



STATE OF MINNESOTA

METROPOLITAN HEALTH PLAN

PROJECT NO: 55017

January 31, 2013

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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 Metropolitan Health Plan (MHP or 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 Minnesota Statutes Section 256B.69, Subdivision 9c (see Appendix 2). These public programs are provided throughout the State of Minnesota by the various Managed Care Organizations (MCO) in Minnesota, including MHP.

Expense Allocations

Appendix A440 of SSAP No. 70, titled Allocation of Expenses, states in part, 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 an administrative expense allocation process that is documented. The process allocates administrative expense by health product line. The allocation basis is largely based on direct costs attributable to the product line. A cost center is assigned for each product line. Each cost center contains four subcategories. The subcategories and department breakdowns within the categories are as follows:

1. Administrative costs - statutory general administrative costs:
 - Department administrative costs included are allocated based on enrollment, member services, government relations, fiscal, outreach, marketing, general administration, contracting data, an allocation of 50 percent of information technology costs is also made.
 - Product line administrative costs are allocated by year to date member months
 - Manual allocation exceptions are made using special entries for actual amounts recorded for Minnesota Surcharge Tax, MinnesotaCare Tax or Provider Tax.
2. Claims adjustment expenses - statutory claims adjustment expenses:
 - Department administrative costs are based on claims data and 50 percent of information technology costs.
 - Product line claims adjustment expenses are based on health expenses.
 - Manual allocation exceptions are made using special entries for actual amounts recorded as required.

3. Cost containment: - Statutory cost containment expenses:
 - Department administrative costs are allocated with provider relations, medical administration, and coordination of benefits data.
 - Product line cost containment expenses are based on health expenses.
 - Manual allocation exceptions are made using special entries for actual amounts recorded as required.

4. Direct Health - Administrative expenses reclassified as health expenses:
 - Administrative expenses reclassified as health expense include “HealthConnection” (in-house nurse triage center), “Outreach” (member car seats - only), and outsourced medical administration.
 - Product line direct health expenses are based on direct costs.
 - Manual allocation exceptions are made using special entries for actual amounts recorded as required.

The Company does not have any affiliates with which it shares or allocates expenses.

The results of an analytical review and testing of samples of various expense categories support the Company’s representation that expenses are allocated 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 \$6.0 million and \$4.1 million, respectively. MHP utilizes a third party actuarial firm to prepare and review its deficiency reserve provision. The calculation method used includes calculations of high and low evaluations. A midpoint selection is made from these evaluations.

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 increased from \$18.0 million in 2010 to \$23.4 million in 2011.

Annual Statement Liability Line Item	Description	12/31/2011 balance (000)	12/31/2010 balance (000)
1	Claims unpaid	\$ 23,428	\$ 17,984
3	Unpaid claim adjustment expenses	\$ 954	\$ 469
4	Aggregate health policy reserves	\$ 6,005	\$ 4,228

The Company reported redundancies in the reserves for the years 2010 and 2011. The Company's actuary indicated that the favorable development was the result of uncertainty of claims data and was within expected margins used in developing the reserves. The changes in claims unpaid for 2010 and 2011 were as follows.

Description	12/31/2011 (000)	12/31/2010 (000)
Claims payable at the beginning of the year	\$ 17,984	\$ 15,020
Add provision for claims occurring in the current year	\$ 137,779	\$ 117,964
Add provision for claims occurring in the prior years	\$ (6,484)	\$ (4,328)
Net incurred losses during the year	\$ 131,295	\$ 113,636
Deduct payment for claims occurring in the current year	\$ 115,567	\$ 100,404
Deduct payments for claims made in the prior years	\$ 10,284	\$ 10,269
Net claim payments made during the year	\$ 125,851	\$ 110,672
Claims reserve payable at the end of the year	\$ 23,428	\$ 17,984

Background

The Minnesota Department of Health (MDH) issued Hennepin County, Minnesota (County) a certificate of authority on October 19, 1983, in accordance with Minnesota Statutes 62D, to operate a health maintenance organization (hereinafter referred to as an HMO). The County, a metropolitan governmental unit of the State of Minnesota, subsequently created MHP as an "enterprise fund" within its governmental system and commenced business as an HMO on June 1, 1984.

The County acts as a guaranteeing organization for MHP. This guarantee provides that the County will fund any deficiencies in MHP's surplus in order to meet minimum regulatory surplus requirements. The County was not called on to fund any surplus deficiencies during the period under examination.

The County provides MHP with certain management and administration services on a cost basis. Included in these costs are certain allocated indirect costs. Administrative costs, not including personnel salaries and benefits, paid by MHP to the County were \$3.4 million, \$2.5 million and \$2.4 million, respectively for the years 2011, 2010 and 2009.

The Company is affiliated with the Hennepin County Medical Center (HCMC). HCMC is a public subsidiary corporation of the County. HCMC is a major health care provider utilized by MHP. MHP incurs costs for health care services provided to its members by HCMC.

MHP's market servicing area includes four Minnesota counties. The counties are Anoka, Carver, Dakota, and Hennepin.

MHP contracts with the Minnesota Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS) to provide health care services to qualified enrollees in certain DHS and CMS programs. MHP receives monthly capitation payments from DHS and CMS for enrollees in the government sponsored plans.

MHP contracts out to third-party administrators the pharmacy and dental aspects of the programs. The pharmacy and dental administrators also process and pay claims.

MHP does not market its products through traditional insurance sales channels. Coverage is available to enrollees only through that person's eligibility for one of the aforementioned public programs.

Minnesota Public Programs

MHP provides coverage for several public programs administered by DHS and the 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 co-pay for some services.

In 2011, MHP provided coverage to PMAP members in 4 of the 65 counties that are available for prepaid health care contracting. 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. MHP refers to this coverage as MAXX. 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. 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. 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. 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. 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. 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 it is deemed to be appropriate. The following represents our key observations and findings:

1. It was observed that the allocation of salaries by MHP is performed through a comprehensive cost center allocation process to lines of business. MHP did not limit the salary or other compensation amounts that are allocated in the cost center process. All lines of business written by the Company are Public Programs.

No recommendations were identified during the procedures performed.

Scope and Procedures Performed

In accordance with Work Order Contract No. 55017, 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. See Appendix 3 for the 2011 MHP Minnesota Supplement Report.

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. 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 (SSAP) 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 does not have relationships with related parties that are subject to compliance with SSAP No. 25 regarding expense allocation between legal entities.
 - MHP does not have any private or commercial products that require expense allocations.
 - Based on an analytical review and a review of testing 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 (PDR).

The increases in these periods were attributed the following factors:

- The State projected decreases in revenues in the programs for these periods.
- The State terminated significant MHP programs (GA, GAMC) in 2011.
- MHP was excluded from operating in the under age 65 adults with children programs. This was the largest Medicaid population by member count.

In 2012, MHP decreased its PDR levels due to the following factors:

- MHP implemented an expense reduction program.
- The State did not implement the reductions in premiums as early as anticipated
- MHP participated in the Hennepin Health Accountable Care Organization (ACO) which grew enrollment, included provider re-contracting, and added revenue enhancement programs.
- Large claims that were in disputed or had been anticipated were resolved in MHP's favor.

The 2010 and 2011 opinions of MHP's consulting actuary and external CPA were reviewed and it was noted that the PDR reported amounts were affirmed.

6. Perform retrospective review of reserves established for public programs at year end 2009, 2010 and 2011.

MHP writes only public programs. A retrospective review of reserves established for these programs was performed as of December 31, 2012 for the years ending 2009, 2010 and 2011. The table indicates consistent redundancies in all periods.

Retrospective Review of Reserves	All MCO Lines (000)
Reserves as of December 2009	\$ 15,020
Restated Reserves as of December 2012	12,457
Favorable (Unfavorable) Restatement	2,563
Favorable (Unfavorable) Percent	17%
Outstanding Reserves as of December 2012	0
Reserves as of December 2010	17,984
Restated Reserves as of December 2012	12,968
Favorable (Unfavorable) Restatement	5,016
Favorable (Unfavorable) Percent	28%
Outstanding Reserves as of December 2012	0
Reserves as of December 2011	23,427
Restated Reserves as of December 2012	16,732
Favorable (Unfavorable) Restatement	6,659
Favorable (Unfavorable) Percent	29%
Outstanding Reserves as of December 2012	75

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.

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 & 256B.69, Subdivision 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

Metropolitan Health Plan
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	228567		228567				8530	3332	3093	189630	24982			
REVENUES:															
2	Net Premium Income (including \$ non-health premium income)	163,784,478.00		163,784,478.00				23,542,846.00	8,816,343.00	5,920,426.00	116,545,932.00	8,958,931.00			
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)	\$163,784,478.00		\$163,784,478.00	NR	NR	NR	\$23,542,846.00	\$8,816,343.00	\$5,920,426.00	\$116,545,932.00	\$8,958,931.00	NR	NR	NR
EXPENSES:															
9	Hospital/medical benefits	84,115,788.00		84,115,788.00				12,740,417.00	2,844,428.00	3,046,244.00	62,495,077.00	2,989,622.00			
10	Other professional services	14,085,779.00		14,085,779.00				1,424,078.00	836,261.00	895,595.00	9,324,830.00	1,605,015.00			
11	Outside referrals														
12	Emergency room and out-of-area	5,131,207.00		5,131,207.00				444,591.00	251,719.00	269,579.00	3,521,464.00	643,854.00			
13	Prescription drugs	12,533,623.00		12,533,623.00				1,232,124.00	882,108.00	944,694.00	7,201,142.00	2,273,555.00			
14	Aggregate write-ins for other hospital and medical expenses (Line 1499)	\$15,798,975.00	NR	\$15,798,975.00	NR	NR	NR	\$5,422,840.00	\$1,051,840.00	\$1,126,470.00	\$7,488,063.00	\$709,762.00	NR	NR	NR
15	Incentive Pool and Withhold Adjustments														
16	TOTAL EXPENSES (Lines 9 through 15)	\$131,665,372.00	NR	\$131,665,372.00	NR	NR	NR	\$21,264,050.00	\$5,866,356.00	\$6,262,582.00	\$90,030,576.00	\$8,221,808.00	NR	NR	NR
LESS:															
17	Net reinsurance recoveries	370,708.00		370,708.00							370,708.00				
18	Total hospital and medical (Lines 16 minus 17)	\$131,294,664.00	NR	\$131,294,664.00	NR	NR	NR	\$21,264,050.00	\$5,866,356.00	\$6,262,582.00	\$89,659,868.00	\$8,221,808.00	NR	NR	NR
19	Non-health claims														
20	Claims adjustment expenses	7,031,318.00		7,031,318.00				1,138,769.00	316,736.00	333,885.00	4,801,620.00	440,308.00			
21	General administrative expenses	15,612,497.00		15,612,497.00				652,589.00	247,493.00	260,893.00	12,818,856.00	1,632,666.00			
22	Increase in reserves for life, accident and health contracts (including \$ increase in reserves for life only)	1,854,305.00		1,854,305.00				850,000.00	2,336,731.00	2,463,269.00	(3,795,695.00)				
23	Total underwriting deductions (Lines 18 through 22)	\$155,792,784.00	NR	\$155,792,784.00	NR	NR	NR	\$23,905,408.00	\$8,767,316.00	\$9,340,629.00	\$103,484,649.00	\$10,294,782.00	NR	NR	NR
24	Net underwriting gain or (loss) (Lines 8 minus 23)	\$7,991,694.00	NR	\$7,991,694.00	NR	NR	NR	(\$382,562.00)	\$49,027.00	(\$3,420,203.00)	\$13,061,283.00	(\$1,335,851.00)	NR	NR	NR
25	Net investment income earned	611,201.00		611,201.00				87,734.00	26,761.00	28,211.00	435,071.00	33,424.00			
26	Net realized capital gains or (losses)														
27	Net investment gains or (losses) (Lines 25 plus 26)	\$611,201.00	NR	\$611,201.00	NR	NR	NR	\$87,734.00	\$26,761.00	\$28,211.00	\$435,071.00	\$33,424.00	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)	\$8,602,895.00	NR	\$8,602,895.00	NR	NR	NR	(\$274,828.00)	\$75,788.00	(\$3,391,992.00)	\$13,496,354.00	(\$1,302,427.00)	NR	NR	NR
31	Federal and foreign income taxes incurred														
32	Net income (loss) (Lines 30 minus 31)	\$8,602,895.00	NR	\$8,602,895.00	NR	NR	NR	(\$274,828.00)	\$75,788.00	(\$3,391,992.00)	\$13,496,354.00	(\$1,302,427.00)	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 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.

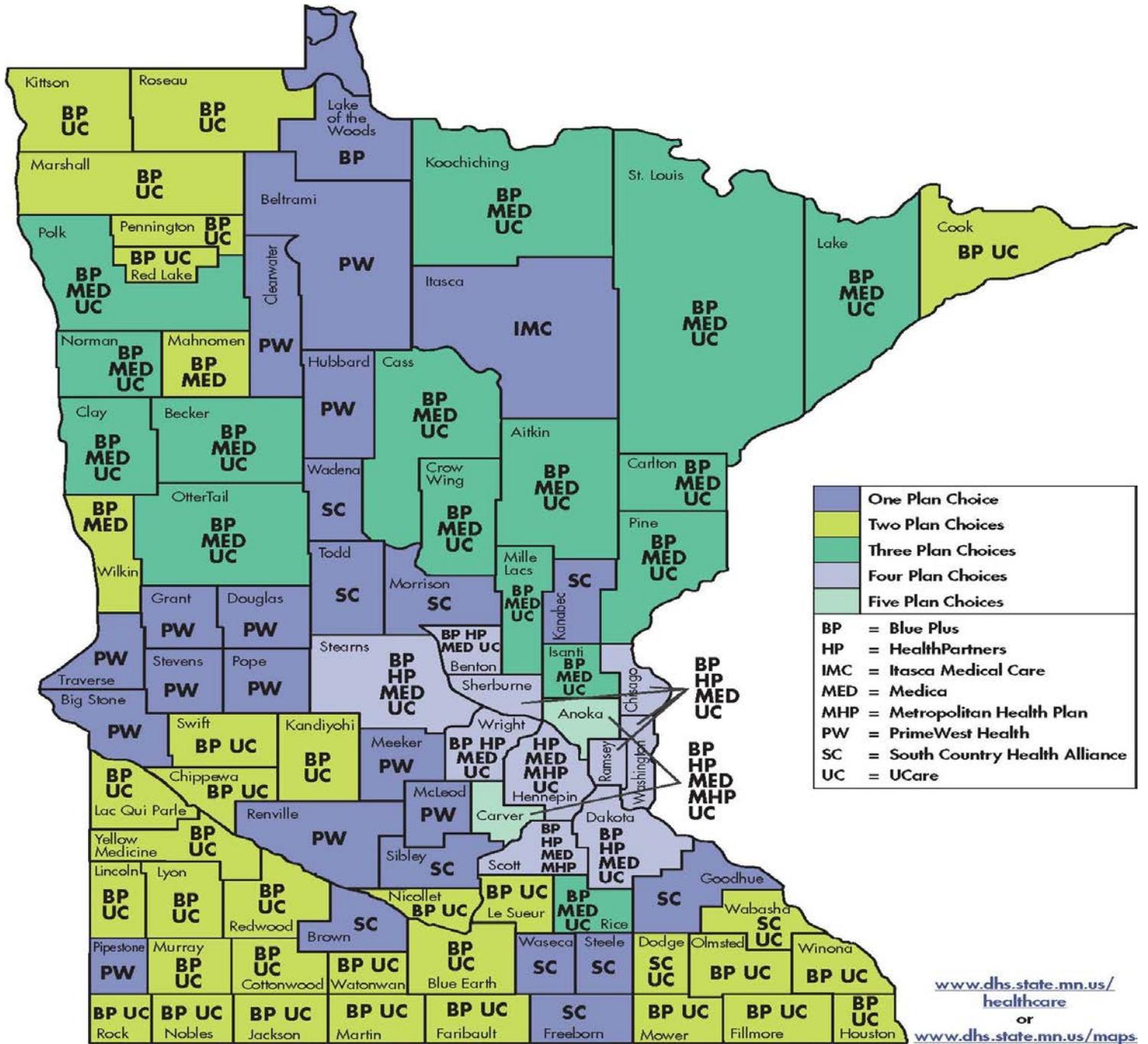
Minnesota Supplements Filing Instructions: It is not necessary to send a paper copy in addition to the electronic submission; none of these reports require a signature. Send the completed Minnesota Supplement forms on a CD to:

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

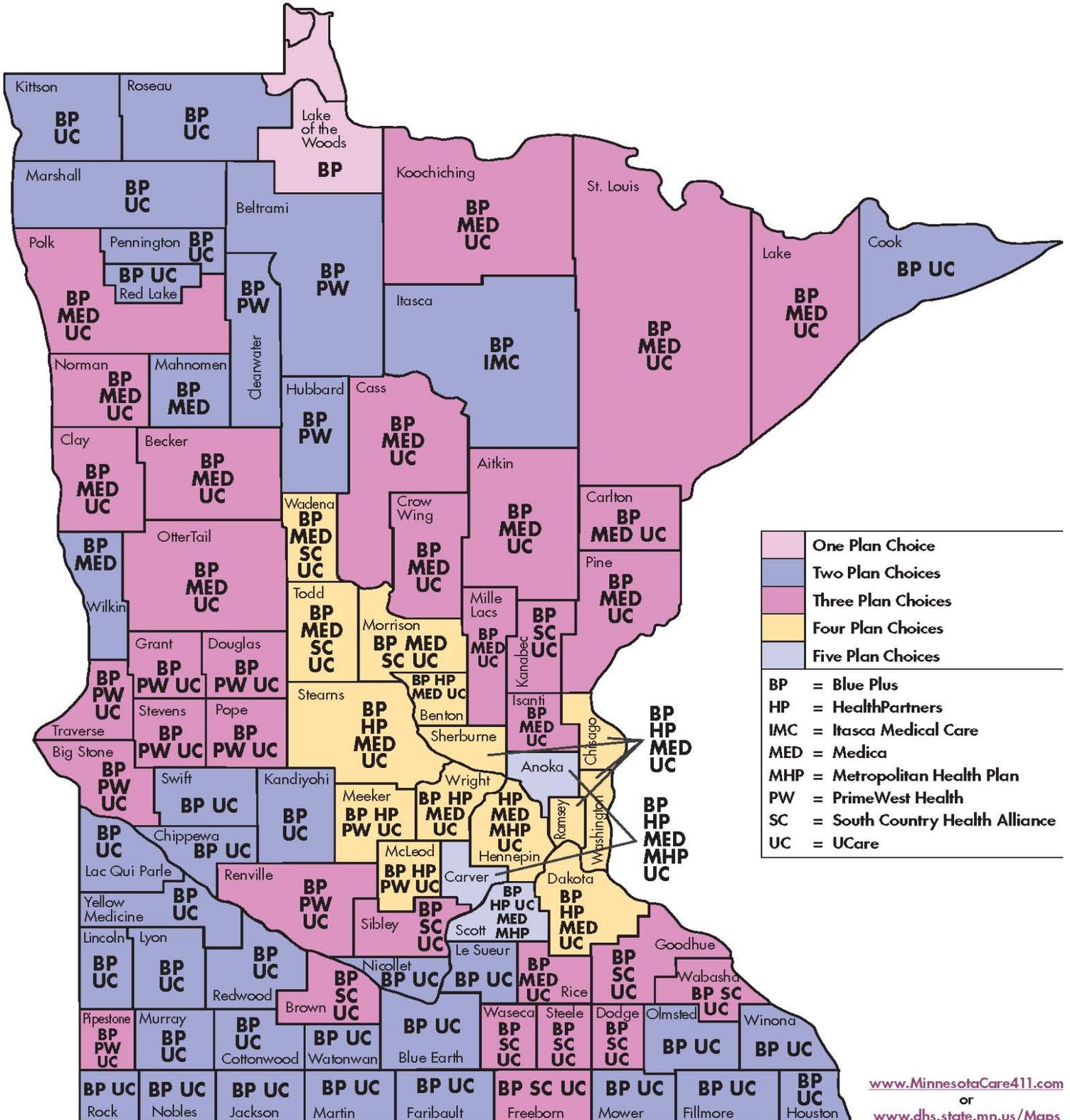
DRAFT

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



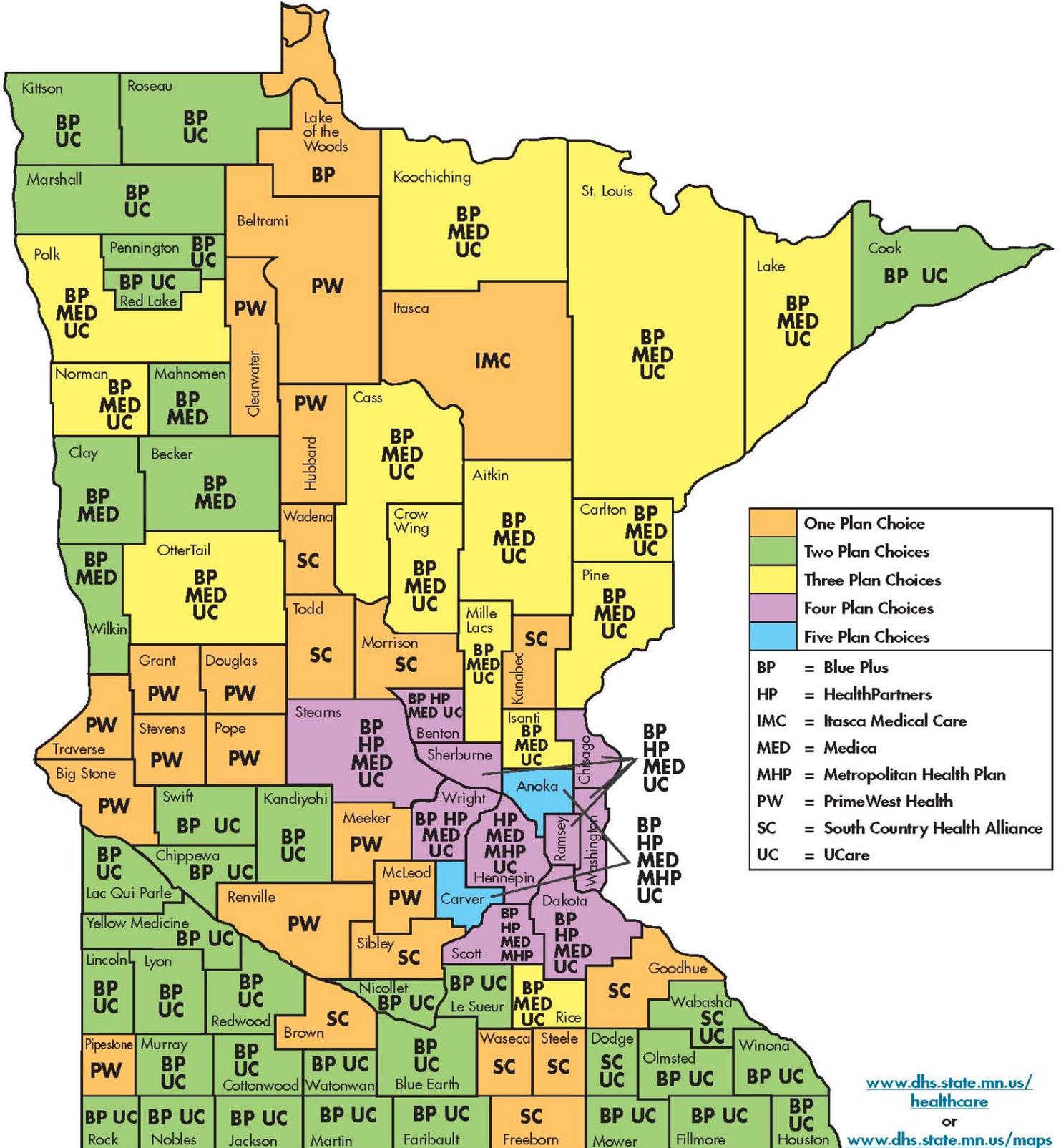
www.dhs.state.mn.us/healthcare
 or
www.dhs.state.mn.us/maps

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



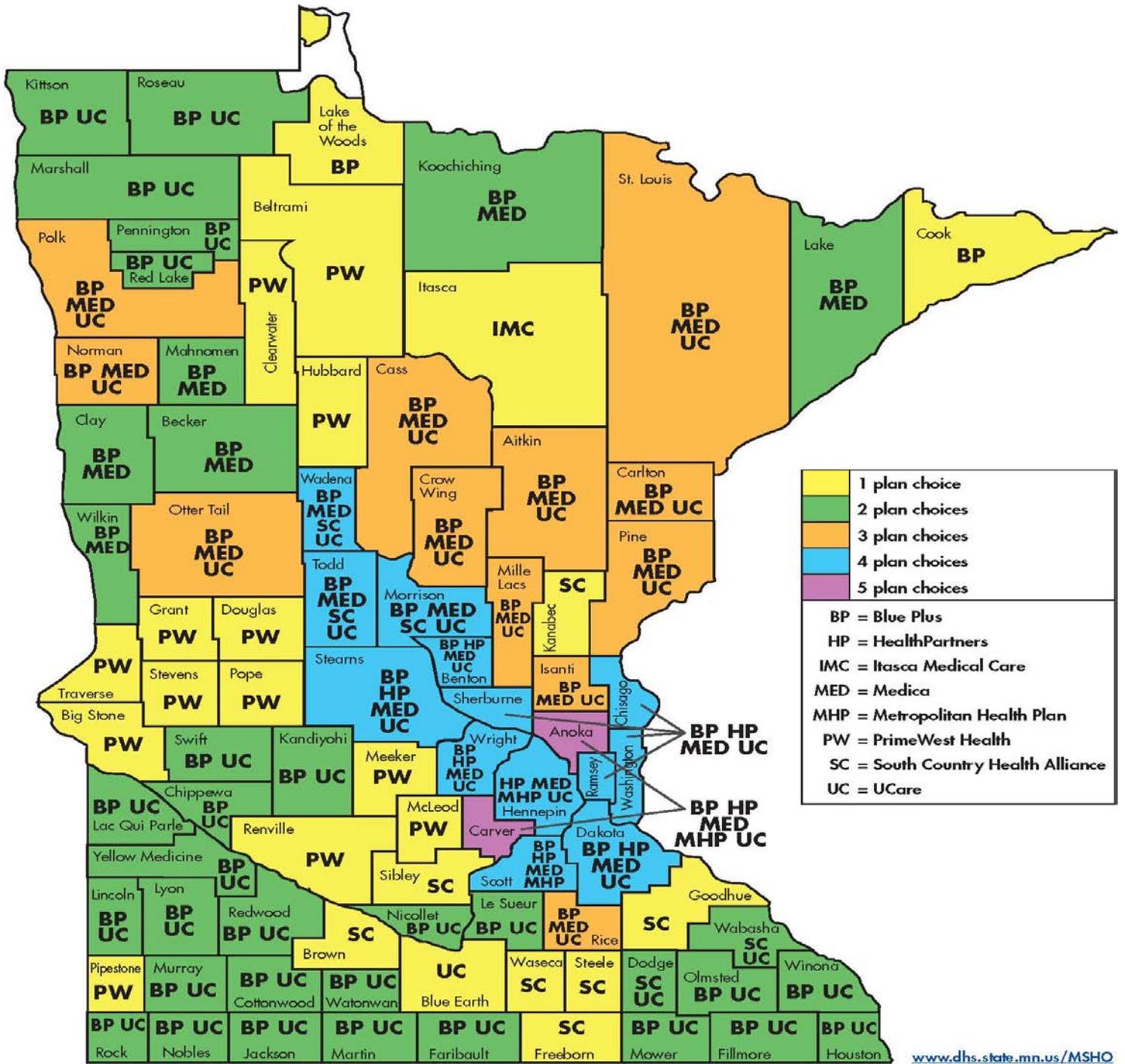
www.MinnesotaCare411.com
 or
www.dhs.state.mn.us/Maps

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

