



STATE OF MINNESOTA

MEDICA HEALTH PLANS

PROJECT NO: 50686

November 26, 2012

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

Expense Allocations

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

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

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

PMPM Fees

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

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

•UHG Incentive Pool: The UHG contract also provides for an incentive pool (up to 3% of base fees). The incentive payment is based on UHG's performance on the SLA. Medica accrues for

the estimated incentive pool earnings, but the amount is not finalized until March of the following year. The incentive pool is allocated by product based on the base fees.

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

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

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

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

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

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

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

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

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

Cost Center Allocations

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

regulatory costs which are charged directly to the appropriate entity. This can result in several PMPMs which are combined to determine the total cost for a product.

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

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

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

Intercompany Fees

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

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

Premium Deficiency Reserves

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

As of December 31, 2011 and 2010, MHP had premium deficiency reserves for all lines of business of \$37.2 million and \$19.9 million, respectively. The breakdown of the 2011 deficiency reserves is as follows:

Line of Business	Total 2011 Premium Deficiency Reserve
Prepaid Medical Assistance Program (PMAP)	\$ 4,500,000
MNCCare	14,000,000
CompleteSolutions (Commercial)	475,000
Special Needs Basic Care (SNBC)	17,800,000
Medicare Fee For Service (FSS)	425,000
Total	\$ 37,200,000

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

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

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

The Company reported redundancies in the reserves for prior years of \$45.4 million as of 2011 and \$30.1 million as of 2010. This favorable development is the result of lower than expected medical costs and utilization.

Description	12/31/2011 (000)	12/31/2010 (000)
Claims payable at the beginning of the year	\$ 151,557	\$ 135,151
Add provision for claims occurring in the current year	\$ 1,519,406	\$ 1,595,963
Add provision for claims occurring in the prior years	\$ (45,400)	\$ (30,125)
Net incurred losses during the year	\$ 1,474,006	\$ 1,565,838
Deduct payment for claims occurring in the current year	\$ 1,377,901	\$ 1,446,288
Deduct payments for claims made in the prior years	\$ 102,716	\$ 103,144
Net claim payments made during the year	\$ 1,480,617	\$ 1,549,432
Claims reserve payable at the end of the year	\$ 144,946	\$ 151,557

Background

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

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

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

The group is collectively referred to as Medica.

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

The Company participates in Medicaid programs in the state of Minnesota. The Company agreed to limit its operating margin for certain programs to one percent for 2011. The Company

exceeded the one percent operating margin by \$25.3 million and returned this amount to Minnesota.

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

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

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

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

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

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

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

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

Minnesota Public Programs

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

Prepaid Medical Assistance Program (PMAP)

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

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

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

Minnesota Senior Care Plus (MSC)

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

MinnesotaCare (MNCare)

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

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

Public Programs Integrated with Federal Programs provided by MHP

Minnesota Senior Health Options (MSHO)

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

SNBC

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

Public Programs managed by CMS and provided by MHP

Medicare Part D Prescription Program

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

Private Programs provided by MHP

Commercial

MHP offers commercial managed care plans for groups.

Observations & Findings

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

1. It was observed that the allocation of salaries within the Medica group and in MHP's public and non-public programs is performed through a comprehensive cost center allocation

process. MHP did not limit the salary or other compensation amounts that are allocated in the cost center process prior to allocating them to the Public Programs or any other programs administered by the Company.

2. It was observed that MHP contributed \$3.5 million to the Medica Foundation in both 2011 and 2010. The Medica Foundation is an affiliated charitable organization with the stated mission to fund community-based initiatives and programs that support the needs of Medica's customers and the greater community by improving their health and removing barriers to health care services.
3. It was observed that MHP contributed \$6.5 million to the Medica Research Institute in both 2011 and 2010. The Medica Research Institute is an affiliate nonprofit organization with the stated mission to conduct research that generates valid and meaningful evidence-based information for timely translation into activities that promote health and improve lives.

No recommendations were identified during the procedures performed.

Scope and Procedures Performed

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

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

The 2011 PMAP detail which was provided to the Department of Human Services was agreed without exception to the Minnesota Supplement Report filed with the Minnesota Department of Health. A summary of the Minnesota Supplement Report is included below.

NAIC Description		2010	2011
		Prepaid Medical Assistance Program (PMAP)	Prepaid Medical Assistance Program (PMAP)
REVENUES:			
1	Member Months	1,232,513	1,378,029
2	Net Premium Income	\$ 565,131,341	\$ 637,483,545
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)		
7	Aggregate write-ins for other non-health revenues (Line 799)		
8	TOTAL REVENUES (Lines 2 through 7)	\$ 565,131,341	\$ 637,483,545
EXPENSES			
9	Hospital/medical benefits	373,236,700	453,724,306
10	Other professional services	15,096,237	14,675,113
11	Outside referrals		
12	Emergency room and out-of-area	31,293,226	50,637,407
13	Prescription drugs	45,620,054	61,717,644
14	Aggregate write-ins for other hospital and medical expenses (Line 1499)		
15	Incentive Pool and Withhold Adjustments		
16	TOTAL EXPENSES (Lines 9 through 15)	\$ 465,246,217	\$ 580,754,470
LESS:			
17	Net reinsurance recoveries		
18	Total hospital and medical (Lines 16 minus 17)	465,246,217	580,754,470
19	Non-health claims		
20	Claims adjustment expenses	11,150,925	12,635,329
21	General administrative expenses	28,022,922	34,223,018
22	Increase in reserves for life, accident and health contracts		4,500,000
23	Total underwriting deductions (Lines 18 through 22)	504,420,064	632,112,817
24	Net underwriting gain or (loss)(Lines 8 minus 23)	60,711,277	5,370,728
25	Net investment income earned	3,203,018	3,045,193
26	Net realized capital gains or (losses)	971,123	2,297,516
27	Net investment gains or (losses)(Lines 25 plus 26)	4,174,141	5,342,709
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, 27, 28, 29)	64,885,418	10,713,437
31	Federal and foreign income taxes incurred		
32	Net income (loss) (Lines 30 minus 31)	\$ 64,885,418	\$ 10,713,437

2. Verify the Minnesota Supplement Report was completed in accordance with the instructions set forth by the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Based on an analytical review and a sampling of various expense categories it was determined that the expenses reported for the year ending December 31, 2011, were accounted for and reported in accordance with the entity's expense allocation agreements and guidelines.

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

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

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

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

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

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

This document is made available electronically by the Minnesota Legislative Reference Library as part of an ongoing digital archiving project. <http://www.leg.state.mn.us/rl/execorders/execorders.asp>

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:

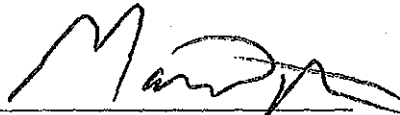
1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.
2. Develop an annual comprehensive managed care report 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
	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
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
7	Aggregate write-ins for other non-health revenues (Line 799)	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
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
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
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
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
24	Net underwriting gain or (loss)(Lines 8 minus 23)	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
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
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
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

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.

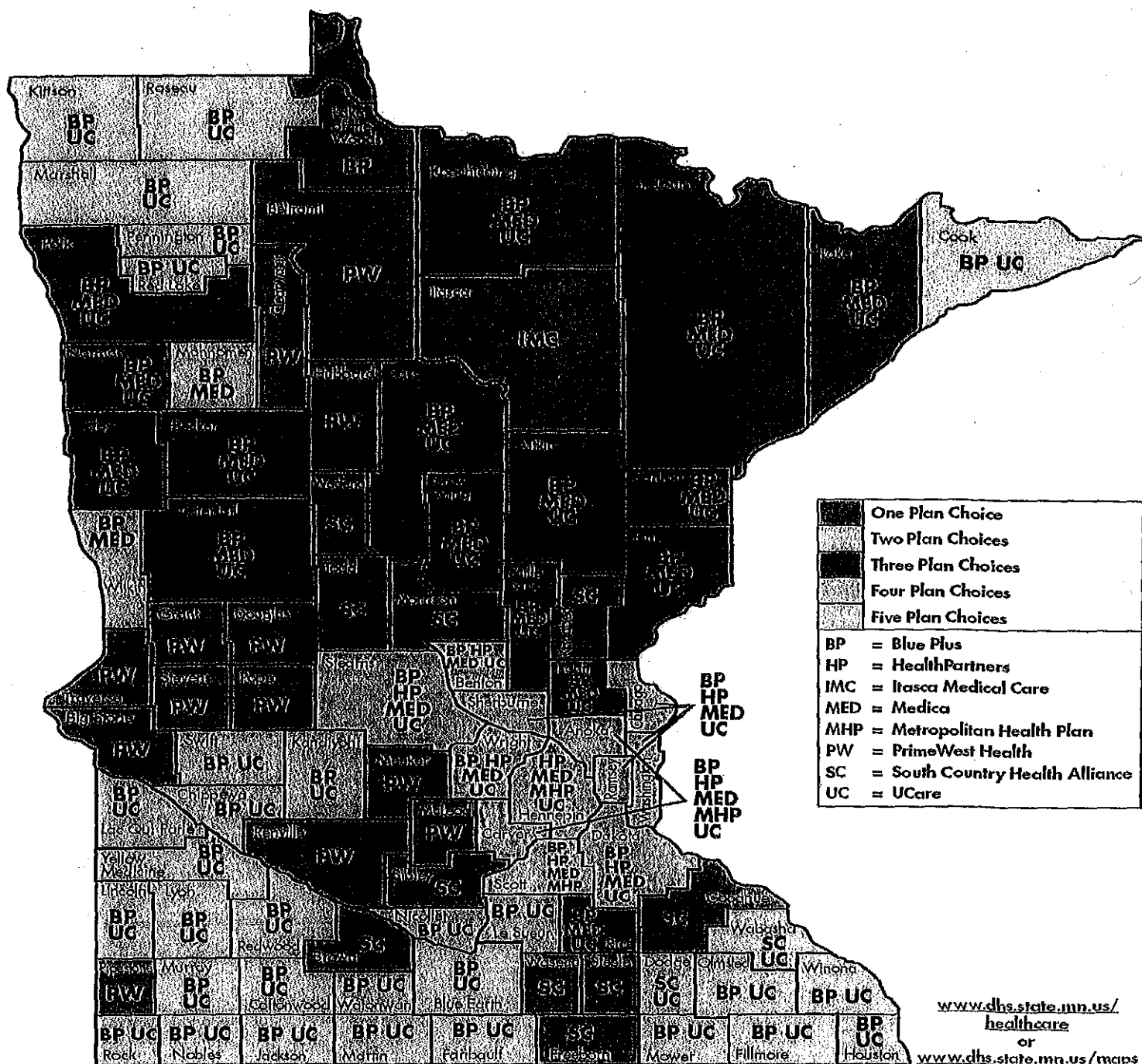
All financial information in reports 1-7 should reconcile with the applicable statement, exhibit or schedule data contained in the NAIC Annual Statement health blank filing.

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:

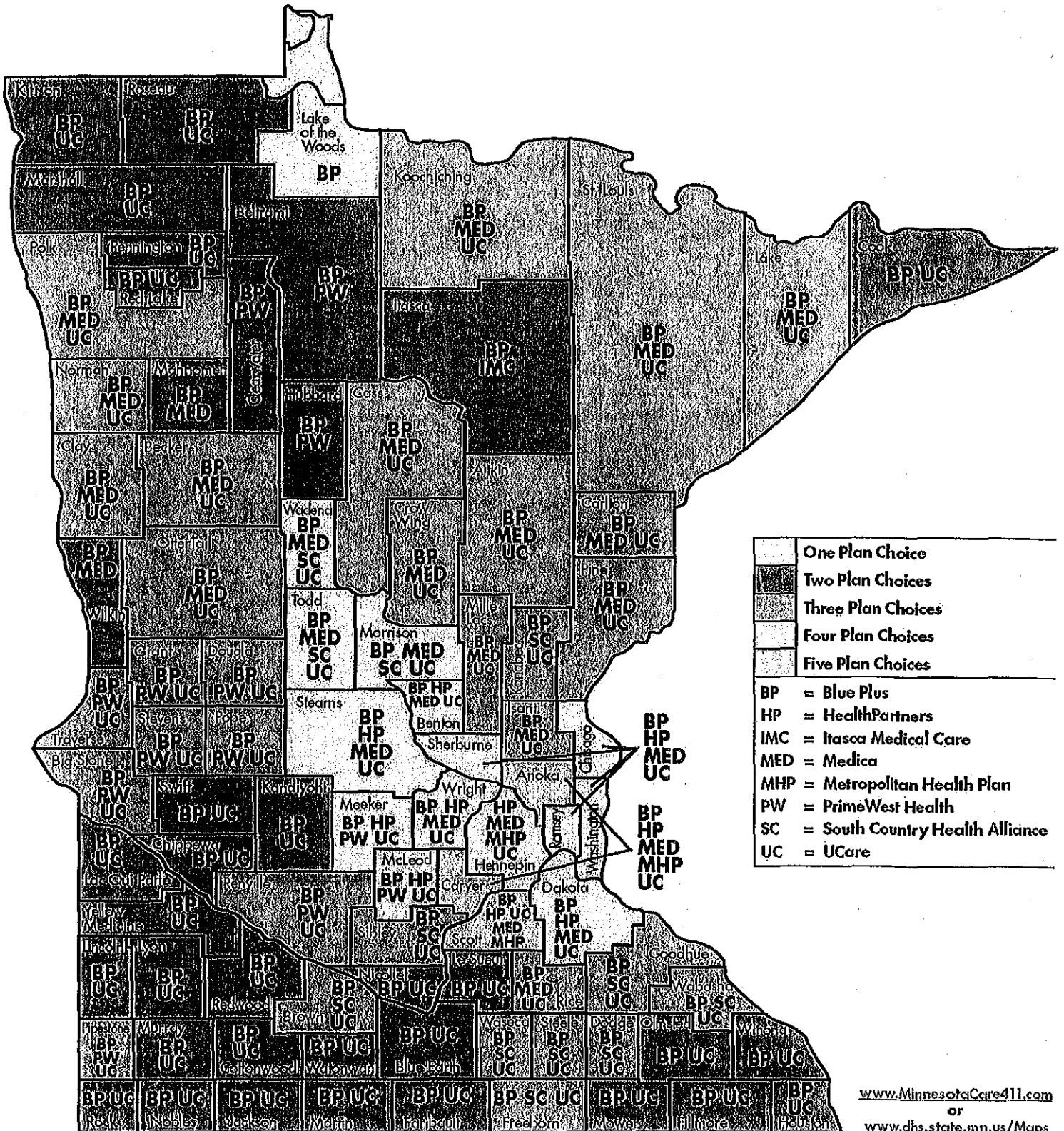
Mailing Address: Dedra Johnson
Managed Care Systems Section
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

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

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

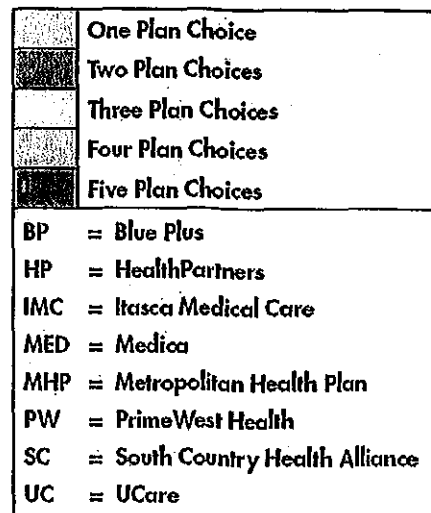


Appendix 6 - MinnesotaCare (MNCare) map **Health Plan Choices by County Effective April 1, 2011**



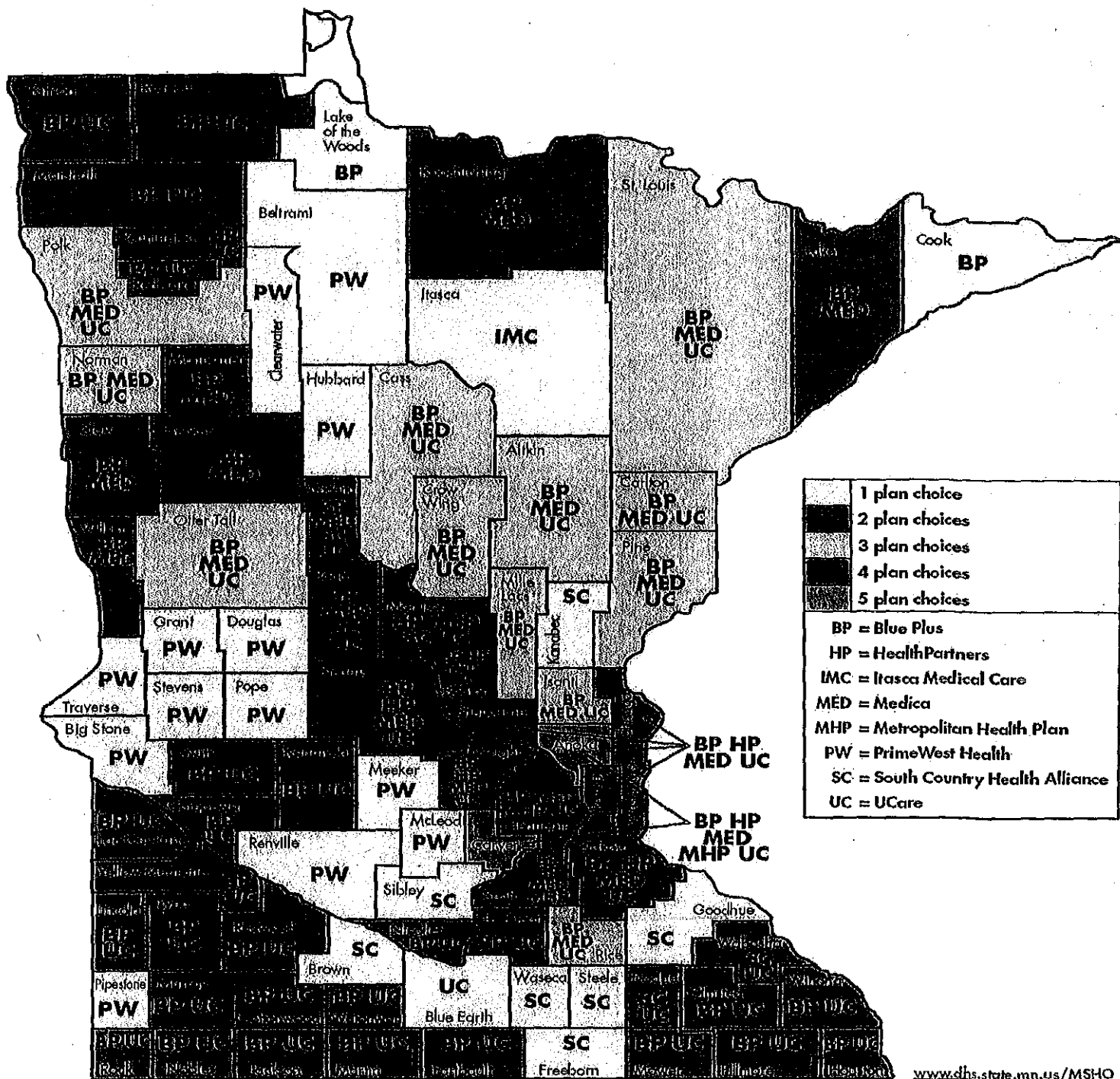
www.MinnesotaCare411.com
or
www.dhs.state.mn.us/Maps

Health Plan Choices by County Effective April 1, 2011

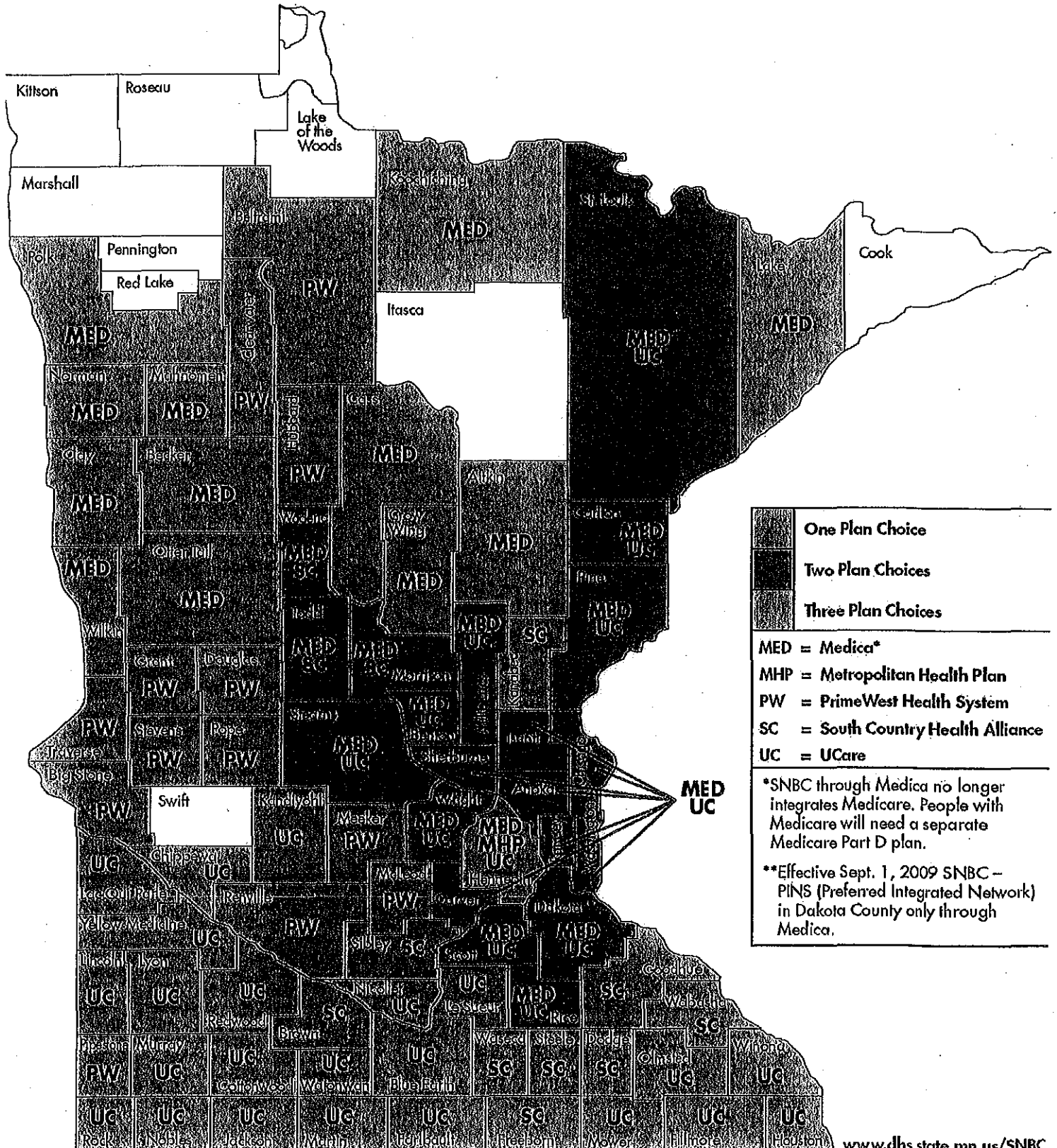


Appendix 8 - Minnesota Senior Health Options (MSHO) map

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**



Addendum to Report

Medica Comment Letter

