STATE OF MINNESOTA

HealthPartners, Inc.

WORK ORDER CONTRACT NO: 50693

December 3, 2012

Table of Contents

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 HealthPartners, Inc. (hereinafter referred to as "HPI" 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.

The HealthPartners family of Companies consists of approximately 30 different legal entities. These companies are supported centrally by administrative departments that are expensed through the Group Health Plan, Inc. (GHI) corporation. GHI uses an administrative model to allocate these administrative expenses across companies, divisions and at a product or line of business level. HPI's businesses are organized by corporation (Health Plan, Hospital and Foundations) and by divisions within each corporation. Examples of these divisions are the HealthPartners Medical Group, HealthPartners Pharmacy Division, HealthPartners Dental Group, Foundations, Health Plans and Administration Divisions. Each of these divisions consists of accounting units which accumulate the expenses for each business unit within HPI companies.

The expense allocation model was developed in the late 1980's and is updated each year. HPI Finance staff interviews each accounting unit owner to determine if the current allocation methodology used is still the best method and properly reflects changes in the business.

The results of our analytical review and testing of samples of various expense categories show that HPI 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.

HPI assesses the need for a PDR by reviewing internal Product Line Reports. If the Medical Loss Ratio (MLR) for the current year, excluding administration expenses for the selected grouping is less than 100%, then a PDR is deemed unnecessary. This review is supplemented by discussions amongst the Finance, Actuarial and Underwriting Departments. HPI determined that a PDR was not necessary as of December 31, 2011. The Appointed Actuary, Steven H. Mahan, FSA, MAAA, confirmed the Company's conclusion in his "Actuarial Memorandum in Support of the Actuarial Statement of Opinion" as of December 31, 2011. RRC was provided with the Product Line Reports as of December 31, 2011 as well as the Actuarial Memorandum.

The Company's decision that a PDR was not necessary as of December 31, 2011 appears reasonable from a financial perspective. However, it was concluded that the Company lacks a formal PDR analysis process, lacks any formal documentation of its process and its analysis relies on retrospective results of operations rather than prospective projections or forecast of its operations in the coming year. In addition, the Company did not provide supporting documentation of its rationale for combining all public programs in one group for the purpose of assessing the need for a premium deficiency or how its grouping methodology was in compliance with SSAP No. 54. SSAP No. 54 requires policies to be grouped in a manner consistent with how they are marketed, serviced and measured, for purposes of determining if a premium deficiency exists.

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.

Annual Statement Liability Line Item	Description	12/31/11 balance	12/31/10 balance
1	Claims unpaid	$96,241,000	$105,577,000
2	Accrued medical incentive pool and bonus amounts	$0	$0
3	Unpaid claim adjustment expenses	$ 2,186,000	$2,398,000
4	Aggregate health policy reserves	$0	$0

The Company's reserving methodology involves the use of the Developmental Method, also referred to as the Lag Factor Method, developed on a Generally Accepted Accounting Principles (GAAP) basis, with adjustments to convert to a statutory basis of accounting. A variety of data sources and supplementary information are reviewed to determine the adjustments necessary for conversion to Statutory basis of accounting. Best estimates are made, with an explicit load representing both a margin for adverse claim deviation and Loss Adjustment Expense ("LAE") applied. As represented to RRC's actuary, the Company's estimates do not incorporate implicit margins.

For the initial GAAP unpaid claims liability (UCL) estimates, reserving cells are service types within each related legal entity (Group Health Plan, Inc.; HealthPartners, Inc.; HealthPartners Insurance Company). The splits differ for Statutory UCL estimates. The Statutory UCL estimates are adjusted to match the GAAP amounts. The adjustment is typically small and immaterial. The methodology employed appears reasonable and appropriate. It follows generally accepted actuarial practice for coverage with a relatively short time period between the incurred date and payment of claims. Further, the methodology is consistent with that seen during the Financial Examination as of December 31, 2009 performed by MNDOC.

Run-out

For HPI, claim lag data is summarized on an incurred-and-processed basis, as opposed to an incurred-and-paid basis. Claim lag date includes both claims processed but not yet paid as well as claims incurred and paid. The lag period between claim processing and claim payment is extremely small, and does not appear to materially impact the reserve estimation.

For GHI and HPI, the Company applies a 12.5% load to their Best Estimates consisting of a 10.0% margin for adverse claim deviation and a 2.5% Loss Adjustment Expense (LAE). We concluded that the margin was overly conservative compared when considering historic redundancies and profitability analysis of the company's public programs.

Based upon the information provided, the December 31, 2010 estimates in total were redundant by 13.0%, which can be viewed as almost entirely related to the 12.5% explicit margin.

Utilizing May 31, 2012 claims paid data, indications are that estimates as of December 31, 2011 were deficient by 5.1%. There are wide variations within the public product line reserves

established as of 2011 and the subsequent year run-off of related claims. The Company indicated that within the PMAP MA program, exceptionally high ranges of completion factors were incurred during 2012 for claims with 2011 dates of service. These types of payments are not picked up in the Company's normal completion factors when setting IBNR; the margins built into their reserves serve to mitigate such variations. In collaboration with its consideration of appropriate margin level, the Company should review its reserving methodology for public programs as it relates to improving precision.

Background

HealthPartners, Inc. is a nonprofit corporation licensed as a health maintenance organization (HMO) in Minnesota. HPI provides health care services and coverage to approximately 237,000 members throughout Minnesota. It provides these services through a network of contracted medical and dental centers, physician groups, hospitals and related health care providers located primarily in the Minneapolis – Saint Paul metropolitan area. HPI is exempt from taxation under Section 501(c) (4) of the Internal Revenue Code.

HPI 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.

HPI 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.

Group Health Plan, Inc. (GHI), a subsidiary of HPI, provides management, administrative and healthcare services to HPI, its affiliates, as well as their respective members through the Management and Administration Expense Allocation Agreement and the HealthCare Expense Allocation Agreements. Under these agreements, HPI paid GHI $79 million and $73 million in 2011 and 2010, respectively, for management and administrative services and $64 million and $111 million in 2011 and 2010, respectively, for healthcare services.

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

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, HPI provided coverage to PMAP members in 12 of the 65 counties that are available for prepaid health care contracting. HPI has approximately 12% 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) requires 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.

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 HPI provided coverage to approximately 10% of the statewide MSC+ enrollment.

See Appendix 7 for the MSC+ health plan choices by county.

MNCare

This program provides coverage to 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 also qualify.

MNCare provides subsidized coverage for individuals and children who are not covered by group insurance and not eligible for Medical Assistance.

In 2011, HPI provided coverage to approximately 13% of the statewide MNCare enrollment and is available in 14 of Minnesota's 87 counties.

See Appendix 6 for the MNCare health plan choices by county.

Public Programs Integrated with Federal Programs provided by HPI

MSHO
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 Medical Assistance (MA) and enrolled in Medicare Parts A and B. In 2011 HPI provided coverage to approximately 8% of the statewide MSHO enrollment.

See Appendix 8 for the MSHO health plan choices by county.

Public Programs managed by CMS and provided by HPI

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

Private Programs provided by HPI

Commercial
Commercial Programs are managed care plans for individuals, families, and groups.

HPI does not offer the Special Needs Basic Care (SNBC) program to its members.

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. RRC reviewed how salaries were allocated to the Company's public and non public programs, including the salaries of its executives. HPI is allocated salaries based on membership, first by corporation, then by operating divisions, then by product/program.

   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.

2. In 2011, HPI changed the way they reported allocations to claims adjustment expenses and general administrative expenses to be consistent with the new Medical Loss Ratio (MLR) reporting requirements stemming from the Affordable Care Act. The changes

were related to those expenses considered by the Affordable Care Act MLR reporting requirements as "Improving Health Care Quality Expenses", which are considered claims adjustment expenses for purposes of the MLR calculation.

In 2010 (as in prior years), HPI applied the NAIC definition to determine which expenses to categorize as general administration expenses and claims adjustment expenses, respectively. In 2011, HPI modified its allocation process to consider the expense categories related to "Improving Health Care Quality Expenses" as defined in the Affordable Care Act MLR reporting criteria. This had the impact of an increase in claims adjustment costs across all Medicare and Medicaid products. However, that increase had a corresponding decrease in general administrative expenses and no impact for the financial results as a whole of the Medicaid programs, or the administrative expenses that were reported for the Medicaid program. This change had no impact on the financial performance of the public programs or the total general administrative and claims adjustment expenses of the public programs. HPI total claims adjustment expenses were $28,935,000 in 2011 and were $28,736,000 in 2010.

3. Total administrative expenses for MSHO decreased from $7,588,000 in 2010 to $6,571,000 in 2011. In 2011 and prior years, the financial results of MSHO have been correctly reported in the MSHO column of the Minnesota Supplement Report #1 submitted to the Minnesota Department of Health and within the Title XIX Medicaid column of the Analysis of Operations by Lines of Business on its Statutory Annual Report. The primary reason for the decrease in administrative expenses for MHSO during 2011 was a change in the way that HPI allocated taxes and assessments to the program. From a tax perspective only, the MSHO program is considered by the Company to be a Medicare Advantage program even though it is reported as a Medicaid program on HPI's Annual Report and the Minnesota Supplement Report #1. The Company's justification for this position is that the contract for MSHO is with the Centers for Medicare and Medicaid Services (CMS) and is considered a Medicare Advantage program by CMS. Because it is treated as a Medicare Advantage program, MSHO is exempt from all State of Minnesota assessed taxes. Prior to 2011, the MSHO program was allocated certain State of Minnesota assessment taxes on HPI's internal product line financial statements. MSHO showed improved financials in 2011 due to the removal of taxes as described above as well as improved claim trends during 2011 and a resulting improved Medical Loss Ratio.

4. As of December 31, 2011, the Company determined that it did not require accrual of a PDR liability, which we agree is a reasonable conclusion. However, the manner in which the Company made this determination does not appear reasonable. The Company's process includes analyzing current year product line financial statements to determine if any product line grouping (Commercial, Medicare, and Medicaid) is in a loss position. The Company's analysis was not documented and appeared to be informal in nature. We also note that the approach taken by the Company is retrospective in nature. The reports on the prior year are reviewed and are supplemented by subjective insights. It can be argued that a prospective view, such as that found in forecasts, would be more appropriate and precise as well as adhering to generally accepted actuarial principles. The

current approach relies heavily on judgment as well as the idea that results for the previous year is an accurate predictor of the next year's results.

The Company should consider formalizing its analysis related to determining the need for a premium deficiency, including documentation of the analysis for future review by auditors, its actuary as well as regulators. The analysis should include both retrospective and prospective analysis, including the use of financial projections of the profitability of its public programs.

Findings:

1. Finding:
   The Company combines all public programs for the purpose of assessing the need for a premium deficiency. The Company did not provide supporting documentation for its rationale for this grouping or how this grouping methodology was in compliance with SSAP No. 54, which requires policies to be grouped in a manner consistent with how they are marketed, serviced and measured, for purposes of determining if a premium deficiency exists. The Company's approach is consistent with that seen during the Financial Examination as of December 31, 2009, performed by MNDOC. The Company has a separate contract with the State of Minnesota, acting through its Department of Human Services covering PMAP and MNCare services. In addition, the Company has a separate contract covering MSHO and MSC+ services together. We concluded that grouping the programs in accordance with the contracts entered into with the State for purposes of determining if a premium deficiency exists would be a reasonable approach to comply with SSAP No.54. If the Company had grouped its public programs during 2011 according to the contracts with the State covering these services under each program, a determination would have still been that no PDR was necessary at 2011. However, the current grouping practice of including all programs could have an impact on the adequacy of the Company's PDR calculation in subsequent years, if certain programs incurred significant underwriting losses.

   Recommendation:
   We recommend that the Company develop documentation supporting its rationale that all public programs should be combined for purposes of determining if a premium deficiency exists and how this methodology is consistent with how policies are marketed, serviced and measured, as required in accordance with SSAP No. 54.

2. Finding:
HPI applies a 12.5% load to their best estimates for its Unpaid Claims Liability (UCL) consisting of a 10.0% margin for adverse claim deviation and a 2.5% Loss Adjustment Expense (LAE). The Company has not changed these percentages from the levels applied during 2009, as noted during the most recent Financial Examination by MNDOC. According to the Company, it had reached an agreement with its prior auditor regarding margins, which was a draw-down of the margin level over a five year period culminating at current levels. HPI feels that the margins it has established in their UCL calculations are consistent with industry averages and provides a reasonable level of comfort that adverse claims run-out experience will not impact future year financial performance. We concluded that while the margins have been reduced significantly since the 2006 Financial Examination by MNDOC, the margins are overly conservative compared to historic redundancies and the varying magnitude of such by reserving category.

Based upon the information provided, the December 31, 2010 UCL for the Company's public programs in total were redundant by 13.0%. It can be concluded that the majority of the redundancies in the December 31, 2010 UCL is almost entirely related to the 12.5% explicit margin carried by the Company. The UCL for the Company's public programs as of December 31, 2011 were shown to be deficient by 5.1%, as of May 31, 2012, the date specific information was requested by MNDOC. There are wide variations within the public product line reserves. For example the PMAP program December 31, 2011 UCL was deficient by $2,223,848, or 15.9%, utilizing data available as of May 31, 2012. The Company indicated that within the PMAP MA program, exceptionally high ranges of completion factors were incurred during 2012 for claims with 2011 dates of service. These types of payments are not picked up in the Company's normal completion factors when setting IBNR; the margins built into their reserves serve to mitigate such variations.

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. We also recommend that in collaboration with its consideration of an appropriate margin level, the Company review its reserving methodology for public programs as it relates to precision. These suggestions further support the previous recommendation that the Company consider its financial projections of profitability at each public program when determining the need for a premium deficiency.

Scope and Procedures Performed

In accordance with Work Order Contract No. 50693, 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 to the Minnesota Supplement Report filed with the Minnesota Department of Health.

For HPI there was no PMAP detail exhibit for HealthPartners (splitting PMAP Non Seniors to MSC+ Seniors data). This is because HPI reported MSC+ separately in the Minnesota Supplement Report #1 in Column 14 for both years: The PMAP results reported to DHS matched what was reported in the Minnesota Supplement #1 Report for both 2010 and 2011.

According to the Minnesota Department of Human Services website, the GAMC program ended February 28, 2011. Enrollees were automatically moved to Medical Assistance (MA) Minnesota's Medicaid Program. MA is reflected in the 2011 PMAP numbers (as run-off). HealthPartners provided us with a breakout of the GAMC component of PMAP. In 2011 PMAP total expenses reported on line 16 of the Minnesota Supplement Report #1 were $216,519,000 of which $143,000 were attributed to GAMC run-off.

The following PMAP detail was obtained directly from the HPI Amended 2011 and 2010 Minnesota Supplement Report #1.

NAIC Descritption	2010	2011
	Prepaid Medical Assistance Program (PMAP)	Prepaid Medical Assistance Program (PMAP)
REVENUES:		
1 Member Months	459,739	552,308
2 Net Premium Income	183,312,000	235,728,000
3 Change in unearned premium reserves and serve for rate credits		
4 Fee-for-service		
5 Risk revenue		
6 Aggregate w rite-ins for other health care related revenues (Line 699)		
7 Aggregate w rite-ins for other non-health revenues (Line 799)		
8 TOTAL REVENUES (Lines 2 through 7)	183,312,000	235,728,000
EXPENSES:		
9 Hospital/medical benefits	142,304,000	178,867,000
10 Other professional services		16,820,000
11 Outside referrals		
12 Emergency room and out-of-area		
13 Prescription drugs	13,058,000	20,832,000
14 Aggregate w rite-ins for other hospital and medical expenses (Line 1499)		
15 Incentive Pool and Withhold Adjustments		
16 TOTAL EXPENSES (Lines 9 through 15)	155,362,000	216,519,000
LESS:		
17 Net reinsurance recoveries		
18 Total hospital and medical (Lines 16 minus 17)	155,362,000	216,519,000
19 Non-health claims		
20 Claims adjustment expenses	2,623,000	5,366,000
21 General administrative expenses	9,381,000	12,921,000
22 Increase in reserves for life, accident and health contracts		
23 Total underw riting deductions (Lines 18 through 22)	167,366,000	234,806,000
24 Net underw riting gain or (loss)(Lines 8 minus 23)	15,946,000	922,000
25 Net investment income earned	57,000	(129,000)
26 Net realized captial gains or (losses)		
27 Net investment gains or (losses)(Lines 25 plus 26)	57,000	(129,000)
28 Net gain or (loss) from agents' or premium balances charged off		
29 Aggregate w rite-ins for other income or expenses (Line 2999)		
30 Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	16,003,000	793,000
31 Federal and foreign income taxes incurred		
32 Net income (loss) (Lines 30 minus 31)	16,003,000	793,000

RRC noted the programs reported in column 10 (PMAP) of the Minnesota Supplement Report #1 varied significantly from 2010 to 2011.

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 (MA), Minnesota's Medicaid program. In 2010, the GAMC program information was reflected in a separate column. In 2011, Minnesota participated in the Medicaid Expansion. The majority of the increases can be attributed to Medicaid Expansion.

In 2011, Column 10 contained PMAP results (which included Medicaid Expansion) plus GAMC run-off expenses and was labeled "PMAP". In 2010, Column 10 contained PMAP results only and was labeled "PMAP"

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

See Appendix 3 & 4.

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.

According to §62D.08 Subd. 7(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".

HPI completed the Amended 2011 MN Supplement Report #1 in accordance with the instructions. "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".

HPI also completed the instructions according to MN Statute §62D.08 Subd. 7(b) in regards to the reporting and allocation of Investment Income.

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

*An analytical review was performed comparing the 2010 and Amended MN Supplement Report #1. Any fluctuations greater than 20% AND the individual programs materiality were identified and sent to HPI for explanation. Materiality was calculated for the individual programs based on 5% of the individual programs' net income (rounded). i.e. materiality for MN Senior Health Options (MSHO) = $9,237,000 (2011 net income) * 5% = $461,850 rounded to $461,900.*

In 2011, HPI changed the way they reported allocations to claims adjustment expenses and general administrative expenses to be consistent with the new Medical Loss Ratio (MLR) reporting requirements stemming from the Affordable Care Act. The changes were related to those expenses considered by the Affordable Care act MLR reporting requirements, related to "Improving Health Care Quality Expenses".

In 2010 (as in prior years), HPI used its own internal definitions to determine what expense categories were considered to be related to "Improving Health Care Quality Expenses". In 2011, HPI modified what expense categories were considered to be related to "Improving Health Care Quality Expenses" to those categories defined in the Affordable Care Act MLR reporting criteria. This had the impact of an increase in claims adjustment costs across all Medicare and Medicaid products. However, that increase had a corresponding decrease in general administrative expenses and no impact for the financial results of the Medicaid programs, or on the administrative expenses that were reported for the Medicaid program. When a variance analysis is performed where claims adjustment expenses are combined with general administrative expenses and looked at as a total claims expense figure, the variances are mitigated. HPI total claims adjustment expenses were $28,935,000 in 2011 and were $28,736,000 in 2010. According to the Company, the reason for this increase, coupled with the change in methodology of allocating claims adjustment expenses, was related to HPI's continued investment in Health Improvement costs such as Disease Management, Case Management and Quality and Utilization Management.

For the most part the Company's responses to the questions related to the significant fluctuations appeared reasonable. Significant differences of note include:

Medicare + Choice (Medicare Advantage):
In 2011, HPI eliminated this Medicare Advantage product. All members in this program were given the opportunity to move to the HPI Medicare Cost products. The elimination of this program significantly reduced premium revenue in the MSC+ Column (Column 5) of the Amended 2011 Minnesota Supplement Report #1 from $12,629,000 in 2010 to $1,270,000 in 2011. In 2011 all that remained in the MSC+ Column was the stand alone Medicare Part D program whereas in 2011 this column contained results for both the stand alone Medicare Part D program and the Medicare Advantage program.

MSHO:
In 2011 there were large fluctuations (increases in claim adjustment expenses and decreases in general administration expenses) in the MSHO program. MSHO claims adjustment expenses increased from $1,658,000 in 2010 to $2,335,000 in 2011. MSHO general administrative expenses decreased from $5,930,000 in 2010 to $4,236,000 in 2011. This was attributed to the change in the way the Company reported allocations to these two expense categories, as previously noted.

Total administrative expenses for MSHO decreased from $7,588,000 in 2010 to $6,571,000 in 2011. The primary reason for this decrease was that HPI did not allocate taxes and assessments to MSHO in 2011 as it is a Medicare Advantage program and there should not be any taxes allocated to it. In previous years (2010 and prior) HPI allocated MSHO a

portion of taxes. The decrease was $1,300,000 in MSHO administrative expenses in 2011 due to this tax treatment change.

MSHO showed improved financials in 2011 due to the removal of taxes as described above as well as claim trends from 2010 were only .63% where as revenue increased 3.15%. The low claim trends improved the Medical Loss Ratio for 2011.

PMAP

In 2011 there were large fluctuations (large percentage increases in claim adjustment expenses and lesser percentage increases in general administration expenses) in the PMAP program. PMAP claims adjustment expenses increased from $2,623,000 in 2010 to $5,366,000 (49% increase) in 2011. PMAP general administrative expenses increased from $9,381,000 in 2010 to $12,921,000 in 2011 (27% increase). This was primarily because HPI changed the way they reported allocations to these two expense categories (as previously noted) plus the increases driven by the addition of the Medicaid Expansion population to PMAP in 2011.

The PMAP prescription drug expenses increased 60% from $13 million in 2010 to $20.1.million in 2011. The increase in expenses for pharmacy in 2011 is also attributable to the new Medicaid Expansion program. The Pharmacy PMPM's for the Medicaid Expansion population was $98.40 PMPM compared to HP Care MA which is only $27.65. Most of the Medicaid Expansion population is coming from the General Assistance Medicaid program (GAMC) which also had high Pharmacy PMPM's. In 2011 the PMAP column included Medicaid Expansion, HP Care MA, and some GAMC run-off expenses where in 2010 it only included HP Care MA.

Total administrative expenses for PMAP increased from $12,004,000 in 2010 to $18,287,000 in 2011. The primary reason for this increase was the addition of the Medicaid Expansion program.

MNCare

In 2011 there were large fluctuations (increases in claim adjustment expenses and decreases in general administration expenses) in the MNCare program. MNCare claims adjustment expenses increased from $1,258,000 in 2010 to $2,034,000 in 2011. MNCare general administrative expenses decreased from $4,501,000 in 2010 to $4,164,000 in 2011. This was because HPI changed the way they reported allocations to these two expense categories (as previously noted).

The MNCare program had a net underwriting loss $215,000 in 2010 and a net underwriting loss of $627,000 in 2011. In 2011 the MNCare product was impacted by membership moving to the new Medicaid Expansion product. As a result premium revenue PMPM's decreased 9.31% where as underwriting expenses PMPM only decreased 8.84%. This difference contributed to the MNCare program decreased earnings in 2011.

MSC+

In 2011 there were large fluctuations (increases in claim adjustment expenses and decreases in general administration expenses) in the MSC+ program. MSC+ claims adjustment expenses increased from $293,000 in 2010 to $397,000 in 2011. MSC+ general administrative expenses decreased from $1,050,000 in 2010 to $998,000 in 2011. As previously noted, this was caused by the changes implemented by HPI in the way it allocates various items between claims adjustment expenses and administrative expenses. .

The reason for the increased underwriting gain in 2011 in the MSC+ program was due to claim trends actually decreasing 1.58% from 2010. Coupled with an increase in premium revenue of 3.73%, the underwriting gain for this program increased significantly in 2011. According to the Company, in 2011, claim trends across all HPI product lines were around 1% from 2010. This contributed to the significant underwriting gain that all HPI products saw in 2011.

Commercial

HPI Commercial net reinsurance recoveries decreased from $1.0 million in 2010 to $46K in 2011. This was caused by the low claim trends for 2011. HPI only had one reinsurance recovery in 2011. In addition HPI increased its reinsurance limits from $2,250,000 to $2,500,000 from 2010 to 2011.

The primary reason for the financial improvement was the positive claim trends that HPI saw in 2011. According to the Company, the overall claim trends were around 1% in 2011 compared to premium trends around 2%. This difference contributed significantly to HPI's positive financial performance for its Commercial insurance line of business.

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 *Appendix A-440* (fair and reasonable) and SSAP No. 70 "*Allocation of Expenses*".

   - 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 HPI. The $122,400,000 expense detail provided was tied to the Underwriting and Investment Income Exhibit Part 3 – Analysis of Expenses in the 2011 annual statement for completeness.

The HealthPartners family of Companies (HPI) consists of approximately 30 different legal entities. These companies are supported centrally by administrative departments that are

expensed through the Group Health Plan, Inc. (GHI) corporation. GHI uses an administrative model to allocate these administrative expenses across companies, divisions and at a product or line of business level. HPI's businesses are organized by corporation (Health Plan, Hospital and Foundations) and by divisions within each corporation. Examples of these divisions are the HealthPartners Medical Group, HealthPartners Pharmacy Division, HealthPartners Dental Group, Foundations, Health Plans and Administration Divisions. Each of these divisions consists of accounting units (A/Us) which accumulate the revenue and each business unit within HPI companies. A/Us are expensed centrally through GHI and then used in the HPI administration allocation model. Each A/U is given an attribute within the HPI financial system to determine whether it is either an administrative expense or a hospital medical expense. A/Us can only be an administrative expenses type or a medical expense type, but not both.

A/Us include the following areas:

- *Presidents Division*
- *Chief Health Officer Division*
- *Health Plan Administration Division*
- *Finance Division*
- *Health Plan Operations Division*
- *Information Services Division*
- *Marketing/Sales and Member Communications Division*
- *Health Plan Medical Management and Contracting Division*
- *Taxes and Assessments (include: Minnesota Comprehensive Health Association, Medical Care Surcharge, Premium Taxes and Income Taxes)*

Once an A/U has been identified as an administrative expense type it is included in the HPI administration model which allocates those costs across corporations, operating divisions and across product lines that are disclosed in the HPI statutory filings. The model allocates based on a number of methods depending on the function of the A/U. The allocation methods include:

- *Direct allocation to a product line*
- *Member Months*
- *Weighted Member Months*
- *Claim Counts Employee Counts – Full Time Equivalents (FTEs)*
- *Square Footage*
- *Annual Interviews with A/U owners to determine best allocation method*

The HPI expense allocation model is broken into three sections.

- *Section 1 of the model allocates administrative costs by corporations from GHI to HPI, HealthPartners Administrators, Inc., HealthPartners Insurance Company, HealthPartners Services, Inc. and HealthPartners Associates, Inc. Each A/U is reviewed each year to determine the best allocation methodology to allocate across corporations.*

- *Section 2 of the model allocates administrative costs that remain in GHI, after allocating administrative costs to the various corporations, by operating division within GHI. These divisions include the HealthPartners Medical Group, HealthPartners Dental Group and Pharmacy Operations. Each A/U is reviewed each year to determine the best allocation methodology to allocate across operating Division.*
- *Section 3 of the model allocates all administrative costs that are allocated to HPI and the remaining administrative costs on GHI, after allocating to corporations and operating divisions, by the products that HPI and GHI sell. These products include Commercial, Medicare and Medicaid products (by program: PMAP, MNCare, MSHO, MSC+, etc.). Each A/u is reviewed each year to determine the best allocation methodology to allocate across each product/program that HPI and GHI offers.*

The expense allocation model was developed in the late 1980's and is updated each year HPI Finance staff interviews each A/U owner to determine if the current allocation methodology used is still the best method and to reflect changes in the business.

The results of our analytical review and testing of samples of various expense categories show that HPI appears to be allocating expenses in a manner consistent with their expense allocation methodology and model, according to the NAIC Accounting Practices and Procedures Manual - Appendix A-440 and in a manner consistent with SSAP No. 70 "Allocation of Expenses" and Minnesota Statute §62D.08.

The results of our analytical review show HPI appears to be allocating expenses between public and private programs appropriately.

RRC performed an analytical review and tested by sampling various expense categories to determine if expenses were accounted for in accordance with the entity's expense agreements and guidelines.

The description below is the process we used to meet this objective of our review.

- *We obtained and reviewed copies of the Intercompany Agreements from HPI, the 2012 Master Intercompany Agreement and the MNDOC Non-Disapproval Letter re: Form D dated 3.7.12.*

- *We also obtained and reviewed HPI Admin Model Description document and notes from an August 23, 2012 meeting attended by members of the RRC team and HPI representatives where the Admin Model was discussed in detail.*

- *We also obtained and reviewed the HPI Administrative Allocation EXCEL Workbook that contains 10 tabs.*

- *From Tab one of the HPI Administrative Allocation Workbook we selected a sample of 12 allocated expense items and requested supporting detail for each item for*

testing purposes for the months of June and December 2011. The selection was done by judgmentally selecting large dollar items in various key Operating Divisions.

- *For each sample selected HPI provided an EXCEL workbook containing the expense account totals for each Accounting Unit selected with the selected accounts highlighted, the GL detail for each selected account and the AP detail for each selected account for the months of June and December.*

- *HPI also provided another workbook that is a cross walk table for each of the sample selection. The first tab shows how the entire amount of the Accounting Unit (A/U) (e.g. Legal, Underwriting, Government Programs, etc.) is allocated to the various corporations and then the summary level products. The second tab shows how the expense totals for each A/U selected are allocated to just the HPI corporations' products. The expense account totals for each A/U selected on tab 1 of each workbook for the twelve samples tied to the 2011 expense totals for each A/U on this spreadsheet. And the GL and AP detail for each A/U for the months of June and December tied to each other.*

- *HPI uses various methods to allocate administrative expenses. For the twelve samples tested most were allocated based on member months or claim counts. For Underwriting, the method of allocation is based on input directly from the Underwriting Department on an annual basis and is based on the mix of business HPI underwrites in a given year. For Government programs, allocations are based on direct input from the Director of Government programs who established an allocation percentage for Medicare and for Medicaid programs as they staff in this group works on both. The Allocation methodology for member months had many variations and we sent a request to HPI to elaborate on the differences between the types on member month allocation methodologies and to explain why they are used for specific A/Us. Their answers to our questions appeared reasonable.*

- *For all twelve samples tested the allocation methodology was applied correctly and the percentages of each A/U total expenses by program and product calculated to the correct percentages per the HPI Allocation Model.*

The only difference that was noted was an immaterial difference in the member months used in the model versus the member months used on the Minnesota Supplement Report #1 for 2011. The Company explained the difference was due to the fact that HPI's administrative allocation model uses a snap shot of membership counts at exactly midnight on December 31, 2011. For the HPI Minnesota Supplement Report #1, the Company uses a membership count from the Sales and Marketing department which takes into consideration any retro membership changes that occur in January and are added to the number from the 12/31/2011 snap shot membership count. We concluded the explanation was reasonable.

- *In addition to requesting samples for 12 Allocated Expense A/Us we selected in our expense sample request, we selected three additional expense categories for unallocated expenses. We checked the amounts in these A/Us and confirmed they were not allocated.*

  From this analysis and testing we concluded it appears HPI expenses were accounted for in accordance with the entity's expense allocation agreements and guidelines.

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

   RRC conducted a review to verify the appropriateness with regards to HPI's establishment of any Premium Deficiency Reserve (PDR) allocated to public programs.

   HPI assesses the need for a PDR by reviewing internal Product Line Reports. If the Medical Loss Ratio (MLR) for the current year, excluding administration expenses for the selected grouping is less than 100%, then a PDR is deemed unnecessary. This review is supplemented by discussions amongst the Finance, Actuarial and Underwriting Departments. HPI determined that a PDR was not necessary as of December 31, 2011. The Appointed Actuary, Steven H. Mahan, FSA, MAAA, confirmed the Company's conclusion in his "Actuarial Memorandum in Support of the Actuarial Statement of Opinion" as of December 31, 2011. RRC was provided with the Product Line Reports as of December 31, 2011 as well as the Actuarial Memorandum.

   As of December 31, 2011, the Company determined that it did not require accrual of a PDR liability, which we agree is a reasonable conclusion. However, the manner in which the Company made this determination is not reasonable. The Company's analysis was not documented and appeared to be informal in nature. We also note that the approach taken by the Company is retrospective in nature. The reports on the prior year are reviewed and are supplemented by subjective insights. It can be argued that a prospective view, such as that found in forecasts, would be more appropriate and precise as well as adhering to generally accepted actuarial principles. The current approach relies heavily on judgment as well as the idea that results for the previous year is an accurate predictor of the next year's results.

   We recommend that the Company formalize its analysis related to determining the need for a premium deficiency, including documentation of the analysis for future review by auditors, its actuary as well as regulators. We also recommend that the analysis include both retrospective and prospective analysis, including the use of financial projections of the profitability of its public programs.

The following is a summary of the Profitability Analysis provided by the Company.

HealthPartners, Inc. Public Program Product Profitability Calendar Year 2011	
	Net Income / (Loss)
HP Care Medical Assistance	$4,106,957
HP MSC	2,819,020
HP Care General Assistance Medical Care	(142,579)
HP Medicaid Expansion	866,092
HP MinnesotaCare	(626,658)
HP Minnesota Senior Health Options	9,144,129
TOTAL	**$16,166,961**

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."*

The Company combines all public programs for the purpose of assessing the need for a premium deficiency. SSAP No. 54 requires policies to be grouped in a manner consistent with how policies are marketed, serviced and measured, for purposes of determining if a premium deficiency exists. The above approach is consistent with that seen during the Financial Examination as of December 31, 2009, performed by MNDOC. The Company has a separate contract with the State of Minnesota, acting through its Department of Human Services covering PMAP and MNCare services. In addition, the Company has a separate contract covering MSHO and MSC+ services together. Grouping the premium deficiency analysis according to this grouping would be a more transparent approach to comply with SSAP No.54. Grouping all public programs together under the assumption that they are marketed, serviced and measured consistently is not reasonable. If the Company had grouped its public programs according to the contracts with the State covering these services, a determination would have still been that no PDR was necessary at 2011. However, this conclusion of whether or not to accrue a premium deficiency could be different in subsequent years depending on the grouping implemented by the Company.

HealthPartners, Inc.
Unpaid Claim Liabilities as of December 31, 2010
Data Through May 2012

	Initial Estimate	Restated Liability	Change
MNCare Total *	$4,459,429	$3,389,207	(24.0%)
HP MSC	1,273,604	1,525,854	19.8%
HP Care General Assistance Medical Care	120,500	(25,589)	-----
PMAP Adults w/o Children	$0	$0	-----
PMAP Families and Children	12,195,437	9,776,075	(19.8%)
PMAP Total	$12,195,437	$9,776,075	(19.8%)
HP Minnesota Senior Health Options	5,591,526	5,912,097	5.7%
TOTAL	**$23,640,496**	**$20,577,644**	**(13.0%)**

* Prior to 2011, data was submitted for Total MNCare (MNCare Families & Children and MNCare Adults without Children)

HealthPartners, Inc.
Unpaid Claim Liabilities as of December 31, 2011
Data Through May 2012

	Initial Estimate	Restated Liability	Change
MNCare Adults w/o Children	$1,000,000	$1,007,003	0.7%
MNCare Families and Children	2,385,767	1,524,825	(36.1%)
MNCare Total	$3,385,767	$2,531,828	(25.2%)
HP MSC	$1,401,936	$1,512,597	7.9%
HP Care General Assistance Medical Care	N/A	N/A	N/A
PMAP Adults w/o Children	$4,740,000	$4,856,947	2.5%
PMAP Families and Children	9,235,290	11,342,191	22.8%
PMAP Total	$13,975,290	$16,199,138	15.9%
HP Minnesota Senior Health Options	6,250,344	6,046,408	(3.3%)
TOTAL	**$25,013,337**	**$26,289,971**	**5.1%**

Based upon the information provided, the December 31, 2010 estimates in total were redundant by 13.0%, which can be viewed as almost entirely related to the 12.5% explicit margin. Estimates as of December 31, 2011 were deficient by 5.1%. There are wide

Appendix 1 – Executive Order 11-06

STATE OF MINNESOTA

EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 11-06

Creating Public Disclosure for Minnesota's Managed Care Health Care Programs

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, over 500,000 Minnesotans receiving public health insurance coverage are enrolled in managed care; and

Whereas, the State spends approximately $3 billion annually on purchasing health care from managed care plans for state public programs; and

Whereas, it is critical for public trust that Minnesota's taxpayers understand how public dollars for health care are being used; and

Whereas, the State needs greater disclosure and accountability of managed care plan spending on health care and long-term care services and administrative expenses for state public programs;

Now, Therefore, I hereby order the Commissioner of Human Services to:

1. Establish a managed care website for all publicly available information and reports that relate to the managed care procurement, financials, health outcome performance measures, contracts, and other public information for state public programs.

2. Develop an annual comprehensive managed care report in consultation with the Commissioners of Health and Commerce that includes detailed information on administrative expenses, premium revenues, provider payments and reimbursement

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.

endix 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	1	2	3	4	5	6	7	8	9	10	11	12	
As found on page 4 of the Annual Statement	NAIC Totals	Non-Minnesota Products (Eliminations)	Total Minnesota Products	Commercial	Medicare + Choice	Medicare Cost	Minnesota Senior Health Options (MSHO)	SNBC (MA Only)	SNBC (Integrated)	Prepaid Medical Assistance Program (PMAP)	MNCare	Dental	Ot (Please
ember Months													
et Premium Income (including $ non-health premium income)													
hange in unearned premium reserves and serve for rate credits													
e-for-service (net of $ medical expenses)													
sk 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													
escription 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													
tal hospital and medical (Lines 16 minus 17)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
on-health claims													
aims adjustment expenses													
neral administrative expenses													
crease in reserves for life, accident and health contracts (including $ increase in reserves for life only)													
tal 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 capital 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 nes 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

Description	Number of Copies	Due Date	Primary MN Statute Reference	Additional Notes
				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.

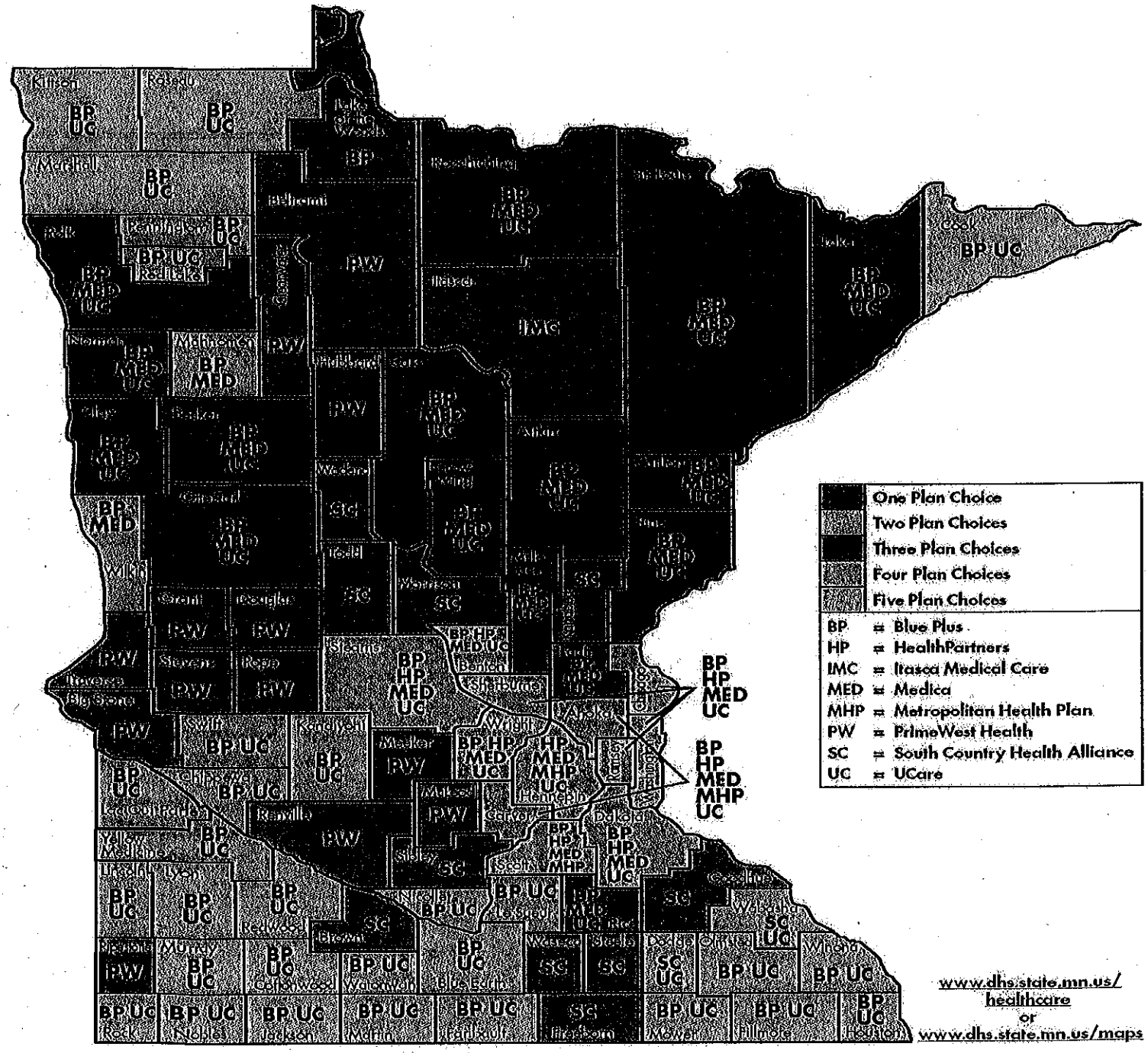
Minnesota Supplements Filing Instructions: It is not necessary to send a paper copy in addition to the electronic submission; none of these reports require a signature. Send the completed Minnesota Supplement forms on a CD to:

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

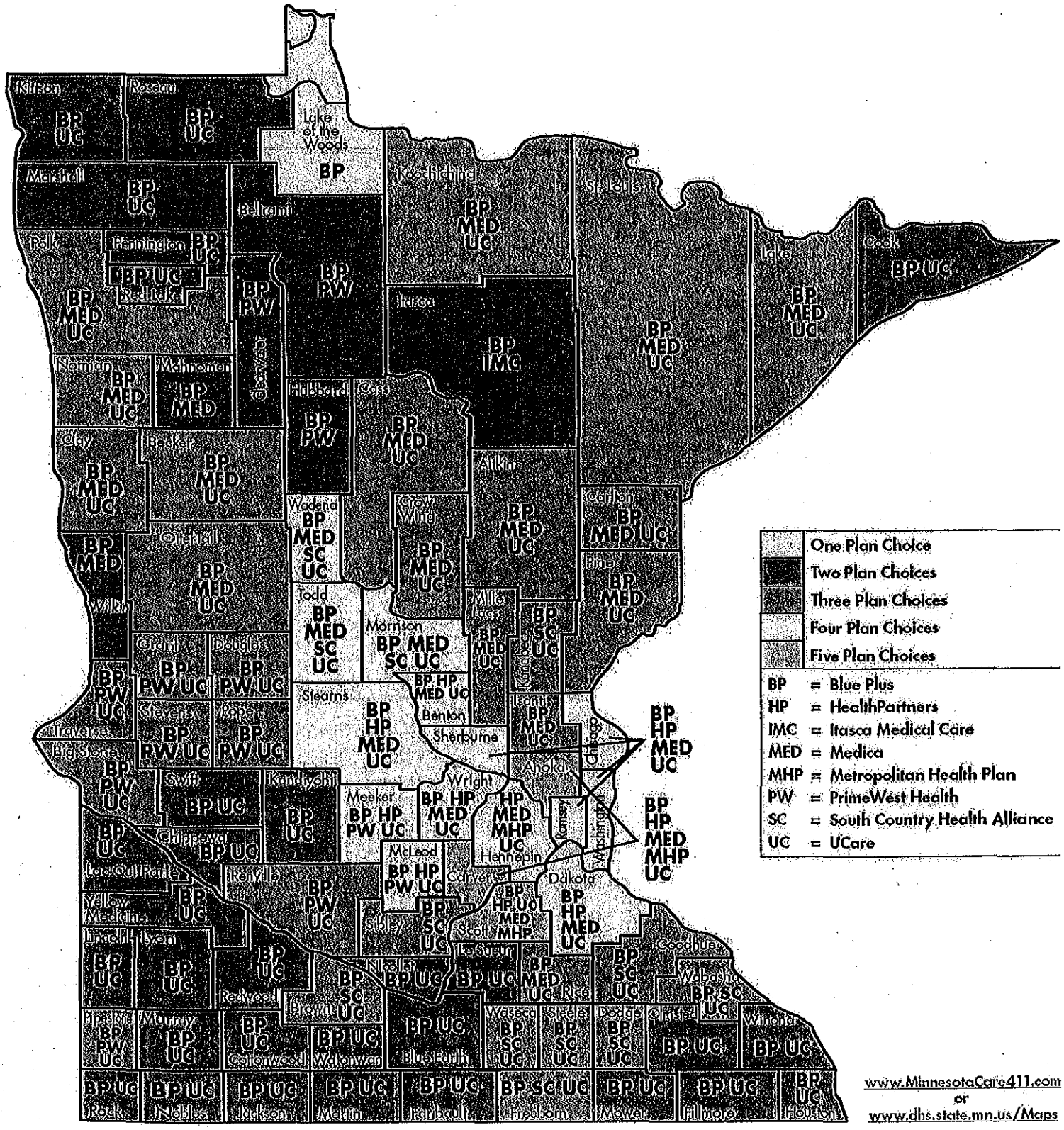
Appendix 5 – Prepaid Medical Assistance Program (PMAP) Map

Health Plan Choices by County Effective April 1, 2011



Appendix 6 – MinnesotaCare (MNCare) Map

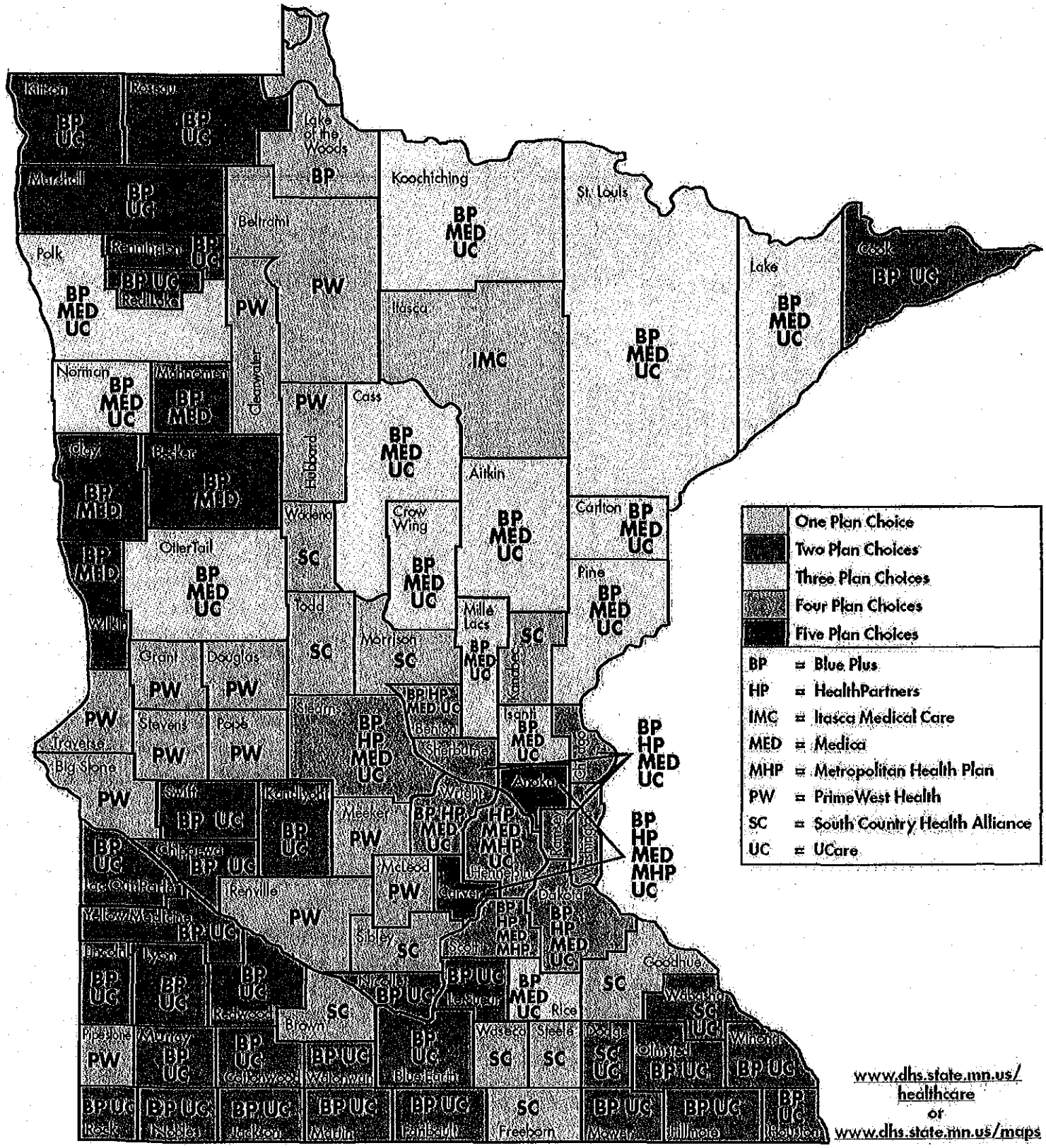
Health Plan Choices by County Effective April 1, 2011



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

Appendix 7 – Minnesota Senior Care Plus (MSC+) Map

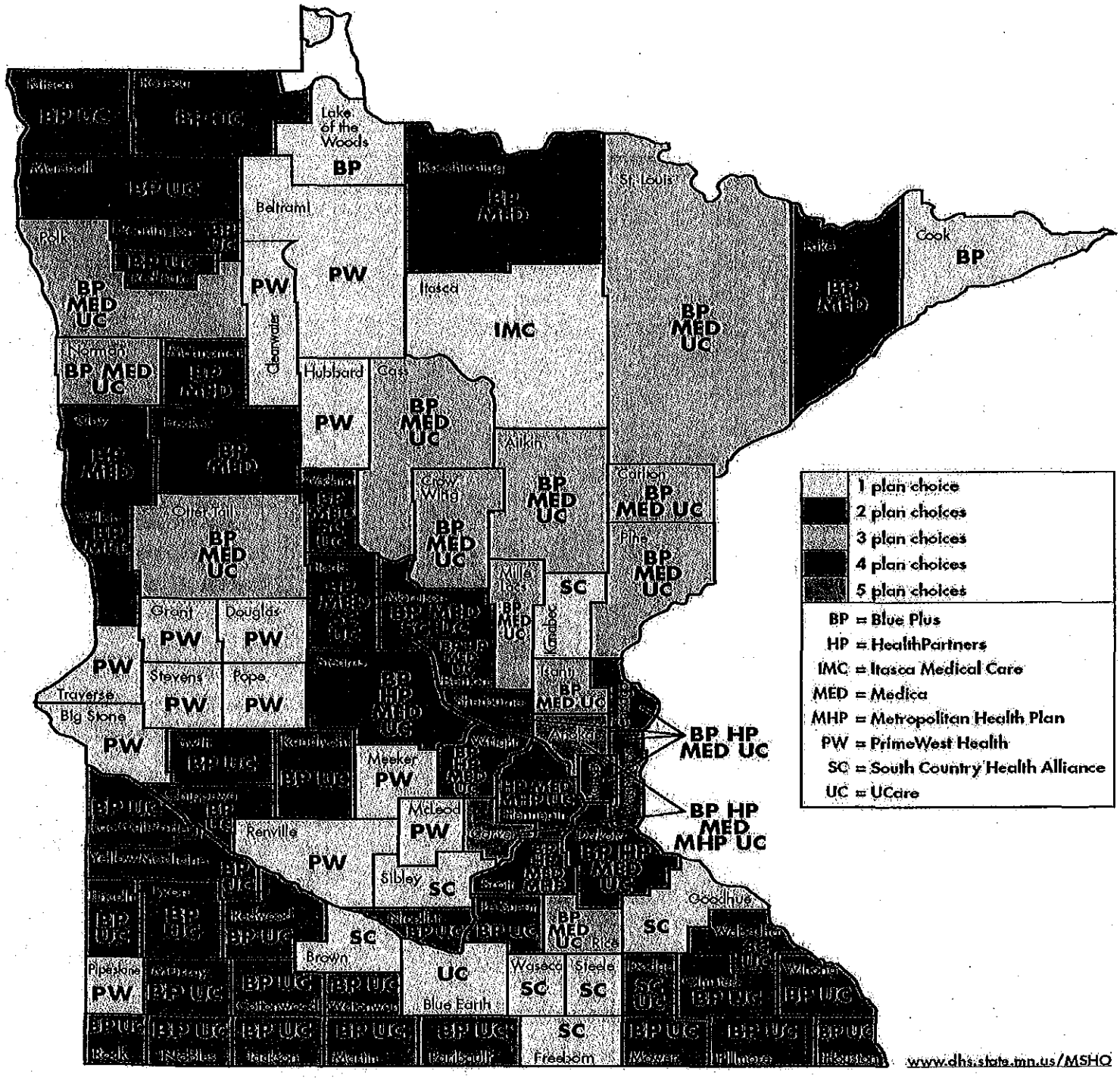
Health Plan Choices by County Effective April 1, 2011



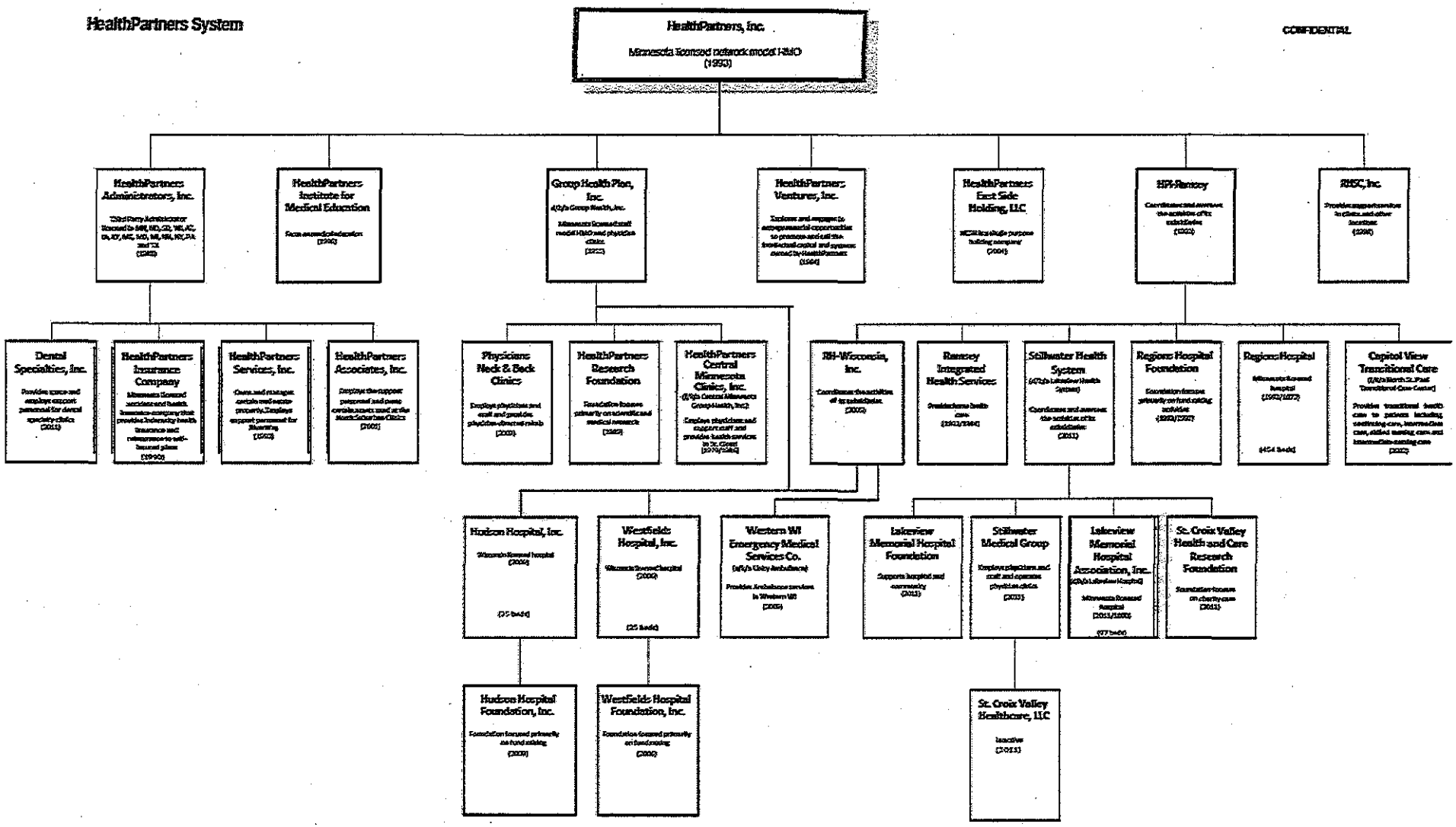
www.dhs.state.mn.us/healthcare
or
www.dhs.state.mn.us/maps

Appendix 8– Minnesota Senior Health Options (MSHO) Map

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



Appendix 9 – Corporate Organization Chart



Addendum to Report

Health Partners Comment Letter

HealthPartners, Inc. (HPI) has reviewed the final audit report related to WORK ORDER CONTRACT NO: 50693 and is providing the following formal public comment letter in response to the two findings included in the final audit report.

Findings #1:

"The Company combines all public programs for the purpose of assessing the need for a premium deficiency. The Company did not provide supporting documentation for its rationale for this grouping or how this grouping methodology was in compliance with SSAP No. 54, which requires policies to be grouped in a manner consistent with how they are marketed, serviced and measured, for purposes of determining if a premium deficiency exists. The Company's approach is consistent with that seen during the Financial Examination as of December 31, 2009, performed by MNDOC. The Company has a separate contract with the State of Minnesota, acting through its Department of Human Services covering PMPA and MNCare services. In addition, the Company has a separate contract covering MSHO and MSC+ services together. We concluded that grouping the programs in accordance with the contracts entered into with the State for purposes of determining if a premium deficiency exists would be a reasonable approach to comply with SSAP No 54. If the Company had grouped its public programs during 2011 according to the contracts with the State covering these services under each program, a determination would have still been that no PDR was necessary at 2011. However, the current grouping practice of including all programs could have an impact on the adequacy of the Company's PDR calculation in subsequent years, if certain programs incurred significant underwriting losses.

We recommend that the Company develop documentation supporting its rationale that all public programs should be combined for purposes of determining if a premium deficiency exists and how this methodology is consistent with how policies are marketed, serviced and measured, as required in accordance with SSAP No. 54."

Comment to Findings #1:

HealthPartners disagrees with this finding. HealthPartners has provided adequate and appropriate documentation to Risk and Regulatory Consulting, LLC (RRC) supporting our position that grouping all Medicaid products together is reasonable for purposes of determining premium deficiency reserves. Specifically, we provided the following information. Marketing of these products is strictly limited by the Minnesota Department of Human Services and any marketing of them is as one group. We have dedicated member services, claims, appeals and grievances, and membership departments specifically supporting these programs. We measure these programs together not separately in our product line reporting, board financial presentations and monthly, quarterly and annual financial statements and have done so historically. Our combining these products for purposes of assessing the need for premium deficiency reserves is therefore consistent with SSAP No. 54.

Findings #2:

"HPI applies a 12.5% load to their best estimates for its Unpaid Claims Liability (UCL) consisting of a 10.0% margin for adverse claim deviation and a 2.5% Loss Adjustment Expense (LAE). The Company has not changed these percentages form the levels applied during the 2009, as noted during the most recent Financial Examination by MNDOC. According to the Company, it had reached an agreement with its prior auditor regarding margins, which was a draw-down of the margin level over a five year period culminating at current levels. HPI feels that the margins it has established in their UCL calculations are consistent with industry averages and provides a reasonable level of comfort that adverse claims run-out experience will not impact future year financial performance. We concluded that while the margins have been reduced significantly since the 2006 Financial Examination by MNDOC, the margins are overly conservative compared to historic redundancies and the varying magnitude of such by reserving category.

Based upon the information provided, the December 31, 2010 UCL for the Company's public programs in total were redundant by 13.0%. It can be concluded that the majority of the redundancies in the December 31, 2010 UCL is almost entirely related to the 12.5% explicit margin carried by the Company. The UCL for the Company's public programs as of December 31, 2011 were shown to be a deficient by 5.1%, as of May 31, 2012, the date specific information was requested by MNDOC. There are wide variations within the public product line reserves. For example the PMAP program December 31, 2011 UCL was deficient by $2,223,848, or 15.9%, utilizing data available as of May 31, 2012. The Company indicated that with the PMAP MA program, exceptionally high ranges of completion factors were incurred during 2012 for claims with 2011 dates of service. These types of payments are not picked up in the Company's normal completion factors with setting IBNR; the margins built into their reserves serve to mitigate such variations.

We recommend that the Company consider varying the margin level for particular blocks of business based upon historic estimation accuracy and anticipated estimation risks. We also recommend that in collaboration with its consideration of an appropriate margin level, the Company review its reserving methodology for public programs as it relates to precision. These suggestions further support the previous recommendation that the Company consider its financial projections of profitability at each public program when determining the need for premium deficiency."

Comment to Findings #2:

HealthPartners disagrees with the statement that our margin for adverse claims deviation is too conservative. HealthPartner's margins for adverse claims deviation are consistent with industry

standards and are independently certified both by an outside actuary and our independent auditor KPMG. The analysis prepared by RRC shows using claims run-out with perfect hindsight that we missed our initial estimate of unpaid claims by 13% one year and 5% the other direction the following year. This type of change in estimate is the reason for a margin for adverse claims deviation in the calculation of unpaid claims. At December 31 each year we use the best data available to us at that time and determine our best point estimate for unpaid claims liability. We do not believe varying the margin level at a higher level of granularity will add value and improve the estimation of unpaid claims. It actually could have just the opposite effect.