STATE OF MINNESOTA

UCare Minnesota

WORK ORDER CONTRACT NO: 50691

December 3, 2012

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Executive Summary

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

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

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

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

Premium Deficiency Reserves – According to SSAP No. 54 "*Individual and Group Accident and Health Contracts*", when the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent

with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started.

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

Reserves – According to SSAP No. 54 "*Individual and Group Accident and Health Contracts*", claim reserves shall be accrued for estimated costs of future health care services to be rendered that the reporting entity is currently obligated to provide or reimburse as a result of premiums 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.

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

Based upon the information provided, the unpaid claim liabilities as of December 31, 2010 and December 31, 2011 contain large redundancies in total. In addition, each product line also contains redundancies. Using claim data through May 31, 2012 the magnitude of the redundancies is approximately 24.3% and 19.0%, for claims incurred as of December 31, 2010 and December 31, 2011, respectively. The redundancies noted include the 10% explicit margin and are greater than the margin levels established by the Company.

Annual Statement Liability Line Item	Description	12/31/11 balance	12/31/10 balance
1	Claims unpaid	$ 213,240,820	$ 168,846,694
2	Accrued medical incentive pool and bonus amounts	$14,534,656	$16,709,450
3	Unpaid claims adjustment expenses	$ 4,701,343	$ 3,679,098
4	Aggregate health policy reserves	$ 8,223,685	$ 490,393

Background

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

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

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

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

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

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

In 2011, UCare provided coverage to PMAP members in 59 of the 65 counties that are available for prepaid health care contracting. UCare has 24% of the statewide PMAP market share. See Appendix 5 for the PMAP health plan choices by county.

Medicaid Expansion

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

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

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

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

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

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

Public Programs Integrated with Federal Programs provided by UCare

Minnesota Senior Health Options (MSHO)
The Minnesota Senior Health Options (MSHO) is a health care program that combines separate health programs and support systems into one health care package. It is for people ages 65 and older who are eligible for MA and enrolled in Medicare Parts A and B. In 2011 UCare provided

coverage to approximately 25% of the statewide MSHO enrollment. See Appendix 8 for the MSHO health plan choices by county.

SNBC Integrated

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

Public Programs managed by CMS and provided by UCare

Medicare + Choice

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

Other

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

Observations & Findings

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

Observations:

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

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

   Contributions of $341,000 were specifically allocated to the Medicare product line, the largest of which was a $150,000 contribution to the City of Minneapolis.

2. UCare's salaries and wages, including executive salaries, are allocated on an indirect allocation basis to all products based upon premium revenue. The Company was not required to, and did not, cap executive salaries prior to allocating them to the public programs or any other programs administered by the Company.

Findings:

1. Marketing and Advertising

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

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

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

> *(C) Except through mailings and publications as set forth below, the MCO and any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO. This restriction includes, but is not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling and/or direct mail marketing.*
>
> > *(2) Mailings to recipients. The MCO may make no more than two mailings per calendar year to Enrollees of the MCO covered under this Contract or potential Enrollees who reside in the MCO's Service Area.*

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

2. Error in Supplemental Report #1

Finding:
In the course of our review, UCare management discovered and disclosed to us that a spreadsheet formula used to allocate indirect administrative costs for reporting of administrative expenses in the 2011 Minnesota Supplement Report #1 contained an error. We were informed that the reported total administrative costs were accurate, but the allocation to state program products was inconsistent with UCare's internal policy. This error resulted in an overstatement

of indirect costs allocated to UCare's Prepaid Medical Assistance Plan (PMAP) product and a corresponding, identical understatement to UCare's other products, including MinnesotaCare.

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

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

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

3. Explicit Margin for Adverse Claim Deviation

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

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

Scope and Procedures Performed

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

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

   RRC obtained the Minnesota Supplement Report #1 filed with the DOH and compared this to the PMAP detail provided to RRC. An example of the Minnesota Supplement Report #1 can be found in Appendix 3. The following PMAP detail was obtained directly from the Minnesota Supplement Report #1.

NAIC Description	2010	2011
	Prepaid Medical Assistance Program (PMAP)	Prepaid Medical Assistance Program (PMAP)
REVENUES:		
1 Member Months	964,415	1,120,866
2 Net Premium Income	408,617,336	479,624,690
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)	57,996	(7,943,116)
7 Aggregate write-ins for other non-health revenues (Line 799)		
8 TOTAL REVENUES (Lines 2 through 7)	408,675,332	471,681,574
EXPENSES:		
9 Hospital/medical benefits	162,613,861	198,352,167
10 Other professional services	119,628,996	115,788,527
11 Outside referrals	3,270,370	2,671,625
12 Emergency room and out-of-area	21,198,362	30,305,125
13 Prescription drugs	31,136,815	46,919,215
14 Aggregate write-ins for other hospital and medical expenses (Line 1499)		
15 Incentive Pool and Withhold Adjustments	1,752,551	3,107,071
16 TOTAL EXPENSES (Lines 9 through 15)	339,600,955	397,143,730
LESS:		
17 Net reinsurance recoveries	870,483	1,612,840
18 Total hospital and medical (Lines 16 minus 17)	338,730,472	395,530,890
19 Non-health claims		
20 Claims adjustment expenses	8,699,100	14,791,747
21 General administrative expenses	31,117,578	55,734,197
22 Increase in reserves for life, accident and health contracts		
23 Total underwriting deductions (Lines 18 through 22)	378,547,150	466,056,834
24 Net underwriting gain or (loss)(Lines 8 minus 23)	30,128,182	5,624,740
25 Net investment income earned	2,832,188	2,815,311
26 Net realized captial gains or (losses)	2,462,311	3,667,755
27 Net investment gains or (losses)(Lines 25 plus 26)	5,294,499	6,483,066
28 Net gain or (loss) from agents' or premium balances charged off		
29 Aggregate write-ins for other income or expenses (Line 2999)		
30 Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	35,422,681	12,107,806
31 Federal and foreign income taxes incurred		
32 Net income (loss) (Lines 30 minus 31)	35,422,681	12,107,806

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

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

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

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

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

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

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

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

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

The PMAP claims adjustment expenses increased 70% (from $8,699,100 to $14,791,747) and general administration expenses increased 79% (from $31,117,578 to $55,734,197) between 2010 and 2011. The driving factor for the overall increase in both categories relates to the impact of including UCare's $30 million contribution to the State of Minnesota in the overall allocation of administrative expenses. The $30 million contribution was directly attributed primarily to the PMAP product line with a small portion included in MnCare. These amounts were included in the overall pro-rata product ratio to ensure that the proper total expense was allocated to each product. Removing the impact of the $30 million contribution to the state, PMAP 2011 expenses on a per-member basis would be $36.65 compared to $41.29 Per-member-per-month (pmpm) in 2010.

PMAP total underwriting deductions increased 23% (from $378,547,150 to $466,056,834) between 2010 and 2011. Total underwriting deductions in 2011, includes $29,550,000 of the voluntary UCare contribution to the State of Minnesota. Without this expense, the increase in total underwriting deductions falls to only 15% which is in line with the overall growth in enrollment between years of 16% and an increase in revenue of 17%.

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

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

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

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

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

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

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

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

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

The differences are described below:

Column 8

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

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

Column 9

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

In 2010 Column 9 was used to report GAMC values only

Column 13

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

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

Due to these significant format changes in what was reported in which columns in the 2010 and 2011 Minnesota Supplement #1 Report reports, RRC performed an analytical review comparing, where possible, data as presented in the 2010 and 2011 MN Supplement Report #1 (for Medicare + Choice, MSHO, and MNCare). Since the Minnesota Supplement Report #1 did not provide separately product level detail for the other product lines for 2010 and 2011, RRC requested and received this detail from UCare and used this information to perform the analytical review for the MSC+, SNBC, MnDho and GAMC programs. Any

*fluctuations greater than 20% and the individual program's materiality were identified and sent to UCare for an explanation. Materiality was calculated for the individual programs based on 5% of the individual programs' 2011 net income (rounded). i.e. materiality for MN Senior Health Options (MSHO) = $11,275,119 (2011 net income) * 5% = $563,755 rounded to $564,000.*

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

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

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

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

The MSHO program had a 935% net increase in underwriting gain (from $801,195 to $8,295,599) between 2010 and 2011. The table below summarizes the high level calculation of the net underwriting gain for UCare's MSHO product in 2010 and 2011.

MSHO	2010		2011		Change	
	Amount	PMPM	Amount	PMPM	Amount	PMPM
Member Months	106,030		110,215		4,185	
Revenue	$ 261,244,486	$ 2,463.87	$ 274,752,401	$ 2,492.88	$ 13,507,915	$ 29.00
Medical Expense	244,972,253	2,310.41	251,666,980	2,283.42	6,694,727.00	(26.99)
Gross Margin	16,272,233	153.47	23,085,421	209.46	6,813,188	55.99
Administrative	15,471,038	145.91	14,789,822	134.19	(681,216.00)	(11.72)
Net Underwriting Gain	$ 801,195	$ 7.56	$ 8,295,599	$ 75.27	$ 7,494,404	$ 67.71
% of Revenue	0.31%		3.02%			

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

MinnesotaCare (MNCare)

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

MSC+

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

therapy, speech therapy and occupational therapy services that resulted in a utilization decrease of 62% in visits per thousand members from 2010 to 2011. This new precertification program/protocol decreased therapy costs for MSC+ significantly.

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

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

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

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

   - Identify expense allocation between public and private programs.

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

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

UCare Allocation Process

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

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

Premium Deficiency Reserve

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

Premium Revenue
minus Medical Costs
minus Administrative Expenses

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

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

UCare *Public Programs Contribution Margins as of 12/31/11*	
Contract B48619	
PMAP	*$10,100,000*
MNCare	*3,900,000*
TOTAL	*$14,000,000*
Contract B48627	
MSHO	*$4,600,000*
MSC+	*(2,600,000)*
TOTAL	*$2,000,000*
Contract B48636	
SNBC	*$600,000*

It is noted that neither Investment Income nor Taxes are included in the calculation. . Taxes are excluded as UCare is a non-profit and not subject to income tax. Per above, since the related contracts did not appear to be in a loss position, excluding investment income from the calculation is reasonable.

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

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

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

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

Incurred But Not Reported Claim Liability

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

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

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

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

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

The Company provided a file which was provided to the Department showing recasts of year-end reserve estimates using claim data through May 2012. The following tables summarize these results.

UCare
Unpaid Claim Liabilities as of December 31, 2010
Data Through May 2012

	Initial Estimate	Restated Liability	Change
Medical Assistance - Families and Children	$41,947,969	$30,241,143	(27.9%)
Medical Assistance - Adults Only	------	------	------
Medical Assistance Total	$41,947,969	$30,241,143	(27.9%)
General Assistance	$1,099,210	$1,027,931	(6.5%)
MNCare Adults w/o Children	$9,887,668	$8,368,884	(15.4%)
MNCare Adults & Children	4,580,863	3,877,225	(15.4%)
MNCare Total	$14,468,531	$12,246,108	(15.4%)
GRAND TOTAL	**$57,515,710**	**$43,515,183**	**(24.3%)**

UCare
Unpaid Claim Liabilities as of December 31, 2011
Data Through May 2012

	Initial Estimate	Restated Liability	Change
Medical Assistance - Families and Children	$55,544,450	$44,084,271	(20.6%)
Medical Assistance - Adults Only	12,290,656	9,754,794	(20.6%)
Medical Assistance Total	$67,835,107	$53,839,065	(20.6%)
General Assistance	$0	$134,106	------
MNCare Adults w/o Children	$7,670,026	$6,745,643	(12.1%)
MNCare Adults & Children	5,774,491	5,078,556	(12.1%)
MNCare Total	$13,444,517	$11,824,199	(12.1%)
GRAND TOTAL	**$81,279,624**	**$65,797,369**	**(19.0%)**

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

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

Wherens, 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.

pendix 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 Description As found on page 4 of the Annual Statement	1 NAIC Totals	2 Non-Minnesota Products (Eliminations)	3 Total Minnesota Products	4 Commercial	5 Medicare + Choice	6 Medicare Cost	7 Minnesota Senior Health Options (MSHO)	8 SNBC (MA Only)	9 SNBC (Integrated)	10 Prepaid Medical Assistance Program (PMAP)	11 MNCare	12 Dental	Plea
lember Months													
et Premium Income (including $ non-health premium income)													
hange in unearned premium reserves and serve for rate credits													
ee-for-service (net of $ medical expenses)													
isk revenue													
ggregate write-ins for other health care related revenues (Line 699)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
ggregate write-ins for other non-health revenues (Line 799)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
OTAL REVENUES (Lines 2 through 7)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
ospital/medical benefits													
ther professional services													
utside referrals													
mergency room and out-of-area													
rescription drugs													
ggregate write-ins for other hospital and medical expenses (Line 1499)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
centive Pool and Withhold Adjustments													
OTAL EXPENSES (Lines 9 through 15)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
et reinsurance recoveries													
otal hospital and medical (Lines 16 minus 17)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
on-health claims													
laims adjustment expenses													
eneral administrative expenses													
crease in reserves for life, accident and health contracts (including $ increase in reserves for life only)													
otal underwriting deductions (Lines 18 through 22)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
et underwriting gain or (loss)(Lines 8 minus 23)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
et investment income earned													
et realized captial gains or (losses)													
et investment gains or (losses)(Lines 25 plus 26)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
et gain or (loss) from agents' or premium balances charged off													
ggregate write-ins for other income or expenses (Line 2999)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
et income or (loss) before federal income taxes ines 24 plus 27 plus 28 plus 29)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
ederal and foreign income taxes incurred													
et 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: • 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.

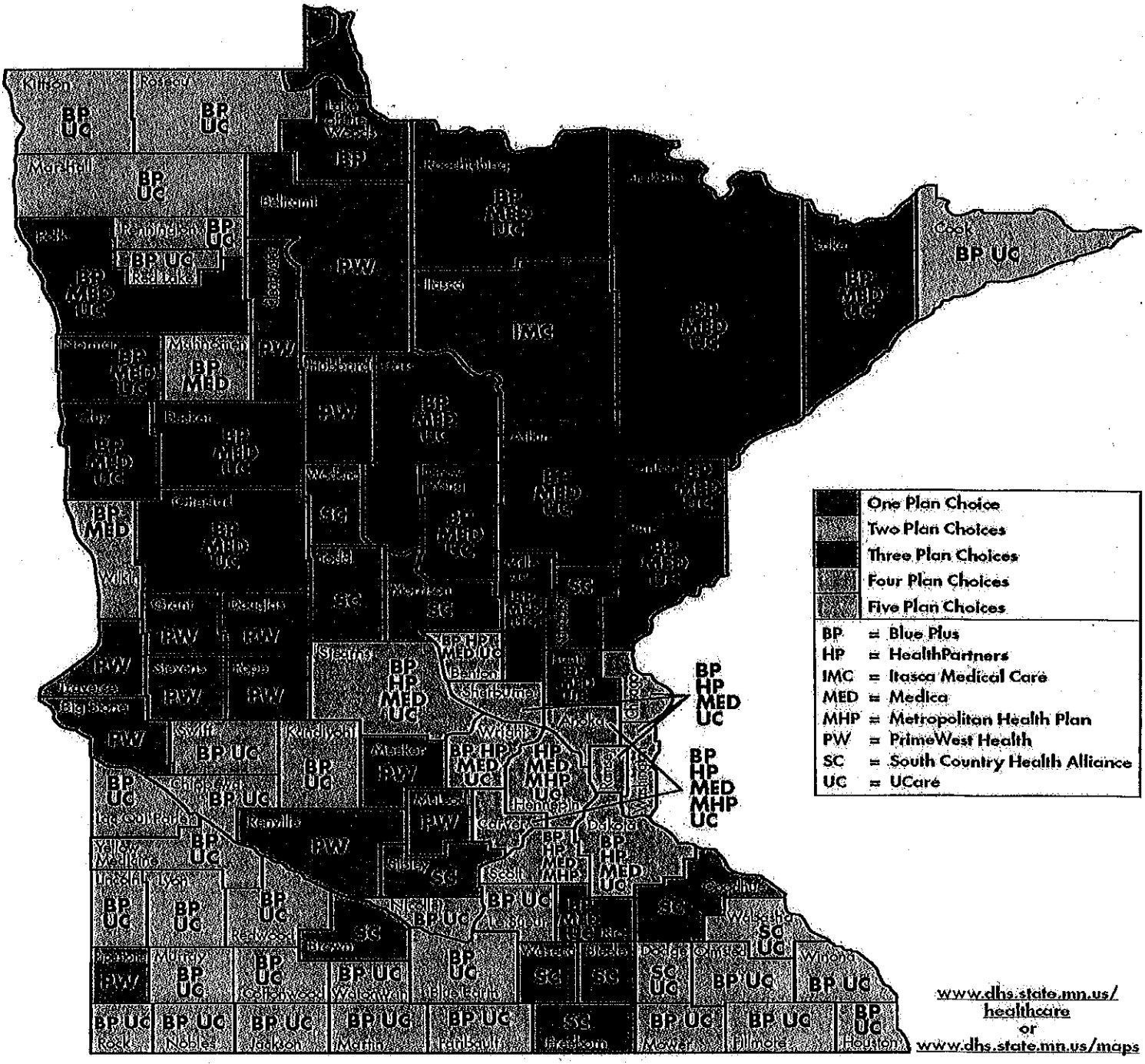
Minnesota Supplements Filing Instructions: It is not necessary to send a paper copy in addition to the electronic submission; none of these reports require a signature. Send the completed Minnesota Supplement forms on a CD to:

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

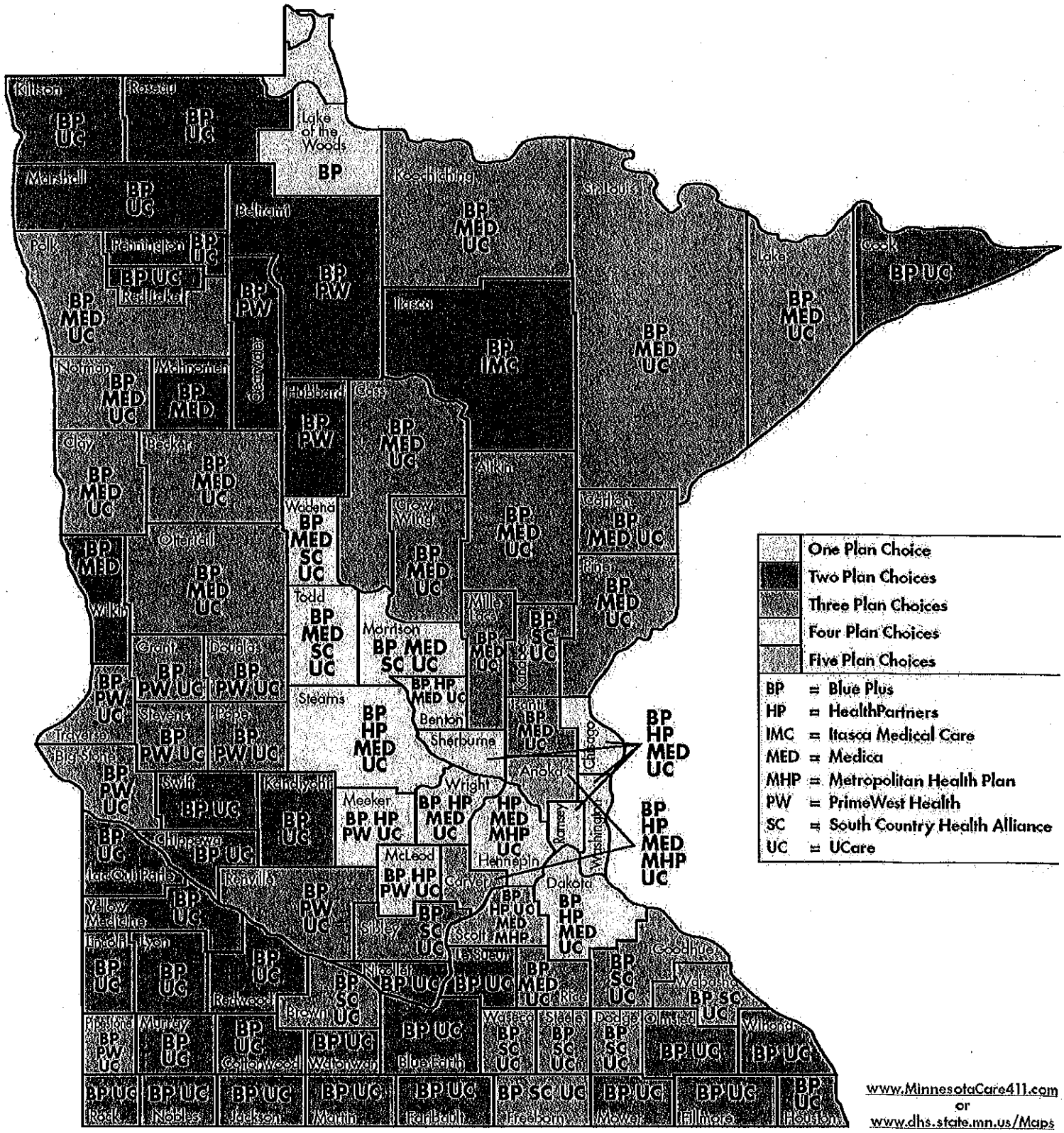
Appendix 5 - Prepaid Medical Assistance Program (PMAP) map

Health Plan Choices by County Effective April 1, 2011



Appendix 6 - MinnesotaCare (MNCare) map

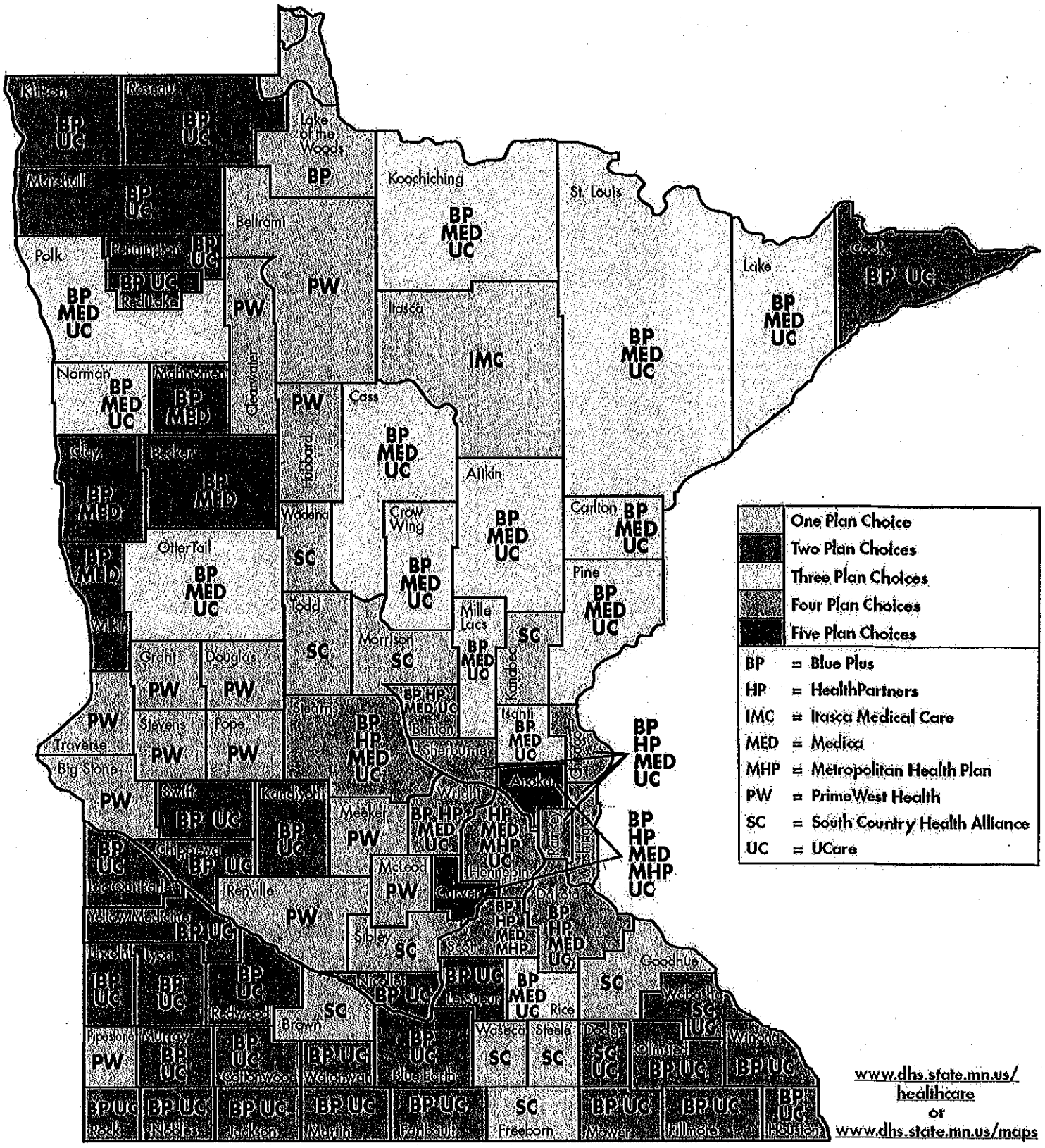
Health Plan Choices by County Effective April 1, 2011



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

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

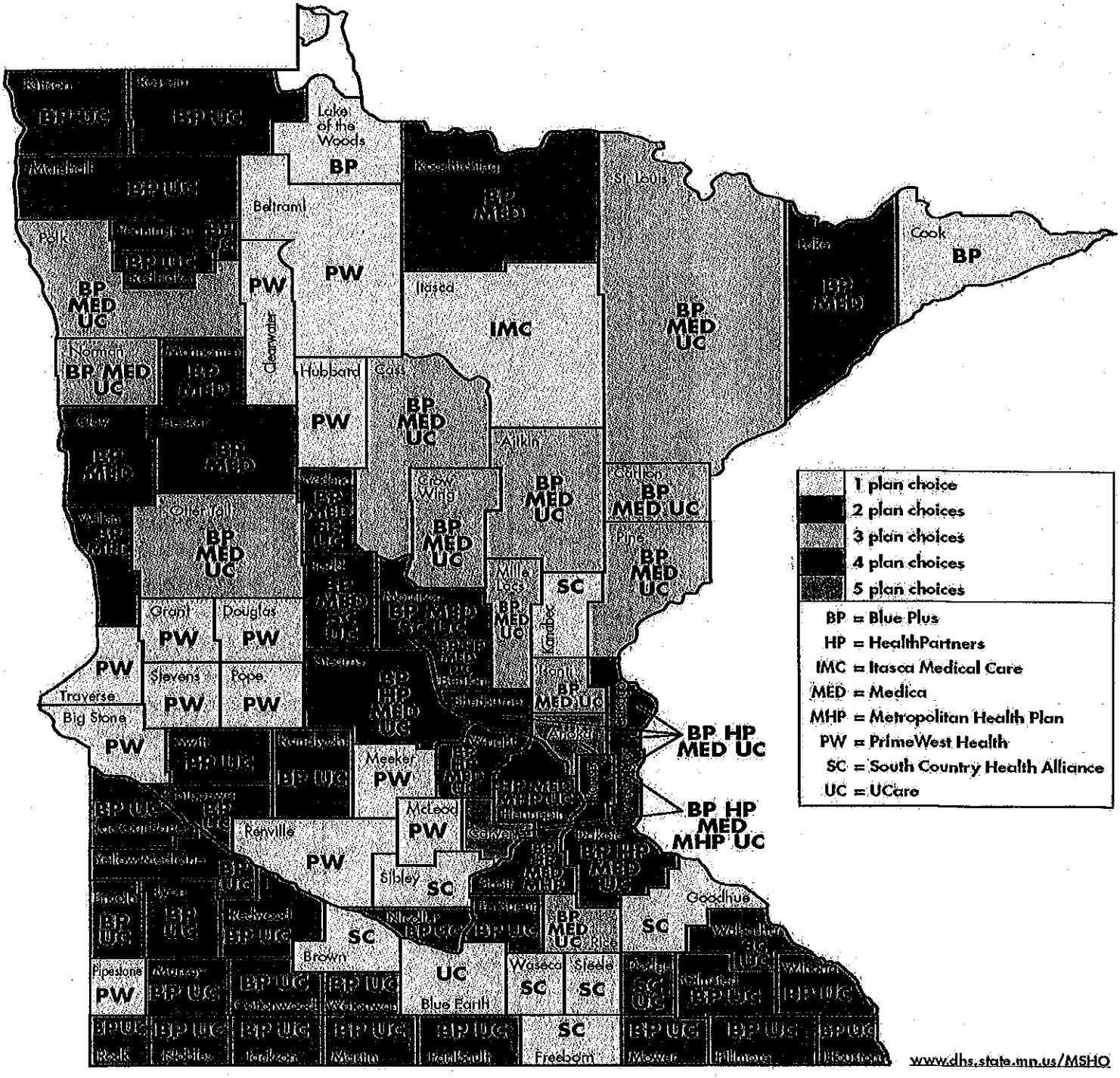
Health Plan Choices by County Effective April 1, 2011



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

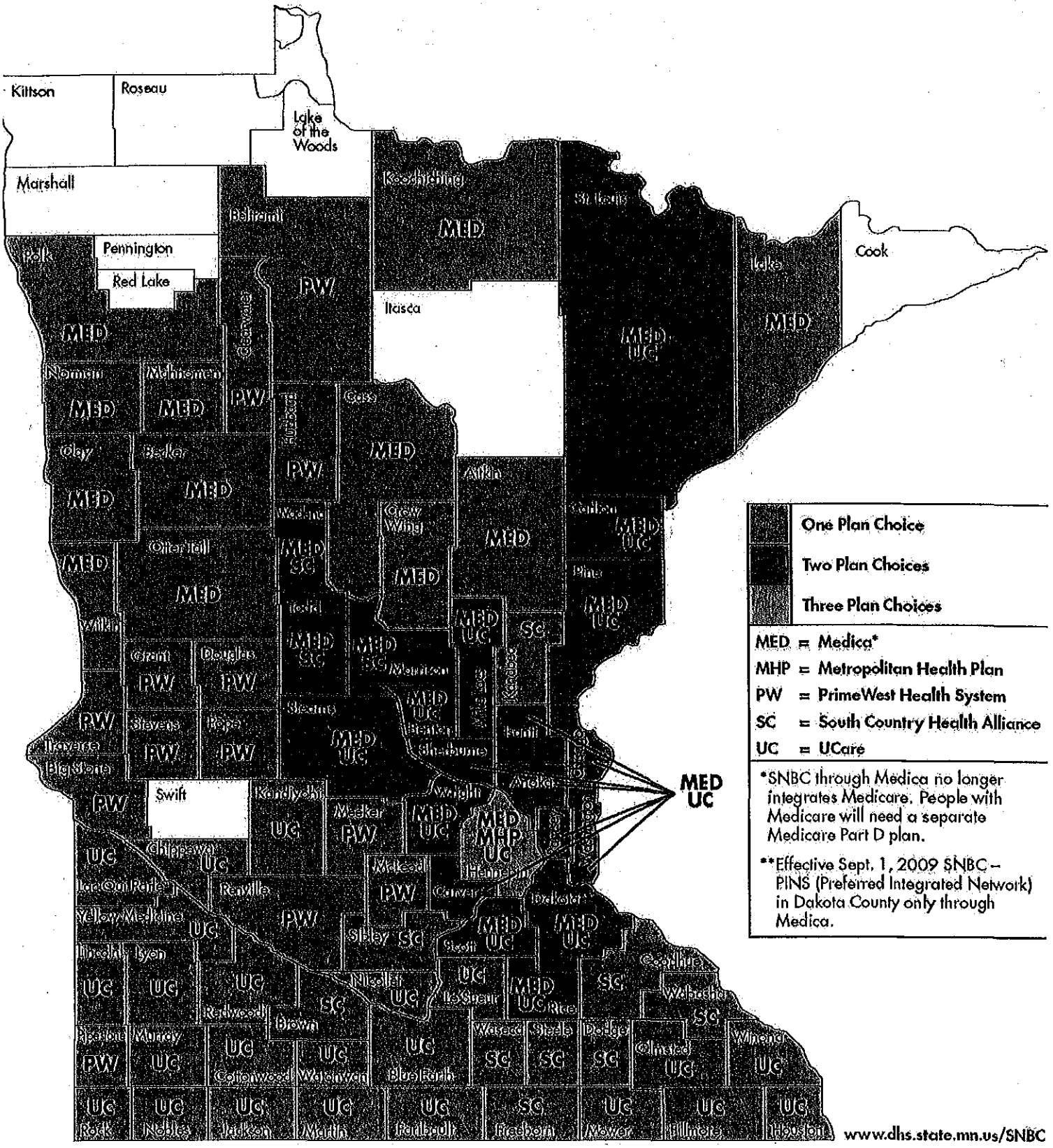
Appendix 8 - Minnesota Senior Health Options (MSHO) map

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



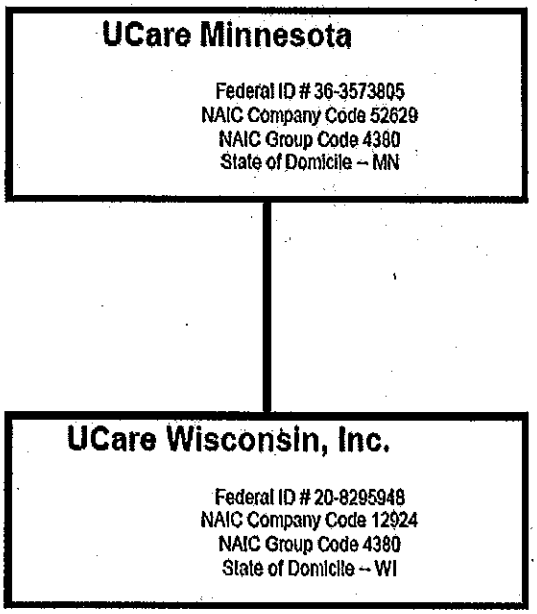
Appendix 9 - Special Needs Basic Care (SNBC) map

Health Plan Choices by County Effective Jan. 1, 2011



Appendix 10 – Organization Chart

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



ibit 1 – Impact of Allocation Calculation Error on Administrative Expenses Reported

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

are Minnesota
.1 Minnesota Supplement Report #1
pact of Allocation Calculation Error on Administrative Expenses Reported

	Administrative Expense By Product Line		
roduct Name - Per Supplement Report #1	Originally Reported	Revised	Difference Over (Under)
Prepaid Medical Assistance Program (PMAP)	70,525,940	68,794,681	1,731,259
MnCare	8,170,421	8,325,313	(154,892)
Minnesota Senior Health Options (MSHO)	14,789,823	15,161,572	(371,749)
Medicare + Choice	49,157,811	50,215,692	(1,057,881)
SNBC (Integrated)	3,019,494	3,091,225	(71,731)
Medicare Supplement and MSC+	3,215,300	3,290,306	(75,006)
Administrative Services Only	(85,877)	(85,877)	-
Total Administrative Expenses	148,792,912	148,792,912	-
npact on 1% PMAP and MnCare Earnings Cap			1,576,367

Addendum to Report

UCare Minnesota Comment Letter

UCare

December 3, 2012

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

Dear Mr. Thelsen:

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

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

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

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

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

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UCare

December 3, 2012

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

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Wages and Salaries Observation - The report accurately describes that we allocated wages and salaries, including executive compensation, as indirect costs across all of our products based on premium revenue, that health plans are not required to cap allocation of executive salaries to any product, and that we did not apply any such cap. However, we do not understand why the report highlights these facts as a noteworthy observation.

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

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

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

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

Even if our margin for adverse claim deviation was more conservative than desired, it did not have a material impact on our financial statements, and to our knowledge should not have affected the DHS rate setting process. The amount of explicit margin and redundant claims liability included in UCare financial statement balances reported in any one year is removed from the cost information provided to DHS for purposes of rate setting.

Finally, the report recommends that UCare consider varying the margin level for particular blocks of business. However, UCare maintains a single claims processing system and department that handles claims processing for all product lines. In addition, provider claims submission patterns and processes generally do not vary by product line. Therefore, UCare does not believe there are signficant differences in estimation risk between the various blocks of business to warrant the need to vary margin levels by product line.

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

Sincerely,

Beth Monsrud
Chief Financial Officer

Cc: Jan Moenck, RRC