

**QUESTIONS AND ANSWERS ON INSTRUCTIONS FOR THE
NY INDIVIDUAL AND SMALL GROUP RISK SHARING POOLS**

**(REG 146, 4TH AMENDMENT:
CIRCULAR LETTER NO. 20 (2002))**

1. **ANNUALIZED PREMIUM VS. EARNED PREMIUM**

Question: According to the Regulation, earned premiums are the basis for the calculation of semi-annual deposit payments, but the instructions and exhibits do not provide for reporting of earned premium to the administrator and appear to utilize annualized premium in the calculation.

Answer: Earned premiums, which are the basis set in the Regulation from which interim semi-annual deposit payments are calculated, are unknown until after the end of each semi-annual period. In order to allow for calculation and collection of Pool contributions within a reasonable time after the calculation date, the Insurance Department directed the administrator to utilize annualized premiums in making the interim calculations. Annualized premiums provide a good estimate of what a carrier's earned premiums are likely to be for the period in proportion to the earned premiums of other carriers in the region, and are known as of the calculation date. Shortly after year-end (May of each subsequent year), contributions are re-calculated substituting incurred losses for annualized premiums as a base, so any nominal differences between what a carrier paid in the interim, because annualized premiums were used in lieu of earned premiums, disappear.

2. **ASSUMED DEPENDENT CALCULATION**

(i) **Who May Use the Assumed Dependent Calculation; Attestation**

Question: Circular Letter No. 20 (2002) contains examples of Exhibits I and II in which an "Assumed Dependent Calculation" is made. If a carrier has a record of dependents, can it opt to use the assumed dependent calculation instead?

Answer: No. The assumed dependent calculation option is established solely to ensure that carriers not maintaining enrollment information by individual have the ability to complete the required pool reporting. The calculation is not an alternative option for carriers that normally maintain records by individual. **Carriers that maintain records of all member counts must supply actual membership data, and are not permitted to substitute estimates. Carriers using the assumed dependent estimates must have their CFO or Chief Actuary attest that they do not normally maintain a record of this enrollment information.**

(ii) **Assumed Dependent Calculation Methodology**

Question: Why and how is the assumed dependent calculation done?

Answer: Carriers are required to report a relative cost factor for every individual covered under all pooled insurance contracts as of each semi-annual calculation date. Carriers that do not ordinarily maintain a record of dependents/individuals covered under family contracts are permitted to substitute an estimate based on the number of "assumed dependents" in family contracts (established in the Regulation at 2.3 dependents per family contract). These carriers must report in Exhibit I the family member who is the contract holder, whether with or without a claim, plus any other dependent/individual covered under the contract who had an eligible paid claim in the period. In summary, for carriers using the assumed dependent calculation, Exhibit I must contain a specific record of every contract holder in the period plus any of their dependents who had eligible paid claims.

Dependents without eligible paid claims are then calculated by formulas contained in the appropriate cells in sample Excel spreadsheet Exhibits I and II attached to Circular Letter No. 20 (2002). These Exhibits provide guidance for carriers to calculate their assumed dependent counts and their average relative cost factors. Carriers are not required to use Excel spreadsheets and may use different modes to create Exhibits if that better suits their needs. However, carriers are reminded that if the data is entered in the Exhibits attached to Circular Letter No. 20 (2002) in accordance with the instructions contained in that Circular Letter, the Exhibits will perform all the necessary calculations.

(iii) Is the ARCF Calculation Weighted by Estimated Assumed Dependents

Question: Does the inclusion of 3.3 as the total count of individuals in family contracts in column (j) of Exhibit I-Example B, weight the corresponding relative cost factor by 3.3?

Answer: No. The counts in column (j) of Exhibit I-Example B are not applied to the factors in column (i). They are only used for purposes of determining a count of assumed dependents where such information is not available, as described above. The calculation does not weight the ARCF by the number of individuals per contract.

3. **CAPITATION**

(i) Use of Encounter Data to Establish Occurrence of an Eligible Claim

Question: How do the instructions relate to capitated providers?

Answer: Most capitated providers maintain encounter data (i.e., services by CPT and ICD-9 code) records so that they can perform fee-for-service equivalent calculations to assess the reasonableness of the capitation rates. This information is often passed on to the insurance company (and in a number of cases is required by the insurance company) as supporting documentation for negotiating new capitation rates and/or filing new rates. As a result, the encounter data can be used as the basis for establishing the occurrence of an eligible claim and the condition treated. It should be noted that this question will be moot for the vast majority of insurance companies with capitated arrangements if the inpatient hospital component is not capitated.

(ii) Determining \$5,000 Threshold for “Certain Conditions” in Capitation Situations

Question: Please describe the approved methodology for capturing paid claims expense associated with capitation and/or medical center operating costs for members with “certain conditions” (that require a minimum of \$5,000). Absent specific claims data, what statistics are carriers advised to use?

Answer: Capitation expenses paid for the member should be included. Medical center operating costs should be allocated across all membership and the appropriate, pro rata share should be included in claims expense for members reported to the pool. These costs, plus any other payments (e.g. for prescription drugs, etc.) are aggregated to determine if the \$5,000 threshold is reached.

4. **CERTIFICATION OF SUBMISSIONS**

Question: Who should certify the semi-annual submissions and the annual reconciliation of incurred claims?

Answer: An officer of the company responsible for the submission must sign both certifications.

5. CLAIMS – DEFINITIONS AND GENERAL RULES FOR POOL REPORTING

(i) Hospital Definition

Question: Section 361.5(b)(2) of Regulation 146 requires an overnight inpatient hospital stay for a claim to be eligible, except for certain conditions. How is hospital defined?

Answer: For purposes of determining whether an individual had an overnight inpatient hospital stay, hospital means only a short term, acute, general hospital, as further defined in 11NYCRR52.2(m).

(ii) Single Overnight Inpatient Hospital Stay Definition

Question: How is “an overnight inpatient hospital stay,” as referred to in Section 361.5 (b)(2) of Regulation 146, defined?

Answer: For purposes of determining whether an individual had a single overnight inpatient hospital stay or more than one separate qualifying overnight inpatient hospital stays, overnight confinement for one day, for consecutive days, or successive confinements as described in 11NYCRR52.2(f), all constitute single overnight inpatient hospital stays, not separate qualifying stays. In addressing successive confinements, 11NYCRR52.2(f) provides, among other things, that when discharge from and readmission to the hospital occur within a period of time of not more than 90 days, this constitutes a continuous hospital confinement. For additional guidance in defining a single versus separate hospital stay in specific situations, carriers should refer to 11NYCRR52.2(f) or contact the Pool administrator.

(iii) Timing of the Hospital Stay

Question: Does an individual have to have a hospital stay in the same period as the claim payment for the claim to qualify?

Answer: The Regulation does not require that the overnight hospital stay take place in the six-month period preceding the calculation date, but only that payment of the claim be in that period. For example, for a January 1, 2003 calculation date, a payment between July 1, 2002 and December 31, 2002 is eligible regardless of whether the hospital stay was prior to July 1 or after July 1.

(iv) One Claim Per Hospital Stay

Question: If multiple claim payments are made for the same qualifying inpatient stay, either due to an adjustment to the original claim or interim payments, and separate payments are made in consecutive six month periods, can such cases be counted in each period or only the period the initial payment was made?

Answer: Once a relative cost factor has been assigned to a claim, with eligibility tied to a specific hospital stay, a second claim paid on the same hospital stay in the same or following period can not be used to assign an additional RCF in the next calculation. For example, if a hospital stay were from June 25 to June 30, 2003, or even running into the next period (e.g., from June 25 through July 5) and the company reported an eligible claim in its July 1 calculation for a payment made on June 30, it could not report a second eligible claim in its January 1 calculation for a second payment made after June 30 related to the same hospital stay. The company should report, and will only receive credit for, the first payment in a series of payments on a single hospital stay.

(v) Second Separate Hospital Stay

Question: Is a second claim payment on the same condition eligible where there is a second separate hospital stay in either the same period or the subsequent period?

Answer: If an individual has two separate qualifying hospital stays, whether in the same or succeeding six-month periods, the carrier is allowed to report only one relative cost factor assignment in each six-month period based on a paid claim within that period. Carriers can report a payment in the next period on the same condition as an eligible claim only if it is for a separate qualifying hospital stay. Consecutive days of overnight inpatient confinement or successive confinements, as discussed above and in 11NYCRR52.2(f), are not considered separate qualifying hospital stays.

(vi) Multiple Conditions Associated with a Single Hospital Stay

Question: Sometimes an individual member will have multiple diagnoses associated with a single overnight inpatient hospital stay, and sometimes a secondary, tertiary or other condition could have a higher cost than the primary condition. Which ICD-9 code should be assigned in these cases?

Answer: The ICD-9 code assigned should be the one with the highest relative cost factor, regardless of whether it is primary, secondary or tertiary, within reason (e.g., where a provider lists several possible diagnoses, but it is clear that the treatment is for the primary, secondary or tertiary diagnosis, the “other possible diagnoses” should be ignored). Assignment of diagnoses and integrity thereof will be a significant audit item.

(vii) Alternative Proof for Claims Without ICD-9 Codes

Question: We anticipate that for individuals with “certain conditions,” the associated prescription drug expense may be high, but the claim records for the six-month period may not always contain ICD-9 codes. Given potentially incomplete claims data, the resulting RCF’s will be depressed. Please comment on this situation.

Answer: Alternative data sources and carrier assessment to support the actual medical condition may be utilized where there is no hospital stay involved nor associated diagnosis codes recorded, subject of course to reasonableness and accuracy of reporting the substance of the medical condition.

(viii) Adjustments to Prior Paid Claims

Question: How should a claim be handled which involves an adjustment for a prior paid claim? For example:

| <u>Submitted</u> | <u>Paid</u> | <u>Paid Date</u> |
|------------------|-------------|------------------|
| \$10,000 | \$3,000 | 5/1/2001 |
| - \$10,000 | - \$3,000 | 8/1/2001 |
| \$10,000 | \$3,300 | 8/1/2001 |

There is a possibility of double dipping if, as above, the adjustment is made in a subsequent reporting period. How should this situation be handled? What if the adjustment for a given reporting period results in a zero or negative paid amount? This situation could occur for both an inpatient stay and reaching the \$5,000 aggregate.

Answer: For inpatient stay claims, one claim is allowed per stay. For conditions involving the \$5,000 threshold, if there is an ultimate reduction in the claim below \$5,000, disregard the effect. It would be too cumbersome to revise data submissions for the possible impact of claims that were reduced below \$5,000 in later periods. Carriers should explain instances involving large numbers of adjustments, and such cases will be reviewed on audit.

(ix) ARCF’s Computed Every Six Months

Question: Please clarify that ARCF’s are re-computed every six months based on the presence of an

overnight stay or \$5,000 in paid claims. In this fashion, the same member will be re-scored twice per year.

Answer: ARCF's are computed each six months on the calculation date based on RCF's assigned for each six-month period. The RCF for an individual member may or may not be the same, depending on the member's actual claim payment history.

(x) Coordination of Benefits (COB)

Question: Where there is a coordination of benefits between two carriers, how is the specified medical condition, which was identified by a paid claim, reported to the pools?

Answer: Only the primary carrier on the hospital claim should report the relative cost factor for the eligible specified medical condition. The same rule applies to those conditions required to meet a \$5,000 threshold. Secondary carriers should report the standard factor of 0.73.

(xi) Eligible Claim Components

Question: Should access fees, HCRA surcharges, graduate medical expense and capitation payments be included when aggregating toward the \$5,000 threshold for "certain conditions"?

Answer: (1) **Access fees** are not a claim payment and should be excluded;
(2) **HCRA surcharges** and **GME** should be included;
(3) **Capitation** payments should be included.

(xii) Deductibles That Eliminate Net Claim Payment

Question: How should a claim be handled which has a zero paid amount but reflects a deductible requirement? For example, if submitted, allowed, deductible and paid are, respectively, \$10,000, \$3,000, \$3,000, and \$0, should the eligible ICD-9 be allowed for submission?

Answer: No, the claim is not eligible since there was no payment.

(xiii) Hospital Stay Without a Payment

Question: It is feasible to identify overnight stays through the medical service/place codes listed on the medical claims. Should ICD-9 codes that are eligible based on this medical system "overnight stay" criterion be included when there is no corresponding hospital claim?

Answer: For a claim to be eligible for assignment of an RCF for a Specified Medical Condition, a payment in the six-month period is required. While the ICD-9 codes may be identifiable as described, without a payment the claim does not qualify.

6. CONFIDENTIALITY – SUBSCRIBER ID'S

Question: How can carriers ensure confidentiality of subscriber claim data and still provide sufficient information for the administrator to calculate Average Relative Cost Factors and validate claims.

Answer: While some carriers still use social security numbers as enrollment ID numbers, many use a unique numeric identifier that has no relationship to the individual beyond identifying him/her as an enrollee. In those cases, submission of data by individual ID should not be an issue. For carriers that use social security numbers as enrollment ID numbers, it will be acceptable to submit the semi-annual exhibits with encrypted identifiers. However, in such cases, carriers' enrollment and claim systems must contain a field displaying the actual ID number directly beside the encrypted number to facilitate audit sample testing,

and such data must be retained.

7. **ENROLLMENT TIMING & IMPACT OF ENROLLMENT CHANGES ON CLAIM ELIGIBILITY**

(i) Reporting Date

Question: Generally, companies' membership systems produce enrollment reports as of the last day of a month. As in the past, the Regulation establishes calculation dates on the 1st of the month. Which enrollment numbers should carriers include in this calculation?

Answer: December 31 enrollment should be reported by all carriers for January 1 calculation dates and June 30 enrollment should be reported for July 1 calculation dates.

(ii) Coverage Change From Large Group to Small Group or Individual

Question: How do carriers report individuals who are enrolled in individual or small group contracts at the calculation date who had claims paid in the six months preceding the calculation date under a large group contract with the same carrier?

Answer: Only claims paid through a qualified individual or small group policy are to be considered in assigning RCFs. For example, if an individual had a claim paid in October 2002 while enrolled under a large group contract, terminated coverage under the contract in November 2002, obtained small group or individual coverage with the same carrier from November forward, but had no additional claims paid through December 31, 2002, the individual would be assigned an RCF of 0.73 for "Members without Specified Medical Conditions." However, if the individual had an eligible paid claim under the new contract in, for example, December, 2002, that claim would be assigned the Relative Cost Factor corresponding to the condition, as set forth in Table 7.

(iii) Coverage Change Within Same Small Group, Switch from Coverage With Another Carrier

Question: If a member has an eligible claim under a small group contract, but subsequently in the same reporting period, has coverage with the same small group, but with another carrier, is the claim eligible on either carrier's pool report?

Answer: No. The member is not enrolled with the carrier that paid the claim at the calculation date, and can not therefore be counted in its report of relative cost factors for its members as of that date. The second company has no paid claim for the member, so it must report the person as a member without a specified medical condition with a factor of .73.

(iv) Coverage Change from POS Contract to PPO Coverage

Question: If a member has an eligible claim under a POS contract shared by two carriers who share the exposure on their POS products, but subsequently in the same reporting period, the coverage is re-written under a PPO arrangement, is the claim eligible?

Answer: No. This is a change from coverage by the carriers in the POS arrangement to coverage by a separate legal entity under the PPO arrangement. However, if there is a material migration of business from POS to PPO arrangements during a six-month period, it is possible that on an exception basis, upon the review and recommendation of the administrator, the Superintendent would allow assignments of RCF's to the continuing block of PPO business.

(v) Coverage Change from One Individual or Small Group Contract to Another Individual or Small Group Contract With the Same Carrier

Question: How do carriers report individuals who are enrolled in individual or small group contracts at the calculation date who had claims paid in the six months preceding the calculation date under a different individual or small group contract with the same carrier?

Answer: Any claim paid under a policy that falls within the Regulation 146 definition of an individual or small group health insurance policy, other than a Medicare Supplement insurance policy, is eligible for assignment of a relative cost factor as long as the individual is still insured by the carrier under the same or another individual or small group policy, other than a Medicare supplement insurance policy, as of the calculation date (i.e., as of 12/31 or 6/30, as discussed in Item 7(i), above).

Following are four examples of coverage changes where claims paid under the original policies are eligible for assignment of a relative cost factor:

- (1) A member had an eligible claim under a small group contract, subsequently in the six month period, the carrier issued a different contract to the group, and the person is covered at the calculation date under the new contract (the person is with the same group and covered by the same carrier; the new policy only represents a change in plan design);
- (2) A member who had eligible claims paid in the six months preceding the calculation date under a small group contract is enrolled in a different small group's contract with the same carrier at the calculation date (e.g., the person changed employers, and the new employer, a small group, uses the same carrier);
- (3) A member who had eligible claims paid in the six months preceding the calculation date under an individual contract is enrolled in a small group contract with the same carrier at the calculation date (e.g. the person obtained employment with a group insured by the same carrier that the person previously had coverage with through an individual policy);
- (4) A member who had eligible claims paid in the six months preceding the calculation date under a small group contract is enrolled in an individual contract with the same carrier at the calculation date (e.g. the person left employment with the group and obtained an individual policy from the same carrier).

(vi) **Member Moves Between Regions**

Question: How should one handle the case where claims appear in multiple regions. For example, if a qualifying member moves between regions during the reporting period the member could technically qualify in two regions. How should the carrier submit such situations?

Answer: If a member changes regions while maintaining coverage under the contract, claims in either region could qualify, subject to the criteria that only one relative cost factor assignment is allowed per individual per six month period, and it is to be the one with the highest relative cost factor. The member should be reported in the region in which he/she is enrolled in on the calculation date regardless of which region the member was enrolled in at the time the claim occurred or was paid.

(vii) **Enrollment – Change In Group Size:**

Question: If a group changes size during the year and becomes larger than 50 contracts, is it permissible to exclude the group from reporting?

Answer: Carriers should determine once a year, based on verification of the number of eligible employees, the groups that are to be reported to the Pool for the year. Once the determination has been made, the group should be treated consistently throughout the policy year for Pool reporting purposes until the next annual determination is made. Changes in the number of employees should not affect the group status during the policy year. Most companies perform the verification of the number of eligible employees of a group as part of the annual renewal process. Documentation on the number of eligible employees by group must be retained for audit purposes.

8. **GEOGRAPHIC REGIONS & INSURED'S LOCATION**

(i) **Region Code**

Question: How do the instructions address the need for carriers to report their data by geographic region?

Answer: Carriers are required to report a geographic indicator in Column (d) of Exhibit I.

(ii) **Association Groups – Members in Multiple Regions**

Question: How is an insured's location determined generally and in cases where the coverage is obtained through an Association group?

Answer: The location of the business unit, not the insured's residence, determines the geographic location of the insured for pool purposes. In cases where a number of employers are insured through a contract issued to an Association group, the location of each individual employer determines the geographic region for its employees. Thus, the claim experience of a single Association group contract can impact the ARCF calculations of multiple regions.

9. **ICD-9 CODES & SUB-CODES**

(i) **Category Code Representing All Sub-codes, and Omission of Some Related Codes**

Question: It appears that in some cases where ICD-9 code categories contain one or more specific sub-codes the sub-codes are listed in Table 7 and in some cases they are not, or only some of the sub-codes are listed. How should these be read/treated?

Answer: Where a single category code is listed without any sub-code breakdown, all sub-codes under the category should be considered included in the category code listed, and reported by the category code number and relative cost factor listed in Table 7. (Example: ICD-9 Code 651 in the Table should be used where a claimant's actual ICD-9 code is sub-code 651.1, 651.2 and so forth.) Where individual sub-codes are listed, but not all sub-codes in the category, only those listed should be reported. Claims paid for other conditions under the category should not be included. (Example: Claims paid for treatment of the condition coded 136.3 should be included, but claims for treating conditions coded 136.0, 136.1, 136.2, 136.4 should not be assigned the Code 136.3 factor, but rather the factor for "Members without Specified Medical Condition"(0.73).

(ii) **High Cost Conditions Omitted**

Question: In some cases, it appears a high cost condition is not listed while a similar condition with a slightly lower cost is. For example, the Table lists Code 70.1, Hepatitis A, without coma, but does not list 070.0, Hepatitis A, with coma. Is this an error, and should both be reported?

Answer: Diagnoses not listed should not be included. The list of conditions is derived from an analysis of actual industry data that considered not only the cost but the incidence of claims. If there were no cases of a particular high cost claim found in the study, the condition was not included.

10. **INCURRED CLAIMS**

(i) **General:**

Question: What methodology should be used when reporting Pool incurred claims?

Answer: Reporting of incurred claims remains the same as under the demographic pools. Pool incurred

claims should be reported on the basis of a “stand alone calendar year.” More specifically, incurred claims equal claims incurred and paid in the calendar year plus reserves for claims incurred during the year and unpaid at year-end, including reported and unreported claims. A “bottom line” loss-ratio approach based on all lines of business from the Annual Statement is generally not acceptable. Similarly, an approach that builds Pool incurred claims by determining the claims paid during the year for any year incurred, and then adds the change in reserve, is generally not acceptable.

(ii) Use of Actual Incurred Claims for 1999 – 2001

Question: Circular letter #20, page 2, paragraph 1, 3rd sentence states: " Since actual incurred claims are already known for 1999-2001, incurred claims as consistent with data reported on carriers' statutory annual statements will be used in the initial filings for these years." The figure reported for, for example, 1999 in the annual statement has reserves in it since we didn't know yet what the run-out for the 1999 claims would be. How can this be consistent with the actual incurred claims for 1999?

Answer: The pool reporting of incurred claims by calendar year on a “stand alone” basis is not inconsistent with the Annual Statement reporting viewed across years. The figures should be close unless a material event occurred affecting the carrier’s business or reserve methodology, in which case the carrier should discuss the difference with the administrator.

(iii) Expected Loss Ratio:

Question: The Circular Letter provides that where insurers do not have a “filed” projected incurred loss ratio, .80 is to be used. Where a carrier has an Expected Loss Ratio underlying its pricing but it did not explicitly file it in a formal rate filing, what should the carrier use?

Answer: Carriers should use the ELR underlying the rate setting process, whether or not such was explicitly disclosed in a formal rate filing.

(iv) Weighted PILR

Question: We file loss ratios by rider, not by policy form. Please clarify from which DOI filing plans should we be getting the PILR.

Answer: The carrier should use the weighted average PILR for the basic contract and riders.

(v) Items To Include in Incurred Claims

Question: When reporting Pool incurred claims, what other items should be included in addition to actual medical claims payments and reserves for pending and incurred but not reported claims?

Answer: Incurred claims reported to the Pool for small group and individual policies should be consistent with the line items of hospital and medical expense reported on the Annual Statement by the carrier. Among other items, incurred claims reported should include, where applicable, payments for prescription drug, GME, capitations, and 8.18% HCRA hospital surcharges. Expenses for operating medical clinics should be allocated across all membership, and pool claims should receive a pro-rata share. Expenses for dental and vision policies should be excluded, since these types of policies are not reportable to the Pool. Expenses for stand-alone drug policies are also excluded.

(vii) Incurred Claims of New or Terminated Groups

Question: How should new groups starting during the calendar year or existing groups that terminate during the calendar year be treated with respect to reporting incurred claims?

Answer: Incurred claims for any portion of the calendar year by new or terminated groups should be included in the development of incurred claims. Incurred claims equal claims incurred and paid in the calendar year plus reserves for claims incurred during the year and unpaid at year-end, including reported and unreported claims.

11. **MEDICARE PRIMARY VS SECONDARY**

Question: In cases of contracts where Medicare is primary, is the carrier assigned the factor corresponding to the condition where Medicare covered the hospital inpatient expenses and the carrier only paid a small portion of the charges.

Answer: No. Since Medicare is the primary payor of the hospital inpatient charges, the individual should be reported as a Member without a SMC claim. In the case of claims where a \$5,000 threshold applies, the threshold is still the eligibility determinant. See rules on COB.

12. **MEDICARE SUPPLEMENT**

Question: How do the instructions address the reporting of claims on Medicare supplement products?

Answer: Medicare Supplement policies are reported separately to a demographic Pool as per instructions contained in Circular Letter No. 21 (2002).

13. **MISCELLANEOUS TYPES OF CONTRACTS INCLUDED/EXCLUDED**

Question: Should Association Groups, Conversions, Medicare Risk, Medicare Cost, and COBRA contracts be included in or excluded from the calculations?

Answer(s):

(1) **Association groups** should generally be included. However, an association group in which all member groups have more than 50 eligible employees each should be excluded.

(2) **Conversion policies** that are open for enrollment to the general public must be included. For example, carriers that offer their standard individual products as conversions policies, as allowed by Sections 4304(e) and 4305(d) of the Insurance Law, must include these contracts in pool submissions. Conversion policies offered solely to meet the statutory mandate in Insurance Law Section 3221, and which are not otherwise sold by the carrier, should be excluded.

(3) **Medicare Risk, Medicare Cost contracts** should be *excluded*.

(4) **COBRA and State Mandated Continuations** – persons who were members of small groups and upon separation from the group maintain coverage based on COBRA or State Mandated Continuation rules should be included in the Pools. Generally, these rules allow persons, upon separation from a group, to maintain coverage under the group contract that they were covered under while employed by or associated with the group. Usually the only difference is that the separated individual pays for the coverage. This would not apply to COBRA coverage related to large groups.

14. **POS CONTRACTS**

(i) **Allocating POS Claims Between Carriers**

Question: Should carriers attempt to determine individually which claims on POS contracts belong to the HMO and which to the Indemnity company, or should all claims be allocated between the two carriers based on a reasonable apportionment base.

Answer: For purposes of assigning Relative Cost Factors, individual claims are not assigned to separate carriers. As discussed below, each individual is assigned one Relative Cost Factor based on all claims incurred by that individual, regardless of which carrier paid the claim, and the Relative Cost Factor is reported and used by both. However, for purposes of calculating carriers payments to or from the pools on reconciliation, incurred claims should be assigned based on which carrier actually paid the claim.

(ii) Separate Reports for Each Company

Question: Is a single report filed for the combined entities?

Answer: No. Separate reports must be filed for each company. The Exhibit I reports will have identical shared information for the pool. The Exhibit II reports will show proportionate shares of the total of the RCF's and counts. This allows for application of the same ARCF to each of the separate carriers' respective incurred loss bases to determine their respective payments.

(iii) Allocation Base

Question: How are total cost factors and covered lives assigned?

Answer: These amounts should be allocated in proportion to annualized premium.

(iv) Pro-rating Relative Cost Factors and Counts Between Carriers for Exhibit II Reports

Question: How is the apportionment of relative cost factors and counts done??

Answer: If the POS contract is provided by a single entity, there is no special treatment. If the POS contract is provided under a joint arrangement between an HMO carrier and an indemnity carrier, then special treatment is required, as follows:

(1) Each carrier will prepare a single Exhibit I which should contain the counts and relative cost factors on its non-POS business and on the POS business it shares through the joint underwriting arrangement with the other carrier. For the POS business, the two carriers should use and report identical cost factor assignments and count assignments in their submissions, regardless of which carrier collected the premium or which carrier paid the claims (i.e., each will report 100% of the relative cost factor and count for each individual as if it were the sole carrier on the contract).

(2) An interim Exhibit II entry is prepared based on the Exhibit I entry for this policy. Had there been only one carrier involved, this would be that carrier's Exhibit II entry.

(3) The final Exhibit II entry is prepared for each carrier by reporting the actual annualized premium assigned to each carrier and then allocating the Total Relative Cost Factors and Total Number of Individuals to each carrier based on the assigned annualized premium. The allocated Total Relative Cost Factor and Total Number of Individuals are reported on the respective carrier's Exhibit II for the POS policy.

(See attached example policy XYZ-POS-123 shown in "Internal Worksheet" in the section headed, "POS POLICIES – COMBINED.")

15. **PRIOR YEARS (1999 – 2001, AND 2002) FILINGS**

(i) Use of Actual Premiums vs. Annualized Premiums

Question: For years 2000 and 2001, should carriers report the actual premiums for the twelve months on

the exhibit rather than use the premiums on the calculation date multiplied by 12 (annualized premium), since actual premiums are known at this point?

Answer: No. While some carriers will have actual premiums for prior periods, some will not. Annualized premiums are used to weight carriers' ARCF's in calculating regional average relative cost factors. Using two different weighting bases would produce an arbitrary and possibly inequitable result, and would also be inconsistent with future reporting. Carriers must report annualized premium for all periods.

(ii) Use of Six Months Paid Claims vs. Twelve Months

Question: For the 1999 – 2001 filings, would consideration be given to use full year paid claims in determining ARCF's to more fully reflect the pool's experience for those time periods.

Answer: No. Regulation 146 has specific thresholds related to a six-month period for certain types of claims (e.g. \$5,000 threshold for AIDS/HIV, Asthma, and others), so the calculation can not use a twelve-month period's claims. In addition, the Average Relative Cost Factor is simply a measurement of carriers' relative exposure to high risk claims versus other carriers' exposure, and a mid-year point in time gives a reasonable measurement to apply to incurred claims for the first and second half. However, once the ARCF is calculated, the full year's incurred claims are the basis for calculation of amounts due to or from the pools.

(iii) Credit for Prior Payments

Question: Many companies made one or more payments in 2000. Should carriers reduce payables by these amounts?

Answer: Prior payments will be netted out of amounts due, and will be detailed on invoices to carriers.

(iv) Incurred Claims for 1999 – 2000

Question: For 1999, do insurers report the same amounts reported for the final reconciliation for the demographic pool? For 2000, do insurers report an amount consistent with the 2001 Annual Statement filing (i.e., with 12 months of development for 2000 incurred claims)?

Answer: Yes, to both questions.

(v) Adjustments to Prior Years' Counts

Question: For all prior calculation dates, should the policies in force and associated membership and premium be determined inclusive of all retroactive data adjustments that have occurred through the present?

Answer: Yes.

(vi) 2002 Semi-Annual Filings

Question: Circular Letter No. 20 (2002) states: "The semi-annual data filings required by Regulation 146 will commence with the January 1, 2002 calculation date." Is this a date typo? In looking at the dates provided above this paragraph, the semi-annual filings appear to start with the January 1, 2003 calculation date as all other previous calculation dates have the 1/31/03 due date

Answer: The filings due January 31, 2003 are the single filings for years 1999 to 2001 and the two semi-annual 2002 filings.

16. **RECONCILIATIONS**

(i) **General, and 1999 - 2002**

Question: Please describe the reconciliation process generally, and the process for prior periods.

Answer: The format will be the same as previously used under the demographic pools. For each calendar year's submissions, there will be an initial Annual Reconciliation requested in May of the following year and a final reconciliation in May of the second following year. It is anticipated that the initial Annual Reconciliation for 2002 will be requested in May 2003. Annual Reconciliations for 1999 have already been submitted by all companies under the Demographic Pool, and since incurred claims for 2000 and 2001 are being requested with the initial submissions for those years, due January 31, 2003, it is anticipated that no Annual Reconciliations will be necessary for those years.

(ii) **Revisions on Reconciliation**

Question: When a carrier finds after submitting its reports (Exhibit I, II) to the administrator that it inadvertently omitted some claims, should the carrier submit corrected reports on reconciliation.

Answer: No. If the carrier made a diligent effort in preparing the original reports, omissions should be negligible and have a minimal impact on the pool calculations. Any major errors, such as the omission of a whole segment of business, will, however, have to be adjusted, and **must** be reported. Carriers with questions on specific instances should contact the administrator.

17. **REFUND OF 1999 EXCESS DEPOSIT CONTRIBUTIONS**

Question: If a company's 1999 deposit contributions calculated based on the former pools' demographic formula exceeded or were less than contributions calculated under the new Pool formula, how will the amounts be adjusted?

Answer: Refunds or additional billings for differences between amounts contributed in 1999 based on demographics vs. actual amounts due for 1999 based on the new methodology will be made once all data for 1999 is submitted and reviewed by the administrator. Carriers that paid in amounts based on demographics for 1999 that exceed the amounts ultimately calculated as due under the new pool formula will receive flat refunds of the difference. Those that underpaid will be billed for the difference. The maximum total contribution for 1999 is limited by the Regulation to 5% of a carrier's incurred claims for the year. The 5% is inclusive of what was already paid.

18. **REPORTING AND PAYMENT DUE DATES, AND PENALTIES**

(i) **Due Date**

Question: When are semi-annual filings due and when are payments to be made to and from the Pools?

Answer: Carriers should submit reports in the form of Exhibits I and II of Circular Letter No. 20 by the last day of the month in which the calculation date falls. Payments will be due by the end of the month following the month in which the calculation date falls. For example, reports for the January 1, 2004 calculation date are due by January 31, 2004, and payments are due by the end of February, 2004.

(ii) **Late Filing Penalties**

Question: Is there a penalty for late filing?

Answer: The Fourth Amendment to Regulation 146 contains an express provision for a 1% per month

penalty to be added to a carrier's calculated payments to the pools or deducted from its calculated distributions from the pools for late filings. While the Superintendent has the discretion to allow some leeway in enforcing the 30 day prescribed deadline, and may consider doing so on the first filing in light of the amount of data required, the Department expects submissions to arrive by January 31 absent unusual circumstances, especially in time periods beyond the initial January 2003 submissions.

(iii) Carriers Running Payment Calculations/Estimates Internally

Question: Do we expect to receive a spreadsheet on how to calculate the payment/credits to/from the pool?

Answer: Providing such a spreadsheet is not anticipated. However, prior to billings being sent to carriers, the regional indices will be made available, so that every carrier can determine its own expected liability to or receivable from the pool.