725	21,319,525
3	Change in unearned premium reserves and serve for rate credits		
4	Fee-for-service		
5	Risk revenue		
6	Aggregate write-ins for other health care related revenues (Line 699)	86,005	211,240
7	Aggregate write-ins for other non-health revenues (Line 799)		
8	TOTAL REVENUES (Lines 2 through 7)	26,664,730	21,530,765
EXPENSES:			
9	Hospital/medical benefits	8,110,065	7,436,969
10	Other professional services	5,903,608	5,319,218
11	Outside referrals	412,587	305,525
12	Emergency room and out-of-area	2,221,916	1,576,456
13	Prescription drugs	3,265,601	2,237,926
14	Aggregate write-ins for other hospital and medical expenses (Line 1499)	2,374,153	1,959,276
15	Incentive Pool and Withhold Adjustments		
16	TOTAL EXPENSES (Lines 9 through 15)	22,287,930	18,835,370
LESS:			
17	Net reinsurance recoveries		
18	Total hospital and medical (Lines 16 minus 17)	22,287,930	18,835,370
19	Non-health claims		
20	Claims adjustment expenses	87,091	345,663
21	General administrative expenses	2,050,094	1,453,057
22	Increase in reserves for life, accident and health contracts		
23	Total underwriting deductions (Lines 18 through 22)	24,425,115	20,634,090
24	Net underwriting gain or (loss)(Lines 8 minus 23)	2,239,615	896,675
25	Net investment income earned		21,977
26	Net realized captial gains or (losses)		
27	Net investment gains or (losses)(Lines 25 plus 26)		21,977
28	Net gain or (loss) from agents' or premium balances charged off		
29	Aggregate write-ins for other income or expenses (Line 2999)		
30	Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	2,239,615	918,652
31	Federal and foreign income taxes incurred		
32	Net income (loss) (Lines 30 minus 31)	2,239,615	918,652

The 2011 PMAP detail provided to RRC agreed to the 2011 IMCare MN Supplemental Report #1.

The PMAP column consisted of the following programs in the 2011 MN Supplement Report #1:

- *PMAP (Non seniors)*
- *MSC+*

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

- *PMAP (Non seniors)*
- *MSC+*

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

Premium income for IMCare's PMAP program increased from $21.3 million in 2010 to $26.6 million in 2011. This was due to the increase of approximately 6,000 member months due to Medicaid Expansion. Correspondingly, expenses for Emergency room and out of area, Prescription drugs, Aggregate write-ins for other hospital and medical, and General Administrative also increased due to the increase in member months, with an additional increase in Prescription drug expenses due to an increase in specialty medication and overall medication spend.

Claims adjustment expense decreased from $346,000 in 2010 to $87,000 in 2011. IMCare stated that the explanation for this decrease was the change in allocation methodology. In 2010 all expenses were allocated as a percentage of medical expenses, and in 2011 claims adjustment expenses were allocated based upon a percentage of premium.

IMCare's underwriting gain for the PMAP program increased from $836,675 in 2010 to $2,239,615 in 2011. This was due to increased capitation, claims experience, and a change in allocation methodology, which has been explained above.

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.

MN Senior Health Options (MSHO)

Expenses for Outside referrals and Emergency and out of area had slight increases between 2010 and 2011. The increase is attributable to a small increase in membership and higher claims experience.

Aggregate write-ins for hospital and medical expenses decreased significantly, from $1,413,343 in 2010 to $265,530 in 2011. Aggregate write-ins for IMCare includes Provider Risk Sharing Settlements. IMCare is fully at-risk with their providers and has been since its inception. Per management, given their risk arrangements, the only gain IMCare typically shows in any given year is interest-earned, all other capitation received goes directly to (or comes back) through a settle-up process with the providers. IMCare's provider settlement was higher in 2010 than in 2011. This change, coupled with the change in allocation of expenses is the reason for this decrease.

Claim adjustment expenses for MSHO decreased from $250,054 in 2010 to $44,482 in 2011 due to the change in IMCare's expense allocation methodology. In 2010 all expenses were allocated as a percentage of medical expenses, and in 2011 claims adjustment expenses were allocated based upon a percentage of premium.

Net underwriting loss increased from $589,156 in 2010 to $1,071,871 2011. This is a result of a change in IMCare's expense allocation methodology, allocating a higher percentage of expenses to MSHO as they believe MSHO has higher overall costs. This is a result of the change in allocation basis of claims and other associated expenses.

The pmpm for nearly all expense categories for MSHO was much higher than the corresponding pmpm for other programs. Additionally, as a percentage of revenue, the expense for Other Professional Services is more than double that of the other programs. The rationale for this is that the MSHO demographic is over 65 years old and utilizes the benefit more than other populations.

Hospital/Medical Benefits for MSHO at Itasca are significantly lower than those at other peers; however, Other Professional Services are much higher than at other peers. Emergency Room is higher as well. Emergency Room expenses are higher than IMCare's peers as IMCare did not have urgent care settings available for their members – the only option was the ER. Management indicated that their main clinic/hospital just started urgent care the beginning of 2013 so they expect to see a shift in utilization. For Hospital/Medical vs. Other professional it appears that IMCare includes different services into Other Professional vs. Hospital/Medical.

MinnesotaCare (MNCare)

Claim adjustment expenses for MNCare decreased from $125,082 in 2010 to $22,602 in 2011. IMCare changed allocation methods from 2010 to 2011. This is a result of changed in IMCare's expense allocation methodology. In 2010 all expenses were allocated as a percentage of medical expenses, and in 2011 claims adjustment expenses were allocated based upon a percentage of premium.

Net underwriting loss increased from $437,638 in 2010 to $1,167,744 in 2011. Capitation revenue for MNCare decreased over this time period; approximately $1.1 million decrease, but there was only a $.4 million decrease in claims expense.

4. Perform an 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 IMCare. The $43,458,930 total expense detail was agreed to the Underwriting and Investment Exhibit Part 3 – Analysis of Expenses in the 2011 annual statement for completeness. IMCare's general expense detail is made up of 37 accounts. Five accounts were selected for further testing. We judgmentally selected large accounts, and within those accounts, the three largest expenses, for a total selection of 12 expenses for review. There were 12 selected for testing since some of the large accounts had less than three expenses. Expenses were judgmentally reviewed for these accounts for the month of July, 2011.

   IMCare Allocation Process

   In 2011, IMCare allocated expenses in the following manner:

   - Member months were summarized from the enrollment files received from DHS.
   - Revenue was estimated by using rates for the North Central region provided by DHS. Rates were adjusted for the impact of IMCare's withhold return.
   - Claims totals were developed from the COS report provided as part of IBNR analysis, adjusted by allocated reserves.
   - Administrative expenses were allocated on the same percentage for both MA Under 65 and MSC+. The allocation percent was based on PMAP column.
   - Investment income was allocated as percent of revenue.
   - Other healthcare revenues (prescription drug rebates, DHS incentives, etc.) were reviewed and assumed to be attributable only to MA Under 65.
- Other medical expenses (Stop Loss and Provider Settlements) were allocated for MA Under 65 and MSC+ based on PMAP claims.

   The 2011 allocation was a change from how expenses were allocated in 2010. In 2010 expenses were allocated by percentage of medical expense.

Appendix 1 – Executive Order 11-06

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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);

(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

< Name of HMO >

Minnesota Supplement Report #1

STATEMENT OF REVENUE, EXPENSES AND NET INCOME

For the year ending December 31, 2011

Public Information, Minnesota Statutes § 62D.08

NAIC #	NAIC Descritption	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	As found on page 4 of the Annual Statement	NAIC Totals	Non-Minnesota Products (Eliminations)	Total Minnesota Products	Commercial	Medicare + Choice	Medicare Cost	Minnesota Senior Health Options (MSHO)	SNBC (MA Only)	SNBC (Integrated)	Prepaid Medical Assistance Program (PMAP)	MNCare	Dental	Other: Please Specify	Administrative Services Only
1	Member Months														
REVENUES:															
2	Net Premium Income (including $ non-health premium income)														
3	Change in unearned premium reserves and serve for rate credits														
4	Fee-for-service (net of $ medical expenses)														
5	Risk revenue														
6	Aggregate write-ins for other health care related revenues (Line 699)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
7	Aggregate write-ins for other non-health revenues (Line 799)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
8	TOTAL REVENUES (Lines 2 through 7)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
EXPENSES:															
9	Hospital/medical benefits														
10	Other professional services														
11	Outside referrals														
12	Emergency room and out-of-area														
13	Prescription drugs														
14	Aggregate write-ins for other hospital and medical expenses (Line 1499)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
15	Incentive Pool and Withhold Adjustments														
16	TOTAL EXPENSES (Lines 9 through 15)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
LESS															
17	Net reinsurance recoveries														
18	Total hospital and medical (Lines 16 minus 17)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
19	Non-health claims														
20	Claims adjustment expenses														
21	General administrative expenses														
22	Increase in reserves for life, accident and health contracts (including $ increase in reserves for life only)														
23	Total underwriting deductions (Lines 18 through 22)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
24	Net underwriting gain or (loss)(Lines 8 minus 23)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
25	Net investment income earned														
26	Net realized captial gains or (losses)														
27	Net investment gains or (losses)(Lines 25 plus 26)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
28	Net gain or (loss) from agents' or premium balances charged off														
29	Aggregate write-ins for other income or expenses (Line 2999)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
30	Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
31	Federal and foreign income taxes incurred														
32	Net income (loss) (Lines 30 minus 31)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

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:

Description	Number of Copies	Due Date	Primary MN Statute Reference	Additional Notes
Annual Statement (hard copy)	5	4/1/12	§62D.08, Subd. 2 & 3	
Annual Statement (electronic filing)	1	4/1/12	§62D.08, Subd. 2 & 3	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.
Investment Policy Certification	5	4/1/12	§62D.045, Subd. 2 and §60A.112	Not required for County Based Purchasers.
Audited Financial Statement	3	4/1/12	§62D.08, Subd. 3(a)	
Risk Based Capital Report	3	4/1/12	§62D.04, Subd. 1(e)	
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
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

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

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.

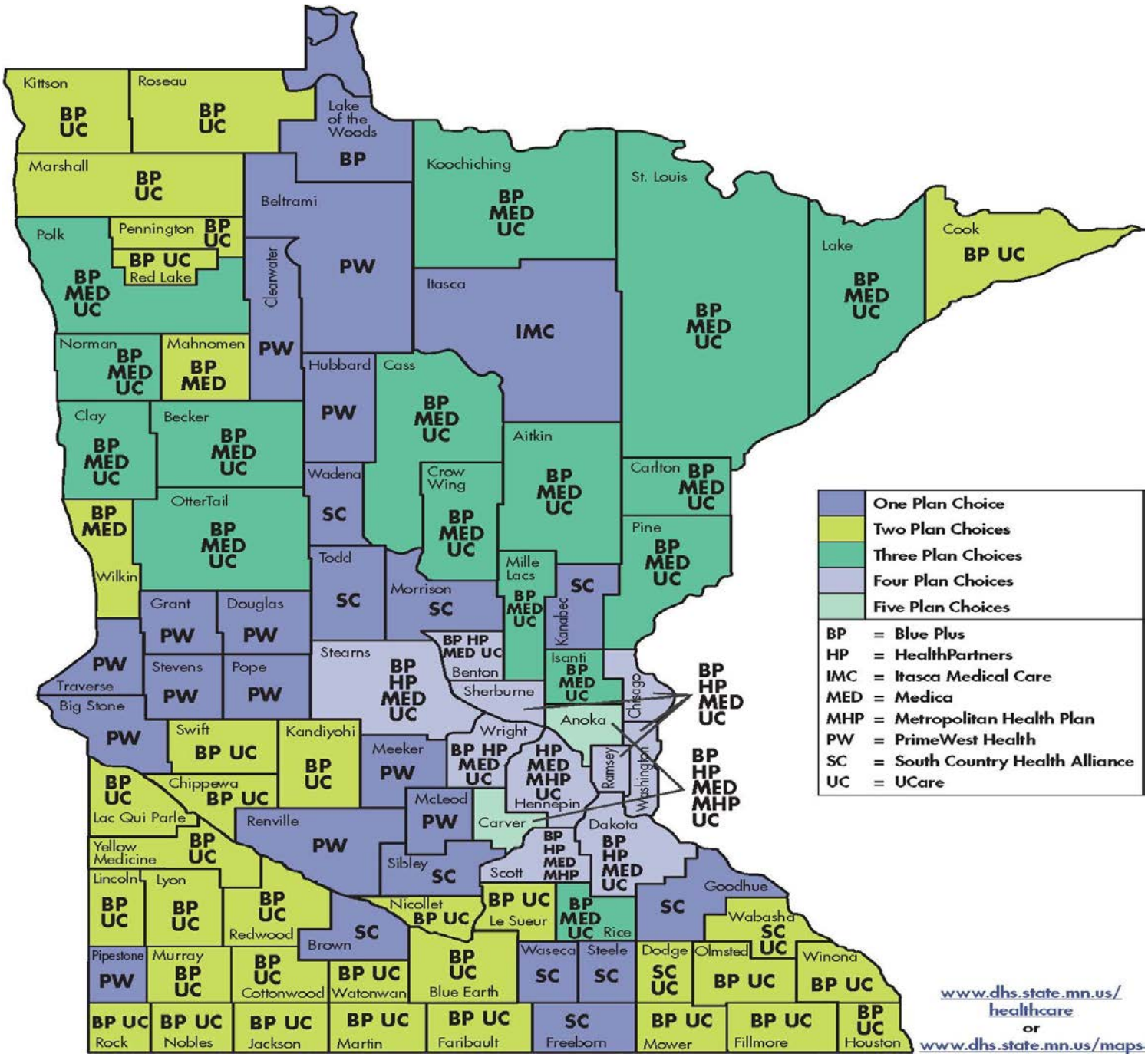
All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.

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

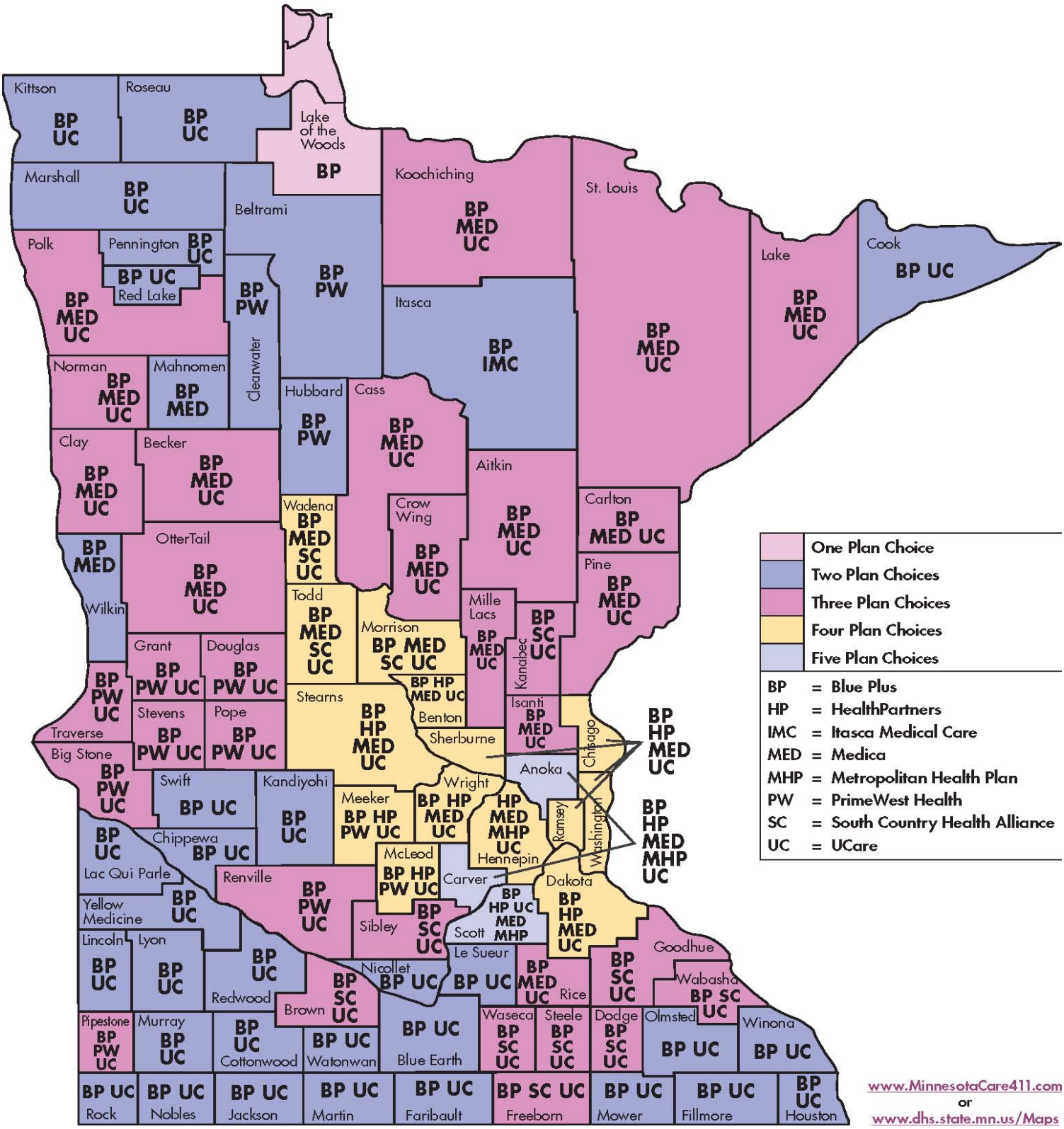
Appendix 5 - Prepaid Medical Assistance Program (PMAP) map

Health Plan Choices by County Effective April 1, 2011



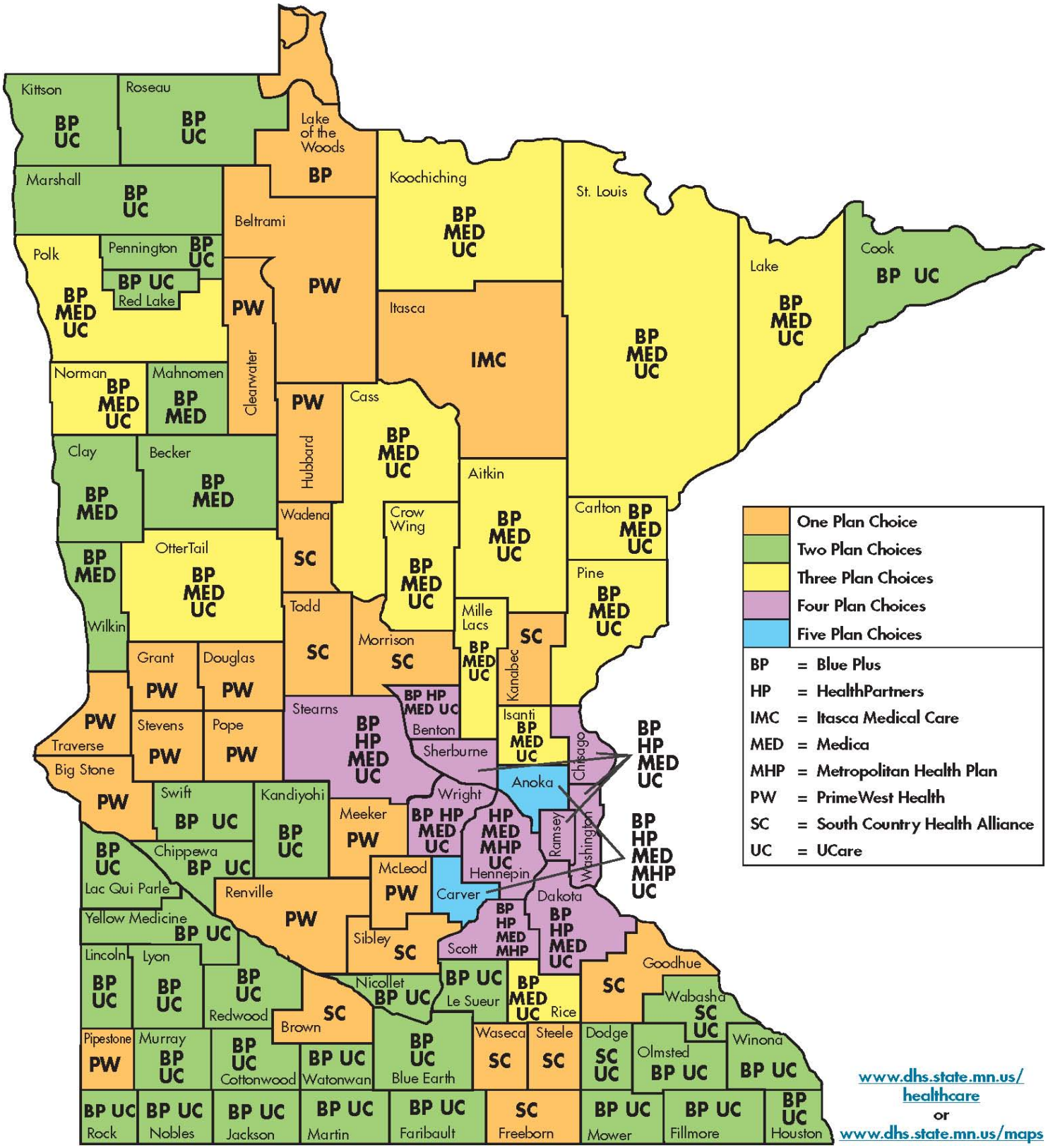
Appendix 6 - MinnesotaCare (MNCare) map

Health Plan Choices by County Effective April 1, 2011

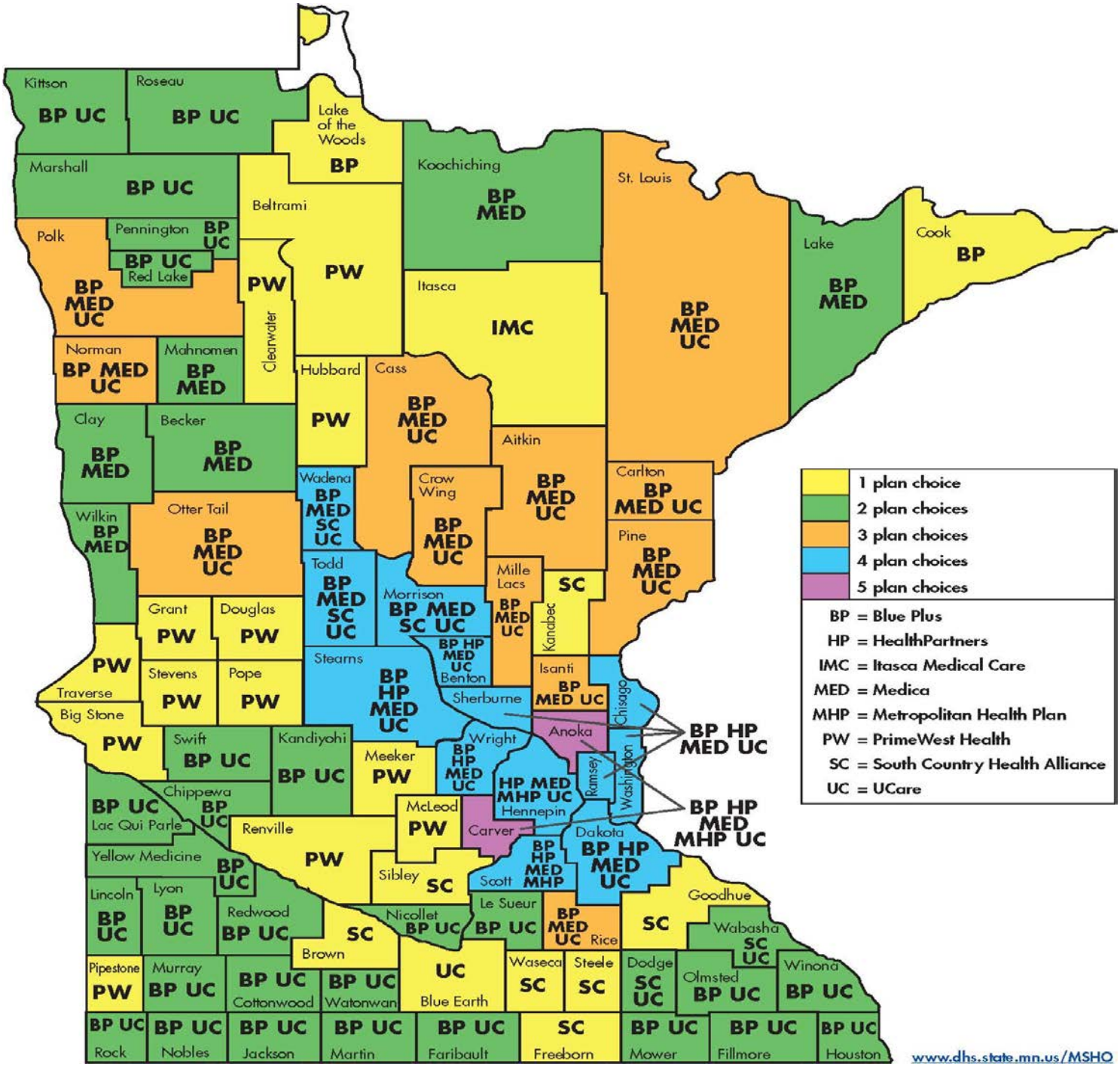


Appendix 7 - Minnesota Senior Care Plus (MSC+) map

Health Plan Choices by County Effective April 1, 2011



www.dhs.state.mn.us/healthcare or www.dhs.state.mn.us/maps

Appendix 8 - Minnesota Senior Health Options (MSHO) map

Health Plan Choices by County for Effective Jan. 1, 2011