

STATE OF MINNESOTA

PRIMEWEST HEALTH

WORK ORDER CONTRACT NO: 55015

APRIL 15, 2013

Table of Contents

Executive Summary	1
Background	2
Observations & Findings	4
Scope and Procedures Performed.....	4
Appendix 1 – Executive Order 11-06	9
Appendix 2 – Minnesota Statutes §62D.08 and 256B.69, subd 9c	12
Appendix 3 – Minnesota Supplement Report #1	16
Appendix 4 – MN HMO Instructions.....	17
Appendix 5 - Prepaid Medical Assistance Program (PMAP) map	20
Appendix 6 - MinnesotaCare (MNCare) map.....	21
Appendix 7 - Minnesota Senior Care Plus (MSC+) map	22
Appendix 8 - Minnesota Senior Health Options (MSHO) map.....	23
Appendix 9 - Special Needs Basic Care (SNBC) map	24

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 PrimeWest Health (hereinafter referred to as "PrimeWest" 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.

PrimeWest allocates general expenses attributable to a single program to that program. General expenses not attributable to a specific program are allocated in a number of ways, based upon the factor driving the expense. For example:

- Expenses for membership materials are allocated based upon enrollment since membership materials are uniform for each member and they are distributed to all enrollees,
- Expenses related to claims adjudication and utilization of services is allocated by program revenue.

For NAIC reporting purposes, general expenses are allocated based upon the categories of Cost Containment, Claims Adjustment, and General Administration.

The results of our analytical review and testing of samples of various expense categories show that PrimeWest 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 - SSAP No. 70 "Allocation of Expenses"*.

Background

PrimeWest Health is a County-Based Purchasing (CBP) health plan operated and governed by the 13 rural Minnesota counties they serve. These counties include Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse.

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, MinnesotaCare, MSHO, MSC+ and SNBC. These residents would otherwise be enrolled in public programs where the State of Minnesota purchases services through contracts with HMOs. The participating counties are entirely 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.

PrimeWest 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.

PrimeWest contracts with the Centers for Medicare and Medicaid Services (CMS) as a Dual Eligible (DE) Special Needs Plan (SNP) under the Medicare Advantage program. PrimeWest has two DE SNPs that are part of programs sponsored by DHS. 1) Minnesota Senior Health Options (MSHO) for beneficiaries age 65 and older who are eligible for DHS Medical Assistance and Medicare Parts A and B, and 2) Special Needs Basic Care (SNBC) for beneficiaries age 18-64 with qualifying disabilities 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 PrimeWest:

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, PrimeWest provided coverage to PMAP members in 13 of the 87 counties. PrimeWest has 4% 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 March 31, 2010. 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 Home & Community Based Services (also known as Elderly Waiver Services) and are not enrolled in Medicare Advantage DE SNP. There is no monthly fee, but enrollee may need to pay small co-pay for some services. In 2011 PrimeWest provided coverage to approximately 7% 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 and adults under age 65 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 PrimeWest provided coverage to approximately 2% of the statewide MNCare enrollment and is available in 13 of Minnesota's 87 counties. See Appendix 6 for the MNCare health plan choices by county.

Public Programs Integrated with Federal Programs provided by PrimeWest

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 PrimeWest provided coverage to approximately 6% 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. PrimeWest offers an SNBC plan which is integrated with Medicare Benefits for eligible enrollees (SNBC Integrated). In 2011 PrimeWest provided coverage to approximately 5% of the statewide SNBC enrollment. See Appendix 9 for the SNBC health plan choices by county.

Observations & Findings

Note, this review is not considered a statutory examination but a special review requested by the Governor. 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 MDH 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.

NAIC Description	2010	2011
	Prepaid Medical Assistance Program (PMAP)	Prepaid Medical Assistance Program (PMAP)
REVENUES:		
1 Member Months	196,110	213,292
2 Net Premium Income	87,734,445	100,504,815
3 Change in unearned premium reserves and serve for rate credits		
4 Fee-for-service		
5 Risk revenue		
6 Aggregate w rite-ins for other health care related revenues (Line 699)		
7 Aggregate w rite-ins for other non-health revenues (Line 799)		
8 TOTAL REVENUES (Lines 2 through 7)	87,734,445	100,504,815
EXPENSES:		
9 Hospital/medical benefits	36,998,339	43,431,430
10 Other professional services	16,202,668	17,540,117
11 Outside referrals		
12 Emergency room and out-of-area	2,091,587	2,604,514
13 Prescription drugs	7,329,308	9,312,091
14 Aggregate w rite-ins for other hospital and medical expenses (Line 1499)	1,464,442	1,466,347
15 Incentive Pool and Withhold Adjustments		
16 TOTAL EXPENSES (Lines 9 through 15)	64,088,344	74,354,499
LESS:		
17 Net reinsurance recoveries	138,031	317,570
18 Total hospital and medical (Lines 16 minus 17)	63,948,313	74,038,929
19 Non-health claims		
20 Claims adjustment expenses	4,573,264	5,371,134
21 General administrative expenses	5,122,357	5,437,342
22 Increase in reserves for life, accident and health contracts		
23 Total underwriting deductions (Lines 18 through 22)	73,643,934	84,845,405
24 Net underwriting gain or (loss)(Lines 8 minus 23)	14,090,511	15,659,410
25 Net investment income earned	14,696	12,690
26 Net realized captial gains or (losses)		
27 Net investment gains or (losses)(Lines 25 plus 26)	14,696	12,690
28 Net gain or (loss) from agents' or premium balances charged off		
29 Aggregate w rite-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)	14,105,207	15,672,100
31 Federal and foreign income taxes incurred		
32 Net income (loss) (Lines 30 minus 31)	14,105,207	15,672,100

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

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

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

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

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

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

Enrollment increased by approximately 17,000 member months from 2010 to 2011 as a result of Medicaid Expansion. Medicaid Expansion also resulted in the expenses for prescription drugs to increase \$2 million dollars, from \$7.3 to \$9.3 million, in 2011.

The per-member-per-month (pmpm) charges for prescription drugs and for other professional services were much lower for the PMAP program than for other programs, this is due to the demographics of the population of PMAP, being mostly families with children versus demographics of other programs which include senior citizens and disabled adults.

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.), PrimeWest 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 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 (Integrated) values.

In 2010 Column 9 was used to report GAMC values only

*An analytical review was performed comparing, where possible, data as presented in the 2010 and 2011 MN Supplement Report #1. Any fluctuations greater than 20% and the individual program's materiality were identified and sent to PrimeWest 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) = $\$-2,147,427$ (2011 net income) * 5% = $\$107,371$ rounded to $\$107,000$.*

MN Senior Health Options (MSHO)

Net underwriting loss for the MSHO program increased from \$556,932 in 2010 to \$2,154,729 in 2011. PrimeWest explained that, with enrollment of approximately 2,000, the year-to-year to experience of the MSHO program is subject to significant volatility. MSHO also has multiple federal and state funding components, increasing the potential for year-to-year changes in revenue methodologies to affect net underwriting results.

As a percentage of revenue, PrimeWest's expenses for prescription drugs were lower for the MSHO program than for some of the other programs. This is due to the fact that the MCOs are only responsible for a portion of the prescription drug expenses for dual-eligible enrollees, therefore, approximately 65% of the total Part D expenses are funded by Medicare on a "pass-through" basis without risk to the PrimeWest.

MinnesotaCare (MNCare)

Net premium income for MNCare decreased from \$12.1M in 2010 to \$9.3M in 2011 due to the decrease in enrollment which resulted from members moving to the Prepaid Medical Assistance Plan (PMAP) as a result of Medicaid Expansion. Hospital/Medical benefits, expenses for Other Professional Services, and General Expenses also decreased correspondingly.

The pmpm for Other Professional Services and Prescription Drugs was lower for MNCare than for other programs due to the demographics of the enrollment in MNCare.

SNBC

PrimeWest's pmpm for Prescription Drugs in the SNBC MA program was significantly higher than for other programs. This is due to the demographics of enrollment in SNBC MA program as disabled adults typically have significantly higher prescription drug expenses and are not eligible for Medicare Part D; therefore, PrimeWest covers the entire prescription drug expense for this population.

As a percentage of revenue, PrimeWest's expenses for Other Professional Services in the SNBC Integrated program is higher than in other programs. This is due to the demographics of enrollment in SNBC Integrated; the disabled adults require more durable medical equipment and mental health services than those enrolled in other programs.

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 PrimeWest. The \$146,433,030 total expense detail was agreed to the Underwriting and Investment Exhibit Part 3 – Analysis of Expenses in the 2011 annual statement for completeness. PrimeWest's general expense detail is separated into fourteen account categories. Five categories were selected for further testing. Within each category, we judgmentally selected large expenses for a total selection of 10 expenses for review. Expenses for review were judgmentally reviewed for these accounts for the month of June, with the exception of a one-time large expense from the month of February.

PrimeWest Allocation Process

PrimeWest allocates general expenses attributable to a single program to that program. General expenses not attributable to a specific program are allocated in a number of ways, based upon the factor driving the expense. For example:

- Expenses for membership materials are allocated based upon enrollment since membership materials are uniform for each member and they are distributed to all enrollees,
- Expenses related to claims adjudication and utilization of services are allocated by program revenue.

For NAIC reporting purposes, general expenses are allocated based upon the categories of Cost Containment, Claims Adjustment, and General Administration.

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);

(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 Description	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	As found on page 4 of the Annual Statement													Other:	
		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	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 capital 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: <ul style="list-style-type: none"> 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

				<p>agrees or disagrees with the statements contained in the insurer's letter, to be forwarded to the Commissioner.</p> <ul style="list-style-type: none"> 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.

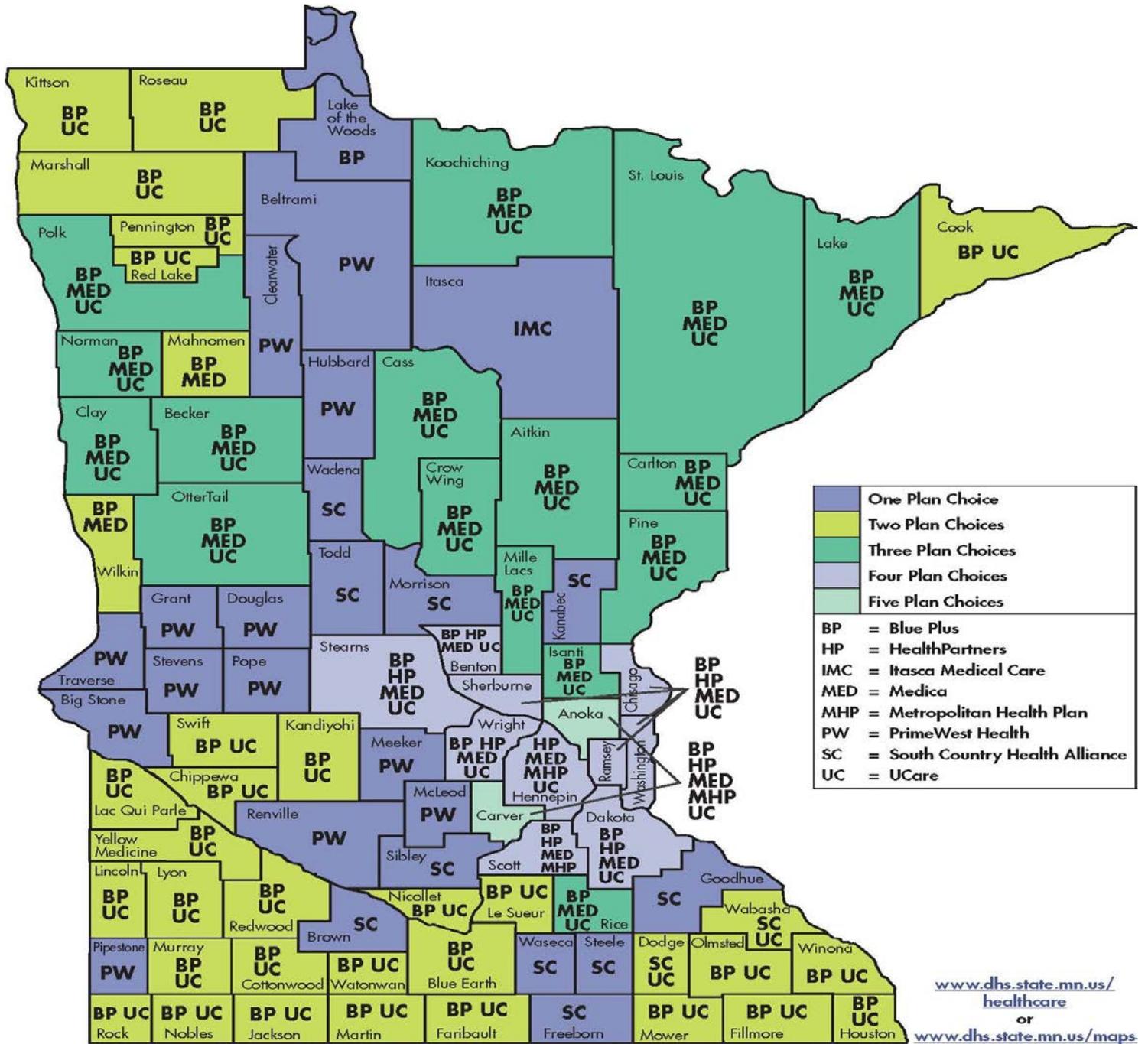
All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.

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

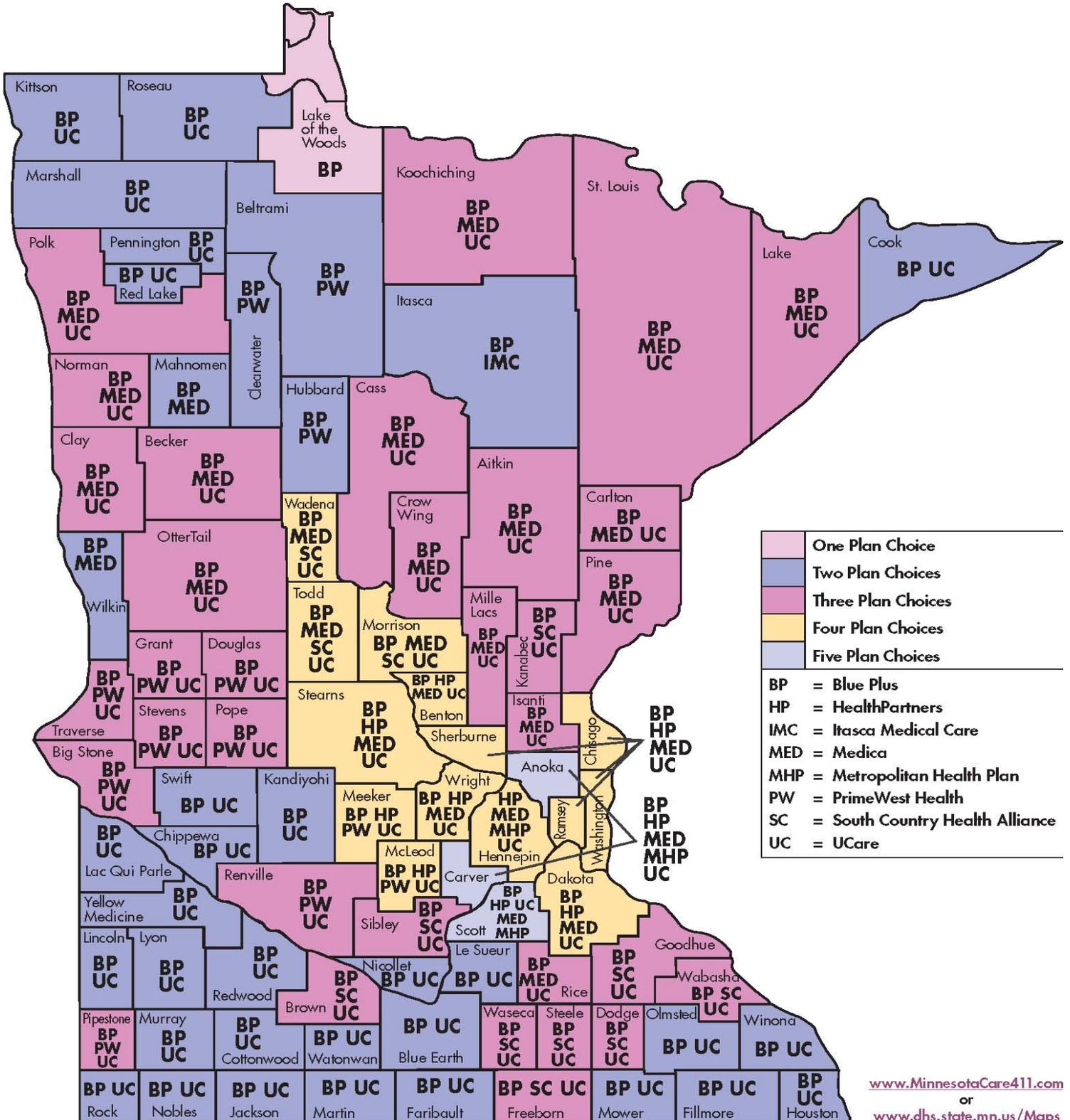
Courier Address: Managed Care Systems Section
Minnesota Department of Health
85 Seventh Place East, Suite 220
St. Paul, MN 55101

Appendix 5 - Prepaid Medical Assistance Program (PMAP) map Health Plan Choices by County Effective April 1, 2011



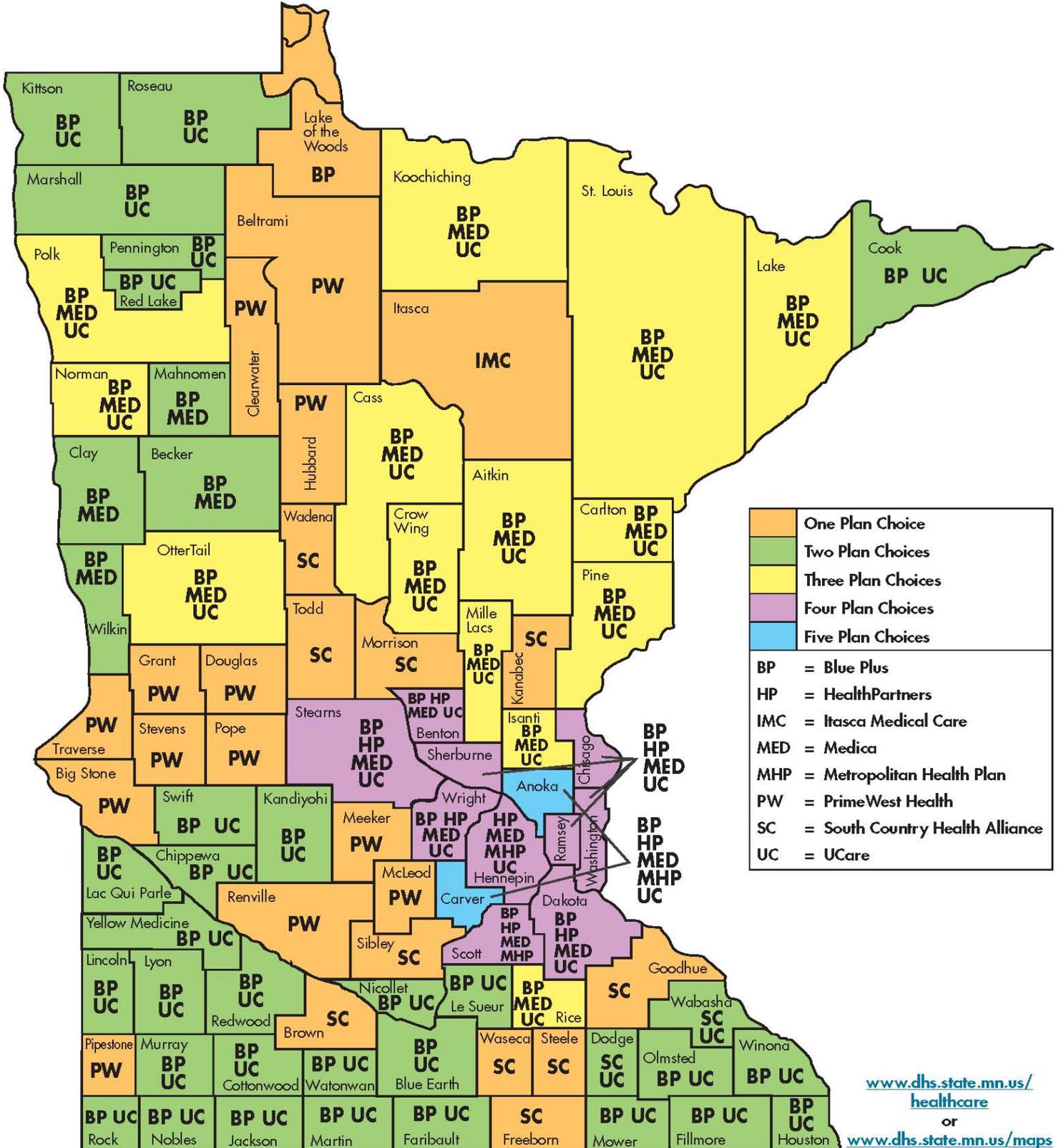
www.dhs.state.mn.us/healthcare
 or
www.dhs.state.mn.us/maps

Appendix 6 - MinnesotaCare (MNCare) map Health Plan Choices by County Effective April 1, 2011



www.MinnesotaCare411.com
 or
www.dhs.state.mn.us/Maps

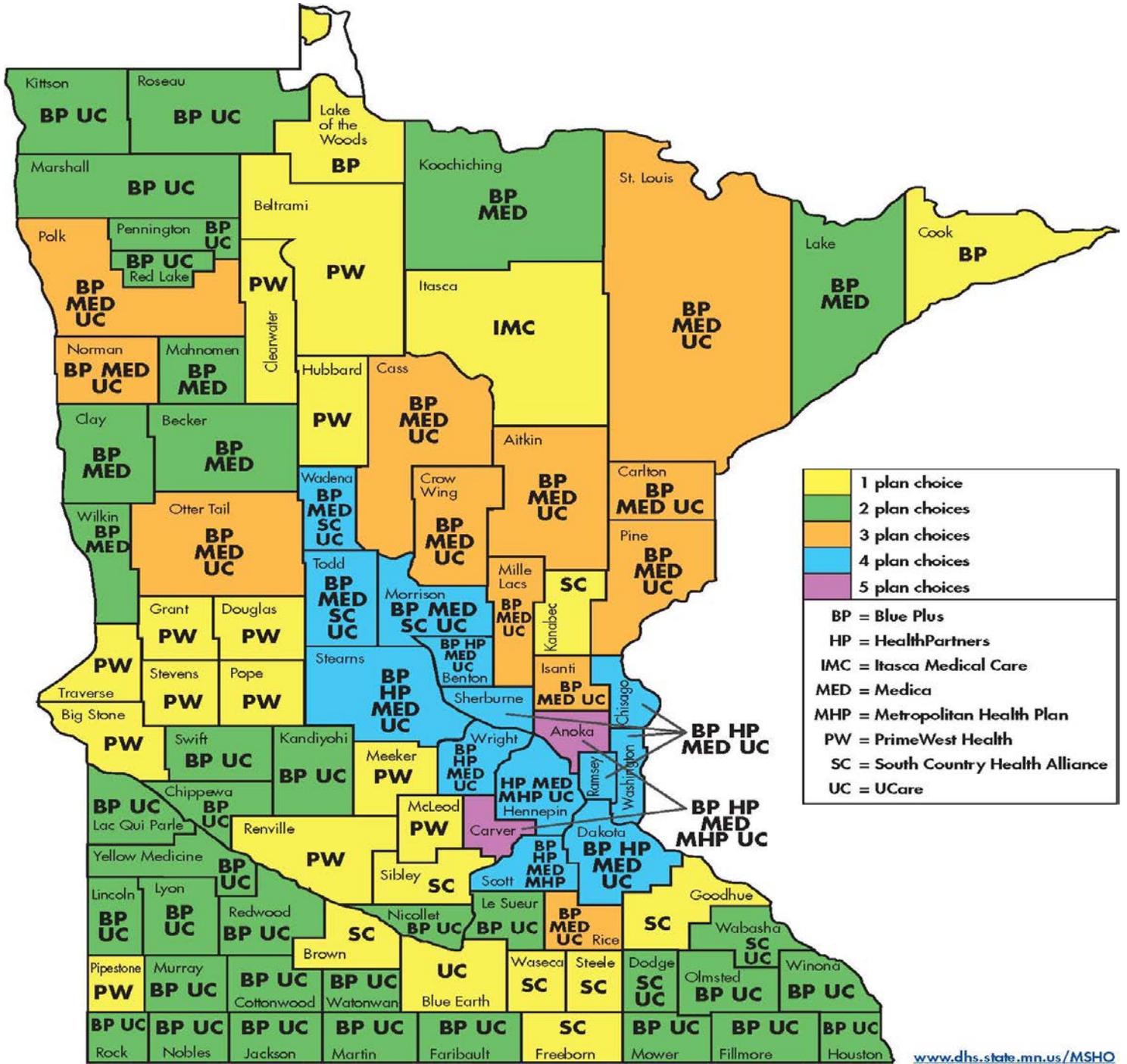
Appendix 7 - Minnesota Senior Care Plus (MSC+) map Health Plan Choices by County Effective April 1, 2011



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

Appendix 8 - Minnesota Senior Health Options (MSHO) map

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



Appendix 9 - Special Needs Basic Care (SNBC) map Health Plan Choices by County Effective Jan. 1, 2011

