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Bill No. 139-31 (COR)

Introduced by:

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AN ACT TO ADD A NEW ARTICLE 3A TO CHAPTER 4, TITLE 4 GCA RELATIVE TO REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF A MEDICAL LOSS RATIO REBATE FOR THE GOVERNMENT OF GUAM HEALTH INSURANCE PROGRAM

Section 1. Legislative Findings and Intent. On March 23, 2010 the President of the United States of America created history by signing into law the Patient Protection and Affordable Care Act (PPACA). The act set into law a multi-component approach to reduce and stem the continued rising cost of health care, a problem that has plagued the United States of America and its Territories for decades.

Section 2718 of the Public Health Service Act (PHSA), as added by Section 1001 and amended by Section 10101 of the PPACA, requires health insurance issuers to offer coverage to meet specific medical loss ratio (MLR) standards as defined by the National Association of Insurance Commissioners (NAIC).

I' Liheslaturan Guahan finds that Guam's health insurance industry must comply with Section 2718 of the PHSA as a minimum standard for providing rebates to consumers when target MLR ratios are not reached.

The Government of Guam Health Insurance Program (Program) is the largest market on Guam. There are over 18,000 eligible employees and retirees of which less than 11,000 or 59% purchase health insurance. In FY 2011 the total amount of premiums paid to the government health insurance provider will exceed $78 million dollars. The people of Guam share of the cost is $59 million from the General Fund and through rates and tariffs assessed by the Guam Power Authority, Guam Waterworks Authority and the Jose D. Leon Guerrero Commercial Port. The remaining $19 million is paid by Government of Guam employees and retirees. The combination of high premiums and high deductible health plans make the insurance unaffordable and undesirable to many government employees and retirees.

I' Liheslaturan Guahan further finds that the cost of the Program is prohibitively expensive for both employees and retirees. The taxpayers and the Government of Guam and its employees and retirees are entitled to the best value for the public funds used to pay health insurance premiums.

I' Liheslaturan Guahan intends to promote high-value coverage through enhanced MLR requirements for the Program, as envision by the national program. The regulation outlined in this Act is specific to the Program and establish guidelines that provide a rebate to Government of Guam employees and retirees if the MLR ratios are less than required levels.

Section 2. A new Article 3A is hereby added to Chapter 4, Title 4 Guam Code Annotated to read:

§4309. Short Title. This Regulation shall be known and may be cited as the Government of Guam Health Insurance Program Medical Loss Ratio Rebate Regulation.

§4310. Purpose. The purpose and intent of this Regulation are to promulgate uniform definitions and a standardized calculation methodology for rebates of health insurance premiums for the Government of Guam Health Insurance Program.

§4311. Definitions.

(a) "Earned premium" means the sum of all moneys paid by a policyholder as a condition of receiving coverage from a health insurance issuer subject to this Regulation, including any fees or other contributions associated with the health plan, such as non-premium revenue collected by the issuer and any subsidiary

holdings providing services to members under the health insurance issuer's products, inclusive of reinsurance receivables, deductibles, copayments, coinsurance, fee-for-service, administrative charges and investment income.

(b) "Expenses to improve health care quality" means those expenses as a defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on 8/17/10.

(c) "Incurred claims" means the sum of direct paid claims incurred in the applicable plan year, unpaid claim reserves associated with claims incurred during the applicable plan year, any experience rating refunds paid or received, and reserves for experience rating refunds.

(d) "Claims unpaid" means claims reported and in the process of adjustment, percentage withholds from payments made to contracted providers, incurred but not reported claims, and recoverables for anticipated claims.

(e) "Credibility adjustment" means the adjustment to account for random statistical fluctuations in claims experience.

(f) "Direct paid claims" means claim payments before ceded reinsurance and excluding assumed reinsurance except as follows: Paid claims for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct paid claims for the assuming entity's and excluded from the ceding entity's medical loss ratio rebate calculations.

(g) "Experience rating refund" means the return of a portion of premiums pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, or the collection of

additional premiums by the issuer pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are greater than earned premium, plus any incurred state premium refunds.

(h) "Fully credible," as it relates to experience, means experience generated by 75,000 or more life years.

(i) "Life years" means the number of member months divided by 12.

(j) "Net healthcare receivables" means the change between prior year healthcare receivables and current year healthcare receivables. The amounts are the gross healthcare receivable assets, not just the admitted portion. This amount does not include those healthcare receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

(k) "Non-credible," as it relates to experience, means experience generated by less than 1,000 life years.

(l) "Partially credible," as it relates to experience, means experience generated by at least 1,000 life years but less than 75,000 life years.

(m) "PHSA" means Public Health Service Act.

(n) "Policyholder" means any entity that has entered into a contract with a health insurance issuer to receive health insurance coverage as defined in Section 2791 (b) of the PHSA.

(o) "Reserves for experience rating refunds" means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement or due but unpaid for a state premium refund.

(p) "Unearned premium reserves" means reserves that are established to account for that portion of the premium paid in the plan year that is intended to provide coverage during a period which extends beyond the plan year.

(q) "Unpaid Claim Reserves" means reserves established to account for claims unpaid.

(r) "Program" means Government of Guam Health Insurance Program as defined in § 4301 of Chapter 3, Article 3 of Title 4 Guam Code Annotated and excluding all Government of Guam Departments, Agencies and Public Corporations that decline participation in the Program.

§4312. Applicability and Scope. The provisions of this Regulation concerning the calculation and payment of medical loss ratio rebates shall apply to any health insurance issuer that provides coverage to the Government of Guam.

§4313. Bringing Down the Cost of Health Care Coverage.

(1) Clear Accounting for Costs. A health insurance issuer offering health insurance coverage to the Government of Guam shall, with respect to each plan year, submit to the Guam Insurance Commissioner, the Office of Public Accountability and the Office of Finance and Budget a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense to earned premiums. The basis of the Medical Loss Ratio Calculation shall be according to provisions outlined in this Section and further defined in Section 9 of this Act. The report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, which such coverage expends:

(a) on reimbursement for clinical services provided to enrollees under such coverage;

(b) for activities that improve health care quality; and

(c) on all other non-claims costs, including an explanation of the nature of such costs.

The Public Auditor shall make reports received under this section available to the public on the Internet website of the Office of Public Accountability.

(2) Ensuring That the Government of Guam Receives Value for Premium Payments.

(a) Requirement to provide value for premium payments. Beginning October 1, 2011, a health insurance issuer offering health insurance coverage to the Government of Guam shall, with respect to each plan year, provide an annual rebate to each enrollee of the Program under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (a) and (b) of subsection (1) to the total amount of premium revenue for the plan year is less than 85 percent or a higher percentage contractually agreed to by the health insurance issuer.

(b) Calculation of Rebate amount. The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of:

(i) the amount by which the percentage described in subparagraph (a) exceeds the ratio described in such subparagraph; and

(ii) the total amount of premium revenue for such plan year.

(c) Certification of Loss Ratio Results and comparison of government of Guam performance relative to the overall health insurance issuer book of business.

(i) Certification of Loss Ratio Results. The actual loss ratio results for plan year the rates are in effect shall be independently audited by the Office of Public Accountability during the first quarter of the following year at the expense of the insurer. The audited results shall be reported to *I Maga'lahi* and the Speaker of *I Liheslaturan Guåhan* no later than April 1 of the following year. The audit shall be conducted in accordance with generally accepted auditing or actuarial standards and shall be signed by a certified public accountant or a member of the American Academy of Actuaries.

(ii) Comparison of Government of Guam Performance Relative to the Overall Health Insurance Issuer Book of Business. In a separate report during the first quarter of the following year the insurer shall produce a report that isolates the following information for the Government of Guam contract and compares the information to the insurers overall book of business:

(I) Medical trend itemized by medical provider price increases, utilization changes and new medical procedures and technology;

(II) Medical trend itemized by pharmaceutical price increases, utilization changes and the introductions of new brand and generic drugs;

(III) Dividends paid;

(IV) Executive salaries, stock options and bonuses;

(V) Insurance producer commissions;

(VI) Payments to legal counsel;

(VII) Provision for profit and contingencies;

(VIII) Administrative expenditures with breakdowns for advertising or marketing expenditures paid lobbying expenditures, and staff salaries;

(IX) Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses;

(X) Charitable contributions;

(XI) Losses on investments or investment income;

(XII) Reserves on hand;

(XIII) The amount of surplus and the amount of surplus relative to the carrier's risk-based capital requirement;

(XIV) Taxes itemized by category;

(XV) Administrative ratio;

(XVI) Actual benefits ratio;

(XVII) The number of lives insured;

(XVIII) The total cost of providing or arranging health care services for:

(1) Guam based expenses: total administrative cost and number of employees;

(2) Philippine based expenses: total administrative cost, number of employees, itemized transaction listing

of all currency deposits or payments to third party administrators;

(3) Other Location based expenses: total administrative cost, number of employees, itemized transaction listing of all currency deposits or payments to third party administrators.

(XIX) Other Income: Non-premium revenue collected by the issuer and any subsidiary holdings providing services to members under the health insurance issuer's products, inclusive of reinsurance receivables, deductibles, copayments, coinsurance, fee-for-service and administrative charges';

(XX) Total annual savings from discounted claims by the Guam Memorial Hospital.

§4314. Levels of Aggregation for Medical Loss Ratio Rebate Calculations. All Plans sold to a Policyholder in the same contract year shall be aggregated for purposes of calculating the Medical Loss Ratio Rebate.

§4315. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Rebate Payments.

(1) Rebates shall be calculated annually by all health insurance issuers that provide coverage to the Government of Guam.

(2) Rebates must be calculated using data as of September 30 of the plan year except for incurred claims, which must be restated as of December 31 of the year following the plan year.

(3) Rebates must be reported to the Insurance Commissioner by February 28 of the year following the plan year using the appropriate reporting format in Appendix A.

(4) Rebates shall be paid annually by March 31 of the year following the plan year.

§4316. Credibility Adjustments to Medical Loss Ratio.

(1) A credibility adjustment is not applicable to any Medical Loss Ratio Calculations that is either non-credible or fully credible based on the Policyholder's aggregate of all plan year life years during the same contract year.

(2) The credibility adjustment for any Medical Loss Ratio Calculations as defined in §4313 and further defined in §4317 of this Act that is partially credible based on plan year life years is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B based on the Policyholder's aggregate of all plan year life years during the same contract year herein determined as:

(a) The Table 1 factor is determined using plan year life years. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the plan year average plan deductible, weighted by life years. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

§4317. Medical Loss Ratio Rebate Calculation.

(1) A rebate is not payable for any aggregation that is non-credible based on plan year life years based on the Policyholder's aggregate of all plan year life years during the same contract year.

(2) If, for any level of aggregation as defined in Section 6, 50% or more of the total earned premium is attributable to policies newly issued with less than 12 months of experience, the experience of these policies can be excluded from the medical loss ratio calculation for plan year. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

(3) The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality are:

(i) Incurred claims are those with incurral dates from October 1, YYYY to September 30, YYYY;

(ii) Expenses to improve health care quality are those expenses associated with incurral dates from October 1, YYYY to September 30, YYYY.

(4) The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums for the period from October 1, YYYY to September 30, YYYY.

(5) The medical loss ratio is calculated as the unrounded ratio of the numerator in (3) to the denominator in (4).

(6) The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in (5) and any applicable credibility adjustment.

(7) The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard.

(8) If the result of (7) is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium The resulting amount is the rebate to be paid. If the result of (7) is zero or less, no rebate is to be paid."

Section 3. Severability. If any provision of this Law or its application to any person or circumstances is found to be invalid or contrary to law, such invalidity shall not affect other provisions or applications of this Law which can be given effect without the invalid provisions or application, and to this end the provisions of this Law are severable.

Appendix A. Formats for Reporting Rebate Calculations

REBATE CALCULATION FORM FOR PLAN YEAR

Company _____ NAIC Company Code _____

For the State of_____ NAIC Group Code _____

Line of Business _____ Minimum Medical Loss Ratio_____

Address _____ Person Completing Exhibit _____

Title _____ Telephone_____

USE GUAM SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1 & PART III TO ASSIST IN COMPLETION OF THIS DOCUMENT

(1) Line	(2) Description	(3) YYYY
1	Life Years	
2	Earned Premium	
3	Expenses to Improve Heath Care Quality	
4	Paid Claims	
5	Unpaid Claim Reserve	
6	Experience Rating Refunds and Reserves for Experience Rating Refunds	
7	Net Healthcare Receivables	
8	Incurred Claims	
9	Medical Loss Ratio	
10	Credibility Adjustment Factor	
11	Credibility Adjusted Medical Loss Ratio	
12	Rebate	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

Appendix A. Formats for Reporting Rebate Calculations (continued)

INSTRUCTIONS REBATE CALCULATION FORM FOR PLAN YEAR

Line 1: Life Years Rebate Supplemental Form for experience year

Line 2: Earned Premium Rebate Supplemental Form for experience year

Line 3: Expenses to Improve Health Care Quality Rebate Supplemental Form for experience year

Line 4: Paid Claims Rebate Supplemental Form for experience year

Line 5: Unpaid Claim Reserve Rebate Supplemental Form for experience year

Line 6: Experience Rating Refunds and Reserves for Experience Rating Refunds Rebate Supplemental Form for experience year

Line 7: Net Healthcare Receivables

Rebate Supplemental Form for experience year

Line 8: Incurred Claims as of 12/31= Line 5 + Line 6 + Line 7 + Line 8

Line 9: Medical Loss Ratio = (Line 4 + Line 9) / (Line 2 – Line 3)

Line 10: Credibility Adjustment based on the number of life years in Line 1 and the methodology in Section 8.

Line 11: Credibility Adjusted Medical Loss Ratio = Line 9 + Line 10 Line 12: If 2011 experience is non-credible as determined by Line 1, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 12) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 11) / (Line 2),where (Minimum Medical Loss Ratio - Line 11) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

Appendix A. Formats for Reporting Rebate Calculations (continued)

REBATE CALCULATION SUPPLEMENTAL FORM Plan Year ____

Experience Year ____ Company _____ NAIC Company Code_____
For the State of_____ NAIC Group Code _____
Line of Business _____ Address _____
Person Completing Exhibit _____ Title _____
Telephone Number_____

REBATE CALCULATION SUPPLEMENTAL FORM

(1) Line	(2) Description	(3) 12/31	(4) Deferred	(5) Added	(6) Total
1	Life Years				
2	Earned Premium				
3	Expenses to Improve Heath Care Quality				
4	Paid Claims				
5	Unpaid Claim Reserve				
6	Experience Rating Refunds and Reserves for Experience Rating Refunds				
7	Net Healthcare Receivables				
8	Incurred Claims				

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

Appendix A. Formats for Reporting Rebate Calculations (continued)

INSTRUCTIONS REBATE CALCULATION SUPPLEMENTAL FORM

Column 3 is data from the Supplemental Health Care Exhibit in the NAIC Annual Statement for the experience year.

Column 4 is data for policies newly issued in the experience year with less than 12 months of experience in that year that are excluded from the medical loss ratio calculation for the plan year of issue and will be added back in the next plan year. Column 5 is data for policies newly issued in a prior experience year with less than 12 months of experience in that year that were excluded from the medical loss ratio calculation for a prior plan year and are added back in this plan year. See Sections 8.B., 9.B. for additional details.

Note that quantities in Lines 2 through 6 should be allocated to represent only the experience associated with the deferred business using reasonable methods.

Line 1: Life Years Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1 Other Indicators, Column(s) for applicable line of business - Line 4 divided by 12 and rounded to zero decimal places.

Line 2: Earned Premium -- Column 3 is from the Supplemental Health Care Exhibit for the experience year –

Line 3: Expenses to Improve Health Care Quality -- Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 4 + Line 6.3

Line 4: Paid Claims -- Amounts paid on claims incurred in the experience year as of December 31 of the year following the plan year.

Line 5: Unpaid Claim Reserve -- The reserve for amounts unpaid on claims incurred in the experience year as of December 31 of the year following the plan year.

Line 6: Experience Rating Refunds and Reserves for Experience Rating Refunds Experience rating refunds incurred in the experience year and paid through December 31 of the year following the plan year, plus the estimate as of December 31 of the year following the plan year for any reserves experience rating refunds

incurred in the experience year, plus any state premium refunds incurred in the experience year.

Line 7: Net Healthcare Receivables Net Healthcare Receivables incurred in the experience year as of March 31 of the year following the plan year.

Line 8: Line 4 + Line 5 + Line 6 + Line 7.

Appendix B. Credibility Tables

Table 1	
Base Credibility Additive Adjustment Factors	
Life Years	**Additive Adjustment**
< 1,000	No Credibility
1,000	8.30%
2,500	5.20%
5,000	3.70%
10,000	2.60%
25,000	1.60%
50,000	1.20%
75,000	0.00%

Table 2	
Deductible Range	**Adjustment Factor**
< $2,500	1
$2,500	1.164
$5,000	1.402
>= $10,000	1.736

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

Expenses to Improve Health Care Quality:

Derived from GUAM SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3:

Improving Health Care Quality Expenses – General Definition: Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

PARTS 3A and 3B COLUMNS:

Column 1 – Improve Health Outcomes Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined above. This category can include costs for associated activities such as:

- Effective case management, Care coordination, and Chronic Disease Management, including:

Patient centered intervention such as:

-Making/verifying appointments,

-Medication and care compliance initiatives,

-Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center),

-Programs to support shared decision making with patients, their families and the patient's representatives; and

-Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;

- Incorporating feedback from the insured to effectively monitor compliance;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Providing coaching or other support to encourage compliance with evidence based medicine;

- Activities to identify and encourage evidence based medicine;

- Use of the medical homes model as defined for purposes of section 3602 of PPACA);

- Activities to prevent avoidable hospital admissions;

- Education and participation in self-management programs; and

- Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;

- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

- Quality reporting and documentation of care in non-electronic format; and

- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:

  -Data extraction, analysis and transmission in support of the activities described above, and

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

-Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care; and

Column 2 – Activities to Prevent Hospital Readmission Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Personalized post discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including.
- Data extraction, analysis and transmission in support of the activities described above, and
- Activities designed to promote sharing of medical records to ensure that all clinical providers rate records from all participants in a patient's care; and

Column 3 – Improve Patient Safety and Reduce Medical Errors Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to avoid harm;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:

  -Data extraction, analysis and transmission in support of the activities described above, and

  -Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; or

Column 4 – Wellness & Health Promotion Activities Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- Public health education campaigns that are performed in conjunction with state or local health departments;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:

  -Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit; Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

  -Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and

  -Health information technology expenses to support these activities (Report in Column 5 – See instructions).

Column 5 – HIT Expenses for Health Care Quality Improvements -- The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways;

1. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history;

3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; or

5. Provision of electronic health records and patient portals.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements.

Expense Allocation

Supplemental Filing: Companies report QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing as well. For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an "X" in the "New"

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable results. Expenses for prospective Utilization Review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an "E" in the "New" column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Notes: a. *Healthcare Professional Hotlines*: Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.

b. *Prospective Utilization Review*: Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent Utilization Review;
- Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;
- Marketing expenses;

- All Accreditation Fees;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.