

**STATE OF CALIFORNIA  
DEPARTMENT OF MANAGED HEALTH CARE  
TITLE 28, CALIFORNIA CODE OF REGULATIONS  
RULES 1300.84.06, 1300.84.2, 1300.84.03, AND 1300.84.3<sup>1</sup>**

**INITIAL STATEMENT OF REASONS**

**ANNUAL, QUARTERLY, AND MONTHLY FINANCIAL REPORTING REGULATIONS  
IN TITLE 28**

Pursuant to Government Code section 11346.2, the Director of the Department of Managed Health Care (Department) submits this Initial Statement of Reasons regarding the adoption of Rule 1300.84.03, the amendment and renumbering of Rule 1300.84.06, and the amendments of Rules 1300.84.2 and 1300.84.3, in title 28 of the California Code of Regulations (CCR).

**I. AUTHORITY**

California Health and Safety Code section 1341, subdivision (a), authorizes the Department to regulate health care service plans (health plans). Health and Safety Code section 1341.9 vests the Director of the Department (Director) with all duties, powers, purposes, responsibilities, and jurisdiction as they pertain to health plans and health plan business.

Health and Safety Code section 1344 grants the Director the authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Act Health Care Service Plan Act of 1975 (Knox-Keene Act).

Health and Safety Code section 1346 vests in the Director additional powers to administer and enforce the Knox-Keene Act, including but not limited to, the power to prescribe by rule or order the form and contents of financial statements required under the Knox-Keene Act, the circumstances under which consolidated statements shall be filed with the Department, and the circumstances under which financial statements shall be audited.

Health and Safety Code section 1348.95 grants the Director the authority to make rules and regulations specifying the form and content of the enrollment reports, by product type, including the number of enrollees that receive health care coverage under a health care service plan contract that covers individuals and small groups inside and outside of the California Benefit Exchange, large groups, administrative services only business lines, and any other business lines.

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<sup>1</sup> References to “Rule” or “Rules” refer to the regulations the Department promulgated at Title 28 of the California Code of Regulations.

Health and Safety Code section 1375.1 requires every health plan to demonstrate to the Director a fiscally sound operation and adequate provision against the risk of insolvency.

Health and Safety Code section 1376 grants the Director authority to adopt rules and regulations as appropriate in the public interest, or for the protection of health plans, subscribers, and enrollees, to provide safeguards with respect to the financial responsibility of health plans, specifically including but not limited to requiring a minimum capital or net worth, limiting indebtedness, procedures for the handling of funds or assets, including segregation of funds, assets and net worth, maintaining appropriate insurance and a fidelity bond, and the maintenance of a surety bond.

Health and Safety Code section 1377 protects enrollees by imposing more stringent financial regulatory requirements on health plans that incur significant liabilities to non-contracted health care providers, including reporting requirements that require the calculation of estimated liability for reimbursements.

Health and Safety Code Section 1382 gives the Director the authority to conduct an examination of a health plan's fiscal and administrative affairs as often as deemed necessary to protect the interest of subscribers or enrollees.

Health and Safety Code section 1384 grants the Director the authority to make rules and regulations specifying the form and content of the reports and financial statements required under the law, including reports required on a periodic basis of the Director's choosing, as well as special reports as the Director requires.

## **II. SPECIFIC PROBLEMS ADDRESSED, AND NECESSITY OF RULES:**

### **Overview of Proposed Rules**

The Department is proposing this regulatory action under the Knox-Keene Act to implement, interpret and make specific Health and Safety Code sections 1348.95, 1384, and 1385. This rulemaking action proposes to amend Rules 1300.84.06, 1300.84.2, 1300.84.3, renumber Rule 1300.84.06 to 1300.84.1, and adopt Rule 1300.84.03, in title 28 of the CCR.

The purpose of this regulatory action is to update, clarify, and simplify existing Rules for health plan reporting of financial stability. Current law requires health plans to report certain financial information to the Department to enable the Department to conduct a thorough review of the financial viability of the health plan.<sup>2</sup> Health plans must maintain financial viability at all times to protect against claims received on behalf of health plan enrollees. These Rules amend and update existing health plan financial reporting requirements by incorporating reporting forms for the existing annual report requirement, the quarterly report requirement, and the monthly report requirement. In addition, the Department is incorporating by reference an instruction manual that will

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<sup>2</sup> Health and Safety Code section 1384.

advise health plans of what specific financial information is required.<sup>3</sup> These Rules also implement, for the purposes of health plan financial reporting, new requirements for reporting enrollment pursuant to Health and Safety Code section 1348.95.<sup>4</sup>

As explained below, this package proposes to amend the requirements for health plan financial reports required to be filed on an annual and quarterly basis as currently set forth in Rules 1300.84.06 and 1300.84.2, respectively. This package also proposes to amend the existing monthly financial report section under Rule 1300.84.3 and adopt Rule 1300.84.03 regarding notice requirements for monthly financial reports.

A major component of the proposed Rules is the incorporation by reference of four documents, consisting of an instruction manual and three financial reporting forms, as follows: the “Annual DMHC Financial Reporting Form (Form No. 10-072)” (Annual Report), the “Quarterly DMHC Financial Reporting Form (Form No. 10-071)” (Quarterly Report), the “Monthly DMHC Financial Reporting Form (Form No. 10-070)” (Monthly Report), and the “Annual, Quarterly, and Monthly Reporting Forms Instruction Manual (Eff. Date, OAL insert)” (Instruction Manual). The Instruction Manual provides detailed instructions for health plan financial reporting and its purpose and necessity is described below. The text of the Rules identifies the occurrence with which each financial reporting form must be filed with the Department and incorporates by reference the Instruction Manual and the applicable reporting forms. In addition, the monthly report regulations describe the criteria explaining when a health plan is required to file the monthly reports and explain the requirements a health plan must meet in order to discontinue filing monthly reports with the Department. The Instruction Manual advises health plans how to complete each report and addresses other financial reporting matters, such as which health plan financial reports must be audited.

The Knox-Keene Act has required health plan financial reporting since its inception into California law in 1975. The financial reporting law has evolved over time based on new technologies, health plan operation changes, health care delivery trends, and varying concerns over health plan solvency. The Department has worked closely with health plans over the years to collaborate and discuss the best and clearest methodologies for reporting financial information to the Department. The changes proposed in this regulatory package reflect the outcome of discussions with health plans related to best practices for health plan financial reporting and it is important to note the health plans are currently submitting similar reports to the Department under existing law. Therefore, it is necessary to update Rules to reflect current business practices for both the health plans and the Department.

#### *Amendment of Rule 1300.84.06 and Renumbering to Rule 1300.84.1*

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<sup>3</sup> The Department is incorporating by reference an instruction manual titled “Annual, Quarterly, and Monthly Reporting Forms Instruction Manual” and the three reporting forms themselves. The Instruction Manual describes what information must be filled out and provided by a health plan for each reporting form, as applicable.

<sup>4</sup> The enrollment by health plan product reporting in Health and Safety Code section 1348.95 is separate and distinct from current enrollment reporting requirements in Rule 1300.84.6 of the CCR.

The Department is amending and renumbering Rule 1300.84.06 to 1300.84.1 to better align with the other relevant Rules requiring health plans to submit the Quarterly Financial Report, as specified in current Rule 1300.84.2, and the Monthly Financial Report specified in Rule 1300.84.3. Current subdivision 1300.84.06(a) is problematic because it refers to an obsolete annual report form that no longer exists, making the subdivision inaccurate and unclear for health plans who are required to submit the annual report to the Department. It is necessary to amend subdivision 1300.84.06(a) to clarify the document that must be included in a health plan's Annual Financial Report to the Department, and to renumber the section to Rule 1300.84.1 to better align with other relevant provisions.

Current subdivision 1300.84.06(b) of the Rule is problematic because the subdivision is unclear and needlessly lengthy. The current language makes it unclear that the health plan is required to submit all the information in subdivisions (b)(1) through (b)(9) of the Rule. In order to clarify this subdivision, the Department is removing the information and replacing it with text that specifies the proper form, information in the form the health plan must submit, and when the health plan must submit the information to the Department.

Proposed subdivision 1300.84.1(a) of the Rule is necessary because the subdivision incorporates by reference the "Annual DMHC Financial Reporting Form" and describes when the health plan is required to submit the reporting form for compliance. This clarifies for the health plan what form the health plan is required to submit and when the health plan must submit the form to the Department.

Proposed subdivision 1300.84.1(b) of the Rule is necessary because the subdivision incorporates by reference the "Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual" (Instruction Manual), which is the comprehensive guide that will instruct the health plan on how to show compliance with the Department's annual financial reporting requirements. This change to the subdivision will allow for consistent and accurate reporting by health plans and will enable the Department to conduct a thorough review to ensure enrollees are protected from potential health plan insolvency that could impact their access to health care services.

Proposed subdivision 1300.84.1(c) of the Rule is necessary because the subdivision clarifies for the health plan that the Annual Report is considered the health plan's annual financial reporting form under Health and Safety Code section 1384 and that it should cover the applicable reporting period as specified in the Instruction Manual. This subdivision is necessary to ensure there is no health plan confusion on what the health plan must report to the Department for compliance with this Rule.

#### *Amendment to Rule 1300.84.2*

Subdivision 1300.84.2(a) is problematic because the subdivision refers to an obsolete form, making the subdivision of this Rule inaccurate and unclear. The amendment to subdivision 1300.84.2(a) of the Rule is necessary to eliminate the reference to an

obsolete financial reporting form and replace it with the Quarterly DMHC Financial Reporting Form, incorporated by reference in this subdivision. The change will clarify the Department's quarterly financial reporting requirement by clarifying for a health plan what form the health plan is required to submit and when the quarterly report must be submitted to the Department.

Subdivision 1300.84.2(b) is being revised since it refers to a subdivision that is being amended pursuant to this proposed regulation package. Proposed subdivision 1300.84.2(b) is necessary because the subdivision incorporates by reference the "Annual, Quarterly, and Monthly DMHC Financial Reporting Forms Instruction Manual," which is the comprehensive guide that will instruct the health plan on how it is to show compliance with quarterly financial reporting requirements. This amendment will allow for consistent and accurate reporting by health plans and will enable the Department to conduct a thorough review to ensure enrollees are protected from potential health plan insolvency, which could impact their access to health care services.

Proposed subdivision 1300.84.2(c) is necessary because the subdivision incorporates by reference the Instruction Manual, which is the comprehensive guide that will instruct the health plan on how to show compliance with the Department's quarterly financial reporting requirements. The subdivision is necessary because it also clarifies for the health plan that the Quarterly Report should cover the applicable reporting period as specified in the Instruction Manual and to ensure there is no confusion on what the health plan must report to the Department for compliance with the Rule.

#### *Amendment to Rule 1300.84.3 and Adoption of Rule 1300.84.03*

Rule 1300.84.3 is problematic because the Rule contains obsolete language regarding monthly financial reporting requirements and is needlessly lengthy and unclear. The Department is removing existing subdivision 1300.84.3(b) because the subdivision is unclear and difficult for the Department to enforce. Rule 1300.84.3 also contains two separate requirements for the health plan that cause confusion and require clarification for the health plans.<sup>5</sup> The first requirement in existing subdivision (c) of the Rule requires the health plan to advise the Department if the health plan is unable to meet financial obligations as they become due or if the health plans' tangible net equity (TNE) falls below a certain amount.<sup>6</sup> There is a second reporting requirement in (d) of the Rule that involves monthly reporting to the Department. The Department has created and is proposing the adoption of a new Rule 1300.84.03 in order to separate and clarify when health plans must notify the Department of the health plan's inability to meet financial obligations, and to make clear when a health plan must notify the Department if a health plan determines it is unable to meet financial obligations or meet TNE requirements.

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<sup>5</sup> See existing subdivision 1300.84.3(c) and (d).

<sup>6</sup> Tangible Net Equity is defined in title 28, section 1300.76(c) and describes the calculation a health plan must use to determine tangible net equity.

Proposed subdivision 1300.84.03(a) of the Rule is existing language contained in Rule 1300.84.3(a) that has been adopted as part of the new subdivision. The amendment is necessary to move this requirement into the proposed subdivision of the Rule since the general requirement is related to health plan internal procedures to ensure appropriate financial reporting by the health plan.

Proposed subdivision 1300.84.03(b) of the Rule is a general requirement that is adopted from existing Rule 1300.84.3(c). Since the general requirement is separate from the reporting requirements, it is necessary to separate out the general requirement to be clear and concise and to make the subdivision easier for health plans to understand. The amendment is necessary to eliminate references to obsolete language and to distinguish clearly between general requirements and reporting requirements.

Proposed subdivision 1300.84.03(b)(2) of the Rule requires the health plan to notify the Department within 5 business days if the health plan becomes aware the health plan is unable to meet financial obligations. Rule 1300.84.03(b)(2) is necessary because the Department must know as soon as possible if a health plan is nearing insolvency in order to protect consumers and ensure enrollee access to health care services.

Proposed subdivision 1300.84.3(a) describes the circumstances in which the health plan must file monthly reports with the Department. The amendment is necessary because it incorporates by reference the "Monthly DMHC Financial Reporting Form," and describes when the health plan must submit the reporting form for compliance.

Proposed subdivisions 1300.84.3(b)(1) and (b)(2) of the Rule are requirements adopted from current subdivision 1300.84.3(d). It has been updated to reflect a change regarding TNE. In the current subdivision, the health plan is required to report to the Department if its TNE falls below 130% of the requirements in Rule 1300.76(a) or (b). The proposed regulation increases that amount to 150%, meaning, if a health plan falls below 150% TNE, the health plan must report to the Department. The TNE requirement for Point-of-Service contracts will remain at 130% because the requirement is required by Health and Safety Code section 1374.64(b)(1)(A)(I) and (II). Rules 1300.84.3(b)(1) and (b)(2) are necessary because the Department needs to be made aware at an earlier point if the health plan is nearing financial trouble to begin working with the health plan to devise corrective action or develop a contingency plan. Rule 1300.84.3(b) is necessary to enable the Department to ensure the Department is able to mitigate any potential consequences of health plan financial insolvency for enrollees.

Proposed subdivision 1300.84.3(c) describes the circumstances that must occur before the health plan ceases submitting the monthly report to the Department. Existing Rule 1300.84.3(d) is problematic and confusing to health plans because it is unclear when the health plan is required to cease monthly reporting to the Department. Therefore, the proposed language clearly describes the three instances that must occur before the health plan ceases to report to the Department.

Proposed subdivision 1300.84.3(c)(1) describes the health plan must meet the applicable TNE threshold (150%, or 130% for Point-of-Service contracts) for six consecutive months. As part of the duties delegated to the Department by the Legislature in the Knox-Keene Act, the Department must ensure that a health plan is adequately funded with enough reserves to cover enrollee health care claims. Six consecutive months offers an adequate snapshot of the health plan's stability.

Proposed subdivision 1300.84.3(c)(2) is necessary because a health plan is currently required to maintain fiscal soundness and assumption of full financial risk as provided for in subdivision 1300.75.1. This amendment is necessary for the Department to ensure the health plan is able to adequately demonstrate over a six-month period that it is adequately insured and financially stable in order to protect enrollees from potential health plan insolvency.

Proposed subdivision 1300.84.3(c)(3) is necessary to clarify and update the existing provision located in subdivision 1300.84.3(d)(3) regarding the time period for which a health plan must be licensed by the Department in order to qualify to cease filing the monthly financial reports required by Rule 1300.84.3.

Proposed subdivision 1300.84.3(d) is necessary because the subdivision incorporates by reference the Instruction Manual, which is the comprehensive guide that will instruct the health plan on how to show compliance with the Department's monthly financial reporting requirements. The subdivision is necessary because it also clarifies for the health plan that the Monthly Report should cover the applicable reporting period as specified in the Instruction Manual and to ensure there is no confusion on what the health plan must report to the Department for compliance with the Rule. Rule 1300.84.3(d) will allow for consistent and accurate reporting across health plans and will enable the Department to conduct a thorough review to ensure enrollees are protected from potential health plan insolvency.

Subdivision 1300.84.3(e) is being deleted because it is unnecessary due to technological advances. Specifically, the Department has invested in new technological capabilities, such as electronic submission of documents through the Department's secure web portal. Electronic submissions now allow for attestations to be submitted at the time the health plan submits its financial reporting forms and documents electronically. The attestations are being incorporated by reference in each form and identified by a screenshot of the web portal. Health plans will be prompted to attest to certain financial filings within the Department's electronic submission portal upon electronically filing financial reporting submissions. Therefore, this subdivision is no longer necessary.

### **III. SPECIFIC PURPOSE AND NECESSITY OF DOCUMENTS INCORPORATED BY REFERENCE**

## **Overview: Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual**

The amendments to Rule 1300.84.06 (renumbered to 1300.84.1), Rule 1300.84.2, and Rule 1300.84.3 all incorporate by reference the Instruction Manual because it is necessary to provide health plans with detailed instructions on how the health plan is to file the financial Annual Report, Quarterly Report, and the Monthly Report.

The purpose of the Instruction Manual, incorporated by reference for each financial reporting requirement, is to provide health plans with detailed instructions on how to file the financial Annual Report, Quarterly Report, and the Monthly Report. The Instruction Manual is necessary because it serves as a guide for the health plan's compliance filings and ensures the health plan is accurately reporting its financial status to the Department. Accurate reporting enables the Department to conduct a thorough review of the health plan's financial status to ensure enrollees are protected against health plan insolvency. In addition, it assists the health plan in preparing and filing the financial reporting forms required by these proposed Rules with the Department on a consistent basis and as required by Health and Safety Code section 1384, Rule 1300.84.06 (renumbered to Rule 1300.84.1), Rule 1300.84.2, and Rule 1300.84.3. The Instruction Manual will be made available for the health plans and the general public, including enrollees, on the Department's website, located at: [www.dmh.ca.gov](http://www.dmh.ca.gov).

The following descriptions of the items in the Instruction Manual provide the specific purpose and necessity of each item instruction whose purpose is to assist the health plan in completing the Annual Report, Quarterly Report, and Monthly Report, incorporated by reference in these proposed Rules.<sup>7</sup> A table on pages 2 and 3 of the Instruction Manual explains what items the health plan must submit depending on the type of report that is being submitted, described below in further detail.

### **Specific Purpose and Necessity of Instructions Contained in the Instruction Manual**

- **Page 1 - General Instructions:** The purpose of the General Instructions is to provide an overview of what the Instruction Manual is; it is a guide to assist the health plans in filing all three of the required financial reporting forms. The General Instructions section is necessary to introduce and make clear to the health plan what documents the health plan is to file and when. Accurate reporting is necessary to enable the Department to conduct an adequate review of the health plan's financial viability.
- **Page 1 – Item 1, How and When to File the Financial Reporting Forms with the Department:** The purpose of this item in the General Instructions is to explain how a health plan is to submit to the Department the reports required by these

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<sup>7</sup> The Specific Purpose and Necessity of each item contained within the Reporting Forms are described in the **Specific Purpose and Necessity of Items Contained within Reporting Forms** section of this Initial Statement of Reasons.



Rules including the web portal address and provides a table that indicates filing deadlines for each report. These instructions are necessary to make clear how a health plan must file its report to the Department and when each report is due to the Department.

- Pages 2-3 – Item 2, Required Information for the Annual, Quarterly, and Monthly Reports: The purpose of the second section in the General Instructions is to provide a table that describes what financial statement type needs to be filed with the Department depending upon which report (Annual Report, Quarterly Report, or Monthly Report) is being filed. These instructions and tables are necessary to clarify for the health plan and inform the health plan of what documents need to be filed for each financial report form incorporated by reference in these Rules.
- Page 4 - Item 3, Change of Accountants: The purpose of the General Instructions is to inform the health plan of the requirement to notify the Department if there has been a change in accountants at the health plan between the health plan's most recent filing and the current filing. The health plan must inform the Department of the change by letter and file the letter with the Department via the Department's web portal. This instruction is necessary to ensure the integrity of the financial reports and to comply with Rule1300.84.05, if applicable.
- Page 4 – Item 4, Annual Financial Statements vs Auditor's Report: The purpose of this instruction is to inform the health plan that a reconciliation schedule is required, and it must provide an explanation for variances between the Annual Report and the independent auditor's report. This instruction is necessary for the health plan to explain if its annual financial statements are not reconciling with the independent auditor's report required pursuant to Health and Safety Code section 1384(c). If applicable to the health plan's annual financial filing, this instruction will assist the health plan in understanding how to inform the Department of the issue. This is necessary to enable the Department to understand the discrepancy and assess the health plan's submission accordingly.
- Page 4 – Item 5, Additional Supporting Statements or Schedules: The purpose of this instruction is to explain to the health plan that it can provide additional information to the Department to complete its financial statement submission. The instruction is necessary to clarify how the health plan is to describe any supplemental information to enable the Department's review, and to allow the Department to assess the health plan's finances accurately against the audited reports provided by the health plan.
- Page 4 – Item 6, Details of Write-Ins Aggregated at Item: The purpose of this instruction is to inform the health plan to report items in the "Write-Ins" tab when additional information cannot be classified in any of the accounts listed in the financial statements. This instruction is necessary to allow the health plan to provide additional information to the Department. The instruction also explains to

the health plan how to provide the Department with any additional information for review that may not fit into the cells in the forms.

- Page 5 – Item 7, Actuarial Certification: The purpose of this instruction is to remind the health plan that it is required by law to submit an actuarial certification if it is using an actuarial estimate to calculate its incurred and unreported claims. It also clarifies that the health plan is not required to file a Schedule I if it is submitting an actuarial certification. This instruction is necessary to ensure the health plan's financial statement is filed in accordance with legal requirements for actuarial estimates filed with the Department.
- Page 5 - Instructions for Cover Page Tab: The purpose of this instruction is to explain the purpose of the Cover Page Tab that is required of each reporting form and describes to the health plan how to fill out the Cover Page in its submission. This instruction is necessary to ensure the health plan can appropriately fill out the Cover Page in the Annual Report, Quarterly Report, and Monthly Report. The instruction is also necessary to assist the Department in identifying the reporting period, the health plan that is reporting the information, the health plan's Department issued identification number, whether the health plan is reporting monetary amounts in the thousands, whether the health plan is offering full-service benefits or specialized benefits, and the type of health plan. There is also a column that allows the health plan to enter any additional notes it would like to provide to the Department. All of this information ensures the Department is assessing the health plan properly in its review.
- Pages 6-7- Instructions for Report #1A Tab- Assets: The purpose of these instructions for Report #1A Tab-Assets is to provide the health plan with a background and purpose of the report and explain how the health plan is to report assets for its TNE calculation. These instructions are necessary for the health plan to explain how it is complying with title 28, section 1300.76 which requires a health plan to have requisite monetary reserves to ensure financial solvency. The Part A – Balance Sheet Assets table explains what assets are to be included and what assets are to be excluded from the health plan's calculation when completing the corresponding Report #1, Part A. These instructions are necessary for the health plan to understand how to accurately tabulate assets for each report required by these Rules.
- Page 7-9 – Instructions for Report #1A: Assets Tab: Current Assets
  - Line #1: Cash and Cash Equivalents: The purpose of this instruction is to clarify assets reportable for the corresponding line item in Report #1, Part A, which requires the health plan to report their cash and cash equivalents as stated above. The Department must understand how much liquidity a health plan has to be able to accurately monitor and regulate the financial stability of the health plan. Further, understanding the health plan's cash

on hand allows the Department to accurately assess the financial viability of the health plan and assess its ability to continue providing health care services to enrollees. The instruction is necessary in order for the health plan to accurately report current assets to the Department in Report #1, Part A.

- Line #2 Short-Term Investments: The purpose of this instruction is to assist the health plan in reporting short-term investments to the Department for the corresponding line item in Report #1, Part A. Short-term investments are part of a health plan's current assets and assist the Department in understanding the health plan's financial viability and assess its ability to continue providing health care services to enrollees. The instruction is necessary in order for the health plan to accurately report current assets to the Department in Report #1, Part A. Accurate information allows the Department to adequately monitor and regulate the financial viability of the health plan.
- Line #3 Premiums Receivable: The purpose of this instruction is to clarify how the health plan should report premiums receivable for the corresponding line item in Report #1, Part A, which requires the health plan to report its premium receivables that are collectible from other entities or individuals receiving services from the health plan. The instruction is necessary to assist the health plan in accurately reporting current assets to the Department. Accurate information allows the Department to adequately monitor and regulate the financial viability of the health plan.
- Line #4 Interest Receivable: The purpose of this instruction is to clarify how the health plan should report interest receivable on the corresponding line item in Report #1, Part A, which requires the health plan to report any interest it has earned on investments. The instruction is necessary to assist the health plan in accurately reporting current assets to the Department. Accurate information allows the Department to adequately monitor and regulate the financial viability of the health plan.
- Line #5 Shared Risk Receivables - Net: The purpose of this instruction is to clarify how the health plan should report its shared risk receivables if it enters into contracts with parties, such as provider groups, where parties share financial risk. This is necessary for the health plan to accurately report risk receivables in the corresponding line item in Report #1, Part A. Accurate reporting assists the Department in understanding the assets involved in these arrangements and enables the Department to accurately assess and monitor the financial stability of the health plan.
- Line #6 Other Health Care Receivables - Net: The purpose of this instruction is for the health plan to report its other health care receivables from other sources as assets in the corresponding line item in Report #1, Part A. This instruction is necessary to enable the health plan to

accurately report the assets involved in these arrangements. Accurate information allows the Department to adequately monitor and regulate the financial viability of the health plan.

- Line #7 Prepaid Expenses: The purpose of this instruction is for the health plan to report expenses paid in advance and charged to the operations of the health plan within one year as assets in the corresponding line item in Report #1, Part A. This instruction is necessary to enable the health plan to accurately report the assets involved in these arrangements. Accurate information allows the Department to adequately monitor and regulate the financial viability of the health plan.<sup>8</sup>
  - Line #8 Secured Affiliate Receivables - Current: The purpose of this instruction is for the health plan to report its affiliate receivables that are properly secured by the affiliated entity's assets in the corresponding line item in Report #1, Part A. This instruction is necessary to enable the health plan to accurately report the assets involved in these arrangements. Accurate information allows the Department to adequately monitor and regulate the financial viability of the health plan.
  - Line #9: Unsecured Affiliate Receivables – Current: The purpose of this instruction is for the health plan to accurately report its affiliate receivables that are unsecured in the corresponding line item in Report #1, Part A. Accurate information allows the Department to adequately monitor and regulate the financial viability of the health plan.
  - Line #10 Aggregate Write-Ins for Current Assets: The purpose of this instruction is to inform the health plan that it can report additional items related to its overall financial position as described in the instruction. The instruction is necessary for the health plan to know where to provide the additional information to the Department. The Department must allow the health plan to report all known applicable assets to adequately monitor and regulate the financial viability of the health plan.
  - Line #11: Total Current Assets: The purpose of this instruction is to provide the health plan with the calculation for totaling all of its assets for this section of reporting. The instruction is necessary because the health plan needs to understand how to calculate its assets for accurate reporting to the Department. Accurate reporting is necessary for the Department to adequately monitor and regulate the financial viability of the health plan.
- Page 9,10 - Instructions for Report #1A: Assets Tab: Other Assets

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<sup>8</sup> It is important to note that financial reporting requirements are submitted in accordance with the Generally Accepted Accounting Principles (GAAP). These principles are an accounting industry standard. See <https://www.accounting.com/resources/gaap/>.

- Line #12: Restricted Assets: The purpose of this instruction is for the health plan to report its restricted assets in the corresponding line items in Report #1, Part A and Schedule A. The instruction is necessary because the health plan must know how to accurately report its restricted assets to the Department. Accurate reporting is necessary to ensure the Department is able to assess the health plan's non-current restricted assets including any assets the health plan has to maintain solvency.
- Line #13: Long Term Investments: The purpose of this instruction is to clarify how the health plan should report long-term investments on the corresponding line item in Report #1, Part A. This instruction is necessary because the Department must take into account any long-term investments the health plan has made in order to understand the health plan's financial stability. This is necessary for the health plan to accurately report long-term investments to the Department. Accurate reporting allows the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #14: Intangible Assets and Goodwill - Net: The purpose of this instruction is to clarify how the health plan should report intangible assets and goodwill on the corresponding line item in Report #1, Part A. This instruction is necessary because it enables the health plan to report intangible assets and goodwill as described in the instruction. Accurate reporting allows the Department to adequately monitor and regulate the financial stability of the health plan.
- Line #15: Secured Affiliate Receivables-Long Term: The purpose of this instruction is to clarify how the health plan should report long-term secured affiliate assets receivable to the health plan in the corresponding line item for Report #1, Part A. This instruction is necessary for the health plan to accurately report its affiliate receivables that are properly secured by the affiliated entity's assets due in the long term. Accurate reporting ensures the Department understands the secured receivables involved in these arrangements when monitoring and regulating the financial stability of the health plan.
- Line #16: Unsecured Affiliate Receivables-Long Term: The purpose of this instruction is to clarify how the health plan should report unsecured affiliate assets receivable to the health plan in the corresponding line item in Report #1, Part A. This instruction is necessary for the health plan to accurately report its affiliate receivables that are unsecured and due in the long term. Accurate reporting ensures the Department understands the unsecured receivables involved in these arrangements and enables the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #17: Aggregate Write-Ins for Other Assets: The purpose of this instruction is to explain the corresponding line item in Report #1, Part A for write-ins where the health plan may provide additional information. This instruction is necessary because the health plan may have additional assets

to report to the Department not specifically called for in the previous line items. The Department must allow the health plan to report all the applicable assets involved in the health plan's financial dealings in order to be able to accurately monitor and regulate the financial stability of the health plan.

- Line #18: Total Other Assets: The purpose of this instruction is to explain the corresponding line item in Report #1, Part A. This instruction is necessary to assist the health plan in adding up the total assets from this section and report them to the Department. The total assets number provides the calculation for the health plan. This is necessary to assist the health plan in reporting the proper total to the Department.
- Page 10, Instructions for Report #1A: Assets Tab Property and Equipment
  - Line #19: Land, Building, and Improvements: The purpose of this instruction is to clarify how the health plan should report real estate assets in the corresponding line item for Report #1, Part A and using Schedule E. This instruction is necessary because the Department takes into account the full value of the real properties owned by the health plan and any improvements made to those buildings to evaluate the financial viability of the health plan.
  - Line #20: Furniture and Equipment: The purpose of this instruction is to clarify how the health plan should report equipment as assets in the corresponding line item in Report #1, Part A and using Schedule E. This instruction is necessary because the Department takes into account the full value of any medical equipment, office equipment, and furniture owned by the health plan in evaluating the financial viability of the health plan.
  - Line #21: Computer Equipment-Net: The purpose of this instruction is to clarify how the health plan should report computer equipment as assets in the corresponding line item in Report #1, Part A and using Schedule E. This instruction is necessary because the Department takes into account a health plan's electronic equipment as a health plan asset when evaluating the overall financial stability of the health plan.
  - Line #22: Leasehold Improvements- Net: The purpose of this instruction is to clarify how the health plan should report leaseholds of the health plan in the corresponding line item in Report #1, Part A and using Schedule E. This instruction is necessary because the Department takes into account any improvements performed on a property not owned by the health plan when evaluating the overall financial stability of the health plan.
  - Line #23: Construction in Progress: The purpose of this instruction is to clarify how the health plan should report buildings or improvements as assets in the corresponding line item in Report #1, Part A and using Schedule E. This instruction is necessary because it clarifies the health plan must report as part of its total assets any construction on buildings or

any improvements that have been made on its property. This information is necessary because the Department uses the information to evaluate the health plan's financial stability and viability.

- Line #24: Software Development Costs: The purpose of this instruction is to clarify how the health plan should report software development costs in the corresponding line item in Report #1, Part A and using Schedule E. This instruction is necessary because the Department uses the information to understand the cost involved in the software assets being developed when evaluating the health plan's financial stability and viability.
- Line #25: Aggregate Write-Ins for Other Equipment: The purpose of this instruction is to clarify how the health plan should report any additional other equipment using write-ins in Report #1, Part A and using Schedule E. This instruction is necessary because it provides the health plan the ability to report any other fixed assets that are not specifically called for. It is necessary for the Department to understand any other assets the health plan has that are not already provided for in the categories provided when evaluating the health plan's financial stability and viability
- Line #26: Total Property Equipment: The purpose of this instruction is to explain the corresponding line item in Report #1, Part A. This instruction is necessary because it provides the health plan with the calculation for all of the amounts from the previous lines and assists the health plan in reporting the proper total to the Department.
- Line #27: Total Assets: The purpose of this instruction is to explain the corresponding line item in Report #1, Part A. This instruction is necessary because it totals all of the amounts from the previous lines. This instruction is necessary because it provides the health plan with the calculation for all of the amounts from the previous lines and assists the health plan in reporting the proper total to the Department.
- Report Tab 1A Write-Ins: This purpose of this instruction is to provide the health plan with additional space to report information. The instruction is necessary because the health plan may have additional assets it needs to report to the Department that are not specifically called for and it may need additional space to provide that information to the Department. The Department must allow the health plan to provide all applicable assets to enable the Department to conduct a thorough review of the health plan's financial stability and viability.
- Page 12- 16: Instructions for Report #1, Part B Tab: Liabilities and Net Worth
  - Page 12, Table: The purpose of the instructions for Report #1, Part B are to ensure the health plan is able to accurately report its liabilities and net worth to the Department. The instructions provide a table explaining the columns within Report #1, Part B that involve health plan reporting liability

associated with contracting entities, and non-contracting entities. The health plan would report the name of the liability account and the liabilities associated with contracting and non-contracting entities as described in the table. The total of those liabilities would be reported in the total column. This instruction is necessary for the health plan to accurately complete Report #1, Part B. Accurate reporting allows the Department to understand all the applicable liabilities involved in the health plan's financial dealings when evaluating the financial stability of the health plan.

- Current Period: The purpose of this instruction is to clarify for the health plan how to report the applicable time period to the Department for all information in Report #1, Part B. This is necessary for the Department to understand what applicable time frame is being reported by the health plan.
- Page 13, Instructions for Report #1B: Liabilities and Net Worth Tab
  - Line #1: Trade Accounts Payable: The purpose of this instruction is to clarify for the health plan how to report its trade accounts payable in the corresponding line item in Report #1, Part B, to enable the Department to evaluate how the health plan is operating its business and being billed for goods and services related to the delivery of health care. The instruction is necessary for the health plan to accurately report this information to the Department. Accurate reporting is necessary to enable the Department to understand the financial arrangements for these goods and services in assessing the financial viability of the health plan.
  - Line #2: Capitation Payable: The purpose of this instruction is to clarify for the health plan how to report capitation payables in the corresponding line item in Report #1, Part B. The instruction is necessary because the health plan may enter into capitation arrangements with various providers, whereby, it pays a per member per month amount pursuant to the contract entered into. The instruction is necessary to enable the health plan to accurately report this information to the Department. Accurate reporting is necessary to enable the Department to understand the financial arrangements for these goods and services in assessing the financial viability of the health plan.
  - Line #3: Claims Payable-Reported: The purpose of this instruction is to clarify for the health plan how to report its claims payable in the corresponding line item in Report #1, Part B. The instruction is necessary because health plans provide services to enrollees and pay claims based upon the location where the enrollee receives medical services, whether it is in-network or out-of-network. The instruction assists the health plan in accurately reporting this liability to the Department. Accurate reporting is necessary to enable the Department to understand the payment of these claims to assess the financial viability of the health plan.



- Line #4: Incurred But Not Reported Claims: The purpose of this instruction is to clarify for the health plan how to report incurred but not reported (IBNR) claims in the corresponding line item in Report #1, Part B. This item reflects the total amount owed by the health plan to all valid claimants, such as providers, who provided services to the health plan's enrollees but have not yet filed their claim with the health plan. The instruction is necessary for the health plan to accurately complete Report #1, Part B. Accurate reporting enables the Department to understand and assess health plan financial liabilities.
- Line #5: Point-of- Service Claims Payable-Reported: The purpose of this instruction is to clarify for the health plan how to report Point of Service (POS) claims payable in the corresponding line item in Report #1, Part B. For POS products, health plans provide services to enrollees and pay claims based upon the location where the enrollee receives its medical services, whether it is in-network or out-of-network. The instruction for the reporting of this liability is necessary because the payment of these claims, and the amount of the payment of these claims are evaluated by the Department in assessing the health plan's financial viability and its continued ability to provide health care services to enrollees.
- Line #6: Point-of-Service Incurred But Not Reported Claims: The purpose of this instruction is to clarify for the health plan how to report Point of Service (POS) claims that are incurred but not reported (IBNR) claims in the corresponding line item in Report #1, Part B to reflect the total amount owed by the health plan to all valid claimants, such as providers, who provided services to the health plan's enrollees but have not yet filed their claim with the health plan. The instruction is necessary because the health plan must be allowed to report specific amounts of liability not determined yet. The Department uses the reported information to understand and assess these potential financial liabilities when evaluating the financial viability of the health plan including its ability to continue providing health care services to enrollees.
- Line #7: Other Medical Liability: The purpose of this instruction is to clarify for the health plan how to report other medical liability such as bonuses, pharmacy related liabilities, and other medical liabilities in the corresponding line item in Report #1, Part B. The instruction is necessary because the health plan must be able to accurately report this information to the Department. The Department uses the information to assess these potential financial liabilities when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #8: Unearned Premiums: The purpose of this instruction is to clarify for the health plan how to report unearned premiums in the corresponding

line item in Report #1, Part B. The instruction is necessary because unearned premiums are received in advance of the period in which the services are provided and needs to be taken into account as a potential liability until the services are provided. The instruction is also necessary because it assists the health plan in accurately reporting this liability to the Department. The Department uses the information to understand and assess these potential financial liabilities when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.

- Line #9: Loans and Notes Payable: The purpose of this instruction is to clarify for the health plan how to report Loans and Notes Payable in the corresponding line item in Report #1, Part B. The instruction is necessary because it assists the health plan in accurately reporting this liability to the Department. The information allows the Department to understand and evaluate whether loans and notes are more or less important than other liabilities and ultimately accurately assess the financial viability of the health plan.
- Line #10: Amounts Due to Affiliates-Current: The purpose of this instruction is to clarify for the health plan how to report amounts due to affiliates in the corresponding line item in Report #1, Part B. The instruction is necessary because the health plan must accurately report, and the Department must understand, the long-term liability amounts due to the health plan's affiliates. The information enables the Department to accurately assess the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #11: Aggregate Write-Ins for Current Liabilities: The purpose of this instruction is to clarify for the health plan how to report total write-ins for current liabilities in Report #1, Part B. The instruction is necessary because the Department must allow the health plan to provide additional information that is relevant to its liabilities incurred. This is necessary because the information enables the Department to fully understand and assess these potential financial liabilities when evaluating the health plan and its ability to continue providing health care services to enrollees.
- Line #12: Total Current Liabilities: The purpose of this instruction is to explain the corresponding line item in Report #1, Part B and provide the plan with the appropriate calculation for the line item. The instruction is necessary because the health must understand how to calculate the corresponding lines accurately. Accurate information assists the Department in understanding and assessing total current liabilities when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.

- Page 14, Instructions for Report #1B: Other Liabilities: Liabilities and Net Worth Tab:
  - Line #13: Loans and Notes Payable-Not Subordinated: The purpose of this instruction is to clarify how the health plan is to report unsubordinated loans and notes payable on the corresponding line item in Report #1, Part B. The instruction is necessary because the health plan must accurately report this information in order for the Department to understand and evaluate whether loans and notes payable are more or less important than other liabilities when evaluating the financial viability of the health plan.
  - Line #14: Loans and Notes Payable-Subordinated: The purpose of this instruction is to clarify how the health plan is to report subordinated loans and notes payable on the corresponding line item in Report #1, Part B. The instruction is necessary because the health plan must accurately report this information in order for the Department to understand and evaluate whether loans and notes payable are properly subordinated and are more or less important than other liabilities when evaluating the financial viability of the health plan.
  - Line #15: Accrued Subordinated Interest Payable: The purpose of this instruction is to clarify how the health plan is to report accrued subordinated interest payable in the corresponding line item in Report #1, Part B. The instruction is necessary because the health plan must accurately report this information in order for the Department to understand any interest due on subordinated loans or notes and to evaluate whether loans and notes are more or less important than other liabilities when assessing the financial viability of the health plan.
  - Line #16: Amounts Due to Affiliates-Long Term: The purpose of this instruction is to clarify how the health plan is to report long-term amounts due to affiliates in the corresponding line item in Report #1, Part B. This instruction is necessary because the health plan must accurately report this information in order for the Department to understand the long-term liability amounts due to the health plan's affiliates. The Department uses the information in its overall assessment of the financial viability of the health plan and its ability to continue providing health care services to enrollees.
  - Line #17: Aggregate Write-Ins for Other Liabilities: The purpose of this instruction is to clarify how the health plan should report total write-ins for other liabilities in the corresponding sections of Report #1, Part B and Report #1 Write-ins. The instruction is necessary because the Department must allow the health plan to provide additional information that is relevant to their liabilities incurred, and the health plan must know where to report this information. This is necessary because the Department has to understand and assess all reported financial liabilities

when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.

- Line #18: Total Other Liabilities: The purpose of this instruction is to explain the corresponding line item in Report #1, Part B, which calculates the liabilities from the previous lines in determining total liabilities in the Other Liabilities category. This instruction is necessary because the Department has to understand and assess these potential financial liabilities when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #19: Total Liabilities: The purpose of this instruction is to explain the corresponding line item in Report #1, Part B, which totals all of the liabilities from the previous lines and provides the total of liabilities for the health plans. This instruction is necessary because the Department has to understand and assess these potential financial liabilities when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Page 15, Net Worth: Report #1B: Liabilities and Net Worth Tab:
  - Line #20: Common Stock: The purpose of this instruction is to clarify how the health plan is to report common stock in the corresponding line item in Report #1, Part B. This instruction is necessary because the Department must understand how many common stock shares have been issued and the value of these shares to better evaluate the health plan's financial viability. In addition, the definitions in this item provide the health plan with a description of the different common stocks that can be included in the health plan's reporting.
  - Line # 21: Preferred Stock: The purpose of this instruction is to clarify how the health plan is to report preferred stock in the corresponding line item in Report #1, Part B. This instruction is necessary because the health plan must accurately report, and Department must understand, how many shares are preferred over the common stock and the value of these shares. This enables the Department to better evaluate the financial viability of the health plan.
  - Line #22: Paid in Surplus: The purpose of this instruction is to clarify how the health plan is to report paid in surplus in the corresponding line item in Report #1, Part B. This instruction is necessary because it informs the health plan how to accurately report this item. Accurate reporting assists the Department in understanding the surplus available to the health plan and the value of the surplus. This enables the Department to better evaluate the financial viability of the health plan.

- Line #23: Contributed Capital: The purpose of this instruction is to clarify how the health plan is to report contributed capital in the corresponding line item in Report #1, Part B. This instruction is necessary because the health plan must accurately report, and the Department must understand, the value of the capital donated to the health plan and the nature of that donated capital and any restrictions on the capital. This information allows the Department to better evaluate the financial viability of the health plan.
- Line #24: Accumulated Other Comprehensive Income: The purpose of this instruction is to clarify how the health plan is to report other accumulated comprehensive income in the corresponding line item in Report #1, Part B. This instruction is necessary because the Department must understand any unrealized gains and losses the health plan is including in this liabilities and net worth section. This enables the health plan to accurately report net worth. Accurate reporting allows the Department to better evaluate the financial viability of the health plan.
- Line #25: Retained Earnings (Deficit)/Fund Balance: The purpose of this instruction is to clarify how the health plan is to report the balance on any retained earnings in the corresponding line item in Report #1, Part B. This instruction is necessary because the reported amounts will enable the Department to fully understand the health plan's financial status and will assist in determining the financial viability of the health plan.
- Line #26: Aggregate Write-Ins for Other Net Worth Items: The purpose of this instruction is to clarify how the health plan should report total write-ins for net worth in the corresponding sections of Report #1, Part B and Report #1 Write-ins. The instruction is necessary because the Department must allow the health plan to provide additional information that is relevant to their total net worth, and the health plan must know where to enter and total this information. This is necessary because the Department must understand and assess the net worth of the health plan and assess its ability to continue providing health care services to enrollees.
- Line #27: Total Net Worth: The purpose of this instruction is to explain the corresponding line item in Report #1, Part B, which adds up the total net worth from the previous lines to calculate a total net worth of the health plan. This instruction is necessary because the Department must understand and assess the total net worth when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #28: Total Liabilities and Net Worth: The purpose of this instruction is to explain the corresponding line item in Report #1, Part B. This instruction is necessary because it provides the calculation for the health

plan to add up the total liabilities and the total net worth as reported in the previous items in this section. This information is necessary to provide the Department with the information it needs to adequately assess and evaluate the financial solvency of the health plan.

- Report Tab 1B: Write-Ins: The purpose of this instruction is to clarify where the health plan should report additional information on liabilities and net worth as called for in prior line items in Report #1, Part B. This instruction is necessary to allow the health plan to accurately report to the Department what net worth items and liability items are being considered by the health plan in the aggregated total contained in Item 28. This instruction is necessary for a proper accounting of net worth by the health plan. The information is necessary for the to evaluate the financial solvency of the health plan.
- Pages 17-24, Instructions for Report #2- Income Tab: Statement of Revenues, Expenses & Net Worth

The purpose of the instructions for Report #2 is to clarify how the health plan should report to the Department revenues and expenses incurred for the health plan during a given period. This section of the instruction manual (Page 17) includes two separate sets of instruction tables. The first table addresses instructions for the Annual Income Statement Form and the second table addresses instructions for the Monthly and Quarterly Income Statement Forms. These instructions are necessary to instruct the health plan on what information to provide to the Department for each time period.

The note for Report #2 (Page 18) also includes a reminder to the health plan that the amounts from the Monthly Report, the Quarterly Report, and the Annual Report must balance out. If they do not balance out, the health plan must explain the discrepancy in the financial footnotes of the applicable report. This instruction is necessary because it enables the Department to accurately assess the accuracy of the information submitted by the health plan.

- Page 18, Revenues: Instructions for Report #2: Income Tab
  - Line #1: Premiums- Commercial: The purpose of this instruction is to clarify for the health plan how to report premium revenue received from individuals and employers in the commercial market in the corresponding line item in Report #2. Premium is essentially a monthly service fee paid by the enrollees or on behalf of enrollees in return for receiving health care services from the health plan. This instruction is necessary for the health plan to accurately report premium revenue to assist the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.

- Line #2: Capitation: The purpose of this instruction is to clarify for the health plan how to report any payments it is receiving from another health plan for providing services to that health plan's enrollees in the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report capitation payments. Accurate reporting allows the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #3: Copayments, COB, Subrogation: The purpose of this instruction is to clarify for the health plan how to report any revenue recognized from copayments, coordination of benefits payments, or any subrogation payments the health plan has received for the corresponding line item in Report #2. This instruction also defines the term subrogation. The definition ensures the health plan understands the usage of the word. This instruction is necessary for the health plan to accurately report revenue. Accurate reporting allows the Department to fully understand and properly assess the health plan's financial viability.
- Line #4: Medicare Advantage (Title XVIII): The purpose of this instruction is to clarify for the health plan how to report any revenue received from the federal government for services provided to Medicare beneficiaries for the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report revenue. Accurate reporting enables the Department to fully understand and properly assess the health plan's financial viability.
- Line #5: Medi-Cal Managed Care (Title XIX-Medicaid): The purpose of this instruction is to clarify for the health plan how to report any revenue received from the state in providing services to Medi-Cal beneficiaries or other state sponsored health care coverage for the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report revenue. Accurate reporting enables the Department to fully understand and properly assess the health plan's financial viability.
- Line #6: Fee-for-Service: The purpose of this instruction is to clarify for the health plan how to report any revenue recognized from payments received on a fee-for-service basis (as opposed to a capitated payment in Line #2 above) for the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report revenue. Accurate reporting enables the Department to fully understand and properly assess the health plan's financial viability.
- Line #7: Point of Service: The purpose of this instruction is to clarify for the health plan how to report any revenue received from services provided to Point-of-Service enrollees for the corresponding line item in Report #2. Point-of-Service (POS) is a type of benefit structure that allows enrollees

to receive care both within the health plan's network and outside the health plan's network. The instruction is necessary because different types of enrollments may have different utilization trends of certain types of health care services. The health plan must know how to accurately report this line item. Accurate reporting enables the Department to understand the health plan's revenue stream from different types of enrollments to properly assess the health plan's financial viability.

- Line #8: Interest: The purpose of this instruction is to clarify for the health plan how to report any interest earned from all sources for the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report interest as revenue. Accurate reporting assists the Department in fully understanding the health plan's revenue stream and allows the Department to properly assess the health plan's financial viability.
- Line #9: Risk Pool: The purpose of this instruction is to clarify for the health plan how to accurately report revenue received from any risk-sharing contracts it may have with other health care entities for the corresponding line item in Report #2. The instruction is necessary because accurate reporting allows the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #10: Aggregate Write-Ins for Other Income and Revenues: The purpose of this instruction is to clarify for the health plan how to report and account for any other income and revenues not accounted for in the lines above using the write-ins for Report #2. This instruction is necessary because the health plan may need to report additional revenue to the Department and must know where to provide that information in its financial statement. Complete reporting information is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #11: Total Revenue: The purpose of this instruction is to explain the corresponding line item in Report #2 which adds up all of the revenues from line items 1 through 10 in Report #2. This instruction is necessary because it explains to the health plan how the revenue accounts are calculated.
- Page 19 Medical and Hospital Expenses Table: Medical and Hospital Expenses: Reporting Instructions for Staff Model Health Plans: The purpose of this table in the Instruction Manual is to clarify for the health plan how to report financial information applicable to staff models. The table is necessary because it describes what information is needed if the health plan is a staff model. Staff model health plan's own facilities that



provide health care services. This instruction is necessary to describe to the health plan how to accurately report staff model information to the Department. Accurate information allows the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.

- Line #12: Inpatient Services – Capitated: The purpose of this instruction is to clarify for the health plan how to report any capitation costs incurred for routine and ancillary services provided to enrollees who are receiving inpatient care in the corresponding line item in Report #2. This instruction is necessary for the health plan to understand how to accurately report capitated costs for enrollees confined to acute care hospitals. Accurate information allows the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #13: Inpatient Services – Per Diem/Managed Hospital Expenses: The purpose of this instruction is to clarify for the health plan how to report any costs incurred for routine and ancillary services to enrollees who are receiving inpatient care in the corresponding line item in Report #2. Inpatient per diem costs refers to costs that are incurred on a flat rate rather than a capitated fixed payment. This instruction is necessary for the health plan to accurately report expenses. Accurate reporting enables the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #14: Inpatient Services- Fee-for-Service/Case Rate: The purpose of this instruction is to clarify for the health plan how to report inpatient fee-for-service costs in the corresponding line item in Report #2. Inpatient fee-for-service costs refer to costs that are incurred on a fee-for-service basis rather than a capitated fixed payment. This instruction is necessary to assist the health plan in accurately reporting the health plan's expenses. There are also definitions included in this item that explain to the health plan the different services that can be included for the reporting of this item. This instruction is necessary for the health plan to accurately report inpatient expenses. Accurate reporting enables the Department to fully understand and properly assess the health plan's financial viability.
- Line #15: Primary Professional Services – Capitated: The purpose of this instruction is to clarify for the health plan how to report costs associated with primary care physicians, dentists, or other professionals for the delivery of medical services in the corresponding line item in Report #2. This instruction also includes instructions for both full service health plans and specialized health plans on how to report capitated costs. This instruction is necessary for the health plan to accurately report expenses. Accurate reporting enables the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.

- Line #16: Primary Professional Services – Non-Capitated: The purpose of this instruction is to clarify for the health plan how to report non-capitated primary professional services on the corresponding line item in Report #2. This instruction is necessary because it informs the health plan how to accurately report expenses that are related to other types of health care delivery models such as fee-for-service and point-of-service described above. Accurate reporting is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #17: Other Medical Professional Services – Capitated: The purpose of this instruction is to clarify for the health plan how to report other capitated services on the corresponding line item in Report #2. This instruction is necessary because it allows for the health plan to accurately report costs associated for other medical professional services that are capitated. Accurate reporting is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #18: Other Medical Professional Services – Non-Capitated: The purpose of this instruction is to clarify for the health plan how to report other non-capitated services on the corresponding line item in Report #2. This instruction is necessary because it allows for the health plan to accurately report costs associated for other medical professional services that are non-capitated. Accurate reporting enables the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #19: Non-Contracted Emergency Room and Out-of-Area Expense, not including Point-of-Service: The purpose of this instruction is to clarify for the health plan how to report expenses for non-contracted emergency room services and out of area expenses in the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report expenses. Accurate reporting enables the Department to fully understand and properly assess the health plan's financial viability.
- Line #20: Point-of-Service Out-of-Network Expense: The purpose of this instruction is to clarify for the health plan how to report and account for expenses incurred from claims received for those enrollees who have point-of-service coverage for out of network services in the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report expenses and for the Department. Accurate reporting enables the Department to fully understand and properly assess the health plan's financial viability.

- Line #21: Pharmacy Expense – Capitated: The purpose of this instruction is to clarify for the health plan to include and report pharmacy expenses that are capitated in the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report capitated pharmacy expenses. Accurate reporting enables the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #22: Pharmacy Expense – Fee – for – Service: The purpose of this instruction is to clarify for the health plan to include and report pharmacy expenses that are non-capitated in the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report non-capitated pharmacy expenses. Accurate reporting enables the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #23: Aggregate Write-Ins for Other Capitated Medical and Hospital Expenses: The purpose of this instruction is to clarify for the health plan how to report other capitated medical and hospital expenses not accounted for in the other line items on the corresponding line item in Report #2. This instruction is necessary to assist the health plan in reporting additional information related to this section. The Department must ensure the health plan is able to accurately report information. Accurate reporting enables the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #24: Aggregate Write-Ins for Other Non-Capitated Medical and Hospital Expenses: The purpose of this instruction is to clarify how the health plan should report and total other non-capitated medical and hospital expenses using the write-ins for Report #2. This instruction is necessary because the health plan may need additional room to report expenses in Report #2 and must know where to provide that information to the Department. The additional information is necessary to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #25: Total Medical and Hospital: The purpose of this instruction is to explain the corresponding line item in Report #2, which provides the total of the medical and hospital accounts from the lines 12 through 24 of Report #2. This instruction is necessary to inform the health plan of what calculation to use when providing the total medical and hospital costs to the Department. The instruction assists the health plan in accurate reporting. Accurate reporting allows the Department to fully understand the health plan's total medical and hospital expenses and properly assess the health plan's financial viability.

- Page 22, Administration: Report #2: Income Tab

The purpose of the instructions for the administration expense reporting section of Report #2 is to clarify for the health plan how to accurately report the overall management and operational costs incurred in providing health care services to enrollees. The instructions are necessary to assist the health plan in accurately reporting administration expenses. Accurate reporting enables the Department to understand the health plan's operational costs for services provided and to assess the health plan's overall financial viability and stability.

- Line #26: Compensation: The purpose of this instruction is to clarify for the health plan how to report its administrative costs relating to compensation of employees and personnel in the corresponding line item in Report #2. The instruction explains to the health plan what it is required to include and exclude in reporting its costs to the Department to ensure accurate reporting. Accurate reporting is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #27: Interest Expense: The purpose of this instruction is to clarify for the health plan how to report any interest incurred as a result of expenses related to the administration of the health plan in the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report interest expenses. Accurate reporting enables the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #28: Occupancy, Depreciation, and Amortization: The purpose of this instruction is to clarify for the health plan how to report any expenses for costs of using a facility such as lease costs and utilities costs in the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report these costs to the Department. Accurate reporting enables the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #29: Management Fees: The purpose of this instruction is to clarify for the health plan how to report any management fees it incurs in operating the health plan in the corresponding line item in Report #2. This instruction is necessary for the health plan to accurately report these costs. Accurate reporting enables the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #30: Marketing: The purpose of this instruction is to clarify for the health plan how to report any marketing costs associated with conducting its business in the corresponding line item in Report #2. This instruction is

necessary for the health plan to accurately report these costs. Accurate reporting enables the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.

- Line #31: Affiliate Administrative Services: The purpose of this instruction is to clarify for the health plan how to report any management fees for services provided by the health plan's affiliates that it incurs in operating the health plan on the corresponding line item in Report #2. This instruction differs from the instruction for Line #29 of Report #2 above because it asks for any costs paid to affiliates related to the health plan. This instruction is necessary for the health plan to accurately report administration expenses. Accurate reporting is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #32: Aggregate Write-Ins for Other Administration: The purpose of this instruction is to clarify for the health plan how and where to report any other costs associated with administrative expenses using the write-ins for Report #2. This instruction is necessary because the health plan may need additional room to report expenses in Report #2 and must know where to provide that information to the Department. Complete information enables the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #33: Total Administration: The purpose of this instruction is to explain the corresponding line item in Report #2, which totals up all reported costs for administrative services. This instruction is necessary to ensure the health plan understands the calculation for providing the total administrative accounts and accurately reports the information for the Department's review. Accurate information is necessary to enable the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #34: Total Expenses: The purpose of this instruction is to explain the corresponding line item in Report #2, which totals up all expenses for medical and hospital administration. This instruction is necessary to ensure the health plan understands the calculation for accurately providing total expenses. Accurate reporting is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #35: Income (Loss): The purpose of this instruction is to explain the corresponding line item in Report #2, which totals the health plan reported income losses. This instruction is necessary to ensure the health plan understands the calculation for Income Loss and accurately reports the amount. Accurate reporting is necessary for the Department to fully

understand the health plan's operating costs and properly assess the health plan's financial viability.

- Line #36: Unusual or Infrequently Occurring Item(s): The purpose of this instruction is to clarify for the health plan how to report any unusual or infrequently occurring income that is out of the ordinary on the corresponding line item in Report #2. There are also definitions in this item to assist the health plan in understanding what to report in this category. This instruction is necessary because unusual or infrequent costs need to be accounted for in the health plan's overall financial reporting. The instruction also ensures the health plan is able to provide the additional information to the Department. The additional information assists the Department in wholly evaluating the true financial solvency of the health plan.
- Line #37: Provision for Taxes: The purpose of this instruction is to clarify for the health plan how to report state and federal taxes on the corresponding line item in Report #2. This instruction is necessary because it allows the health plan to accurately report payment of taxes that must be accounted for in the health plan's overall financial reporting. Accurate reporting enables the Department to wholly evaluate the financial solvency of the health plan.
- Line #38: Net Income (Loss): The purpose of this instruction is to explain the corresponding line item in Report #2, which instructs the health plan on how to calculate net income using the information reported for lines 35, 36, and 37. This instruction is necessary because it will assist the health plan in calculating total net income for administrative costs. This line item assists the Department in fully understanding the health plan's operating costs to properly assess the health plan's financial viability.
- Line #39: Other Comprehensive Income (Loss) After Tax: The purpose of this instruction is to explain the corresponding line item in Report #2, which totals other income that should be reported after taxes. This instruction is necessary because it explains to the health plan where this information should come from and allows the health plan to accurately report the number. Accurate reporting enables the Department to review the comprehensive income total amount and evaluate the health plan's financial viability.
- Line #40: Total Comprehensive Income (Loss) After Tax: The purpose of this instruction is to explain the corresponding line item in Report #2, which totals the comprehensive income in Line #38 and Line #39. This instruction is necessary because it explains to the health plan where the calculation for this item originates from and allows the health plan to accurately report the number. Accurate reporting is necessary for the Department to understand the total net income and the total other

comprehensive income when assessing the financial viability of the health plan.

- Page 23-24, Net Worth: Report #2: Income Tab

- Line #41: Net Worth Beginning of Period: The purpose of this instruction is to explain to the health plan that it must report its overall net worth at the beginning of the period for which it is reporting in the corresponding line item in Report #2. This instruction is necessary to clarify for the health plan the time period in which it is reporting its net worth to the Department.
- Line #42: Audit Adjustments: The purpose of this instruction is to clarify for the health plan how to account for and report 4<sup>th</sup> quarter earnings adjustments in the Annual Report. This instruction is necessary to assist the health plan in properly and accurately filing out the reporting forms. With accurate information, the Department can fully evaluate any adjustments made to the financial statements of the health plan based on audits. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #43: Increase (Decrease) in Common Stock: The purpose of this instruction is to explain to the health plan it needs to report its increase or decrease in common stock in the corresponding line item in Report #2. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate how many shares have been issued during the reporting period and the value of those shares. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #44: Increase (Decrease) in Preferred Stock: The purpose of this instruction is to explain to the health plan it must report its increase or decrease in preferred stock in the corresponding line item in Report #2. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate how many shares have been issued during the reporting period and consider the value of those shares. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #45: Increase (Decrease) in Paid in Surplus: The purpose of this instruction is to clarify for the health plan where to report its increase or decrease for its Paid In Surplus amount paid by an investor for a company's shares that exceed the par value of the shares. This amount is to be reported in the corresponding line item in Report #2. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate

how many shares have been issued during the reporting period and consider the value of those shares. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.

- Line #46: Increase (Decrease) in Contributed Capital: The purpose of this instruction is to clarify for the health plan where to report any increase or decrease in contributed capital such as the cash and other assets that shareholders have given a company in exchange for stock, in the corresponding line item in Report #2. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #47: Increase (Decrease) in Retained Earnings: The purpose of this instruction is to clarify for the health plan how to report retained earnings in the corresponding line item in Report #2. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #48: Total Comprehensive Net Income (Loss): The purpose of this instruction is to explain the corresponding line item in Report #2, which provides the total for the comprehensive net income reported by the health plan. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #49: Dividends to Stockholders: The purpose of this instruction is to allow the health plan to report dividends made to stockholders on the corresponding line item in Report #2. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #50: Aggregate Write-Ins for Changes in Retained Earnings: The purpose of this instruction is to explain the corresponding line item in Report #2, which totals additional changes in retained earnings reported by the health plan in write-ins for Report #2 that may not be accounted for



in the lines above. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.

- Line #51: Aggregate Write-Ins for Changes in Other Net Worth Items: The purpose of this instruction is to explain the corresponding line item in Report #2, which totals additional changes in other net worth items reported by the health plan in write-ins for Report #2 that may not be accounted for in the lines above. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and take into account the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #52: Net Worth End of Period: The purpose of this instruction is to explain the corresponding line item in Report #2, which totals Lines 41 through 51 of Report #2 and indicates the health plan's net worth for the reporting period. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Report #2 Write-Ins: The purpose of this instruction is to inform the health plan that it should report any other additional, relevant information it needs to report for the Department to evaluate its net worth. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Pages 25- 26, Instructions for Report #3 - Statement of Cash Flows Tab

The purpose of the instructions for Report #3 are to assist the health plan in reporting financial information regarding the amount of net cash used during the reporting period for operating, investing, and financing activities. This instruction is necessary to assist the health plan in properly and accurately filing out the applicable forms. With accurate information, the Department can fully evaluate the net effect of cash flows related to the health plan's cash and cash

equivalents. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.

The purpose of the instructions for Report #3 is to clarify for the health plan that it will use amounts previously entered in Report #1, Parts A and B for Lines 1 through 10, 12 through 17, 19 through 24, and 31 through 37 of Report #3. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and assess the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.

- Line #11: Net Cash Provided by Operating Activities: The purpose of the Line #11 instruction is to explain the corresponding line item in Report #3, which is the total net cash provided from operating activities reported by the health plan in lines 1 through 10 of Report #3. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #18: Net Cash Provided by Investing Activities: The purpose of the Line #18 instruction is to explain the corresponding line item in Report #3, which provides the total net cash provided by investing activities reported by the health plan and is the total from lines 12 through 17 of Report #3. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #25: Aggregate Write-Ins for Cash Provided by Financing Activities: The purpose of the Line #25 instruction is to explain the corresponding line item in Report #3, which provides the total of all write-ins reported by the health plan for cash provided by financing activities in the write-ins for Report #3. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #26: Net Cash Provided by Financing Activities: The purpose of the Line #26 instruction is to explain the corresponding item in Report #3, which provides the total of net cash provided by financing activities

reported by the plan in lines 19 through 25 of Report #3. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.

- Line #27: Net Increase (Decrease) in Cash, Cash Equivalents, and Restricted Cash: The purpose of the Line #27 instruction is to explain the corresponding item in Report #3, which is the total of lines 11, 18, and 26 and reflects the net increase or decrease in cash and cash equivalents reported by the health plan. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #28: Cash, Cash Equivalents and Restricted Cash at the Beginning of the Year: The purpose of the Line #28 instruction is to clarify how the health plan should report the beginning of the year balance of cash and cash equivalents in the corresponding line item in Report #3. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #29: Cash, Cash Equivalents and Restricted Cash at the End of the Year: The purpose of the Line #29 instruction is to explain the corresponding line item in Report #3, which totals Lines 27 and 28 to reflect total cash and cash equivalents at the end of the year. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #30: Net Income: The purpose of the Line #30 instruction is to explain the corresponding line item in Report #3, linking Line #38 from Report #2 to reflect net income of the health plan. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.

- Line #31-Line #38: Depreciation and Amortization through Aggregate Write-Ins for Adjustments to Net Income: The purpose of the instructions for Lines #31 through #38 is to clarify for health plan reporting each corresponding line in Report #3, used to calculate adjustments to net income for cash flow provided by operating activities of the health plan. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #39: Total Adjustments: The purpose of the Line #39 instruction is to clarify for the health plan the corresponding line item in Report #3 reflecting total adjustments to net income for operating activities reported by the health plan by totaling Lines 31 through 38. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With accurate information, the Department can fully evaluate the health plan's worth during the reporting period and take into account the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Line #40: Net Cash Provided by Operating Activities: The purpose of the Line #40 instruction is to explain the corresponding line item in Report #3, which provides the total net cash provided by operating activities and is a summation of Line #30 plus Line #39. This instruction is necessary to assist the health plan in properly and accurately filing out the forms. With complete and accurate information, the Department can fully evaluate the health plan's worth during the reporting period and consider the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Report #3 Write-Ins: The purpose of this instruction is to clarify where the health plan should report any additional information to complete Report #3 using the corresponding write-ins section of Report #3. Write-ins allow for the health plan to include any other pertinent information related to the information above for the Department's consideration. This instruction is necessary to allow the health plan to report to the Department any additional information necessary related to the health plans cash flow. With complete and accurate information, the Department can fully evaluate the health plan's worth during the reporting period and take into account the value of all capital. Accurate reporting is necessary for the Department to fully assess the health plan's financial viability.
- Pages 27-31, Instructions for Report TAB #4 - Enrollment and Utilization Table

The purpose of the instructions for Report #4, enrollment and utilization table, is to clarify for the health plan how to report enrollment and utilization by product type in the corresponding Report #4. The Instructions and Definitions column in the instructions, define the different product types or market segments enrollees are registered in. The definitions for products are commonly used terms in the health care industry and are understood by those in health care. The instructions are necessary to assist the health plan in reporting enrollment composition for each column within the reporting form. The items numbered 1 through 15 in the column's section of the table appear as columns in the corresponding spreadsheet report form. It is necessary for the Department to have an accurate understanding of the enrollment of the health plan including the utilization of services of that enrollment population when assessing financial risk and viability of the health plan.

- Column: Item 1: Source of Enrollment: The purpose of the instructions for this item is to provide definitions for the different types of health care products offered by the health plan. These enrollment categories, by product type, are necessary to properly evaluate the enrollment and utilization that impacts the financial solvency of the health plan. Because different types of enrollment, commercial versus state sponsored (for example), may have different utilization, revenue, and medical cost trends for certain types of health care services, the Department must understand the full scope of a health plan's enrollment when evaluating overall health plan financial status. This instruction is necessary for accurate health plan reporting of enrollment by product for the Department to fully understand the financial operations and assess the financial viability of the health plan.
- Column: Item 2: Total Enrollees at End of Previous Period: The purpose of the item is to clarify for the health plan how to count and report the number of enrollees at the end of the applicable reporting period. This instruction is necessary to assist the health plan in providing the total number of enrollees for the reporting period. Total enrollment numbers assist the Department in evaluating enrollment trends in the various products over a time period. This allows the Department to wholly understand the health plan's financial status.
- Column: Item 3: Additions During the Period: The purpose of the item is to clarify for the health plan how to report enrollment additions during the applicable reporting period. This instruction is necessary to enable the health plan to report its additional enrollment during the reporting period. This information assists the Department in fully evaluating enrollment trends in the various products over a time period and allows the Department to wholly understand the health plan's financial status.

- Column: Item 4: Terminations During the Period: The purpose of the item is to clarify for the health plan how to report the number of enrollment terminations during the applicable reporting period within Report #4. This instruction is necessary to allow the health plan to report its enrollment terminations. The instruction assists the Department in evaluating enrollment trends in the various products over a time period and allows the Department to wholly understand the health plan's financial status.
- Column: Item 5: Total Enrollees at End of Period: The purpose of the item is to provide the calculation for the health plan to determine total enrollment for the applicable reporting period. This instruction is necessary to ensure the health plan understands the methodology in calculating total enrollees at the end of the reporting period and accurately reports the number of total enrollees. Accurate reporting ensures the Department can fully evaluate the health plan's financial status.
- Column: Item 6: On Exchange (Also included in Column 5): The purpose of the item is to clarify for the health plan how to report the number of enrollees who enroll in the health plan through the California's Health Benefit Exchange marketplace. This instruction is necessary to ensure the health plan is accurately reporting its enrollment in the applicable category. Accurate reporting ensures the Department can fully evaluate the health plan's financial status.
- Column: Item 7: Off Exchange (Also included in Column 5): The purpose of the item is to clarify for the health plan how to report the number of enrollees that are not enrolled through the California Health Benefit Exchange in the corresponding column in Report #4. This instruction is necessary to ensure the health plan is accurately reporting its enrollment in the applicable category. Accurate reporting ensures the Department can fully evaluate the health plan's financial status.
- Column: Item 8: Grandfathered Enrollees (Also included in Column 5): The purpose of the item is to clarify for the health plan how to report information for enrollment for grandfathered health care products in the corresponding column of Report #4. This instruction is necessary to ensure the health plan can accurately report its enrollment to the Department. Accurate reporting ensures the Department can fully evaluate the health plan's financial status.
- Column: Item 9: Cumulative Enrollee Months for Period: The purpose of the item is to clarify for the health plan how to determine and report cumulative enrollment in the corresponding column in Report #4 for the applicable reporting period. This instruction is necessary to ensure the health plan is accurately reporting enrollment to the Department. Accurate

reporting ensures the Department can fully evaluate the health plan's financial status.

- Column: Item 10: Total Member Ambulatory Encounters for Period-Physicians: The purpose of the item is to clarify for the health plan how to report enrollee ambulatory encounters for services in the corresponding column in Report #4. The instruction for column 10 clarifies and provides definitions for encounters and ambulatory services for this reporting item. This instruction is necessary to ensure the health plan is accurately reporting the enrollment and utilization that impacts the financial solvency of the health plan. Accurate reporting ensures the Department understands the full scope of the health plan's utilization when evaluating its financial status.
- Column: Item 11: Total Member Ambulatory Encounters for Period – Non-Physicians: The purpose of the item is to clarify for the health plan how to report the total member ambulatory encounters by non-physicians in the corresponding column in Report #4. This instruction is necessary to ensure the health plan is accurately reporting these encounters. Accurate reporting ensures the Department understands the full scope of the health plan's utilization when evaluating its financial status.
- Column: Item 12: Total Number Ambulatory Encounters for Period: The purpose of the item is to explain the corresponding column in Report #4, which provides the total of encounters from Column 10 and Column 11. This instruction is necessary to assist the health plan in accurate reporting. Accurate reporting enables the Department to understand the full scope of the health plan's utilization when evaluating its financial status.
- Column: Item 13: Total Patient Days Incurred: The purpose of the item is to clarify for the health plan how to report the total number of patient days in a hospital that the health plan will be financially responsible for in the applicable reporting period. This instruction is necessary to assist the health plan in calculating a patient day for reporting. Accurate reporting ensures the Department can fully evaluate the health plan's financial status.
- Column: Item 14: Annualized Hospital Days/1000: The purpose of the item is to explain the formula the plan must use when calculating hospital days when completing the corresponding column in Report #4. This instruction is necessary to assist the health plan in reporting financial information. Accurate reporting ensures the Department can fully evaluate the health plan's financial status.

- Column: Item 15: Average Length of Stay: The purpose of the item is to provide the health plan with a calculation method for determining the average length of a hospital stay to complete the corresponding column in Report #4. This instruction is necessary to ensure accurate reporting to the Department. Accurate reporting ensures the Department can fully evaluate the health plan's financial status.
- Page 32: Instructions for Report Tab #5 - Enrollment by Product and by County

The purpose of the instructions for Report #5, enrollment by product and by county, is to clarify how a health plan should complete the corresponding table in Report #5. The instruction and reporting enrollment by county are necessary because the health plan will be able to provide an accurate description of enrollment to the Department. In turn, the Department will be able to assess the health plan's financial liability and viability accurately and appropriately.

- Column: Item 1: County: The purpose of the instruction for this column is to clarify for the health plan the types of enrollments to report in the corresponding column in Report #5. This instruction is necessary to clarify how the health plan should report enrollment by product and by county. The instruction ensures the health plan is accurately reporting its enrollment to the Department. Accurate reporting ensures the Department can fully assess the health plan's financial viability.
- Column Items 2 through 8: Individual On Exchange through Medicare Advantage: The purpose of the instructions for columns 2 through column 8 are to describe the various types of health care products that need to be reported in the corresponding columns in Report #5. These instructions provide categories for the different variations of health benefits offered by any given health plan. This instruction is necessary to ensure the health plan can accurately report enrollment information to the Department, broken down by product/benefit type and county. This information is necessary to properly evaluate the enrollment and utilization that impacts the financial solvency of the health plan. Because different types of enrollments, commercial versus state sponsored (for example), may have different utilization trends, the information assists the Department in understanding the full scope of the health plan's enrollment when evaluating its financial status.
- Column: Item 9: Total: The purpose of the instruction is to provide the health plan with the methodology for calculating the total enrollment reported by the health plan from columns 2 through 8 in Report #5. This instruction is necessary because the health plan must be able to accurately report enrollment. Accurate reporting ensures the Department can adequately assess the health plan's financial liability and viability.



- Page 33: Instructions for Report #6, Part A: Enrollment Contracted to Other Licensed Health Plans

The purpose of the instructions for Report #6, Part A is to clarify and explain how the health plan should complete the corresponding columns in Report #6, Part A. The instructions identify each column with explanations and definitions to assist the health plan in completing Report #6, Part A, which the health plan uses to report enrollment assigned to another health plan licensed by the Department. The instructions for Report #6, Part A are necessary because health plans often delegate certain functions for certain enrollees to other health plans. This report captures the different types of enrollments based on product type that the health plan delegates to another health plan regulated by the Department, and the instructions clarify how the health plan is to report delegated entity enrollment to the Department. This is necessary because the Department must understand the full scope of the health plan's enrollment when evaluating its financial status.

- Column: Items 1 and 2: Health Plan ID and Health Plan: The purpose of the instructions for columns 1 and 2 of Report #6, Part A are for the health plan to identify what other health plan it is delegating the care of enrollees to. These instructions are necessary so the health plan can accurately complete Report #6 and identify the delegated entity (other health plan) for the Department.
- Column: Items 3 through 5: Commercial, Medi-Cal Managed Care, and Medi-Care Advantage: The purpose of the instructions for columns 3 through 5 describe how enrollment is to be reported depending upon what type of product the enrollees are assigned to: Commercial, Medi-Cal Managed Care, or Medicare Advantage. These instructions are necessary to clarify how the health plan should report enrollment from delegated entities according to product type, and to enable the Department to understand the total enrollment the health plan delegates.
- Column: Item 6: Total: The purpose of the instruction for column 6 is to explain the corresponding column in Report #6, Part A, which totals up the numbers of Columns 3 through 5. This instruction is necessary to inform the health plan how total enrollment to delegated entities is calculated and to assist the health plan in providing accurate information to the Department. Accurate reporting ensures the Department can adequately and accurately assess the health plan's financial viability.

- Page 34: Instructions for Report #6, Part B: Enrollment Delegated to Health Plans, Medical Groups, Capitated Providers or Risk Bearing Organizations

The purpose of the instructions for Report #6, Part B is to assist the health plan in completing the corresponding columns in Report #6, Part B. The instructions identify each item within the column and provide explanations and definitions for

health plan use in completing Report #6, Part B. Report #6, Part B captures enrollment that is delegated to other entities that are not necessarily licensed by the Department but are responsible for providing care to the health plan's enrollees. These entities are medical groups, capitated providers, risk bearing organizations or other entities responsible for providing care to enrollees on behalf of the reporting health plan. These instructions are necessary to assist the health plan in completing the corresponding report accurately. Accurate reporting is necessary for the Department to fully evaluate the health plan's financial status.

- Column: Items 1 and 2: Entity ID and Entity Name: The instructions for columns 1 and 2 of Report #6, Part B inform the health plan how it should report identifying information for the delegated entity. This instruction is necessary to ensure the health plan has an option to report additional delegated enrollment. The Department must have a complete picture of the health plan's enrollment to ensure it is adequately assessing health plan compliance.
- Column: Items 3 through 5: Commercial, Medi-Cal Managed Care, and Medicare Advantage: The instructions for columns 3 through 5 identify and describe how enrollment that has been delegated to the other entities should be reported in Report #6, Part B. The enrollment is categorized by type of health care products the enrollees are a part of: Commercial, Medi-Cal Managed Care, or Medicare Advantage. These instructions are necessary to assist the health plan in accurately reporting enrollment from delegated entities according to product type. Adequate reporting is necessary to enable the Department to adequately assess health plan compliance.
- Column: Item 6: Total: The purpose of the instruction for column 6 is to explain the corresponding column in Report #, Part B, which calculates the total sum of Columns 3-5. This instruction is necessary to inform the health of the methodology for calculating this report tab. Adequate instruction ensures the health plan can accurately report its enrollment to the Department. Adequate reporting enables the Department to assess health plan compliance.
- Page 35: Instructions for Report Tab #7: Multiple Employer Welfare Arrangement (MEWA) Enrollment Report

The purpose of the instructions table for Report #7 is to clarify for the health plan how to report MEWA enrollment in the corresponding Report #7. MEWA is another type of coverage a health plan can offer where the employer shares the risk of claims incurred by enrollees belonging to the employer group. A table consisting of two columns is provided to assist the health plan in filing out Report Tab #7. The first column identifies the columns within the Report #7 the health plan is to complete. The second column provides instructions and definitions that

provide additional explanatory information to assist the health plan in filing out Report #7. Instructions are necessary to assist the health plan in accurately reporting MEWA enrollment in Report #7. Accurate reporting ensures the Department is able to adequately assess health plan financial viability. The purpose and specific necessity for each item instruction is described below.

- Column: Item #1: Name of MEWA: The purpose of the instruction for this column is to clarify how the health plan should identify and report the MEWA name and how many health plan enrollees are enrolled in the MEWA. This instruction is necessary to ensure accurate health plan reporting of MEWA and MEWA enrollment. Accurate reporting ensures the Department can adequately assess health plan financial viability.
- Column: Item #2: Market Segment: The purpose of the instruction for this column is to clarify how the health plan should complete the corresponding column in Report #7 by entering the market segment of the MEWA. This instruction is necessary to ensure adequate MEWA enrollment by the health plan. Accurate reporting ensures the Department can adequately assess health plan financial viability.
- Column: Item # 3: Product Type: The purpose of the instruction for this column is to clarify how the health plan should complete the corresponding column in Report #7 by entering the product type of the MEWA. This instruction is necessary because MEWA enrollment is categorized by market type and product type as a secondary category, and the health plan must understand how to Accurately complete Report #7. Accurate reporting ensures the Department is able to adequately assess health plan financial viability.
- Column: Item # 4: Fully Insured, Partially Self-Funded or Self-Funded: The purpose of the instruction for this column is to clarify how the health plan should complete the corresponding column in Report #7 to report whether the MEWA is fully-insured, partially self-funded or self-funded. This instruction is necessary to assist the health plan in accurately reporting what type of risk sharing is involved in the MEWA product. Accurate reporting is necessary to enable the Department to assess the overall financial viability of the health plan.
- Column: Items #5-8: Total Enrollees at End of Previous Period, Additions During Period, Terminations During Period, and Total Enrollees at End of Period: The purpose of the instructions for these columns is to explain how the health plan is to report MEWA enrollment at the end of the prior reporting period, enrollment additions and terminations, and to calculate MEWA total enrollment for the current reporting period. These instructions are necessary to ensure the health plan accurately reports MEWA enrollment to the Department. Accurate reporting allows for comparison

of enrollment from the previous reporting period and is necessary for the Department to assess changes in enrollment to evaluate the overall financial viability of the health plan.

- Page 36-49: Instructions for Supporting Schedules
- Page 36, Instructions for Schedule A: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report and the Quarterly Report. This instruction is necessary because it clarifies how the information required by Schedule A, which provides a snapshot of all cash and cash equivalents the health plan is reporting for the reporting period, is to be reported by the health plan. This information will enable the Department to have a clear understanding of the health plans cash on hand and how it impacts the health plan's overall financial viability.
- Page 36, Instructions for Schedule B: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report and report investments to the Department. This instruction is necessary because it allows the health plan to accurately report both short-term investments and long-term investments in the corresponding schedule. Accurate reporting ensures the Department has a clear understanding of a health plan's overall financial viability.
- Page 36, Instructions for Schedule C: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report and the Quarterly Report for premiums receivable. The instruction is necessary because the health plan must know how to accurately complete Schedule C. Accurate reporting for this Schedule ensures the Department understands the nature of the debtors that owe amounts greater than 5% of the gross premiums receivable to the health plan. Accurate reporting enables the Department to have a clear understanding of where monies are expected, when they are overdue, and how those amounts impact the financial viability of the health plan.
- Page 36, Instructions for Schedule D: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report and the Quarterly Report to indicate health care receivables and amounts due from parents, subsidiaries, and affiliates of the health plan. This instruction is necessary for the health plan to understand how to accurately complete Schedule D. Accurate reporting ensures the Department understands the financial relationship between the health plan and its parent, subsidiary, and affiliates. This information helps the Department understand when certain monies are due and the subsequent impact on the financial status of the health plan.

- Page 37, Instructions for Schedule E: The purpose of this instruction is to clarify how the health plan should accurately complete the corresponding schedule for the Annual Report and report net property and equipment to the Department consistent with Report #1, Part A Lines 19 through 25. The instruction is necessary for the health plan to understand how to complete Schedule E. Accurate reporting enables the Department to understand the property and equipment items that contribute to the health plan's overall financial stability.
- Page 37, Instructions for Schedule F: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report and the Quarterly Report to report trade accounts payable consistent with Report #1, Part B. This instruction is necessary because the health plan must understand how to accurately complete Schedule F. Accurate reporting enables the Department in understanding any account balances due to creditors that are greater than 5 percent of the total trade accounts payable. Amounts due to creditors can render a health plan financially insolvent and therefore, the Department must take into account any amounts owed in order to assess the health plan's overall financial viability.
- Page 37, Instructions for Schedule G: The purpose of this instruction is to clarify how the health plan should accurately complete the corresponding schedule for the Annual Report and the Quarterly Report when providing the health plan's unpaid claims analysis and inventory of claims to be processed consistent with Report #1, Part B. This instruction is necessary because non-payment of claims is often an early indicator of financial difficulty with a health plan. Therefore, the Department must have an accurate and detailed listing of claims paid, and claims unpaid, to properly evaluate the health plan's financial responsibilities under claims payment laws under the Knox-Keene Act as well as the overall financial viability of the health plan in maintaining its contractual obligations with providers. This instruction also contains a table with detailed instructions for how the health plan is required to report the claim information to the Department, which is necessary for the health plan to accurately complete Schedule G. This instruction also includes an example for the health plan's reference to ensure it files the information appropriately and to ensure consistency of reporting across health plans.
- Page 38, Instructions for Schedule H: The purpose of this instruction is to clarify how the health plan should accurately complete the corresponding schedule for the Annual Report and the Quarterly Report to report aging of claims consistent with Report #1, Part B. This instruction is necessary because non-payment of claims is often an early indicator of financial difficulty with a health plan. Therefore, the Department must have a detailed listing of unpaid claims, and how aged the claims are, to properly evaluate the health plan's financial responsibilities under claims payment laws under the Knox-Keene Act as well as the overall financial viability of the health plan in maintaining its contractual obligations with providers. This instruction also contains a table with detailed

instructions for how the health plan is required to report the claim information to the Department. An example is included for the health plan's reference, which is necessary to ensure the health plan files the information appropriately and to ensure consistency of reporting across health plans.

- Page 41, Instructions for Schedule I: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report and the Quarterly Report to provide analysis of total medical claims liability against actual claims paid by the health plan, consistent with Report #1, Part B. This instruction is necessary because the health plan must know how to complete Schedule I, and the Department needs to understand the health plan's lag schedules regarding claims payments and to verify accruals for total claims liability for the health plan. This information is necessary to assist the Department in determining the health plan's total financial viability in its operations. This instruction also contains a table with detailed information for how the health plan is required to report the claim information to the Department, and also includes an example for the health plan's reference to ensure the health plan files the information appropriately and to ensure consistency of reporting across health plans.
- Page 42, Instructions for Schedule J: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report to report loans and notes payable consistent with Report #1, Part B. This instruction is necessary because the health plan must know how to complete Schedule J, and because the Department needs to understand payable amounts due to by the health plan. This instruction is necessary to assist the Department in determining the health plan's total financial viability in its operations.
- Page 42, Instructions for Schedule K: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report to provide a summary of the health plan's affiliate transactions consistent with Report #1 and Report #2. This instruction is necessary because the health plan must know how to complete Schedule K, and the Department needs to understand what financial transactions have occurred between the health plan and other affiliates in order to assess the financial viability of the health plan. This instruction is necessary to assist the Department in determining the health plan's total financial viability in its operations. This instruction also contains a table with detailed instructions for how the health plan is required to report the claim information to the Department. The column section provides the various financial items the health plan must report, and the Instructions column further explains what the health plan is required to include and exclude in its calculations. This instruction is necessary to assist the health plan in completing Schedule K, and for the Department to assess the health plan's total financial viability in its operations.

- Page 44, Instructions for Schedule L: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report to provide an analysis of revenue and expenses by line of business consistent with Report #1, Part B and Report #2. This instruction is necessary because the health plan must understand how to complete Schedule L and is intended to provide detailed information regarding the health plan's revenues and expenses from Report #1 and Report #2 above, including medical liabilities broken down by line of business categories. Line of business is a term of art in the health care regulation industry that refers to the type of health coverage that is being sold. Commercial coverage is sold as individual coverage, or group coverage offered through an employer and is referred to as Large Group Coverage, Small Group Coverage, and Individual Coverage. Point-of-Service is also a type of coverage that is sold in the marketplace that allows for in-network and out-of-network coverage. There is also government sponsored coverage that is either offered through Medi-Cal, the state's Medicaid program, or through Medicare, the federal program. This instruction also provides a table with information on specialized care related to dental coverage and vision coverage. In addition, this instruction clarifies how the health plan should report information related to any liabilities resulting out of plan-to-plan contracts and administrative service agreements or any other agreements the health plan is engaged in. This instruction is necessary to ensure that all lines of business can be reported by the health plan, and also for the Department to fully evaluate the financial viability of the health plan.
- Pages 46-47, Instructions for Schedule M Annual Reporting Form: The purpose of this instruction is to clarify how the health plan should complete the corresponding schedule for the Annual Report to report pass-through items applicable to Medi-Cal managed care health plans and consistent with Report #1, Parts A and B and Report #2. This instruction clarifies how the health plan is to report any pass-through items for the Medi-Cal Managed Care product line in the corresponding Schedule M of the Annual Report. These are amounts that are not realized by the health plan but need to be accounted for a complete and accurate reporting for this state sponsored product line. Here, the health plan will report any pass-through items as described in the Instruction Column Pass-Through Type. Essentially, the health plan is reconciling any pass-through amounts from Report#1A above and Report #2 above as instructed in the Line Reported Column. The health plan is also instructed on reporting the amount in dollars. This instruction is necessary for the health plan to understand how to report applicable pass-through items, and for the Department to evaluate the financial viability of the health plan and allow the health plan to account for amounts it is not realizing.
- Page 48, Instructions for Schedule M Quarterly Reporting Form: The purpose of this instruction is to clarify how the health plan should accurately complete the corresponding schedule for the Quarterly Report to report pass-through items applicable to Medi-Cal managed care health plans and consistent with Report #1,

Parts A and B and Report #2. This instruction clarifies how the health plan is to report any pass-through Items for the Medi-Cal Managed Care product line in the corresponding Schedule M of the Quarterly Report. Pass-through items represent amounts that are not realized by the health plan but need to be accounted for a complete and accurate reporting for this state sponsored product line. Here, the health plan will report any pass-through items as described in the Instruction Column Pass Through-Type. Essentially, the health plan is reconciling any pass-through amounts from Report#1A above and Report #2 above as instructed in the Line Reported Column. The health plan is also instructed on reporting the amount in dollars. This instruction is necessary to ensure accurate health plan reporting of applicable pass-through items in the Quarterly Report. Accurate information assists the Department in adequately assessing the overall financial status of the health plan.

- Page 49: Instructions for Notes to Financial Statements

The purpose of this instruction is to clarify how the health plan is to accurately complete the corresponding notes tab in the Annual Report, Quarterly Report, and Monthly Report. The instruction includes guidance to assist the health plan in providing a detailed narrative description and assumptions related to the reporting requirements above, in accordance with generally accepted accounting principles. This instruction is necessary to explain how the health plan should provide any additional information if it would help provide clarity to the Department.

- Page 49: Instructions for General Interrogatories

The purpose of the instructions for general interrogatories are to direct the plan to complete all interrogatories appearing in the Annual Report by submitted the health plan's answers to each specific financial interrogatory (1-47) appearing in the Annual Report. This instruction is necessary for the health plan to assist the health plan in understanding how the interrogatories must be answered as a part of the health plan's Annual Report filed with the Department. Accurate information assists the Department in fully evaluating the financial viability of the health plan.

- Pages 50-53: Instructions for Supplemental Information Tabs including TNE (1) and TNE (2) and POS TNE (1) and POS TNE (2)

The purpose of the instructions for the supplemental information and tangible net equity (TNE) calculation tabs are to clarify how the health plan is to accurately complete the corresponding items in the Annual Report, Quarterly Report, and Monthly Report. The instructions are necessary for the Department to properly evaluate the information in the financial report submitted by the health plan to the Department, and to provide instructions on how to complete TNE information in the corresponding TNE (1), TNE (2), POS TNE (1), and POS TNE (2) sections of the Annual Report, Quarterly Report, and Monthly Report.



- Item A: The purpose of the instruction for Item A is to clarify how the health plan is to accurately complete the corresponding item in the Annual Report, Quarterly Report, and Monthly Report. The instruction clarifies the health plan must describe its methodology for calculating both incurred claims and unreported claims. This instruction is necessary to ensure the health plan in reporting information accurately. Accurate information ensures the Department can fully evaluate the financial viability of the health plan.
- Item B: The purpose of the instruction for Item B is to clarify how the health plan is to accurately complete the corresponding item in the Annual Report, Quarterly Report, and Monthly Report. The instruction clarifies how the health plan must report to the Department any accountants and notes receivable from health plan officers, directors, owners, or affiliates. This instruction is necessary for the Department to accurately monitor and regulate the financial viability of the health plan.
- Item C: The purpose of the instruction for Item C is to clarify how the health plan is to accurately complete the corresponding item in the Annual Report, Quarterly Report, and Monthly Report. The instruction clarifies how the health plan must report donated materials or services. This instruction is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.
- Item D: The purpose of the instruction for Item D is to clarify how the health plan is to accurately complete the corresponding item in the Annual Report, Quarterly Report, and Monthly Report. The instruction clarifies how the health plan is to report forgiven debt or obligations. This instruction is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.

Rule 1300.76 of the CCR implements, interprets, and makes specific Health and Safety Code section 1376, which requires health plans to comply with Department rules regarding minimum capital or net worth, and limitations on indebtedness, for the purpose of protecting health plan enrollees by ensuring a health plan's financial stability.

Pursuant to Rule 1300.76, subdivisions (a) and (b), health plans must maintain a certain minimum financial reserve known as TNE. Point-of-Service health plan contracts have specific TNE requirements described in Health and Safety Code section 1374.64. Therefore, the Department must evaluate TNE for all health plans as part of its yearly review of health plan financial stability and it must review Point-of-Service contracts specifically to ensure compliance with the requirements for those contracts as described in 1374.64.

- Item E: The purpose of the instruction for Item E is to explain and clarify the Calculation of TNE and Required TNE information in the corresponding item in the Annual Report, Quarterly Report, and Monthly Report. The instruction is necessary to instruct the health plan on how it is to report its subordinated debt with interest and its unsecured affiliate receivables. The instruction also refers the health plan back to Report#1 as a reference for applicable line items. This instruction is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.
- Item F: The purpose of the instruction for Item F is to explain and clarify the Calculation of Percentage of Administrative Costs to Revenue Obtained from Subscribers and Enrollees in the corresponding item in the Annual Report, Quarterly Report, and Monthly Report. The instruction is necessary to assist the health plan in calculating the year-to-date percentage. This instruction is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.
- Item G: The purpose of the instruction for Item G is to clarify how the health plan is to complete the corresponding item Calculation of Percentage of Health Care Expenses for Non-Contracting Providers in the Annual Report, Quarterly Report, and Monthly Report. The instruction is necessary to clarify for the health plan how to accurately report its payments to providers that it does not contract with. Health and Safety Code section 1377 contains specific fiscal requirements related to health plans that reimburse non-contracting health care providers for services provided to the health plan's enrollees. This instruction assists health plans in reporting the required information in the Item G of TNE (1) of each reporting form. This instruction is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.
- Item H: The purpose of the instruction for Item H is to clarify how the health plan is to complete the corresponding item Calculation of Percentage of Premium Revenue Earned from POS Contracts in the Annual Report, Quarterly Report, and Monthly Report. The instruction is necessary because it clarifies how the health is to report how it is complying with TNE requirements for POS contracts and provides the calculation for such information. This instruction is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.
- Item I: The purpose of the instruction for Item I is to clarify how the health plan is to complete the corresponding item Calculation of Percentage of Total Health Care Expenditures incurred for out-of-network services in the Annual Report, Quarterly Report, and Monthly Report. The instruction is

necessary because it clarifies how the health plan is to report its expenditures for out-of-network care costs it incurred for those enrollees who received care from out-of-network hospitals or providers. This instruction is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.

- Item J: The purpose of the instruction for Item J is to clarify how the health plan is to complete the corresponding item Calculation for the POS Deposit Requirement in the Annual Report, Quarterly Report, and Monthly Report. The instruction is necessary because the calculation indicates to the health plan what items it is to calculate in order for the Department to determine whether the health plan complies with the required provision of Section 1374.68.

[End of Instruction Manual.]

#### **IV. SPECIFIC PURPOSE AND NECESSITY OF THE ANNUAL DMHC FINANCIAL REPORTING FORM, THE QUARTERLY DMHC FINANCIAL REPORTING FORM, AND THE MONTHLY DMHC FINANCIAL REPORTING FORM**

##### **Overview: Annual DMHC Financial Reporting Form, Quarterly DMHC Financial Reporting Form, Monthly DMHC Financial Reporting Form**

###### **Annual DMHC Financial Reporting Form**

Rule 1300.84.1 incorporates by reference the Annual DMHC Financial Reporting Form (Annual Report) for health plan use. The purpose of the Annual Report is for the health plan to demonstrate compliance with Health and Safety Code section 1384. Incorporation by reference of the Annual Report is necessary to ensure consistency in the financial information reported to the Department by health plans. The Annual Report will be made available for health plans and the general public, including enrollees, on the Department's website, located at: [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

###### **Quarterly DMHC Financial Reporting Form**

Rule 1300.84.2 incorporates by reference the Quarterly DMHC Financial Reporting Form (Quarterly Report) for health plan use. The purpose of the Quarterly Report is for the health plan to demonstrate compliance with the requirements of Rule 1300.84.2. The Quarterly Report consists of a subset of the items required by the Annual Report. Incorporation by reference of the Quarterly Report is necessary to ensure consistency in the financial information reported to the Department by health plans on a quarterly basis. The Quarterly Report will be made available for health plans and the general public, including enrollees, on the Department's website, located at [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

###### **Monthly DMHC Financial Reporting Form**

Rule 1300.84.3 incorporates by reference the Monthly DMHC Financial Reporting Form (Monthly Report) for health plan use. The purpose of the Monthly Report is for the health to show compliance with Rule 1300.84.3. The Monthly Report consists of a subset of the items required by the Annual Report. Incorporation by reference of the Monthly Report is necessary to ensure consistency in the financial information reported to the Department by health plans. The Monthly Report will be made available for health plans and the general public, including enrollees, on the Department's website, located at [www.dmh.ca.gov](http://www.dmh.ca.gov).

The following section addresses the purpose and necessity of the items included in the financial reporting forms. However, not all items appear in all reports. Certain items are specific to certain reporting forms and are described as such. The item descriptions and explanations provide the specific purpose and necessity of each reporting item required by the Annual Report, Quarterly Report, and Monthly Report.

### *Specific Purpose and Necessity of Items Contained within Reporting Forms*

**Cover Page.** The cover page is required by the Annual Report, Quarterly Report, and Monthly Report.

The cover page is necessary to ensure the Department can identify the health plan reporting period, the health plan that is reporting the information, the health plan's Department issued identification number, whether the health plan is reporting monetary amounts in the thousands, whether the health plan is offering full-service benefits or specialized benefits, and the type of health plan. There is also a row that allows the health plan to enter any additional notes it would like to provide to the Department.

**Report #1, Part A: Assets.** This information appears in the Annual Report, Quarterly Report, and Monthly Report.

- Current Assets: Lines 1 through 11:
  - Line #1: The purpose of this item is for the health plan to report its cash and cash equivalents consistent with the Instruction Manual. It is necessary for the Department to understand how much financial asset liquidity a health plan has in order to accurately monitor and regulate the health plan's financial stability and condition. Further, understanding the health plan's cash on hand allows the Department to accurately assess the financial viability of the health plan and assess its ability to continue providing health care services to enrollees.
  - Line #2: The purpose of this item is for the health plan to report short-term investments to the Department. Short-term investments are part of a health plan's current assets and are necessary for the Department to understand the health plan's financial viability and assess the health plan's ability to continue providing health care services to enrollees.

- Line #3: The purpose of this item is for the health plan to report its premium receivables that are collectible from other entities or individuals receiving services from the health plan. It is necessary for the Department to understand the premium receivables involved in these arrangements in order to determine the financial stability of the health plan.
- Line #4: The purpose of this item is for the health plan to report any interest it has earned on investments. This information is necessary for the Department to understand the health plan's global assets in order to accurately monitor and regulate the financial stability of the health plan.
- Line #5: The purpose of this item is for the health plan to report its shared risk receivables if it enters into contracts with parties, such as provider groups, where parties share financial risk. This information is necessary for the Department to understand the assets involved in these arrangements to be able to accurately monitor and regulate the financial stability of the health plan.
- Line #6: The purpose of this item is for the health plan to report its other health care receivables from other sources. This information is necessary for the Department to understand the assets involved in these arrangements to be able to accurately monitor and regulate the financial stability of the health plan.
- Line #7: The purpose of this item is for the health plan to report expenses paid in advance and charged to the operations of the health plan within one year. This information is necessary for the Department to understand the assets involved in these arrangements to be able to accurately monitor and regulate the financial stability of the health plan.
- Line #8: The purpose of this item is for the health plan to report its affiliate receivables that are properly secured by the affiliated entity's assets. This information is necessary for the Department to understand the receivables involved in these arrangements, whether the affiliates are properly secured, and for the Department to be able to accurately monitor and regulate the financial stability of the health plan.
- Line #9: The purpose of this item is for the health plan to report its affiliate receivables that are unsecured. The information is necessary for the Department to understand the receivables involved in these arrangements, and whether the affiliates are unsecured, to be able to accurately monitor and regulate the financial stability of the health plan.
- Line #10: The purpose of this item is for the health plan to report any additional current assets it needs to report to the Department that are not specifically called for by prior line items, and a health plan may need additional space to provide that information to the Department. The information is necessary so the Department may understand all the applicable assets involved in the health plan's financial dealings in order to be able to accurately monitor and regulate the financial stability of the health plan.

- Line #11: The purpose of this item is for the health plan to add up the total assets from this section and report them to the Department. This information is necessary for the Department to understand the total assets of the health plan and to accurately monitor and regulate the financial stability of the health plan.
- Other Assets: Lines 12 through 18
  - Line #12: The purpose of this item is for the health plan to report what non-current restricted assets the health plan has including any assets the health plan has to maintain solvency. This information is necessary for the Department to accurately monitor and regulate the financial stability of the health plan.
  - Line #13: The purpose of this item is for the health plan to report any long-term investments the health plan has made. This information is necessary in order for the Department to understand the health plan's financial stability and for the Department to accurately monitor the financial stability of the health plan.
  - Line #14: The purpose of this item is for the health plan to report intangible assets and goodwill. This item is necessary to be included in assets in order for the Department to accurately monitor and regulate the financial stability of the health plan.
  - Line #15: The purpose of this item is for the health plan to report its affiliate receivables that are properly secured by the affiliated entity's assets due in the long term. The information is necessary so Department can understand the secured receivables involved in these arrangements, when they are due, in order for the Department to be able to accurately monitor and regulate the financial stability of the health plan.
  - Line #16: The purpose of this item is for the health plan to report its affiliate receivables that are unsecured and due in the long term. The information is necessary for the Department to understand the unsecured receivables involved in these arrangements, and when they are due, to be able to accurately monitor and regulate the financial stability of the health plan.
  - Line #17: The purpose of this item is for the health plan to report additional other assets it needs to report to the Department that are not specifically called for in prior line items, and a health plan may need additional space to provide that information to the Department. The information is necessary for the Department to understand all the applicable assets involved in the health plan's financial dealings in order to be able to accurately monitor and regulate the financial stability of the health plan.
  - Line #18: The purpose of this item is to assist the health plan in adding up the total assets from this section and report them to the Department. The information on total assets is necessary for the Department to accurately monitor and regulate the financial stability of the health plan and assess the health plan's ability to continue providing services to enrollees.

- Property and Equipment: Lines 19 through 27
  - Line #19: The purpose of this item is for the health plan to report the full value of the real properties owned by the health plan and any improvements made to those buildings. The information is necessary in order for the Department to wholly evaluate the financial viability of the health plan and regulate the financial stability of the health plan.
  - Line #20: The purpose of this item is for the health plan to report the full value of any medical equipment, office equipment, and furniture owned by the health plan. The information is necessary in order for the Department to wholly evaluate the financial viability of the health plan and to regulate and monitor the financial stability of the health plan.
  - Line #21: The purpose of this item is for the health plan to report computer and electronic equipment. Given the large amount of computer equipment involved in operating a health plan, it is necessary for the Department to understand the computer equipment and software assets owned by the health plan and the cost of the assets as part of the health plan's financial reporting. The information is necessary in order for the Department to wholly evaluate the financial viability of the health plan and to monitor the financial stability of the health plan.
  - Line #22: The purpose of this item is for the health plan to report the full value from any improvements performed on a property not owned by the health plan. The information is necessary in order for the Department to wholly evaluate the financial viability of the health plan and to regulate and monitor the financial stability of the health plan.
  - Line #23: The purpose of this item is for the health plan to report as part of its total assets any construction on buildings or any improvements that have been made on its property. The information is necessary in order for the Department to wholly evaluate the financial viability of the health plan and to regulate and monitor the financial stability of the health plan.
  - Line #24: The purpose of this item is for the health plan to report its qualifying software development costs for health plan operations. The information is necessary in order for the Department to wholly evaluate the financial viability of the health plan and to monitor the financial stability of the health plan.
  - Line #25: The purpose of this item is for the health plan to report any other fixed assets that are not specifically called for in prior line items, so the Department can understand any other assets the health plan has that are not already provided for in the categories provided. The information is necessary in order for the Department to wholly evaluate the financial viability of the health plan and to regulate and monitor the financial stability of the health plan.

- Line #26: This purpose of this item is to total all of the amounts from the previous lines for the health plan's property and equipment. The information is necessary in order for the Department to correctly categorize the health plan's assets and to regulate and monitor the financial stability of the health plan.
- Line #27: The purpose of this item is to total all of the amounts from the previous lines in Part A of Report #1. The information is necessary in order for the Department to correctly calculate the health plan's assets and to regulate and monitor the financial stability of the health plan.
- Report #1A Write-Ins: The purpose of this item is because the health plan may have additional assets it needs to report a line item to the Department that is not specifically called for, and it may need additional space to provide that information to the Department. The information is necessary for the Department to understand all the applicable assets involved in the health plan's financial dealings in order to be able to accurately monitor and regulate the financial stability of the health plan. Allowing the health plan additional space to provide additional information to the Department ensures the health plan has a designated space to do so.

**Report #1, Part B: Liabilities and Net Worth.** This information appears in the Annual Report, Quarterly Report, and Monthly Report.

- Generally, Part B of Report #1 requires the health plan to report its liabilities and net worth to the Department. There are three columns that involve liability associated with contracting entities, and non-contracting entities. The total of those liabilities would be reported in the total column. The information is necessary for the Department to understand all applicable liabilities involved in the health plan's financial dealings in order for the Department to be able to accurately monitor and regulate the financial stability of the health plan. Current Liabilities: Line 1 through Line 12.
- Line #1: The purpose of this item is for the health plan to report its trade accounts payable. This information is necessary so that the Department can evaluate how the health plan is operating its business and being billed for goods and services related to the delivery of health care. The Department must understand the financial arrangements for these goods and services to accurately monitor and regulate the financial stability of the health plan.
- Line #2: The purpose of this item is for the health plan to report capitation payment payables. This information is necessary because health plans enter into managed care capitation arrangements with various providers, whereby, the health plan pays a per member per month amount pursuant to the contract entered into. It is necessary for the Department to evaluate the financial cost involved in the capitation payments paid to these providers to accurately monitor and regulate the financial viability of the health plan.



- Line #3: The purpose of this item is for the health plan to report its claims payable. This information is necessary because health plans provide services to enrollees and pay claims based upon the location where the enrollee receives its medical services, whether it is in-network or out-of-network. The health plan must report this liability because the payment of these claims, and the amount of the payment of these claims, must be evaluated by the Department to accurately assess the health plan's financial viability and its continued ability to provide health care services to enrollees.
- Line #4: The purpose of this item is for the health plan to report incurred but not reported (IBNR) claims to reflect the total amount owed by the health plan to all valid claimants, such as providers, who provided services to the health plan's enrollees but have not yet filed their claim with the health plan. This information is necessary for the Department to understand and assess the financial liabilities of the health plan in order to accurately monitor and regulate the financial viability of the health plan.
- Line #5: The purpose of this item is for the health plan to report point-of-service (POS) claims payable. The reporting of this liability is necessary because the payment of these claims, and the amount of the payment of these claims, must be evaluated by the Department to accurately assess the health plan's financial viability and its continued ability to provide health care services to enrollees.
- Line #6: The purpose of this item is for the health plan to report (POS) claims that are incurred but not reported (IBNR). This information will reflect the total amount owed by the health plan to all valid claimants, such as providers, who provided services to the health plan's enrollees but have not yet filed their claim with the health plan and the health plan has not determined the specific amount of liability. This information is necessary for the Department to understand and assess the financial liabilities of the health plan in order to accurately monitor and regulate the financial viability of the health plan.
- Line #7: The purpose of this item is for the health plan to report other medical liability such as bonuses, pharmacy related liabilities, and other medical liabilities. This information is necessary because the Department must understand and assess these potential financial liabilities in order to accurately monitor and regulate the financial viability of the health plan.
- Line #8: The purpose of this item is for the health plan to report unearned premiums. This information is necessary because unearned premiums are received in advance of the period in which health care services are provided, and must be taken into account as a potential liability until the services are provided. This information is necessary because the Department must understand and assess these potential financial liabilities in order to accurately monitor and regulate the financial viability of the health plan.

- Line #9: The purpose of this item is for the health plan to report loans and notes payable. This information is necessary because the Department must understand and evaluate whether loans and notes are more or less important than other liabilities to accurately monitor and regulate the financial viability of the health plan.
- Line #10: The purpose of this item is for the health plan to report amounts due to affiliates. This information is necessary because the Department must understand the long-term liabilities due to the affiliates of the health plan to accurately assess the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #11: The purpose of this item is for the health plan to report on current liabilities that are not specifically called for, and additional space may be necessary to provide that information to the Department. This is necessary because the Department must understand and assess potential financial liabilities when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #12: The purpose of this item is to add all of the liabilities from the previous lines to calculate total of liabilities for the health plan. This is necessary because the Department has to understand and assess these potential financial liabilities when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Other Liabilities: Lines 13 through 19
  - Line #13: The purpose of this item is for the health plan to report unsubordinated loans and notes payable. This information is necessary because the Department must understand and evaluate the priority of loans and notes payable against other liabilities of the health plan to accurately monitor and regulate the financial viability of the health plan.
  - Line #14: The purpose of this item is for the health plan to report subordinated loans and notes payable. This information is necessary because the Department must understand and evaluate the priority of loans and notes payable to accurately monitor and regulate the financial viability of the health plan.
  - Line #15: The purpose of this item is for the health plan to report accrued subordinated interest payable. This item is necessary because the Department must understand any interest due on subordinated loans or notes to evaluate the priority of loans and notes payable to accurately monitor and regulate the financial viability of the health plan.

- Line #16: The purpose of this item is for the health plan to report amounts due to affiliates in the long term. This item is necessary because the Department must understand the long-term liability amounts due to the health plan's affiliates to accurately assess the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #17: The purpose of this item is for the health plan to report additional liabilities incurred. This is necessary because the Department has to understand and assess potential financial liabilities reported by a health plan when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #18: This item adds up all of the liabilities from the previous lines to calculate a total of liabilities in the Other Liabilities category for the health plan. This is necessary because the Department must understand and assess financial liabilities to accurately monitor and regulate the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #19: This item adds up all of the liabilities from the previous lines to calculate a total of liabilities for the health plans. This is necessary because the Department must understand and assess financial liabilities to accurately monitor and regulate the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Net Worth: Lines 20 through 28
  - Line #20: The purpose of this item is for health plan to report common stock. Common Stock is a necessary item because the Department must understand how many common shares have been issued and the value of these shares to accurately monitor and regulate the financial viability of the health plan and its ability to continue providing health care services to enrollees.
  - Line # 21: The purpose of this item is for the health plan to report preferred stock. This information is necessary because the Department must understand how many shares of stock are preferred over common stock, and the value of these shares. This is necessary in order for the Department to accurately monitor and regulate the financial viability of the health plan.
  - Line #22: The purpose of this item is for the health plan to report paid-in-surplus amounts. This information is necessary for the Department to understand the surplus available to the health plan and the value of the surplus in order to accurately monitor and regulate the financial viability of the health plan.
  - Line #23: The purpose of this item is for the health plan to report contributed capital. This information is necessary because the Department must understand

the value of the capital donated to the health plan, the nature of that donated capital and any restrictions on the capital in order for the Department to accurately monitor and regulate the financial viability of the health plan.

- Line #24: The purpose of this item is for the health plan to report other accumulated comprehensive income. This information is necessary because the Department must understand any unrealized gains and losses the health plan is including in this liabilities and net worth section in order to accurately monitor and regulate the financial viability of the health plan.
- Line #25: The purpose of this item is for the health plan to report the balance or deficit on any retained earnings. This information is necessary because the reported amounts will enable the Department to fully understand the health plan's financial status in order to accurately monitor and regulate the financial viability of the health plan.
- Line #26: The purpose of this item is for the health plan to report on additional net worth. This information is necessary because the reported amounts will enable the Department to fully understand the health plan's financial status in order to accurately monitor and regulate the financial viability of the health plan.
- Line #27: This item adds up the total net worth from the previous lines to calculate a total net worth of the health plan. This is necessary because the Department must understand and assess the total net worth when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- Line #28: This item adds up the total liabilities and the total net worth of the health plan as reported in the previous items in Part B of Report #1. This is necessary because the Department must understand and assess the total liabilities of the health plan against the total net worth of the health plan when evaluating the financial viability of the health plan and its ability to continue providing health care services to enrollees.
- 1B: Write-In Tab: The purpose of this write-ins for Report #1, Part B is because the health plan may have additional liabilities and net worth items it may need to report to the Department that are not specifically called for, and the health plan may need additional space to provide that information to the Department. The information is necessary for the Department to understand all the applicable liabilities and net worth involved of the health plan in order to be able to accurately monitor and regulate the financial stability of the health plan. Allowing the health plan additional space to provide additional information to the Department ensures the health plan has a designated space to do so.

**Report #2: Revenue, Expenses and Net Worth (Income).** This information appears in the Annual Report, Quarterly Report, and Monthly Report.

- Revenues: Lines 1 through 11

- Line #1: The purpose of this item is for the health plan to report premium revenue received from individuals and employers in the commercial market. Premium is primary source of health plan revenue paid by the enrollees or on behalf of enrollees in return for receiving health care services from the health plan. Premium revenue information is necessary for the Department to understand the revenue stream of the health plan in order to accurately monitor and regulate the financial stability of the health plan.
- Line #2: The purpose of this item is for the health plan to report capitation payments received from another health plan for providing services to that health plan's enrollees. This information is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #3: The purpose of this item is for the health plan to report any revenue recognized from copayments, coordination of benefits payments, or any subrogation payments the health plan has received. This information is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #4: The purpose of this item is for the health plan to report any revenue received from the federal government for services provided to Medicare beneficiaries. This is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #5: The purpose of this item is for the health plan to report any revenue received from the state in order to provide services for Medi-Cal beneficiaries or other state sponsored health care coverage. This information is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #6: The purpose of this item is for the health plan to report any revenue recognized from payments received on a fee-for-service basis as opposed to a capitated payment under Line #2 above. This information is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #7: The purpose of this item is for the health plan to report any revenue received from services provided to Point-of-Service enrollees. Point-of-Service is a type of benefit structure that allows enrollees to receive care both within the health plan's network and outside the health plan's network. This information is necessary for the Department to understand the health plan's revenue stream and properly assess the health plan's financial viability.

- Line #8: The purpose of this item is for the health plan to report any interest earned from all sources. This information is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #9: The purpose of this item is for the health plan to report revenue received from any risk-sharing contracts it may have with other health care entities. This information is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #10: The purpose of this item is for the health plan to report any other income and revenues not called for in prior revenue lines. This information is necessary for the Department to fully understand the health plan's revenue stream and properly assess the health plan's financial viability.
- Line #11: The purpose of this item is to add up all of the revenues from Lines 1 through 10 above. This information is necessary for the Department to fully understand the health plan's total revenue and properly assess the health plan's financial viability.
- Expenses: Medical and Hospital: Lines 12 through 25
  - Line #12: The purpose of this items is for the health plan to report any capitation costs incurred for routine and ancillary services provided to enrollees who are receiving inpatient care. This item is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
  - Line #13: The purpose of this item is for the health plan to report any costs incurred for routine and ancillary services to enrollees who are receiving inpatient care. This item is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
  - Line #14: The purpose of this item is for the health plan to report any costs for inpatient costs incurred on a fee-for-service basis rather than as capitated fixed payment. This item is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
  - Line #15: The purpose of this item is for the health plan to report costs associated with primary care physicians, dentists, or other professionals for the delivery of medical services. This item is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.

- Line #16: The purpose of this item is for the health plan to report costs associated with non-capitated primary professional services. This information accounts for expenses that are related to other types of health care delivery models such as fee-for-service and point-of-service described above. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #17: The purpose of this item is for the health plan to report costs associated with other capitated medical professional services. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #18: The purpose of this item is for the health plan to report costs associated with other non-capitated medical professional services. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #19: The purpose of this item is for the health plan to report costs for non-contracted emergency room services and out of area expenses. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #20: The purpose of this item is for the health plan to report costs from out-of-network claims received for enrollees who have point-of-service coverage. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #21: The purpose of this item is for the health plan to report capitated pharmacy expenses. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #22: The purpose of this item is for the health plan to report non-capitated pharmacy expenses. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #23: The purpose of this item is to allow the health plan to report other capitated medical and hospital expenses. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.
- Line #24: This purpose of this item is to allow the health plan to report other non-capitated medical and hospital expenses. This information is necessary for the Department to fully understand the health plan's expenses and properly assess the health plan's financial viability.

- Line #25: The purpose of this item is to provide the total of medical and hospital costs from the lines 12 through 24 above. This information is necessary for the Department to fully understand the total expenses of the health plan and to properly assess the health plan's financial viability.
- Administration: Lines 26 through 40
  - Line #26: The purpose of this item is for the health plan to report compensation and administrative costs associated with health plan operations. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
  - Line #27: The purpose of this item is for the health plan to report any interest incurred as a result of expenses related to the administration of the health plan. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
  - Line #28: The purpose of this item is for the health plan to report any expenses for costs of using a facility such as lease costs and utilities costs. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
  - Line #29: The purpose of this item is for the health plan to report management fees associated with health plan operations. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
  - Line #30: The purpose of this item is for the health plan to report any marketing costs associated with conducting its business. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
  - Line #31: The purpose of this item is for the health plan to report management fees for services provided by the health plan's affiliates associated with health plan operations. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
  - Line #32: The purpose of this item is for the health plan to report any other costs associated with administrative expenses. This is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
  - Line #33: The purpose of this item is to total all costs for administrative services from lines 26 through 32 above. This is necessary for the Department to fully



understand the health plan's operating costs and properly assess the health plan's financial viability.

- Line #34: The purpose of this item is to total all expenses for medical and hospital costs and administration costs. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #35: The purpose of this line is to calculate the income or loss, reported by the health plan by subtracting line 34 from line 11. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #36: The purpose of this item is for the health plan to report any unusual or infrequently occurring income that is out of the ordinary. This information is necessary because unusual or infrequent costs need to be accounted for in the plan's overall financial reporting in order for the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #37: The purpose of this item is for the health plan to report state and federal taxes. This information is necessary for the Department to fully understand the health plan's operating costs and properly assess the health plan's financial viability.
- Line #38: The purpose of this item is to calculate net income by adding lines 35 and 36 together and subtracting line 37. This information is necessary because it provides a calculated net income total for administrative costs for the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #39: The purpose of this item is to calculate any other income that should be reported after taxes. This information is necessary because it provides the Department with a comprehensive income total amount and for the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #40: The purpose of this item is to calculate the total comprehensive income for the health plan after tax. This information is necessary for the Department to understand the total net income and the total other comprehensive income in order for the Department to accurately monitor and regulate the financial stability of the health plan.
- Net Worth: Lines 41 through 52
  - Line #41: The purpose of this item is for the health to report its net worth in the beginning of the reporting period. This information is necessary for the health plan to provide the Department with reporting results of its calculated net worth over time in order for the Department to accurately monitor and regulate the financial stability of the health plan.

- Line #42: The purpose of this item is for the health plan to account for any adjustments from 4<sup>th</sup> quarter earnings and the annual report. This information is necessary for the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #43: The purpose of this item is for the health plan to report increase or decrease in its common stock. This information is necessary for the Department to understand how many common shares have been issued and the value of the shares in order for the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #44: The purpose of this item is for the health plan to report increase or decrease in its preferred stock. This information is necessary for the Department to understand how many shares are preferred over the common stock and the value of these shares in order for the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #45: The purpose of this item is for the health plan to report increase or decrease for its paid in surplus. This information is necessary for the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #46: The purpose of this item is for the health plan to report increase or decrease in its contributed capital. The Department must understand the contributed capital to accurately monitor and regulate the financial stability of the health plan.
- Line #47: The purpose of this item is for the health plan to report cumulative earnings or deficit from operations, net of reserves and restricted funds. This information is necessary to allow the Department to better understand the financial operations and assess the financial viability of the health plan.
- Line #48: The purpose of this item is to calculate the total for the comprehensive net income. This information is necessary for the Department to accurately monitor and regulate the financial stability of the health plan.
- Line #49: The purpose of this item is for the health plan to report dividends paid to stockholders. Dividends need to be accounted for in assessing the health plan's financial losses and total net worth. This information is necessary to allow the Department to better understand the financial operations and assess the financial viability of the health plan.
- Line #50: The purpose of this item is total all additional reported changes in retained earnings that the health plan includes in write-ins for Report #2. This information is necessary to allow the Department to better understand the financial operations and assess the financial viability of the health plan.

- Line #51: The purpose of this item is to total all other net worth items reported that the health plan includes for write-ins in Report #2. This information is necessary to allow the Department to better understand the financial operations and assess the financial viability of the health plan.
- Line #52: The purpose of this item is to calculate the net worth of the health plan as of the given reporting period by adding lines 41 through 51 together. This information is necessary is item is necessary to allow the Department to better understand the financial operations and to accurately monitor and regulate the financial stability of the health plan.
- Report #2 Write-Ins: This item allows health plans to include any write-in information or supplemental information necessary for Report #2. This information is necessary to allow for any other relevant information the health plan needs to report for the Department to evaluate its net worth. This is necessary to allow the Department to accurately monitor and regulate the financial stability of the health plan. Allowing the health plan additional space to provide additional information to the Department ensures the health plan has a designated space to do so.

**Report #3: Statement of Cash Flows.** This information appears in the Annual Report, Quarterly Report, and Monthly Report.

- Cash Flow Provided by Operating Activities: Lines 1 through 11
  - Lines #1-10: The purpose of these items is to calculate the cash flow of the health plan provided by operating activities. The information submitted for Line 1 through Line 10 is tabulated using entries from Report #1 and Report #2. This information is necessary for the Department to understand the operating cash flow of the health plan to accurately monitor and regulate the financial stability of the health plan.
  - Line #11: The purpose of this item is to calculate the total net cash provided from operating activities by adding up Lines 1 through 10. This information is necessary for the Department to understand the operating cash flow of the health plan to accurately monitor and regulate the financial stability of the health plan.
- Cash Flow Provided by Investing Activities: Lines 12 through 18
  - Lines #12-17: The purpose of these items is to calculate the cash flow of the health plan provided by investing activities. The information submitted for Line 12 through Line 17 is tabulated using entries from Report #1 and Report #2. This information is necessary for the Department to understand the operating cash

flow of the health plan to accurately monitor and regulate the financial stability of the health plan.

- Line #18: The purpose of this item is to calculate the total net cash provided by investing activities by adding up Lines 12 through 17. This information is necessary for the Department to understand the operating cash flow of the health plan to accurately monitor and regulate the financial stability of the health plan.
- Cash Flow Provided by Financing Activities: Lines 19 through 30
  - Lines #19-24: The purpose of these items is to calculate the cash flow of the health plan provided by financing activities. The information submitted for Line 19 through Line 24 is tabulated using entries from Report #1 and Report #2. This information is necessary for the Department to understand the operating cash flow of the health plan to accurately monitor and regulate the financial stability of the health plan.
  - Line #25: The purpose of this item is to all the health plan to report the total of any additional cash flow information provided by financing activities using the write-ins for Report #3. This information is necessary for the Department to understand the operating cash flow of the health plan to accurately monitor and regulate the financial stability of the health plan.
  - Lines #26-30: The purpose of these items is to calculate net cash, cash equivalents, and net income using the information from prior lines. This information is necessary to allow the Department to better understand the financial operations and assess the financial viability of the health plan.
- Reconciliation of Net Income to Net Cash Provided by Operating Activities: Lines 30 through 40
  - Lines #31-38: The purpose of these items is to calculate the adjustments to net income and to net cash provided by operating activities. The information submitted for Line 31 through Line 38 is tabulated using entries from Report #1 and Report #2. This information is necessary for the Department to understand the any adjustments to the operating cash flow of the health plan to accurately monitor and regulate the financial stability of the health plan.
  - Line #39: The purpose of this item is to calculate the total adjustments to net income and net cash by adding up Lines 31 through 38. This information is necessary to allow the Department to better understand adjustments made to health plan cash flows and to accurately monitor and regulate the financial stability of the health plan.
  - Line #40: The purpose of this item is to calculate the total net cash provided by health plan operations by adding together Line 30 and 39. This information is

necessary for the Department to understand solvency of the health plan's operations and to accurately monitor and regulate the financial stability of the health plan.

- Report #3 Write-Ins: The purpose of this item is to allow the health plan to include any other pertinent information related to the information in Report #3 for the Department's consideration. This information is necessary because the health plan may need additional space to explain its cash flow information to the Department. Allowing the health plan additional space to provide additional information to the Department ensures the health plan has a designated space to do so. The information allows the Department to better understand the financial operations of the health plan and assess the financial viability of the health plan.

**Report #4: Enrollment and Utilization Table.** This information appears in the Annual Report, Quarterly Report, and Monthly Report.

The purpose of Report #4 is for the health plan to report utilization and enrollment by type of health care product. It is necessary for the Department to clearly understand the enrollment composition for the health plan and the utilization of services of that enrollment population in order to assess financial risk and viability of the health plan.

- Column 1: Source of Enrollment: The purpose of this column is to identify different categories of types of health care products for the health plan to report enrollment. These enrollment categories by product type are necessary to properly evaluate the enrollment and utilization that impacts the financial solvency of the health plan. Since different types of enrollment may have different utilization, revenue, and medical cost trends depending on services received, the Department must understand the full scope of a health plan's enrollment to accurately monitor and regulate the financial stability of the health plan.
- Column 2: Total Enrollees at the End of Previous Period: The purpose of this column is for the health plan to report the total number of enrollees at the end of the applicable prior reporting period. This information is necessary to compare results from previous reporting periods to assist the Department in evaluating enrollment trends in the various products over a time period and for the Department to accurately monitor and regulate the financial stability of the health plan.
- Column 3: Additions During Period: The purpose of this column is for the health plan to report enrollment additions during the applicable reporting period. This information is necessary to allow the Department to fully evaluate enrollment trends in the various products over a time period and for the Department to accurately monitor and regulate the financial stability of the health plan.
- Column 4: Terminations During Period: The purpose of this column is for the health plan to report the number of enrollment terminations during the reporting period. This information is necessary to allow the Department to fully evaluate enrollment trends

in the various products over a time period and for the Department to accurately monitor and regulate the financial stability of the health plan.

- Column 5: Total Enrollees at the End of Period: The purpose of this column is to calculate the previous columns to determine current total enrollment for the end of the reporting period. This information is necessary to allow the Department to fully evaluate enrollment trends in the various products over a time period and for the Department to accurately monitor and regulate the financial stability of the health plan.
- Column 6: On Exchange Enrollees (also included in Column 5): The purpose of this column is for the health plan to report the volume of enrollment through California's Health Benefit Exchange marketplace. This information is necessary to allow the Department to fully evaluate enrollment trends in the various products over a time period and for the Department to accurately monitor and regulate the financial stability of the health plan.
- Column 7: Off Exchange Enrollees (also included in Column 5): The purpose of this column is for the health plan to report the volume of enrollment outside of the California Health Benefit Exchange. This information is necessary to allow the Department to fully evaluate enrollment trends in the various products over a time period and for the Department to accurately monitor and regulate the financial stability of the health plan.
- Column 8: Grandfathered Enrollees (also included in Column 5): The purpose of this column is for the health plan to report the volume of enrollment for grandfathered health care products in existence before the Affordable Care Act became law. This information is necessary to allow the Department to fully evaluate enrollment trends in the various products over a time period and for the Department to accurately monitor and regulate the financial stability of the health plan.
- Column 9: Cumulative Enrollee Months for Period: The purpose of this column is for the health plan to report the volume of cumulative enrollment months for the reporting period. This information is necessary to allow the Department to fully evaluate enrollment trends in the various products over a time period and allows the Department to wholly understand the health plan's financial status.
- Columns 10 and 11: Total Member Ambulatory Encounters: The purpose of these columns is for the health plan to report enrollee encounters for ambulatory services by physicians (column 10) and by non-physicians (column 11). This information is necessary to properly evaluate the enrollment and utilization that impacts the financial solvency of the health plan, and the Department must understand the full scope of the health plan's utilization to accurately monitor the financial stability of the health plan.

- Column 12: Total Member Ambulatory Encounters for Period: The purpose of this column is to calculate the total number of encounters from Column 10 and Column 11 for ambulatory services. This information is necessary because the Department must understand the full scope of the health plan's utilization to accurately monitor and regulate the financial stability of the health plan.
- Columns 13 and 14: Total Hospital Days Incurred and Annualized Hospital Days: The purpose of this column is for the health plan to report and to calculate the total number of patient days in a hospital that the health plan will be financially responsible for. This information is necessary because the Department must understand the full scope of the health plan's in-patient utilization of hospital services to accurately monitor and regulate the financial stability of the health plan.
- Column 15: Average Length of Stay: The purpose of this column is for the health plan to report the average length of a hospital stay for its enrollment. This information is necessary so all health plans are reporting the average length of stay in a consistent manner in order for the Department to accurately monitor and regulate the financial stability of the health plan.
- Report #4 Write-Ins: The purpose of this item is to allow the health plan to include information in Report #4 about enrollment sourced from other health plans or other lines of business. This information is necessary because the health plan may need additional space to explain enrollment information to the Department, and such enrollment information is necessary for the Department to better understand the financial operations and assess the financial viability of the health plan. Allowing the health plan additional space to provide additional information to the Department ensures the health plan has a designated space to do so.

**Report #5: Enrollment By Product and By County.** This information appears in the Annual Report, Quarterly Report, and Monthly Report.

The purpose of Report #5 is for the health plan to report enrollment by type of health care product described in the Instruction Manual and identified in columns 2 through 8. and by the county where the health benefit product. Reporting enrollment by county is necessary because health plans are licensed to offer health benefits in certain counties and the Department needs to capture enrollment by county in order to accurately monitor and regulate the financial stability of the health plan.

- Column 1: The purpose of this column is for the health plan to report each county the health plan has enrollment in. Reporting enrollment by county is necessary because health plans are licensed to offer health benefits in certain counties and the Department needs to capture enrollment by county in order to accurately monitor and regulate the financial stability of the health plan.
- Columns 2-8: The purpose of columns 2 through 8 is for the health plan to report enrollment by product type for each county the health plan reported in Column 1.

This enrollment information, broken down by product/benefit type and county, is necessary to properly evaluate the enrollment and utilization that impacts the financial solvency of the health plan and the Department must understand the full scope of the health plan's enrollment in order to accurately monitor and regulate the financial stability of the health plan.

- Column 9: The purpose of this column is to calculate the total enrollment by county across all product types reported in column 2 through column 8. This information is necessary because the Department must understand the full scope of the health plan's enrollment when evaluating its financial status and to accurately monitor and regulate the financial stability of the health plan.

**Report #6, Part A: Enrollment Contracted to Other Licensed Health Plans.** This information appears in the Annual Report and the Quarterly Report.

The purpose of Report #6, Part A is for the health plan to report the volume of enrollment assigned to another health plan and to captures the different types of enrollment based on market segment (e.g. Commercial, Medi-Cal Managed Care, and Medicare Advantage). This information is necessary because the Department must understand the full scope of the health plan's enrollment when evaluating its financial status.

- Columns 1-2: The purpose of columns 1 and 2 is for the health plan to identify delegated health plan responsible for assuming enrollee or patient care. It is common practice of the health plan industry to delegate certain health plan functions to other licensed health plans regulated by the Department. Activities delegated often include the delegation of enrollment based on product and market segment and claims functions. This information is necessary to identify the delegated health plan for the Department.
- Columns 3-5: The purpose of columns 3 through 5 is for the health plan to report enrollment delegated to other health plans based on market segment: commercial (column 3), Medi-Cal (column 4), and Medicare Advantage (column 5). This information is necessary for the Department to understand the health plan's delegated enrollment and to accurately monitor and regulate the financial stability of the health plan.
- Column 6: The purpose of this column is to calculate the total volume of delegated enrollment reported in prior columns 3 through 5. This information is necessary for the Department to understand the health plan's total delegated enrollment and to accurately monitor and regulate the financial stability of the health plan.

**Report #6, Part B: Enrollment Delegated to Health Plans, Medical Groups, Capitated Providers, or Risk Bearing Organizations.** This information appears in the Annual Report and the Quarterly Report.



The purpose of Report #6, Part B is for the health plan to report enrollment that is delegated to other entities that are not necessarily licensed by the Department but are responsible for providing care to the health plan's enrollees. These entities include medical groups, capitated providers, risk bearing organizations or other entities responsible for providing care to enrollees on behalf of the reporting health plan. This information is necessary for the Department to understand what enrollment is being delegated by the health plan and to accurately monitor and regulate the financial stability of the health plan.

- Columns 1-2: The purpose of columns 1 and 2 is for the health plan to identify the delegated entity. This is necessary because the Department must understand which delegated entity is responsible for managing care for the health plan's enrollees.
- Columns 3-5: The purpose of columns 3 through 5 is for the health plan to report enrollment delegated based on market segment: commercial (column 3), Medi-Cal (column 4), and Medicare Advantage (column 5). This information is necessary for the Department to understand the health plan's delegated enrollment and to accurately monitor and regulate the financial stability of the health plan.
- Column 6: The purpose of the final column is to calculate the total volume of delegated enrollment reported in prior columns 3 through 5. This information is necessary for the Department to understand the health plan's total delegated enrollment and to accurately monitor and regulate the financial stability of the health plan.

#### **Report #7: Multiple Employer Welfare Arrangement (MEWA) Enrollment Report.**

This information appears in the Annual Report and the Quarterly Report.

The purpose of Report #7 is for the health plan to report MEWA enrollment, which is another type of coverage a health plan can offer where the employer shares the risk of claims incurred by enrollees belonging to the employer group. This information is necessary because the Department must account for this type of enrollment in order to assess the health plan's overall financial viability.

- Column 1: The purpose of this column is for the health plan to report the name of the MEWA. This information is necessary because the Department must know all MEWA enrollment the health plan has to understand overall total enrollment and accurately monitor the financial viability of the health plan.
- Column 2: The purpose of this column is for the health plan to select the appropriate market segment to report MEWA enrollment. This information is necessary because enrollment is categorized by market segment and the Department must understand how many enrollees the market segment has in order to understand overall total enrollment and accurately monitor the financial viability of the health plan.

- Column 3: The purpose of this column is for the health plan to select the product type to report MEWA enrollment. This information is necessary because enrollment is categorized by product type as a secondary category, given different utilization trends in products, it is necessary for the Department to understand enrollment by product type to accurately monitor the financial viability of the health plan.
- Column 4: The purpose of this column is for the health plan to report what type of risk-sharing is involved in the MEWA product. This information is necessary to enable the Department to assess the overall financial viability of the health plan.
- Columns 5-8: The purpose of these columns is for the health plan to report MEWA enrollment at the end of the prior reporting period, enrollment additions and terminations, and to calculate total enrollment for the current reporting period. This information is necessary because the Department must know all MEWA enrollment the health plan has to understand overall total enrollment and accurately monitor the financial viability of the health plan.

**Schedule A: Cash and Cash Equivalents (Including Restricted Deposits).** This schedule appears in the Annual Report and the Quarterly Report.

The purpose of Schedule A is for the health plan to report accounts and balances to the Department consistent with Report #1, Part A. The health plan is prompted, via the Department's electronic filing portal, to submit bank deposits and cash on hand. The information entered by the health plan is confidential and not available to the public. This financial information is necessary because it provides a snapshot of all cash and cash equivalents the health plan is reporting for the reporting period and is necessary for the Department to have a clear understanding of the health plan's cash flow and how the cash flow impacts the health plan's overall financial viability.

**Schedule B: Investments.** This schedule appears in the Annual Report.

The purpose of Schedule B is for the health plan to report both short-term investments and long-term investments to the Department consistent with Report #1, Part A. The health plan is prompted, via the Department's electronic filing portal, to submit investments made by the health plan during the reporting period. This information is necessary to enable the Department to accurately monitor and regulate the financial viability of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule C: Premiums Receivable (Non-Affiliates).** This schedule appears in the Annual Report and the Quarterly Report.

The purpose of Schedule C is for the health plan to report to the Department premiums receivable consistent with Report #1, Part A. This information is necessary for the Department to understand the nature of the debtors that owe amounts greater than 5%

of the gross premiums receivable to the health plan and to enable the Department to have a clear understanding of when payments are expected, when payments are overdue, and how those payment amounts impact the financial viability of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule D: Health Care Receivables & Amounts Due From Parent, Subsidiaries, and Affiliates.** This schedule appears in the Annual Report and the Quarterly Report.

The purpose of Schedule D is for the health plan to report to the Department amounts for health care receivables due from the parent, subsidiaries, and affiliates of the health plan, consistent with Report #1, Part A. This information is necessary because the Department must understand the financial relationship between the health plan and its parent, subsidiary, and affiliates to be able to evaluate when payments are due, and their impact on the financial status of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule E: Property and Equipment.** This schedule appears in the Annual Report.

The purpose of Schedule E is for the health plan to report to the Department property and equipment information consistent with Report #1, Part A. The Department requests information related to what property the health plan owns in order to assess the overall valuation of the health plan. This information is necessary because the Department needs to understand the property and equipment items that contribute to the assets of the health plan and for the Department to accurately monitor and regulate the financial viability of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule F: Trade Accounts Payable.** This schedule appears in the Annual Report and the Quarterly Report.

The purpose of Schedule F is for the health plan to report to the Department any account balances due to creditors that are greater than 5 percent of the total trade accounts payable consistent with Report #1, Part B. The health plan is prompted to enter the name of the debtor and enter how many days the debt has been due. This information is necessary because amounts due to creditors can render a health plan financially insolvent and therefore, the Department must take into account any amounts owed in order to assess the health plan's overall financial viability. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule G: Unpaid Claims Analysis and Inventory of Claims to be Processed.** This schedule appears in the Annual Report and the Quarterly Report.

The purpose of Schedule G is for the health plan to report to the Department unpaid claims and claims to be processed, consistent with Report #1, Part B. Schedule G requests a health plan provide claims for inpatient services, physician services, claims associated with referrals of patients, and other medical claims. Column 1 prompts the health plan to enter claims it is in the process of adjusting. Column 2 requests the health plan enter estimated claims already incurred but not reported so far. This information is necessary because non-payment of claims is often an early indicator of financial difficulty with a health plan, and the Department must have a detailed listing of claims paid, and claims unpaid, to properly evaluate the financial viability of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule H: Aging of All Claims.** This schedule appears in the Annual Report and the Quarterly Report.

The purpose of Schedule H is for the health plan to report on the aging of claims in dollars and by number of claims, consistent with Report #1, Part B. Columns 1 through 5 allow the health plan to report the aging of claims it has on hand at the end of the month and the time frame the claims have aged. This information is necessary because non-payment of claims is often an early indicator of financial difficulty with a health plan. Therefore, the Department must have a detailed listing of unpaid claims and how aged the claims are to properly evaluate the health plan's financial responsibilities as well as the overall financial viability of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule I: Analysis of Total Medical Claims Liability to Actual Claims Paid.** This schedule appears in the Annual Report and the Quarterly Report.

The purpose of Schedule I is for the health plan to report the time between the actual payment of claims and the overall claims liability of the health plan, and consistent with Report #1, Part B. This information is necessary because the Department needs to understand the health plan's lag schedules and to verify accruals for total claims liability for the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule J: Loans and Notes Payable (Including Affiliates).** This schedule appears in the Annual Report.

The purpose of Schedule J is for the health plan to report on loans and notes payable greater than five percent of gross payables of the health plan. The health plan is prompted to enter the lender's information into the Department's secure web portal to provide general information regarding the outstanding loans. This information is

necessary because the Department needs to understand payable amounts due to by the health plan for the Department to accurately monitor and regulate the financial viability of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule K: Summary of Affiliate Transactions.** This schedule appears in the Annual Report.

The purpose of Schedule K is for the health plan to report transactions with affiliates of the health plan, consistent with the information reported by the health plan in Reports #1 and #2. The health plan is prompted to enter the information of any affiliates into the Department's secure web portal to enable the Department to understand the health plan's financial relationships with its Parent company or affiliates. This information is necessary because the Department needs to understand what financial transactions have occurred between the health plan and other affiliates to assist the Department in determining the health plan's total financial viability in its operations. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule L: Analysis of Operations by Line of Business.** This schedule appears in the Annual Report.

The purpose of Schedule L is for the health plan to report information on revenues, expenses, and medical liabilities by line of business, consistent with Reports #1 and #2. This information is necessary to ensure revenues, expenses, and liabilities from all lines of business are broken down and reported by the health plan. The information entered allows the Department to fully evaluate the financial viability of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Schedule M: Pass-Through Items (For Medi-Cal Managed Care Plans Only).** This schedule appears in the Annual Report and the Quarterly Report.

The purpose of Schedule M is for Medi-Cal managed care health plans who contract with the Department of Health Care Services to report any pass-through items for the Medi-Cal Managed Care product line. Pass-through items are amounts not realized by the health plan that need to be accounted for to provide a complete and accurate reporting for this state-sponsored product line. This information is necessary for the Department to fully evaluate the financial viability of the health plan and allow the health plan to account for amounts it is not realizing. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**Notes to Financial Statements.** This item appears in the Annual Report, Quarterly Report, and Monthly Report.

The purpose of the notes to financial statements section is to allow the health plan to provide a detailed narrative description and assumptions related to the reporting requirements in the Annual Report, Quarterly Report, and Monthly Report. It is necessary to allow the health plans the ability to enter in additional information if it would help provide clarity to the financial reporting forms required by these Rules and for the Department to accurately monitor and regulate the financial viability of the health plan. In addition, the information allows the Department to conduct a thorough analysis of the financial viability of the health plan to protect enrollees from potential health plan insolvency.

**General Interrogatories.** General Interrogatories only appear in the Annual Report.

- Interrogatory 1: The purpose of this interrogatory is because the Department must understand whether there has been any change to the corporate structure of the health plan since the last reporting. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 2: The purpose of this interrogatory is because the Department must understand whether the health plan is operating in other states in order to fully assess its financial capability of offering its services to California health plan enrollees. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 3: The purpose of this interrogatory is because the Department must review the financial assessments conducted by other state agencies in order to compare and evaluate whether those financial audits discovered any deficiencies in the health plan's financial stability. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 4: The purpose of this interrogatory is because the Department must understand the corporate ownership of the health plan in order to fully assess assets and liabilities of the health plan. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 5: The purpose of this interrogatory is because the Department must ensure the health plan has established procedures to avoid any financial conflicts between its corporate governance and the operations of the health plan. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.

- Interrogatory 6: The purpose of this interrogatory is because the Department must ensure the health plan avoids any financial conflicts between its corporate governance and the operations of the health plan. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 7: The purpose of this interrogatory is because the Department must ensure the health plan avoids any financial conflicts between its corporate governance and the operations of the health plan. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 8: The purpose of this interrogatory is because the Department must ensure the health plan is insured against any malfeasance of its officers or employees. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 9: The purpose of this interrogatory is because the Department must understand the financial investments of the health plan and whether those financial investments are within its immediate control. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 10: The purpose of this interrogatory is because the Department must understand whether the Board of Directors has control over the purchase of the health plan's investments. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 11: The purpose of this interrogatory is because the Department must understand whether an employee, officer, or other person has made any claim against the health plan that has not been accounted for in the financial statements already. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 12: The purpose of this interrogatory is because the Department must understand whether there are any medical injury claims against the health plan that can affect its TNE requirement. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 13: The purpose of this interrogatory is because the Department must understand whether there has been any enforcement action taken by any governmental agency. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.

- Interrogatory 14: The purpose of this interrogatory is because the Department must understand whether there have been legal actions taken against the health plan related to any financial matters. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 15: The purpose of this interrogatory is because the Department must ensure the health plan is insured against any malpractice actions taken against the health plan. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 16: The purpose of this interrogatory is because the Department must ensure the health plan is insured against any professional malfeasance claims. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 17: The purpose of this interrogatory is because the Department must ensure the health plan maintains general liability insurance to protect against claims. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 18: The purpose of this interrogatory is because the Department must ensure the health plan can cover unexpected claims to protect enrollees. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 19: The purpose of this interrogatory is because the Department must ensure the health plan has taken the necessary steps to protect against insolvency. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 20: The purpose of this interrogatory is because the Department must ensure the health plan has properly set up its claim liability. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 21: The purpose of this interrogatory is because the Department must have a detailed listing of any information being used by the health plan to calculate its TNE to ensure compliance with Section 1300.76 of Title 28, California Code of Regulation and to verify how the health plan is calculating its TNE amount. If there are changes in how the health plan is calculating this amount, the Department must be able to review this information and ensure that the calculation is being done correctly and that the health plan has the necessary TNE for financial viability.



- Interrogatory 22: The purpose of this interrogatory is because the Department must understand whether the health plan has premium rate guarantees. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 23: The purpose of this interrogatory is because the Department must evaluate whether the health plan is delegating claim payment function to another entity and where the entity is located, how the health plan monitors that entity, and whether there is a disaster recovery plan to retrieve records in case of an emergency. This is necessary for the Department to fully evaluate the health plan's monitoring functions of another entity responsible for claims payments on behalf of the health plan.
- Interrogatory 24: The purpose of this interrogatory is because the Department must know whether there has been a change to the health plan's independent auditor of record so the Department can ensure a reliable and qualified auditor is reviewing the health plan's finances. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 25: The purpose of this interrogatory is because the Department must know whether there has been a change to the health plan's corporate structure to ensure the health plan has organizational capacity to operate. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 26: The purpose of this interrogatory is because the Department must know whether there have been any changes to the ownership of the health plan. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 27: The purpose of this interrogatory is because the Department must know whether there has been any change to the claims processing system the health plan utilizes to process health care claims. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatories 28-29: The purpose of these interrogatories is because the Department must know how the health plan's capital is maintained including how stock is held, valued, and classified. This information is necessary for the Department to fully evaluate the financial viability of the health plan.
- Interrogatories 30-35: The purpose of these interrogatories is because the Department must know the health plan's enrollment composition within the context of the annual financial statement. This information is necessary for the Department to fully evaluate the financial viability of the health plan.

- Interrogatories 36-42: The purpose of these interrogatories is because the Department must know whether the health plan maintains reinsurance agreements and how such reinsurance impacts the health plan's fiscal stability. This information is necessary for the Department to fully evaluate the financial viability of the health plan.
- Interrogatory 43: The purpose of this interrogatory is because the Department must know of financial guarantees provided by the health plan including any changes made between reporting periods. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 44: The purpose of this interrogatory is because the Department must know of reinsurance coverage provided by the health plan including any changes made between reporting periods. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 45: The purpose of this interrogatory is because the Department must understand the health plan's holdings and ownership interests including any changes made between reporting periods. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 46: The purpose of this interrogatory is because the Department must know whether financial information reported by the health plan is held under the name of another entity. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.
- Interrogatory 47: The purpose of this interrogatory is because the Department must know if the health plan is complying with its current outstanding obligations. This is necessary for the Department to fully evaluate the financial viability of the health plan when reviewing the annual financial statement.

**Supplemental Information.** This item appears in the Annual Report, Quarterly Report, and Monthly Report.

The purpose of the Supplemental Information section is for the health plan to report supplemental information for its financial report. The supplemental information section is necessary for the Department to properly evaluate the tangible net equity requirements related to the Annual Report and Point of Service products.

- Item A: The purpose of Item A is for the health plan to describe the methodology used for calculating both incurred claims and unreported claims for the reporting

period. This information is necessary for the Department to understand the health plan's calculations to fully evaluate the financial viability of the health plan.

- Item B: The purpose of Item B is for the health plan to report to the Department any accountants and notes receivable from health plan officers, directors, owners, or affiliates. This information is necessary for the Department to accurately monitor and regulate the financial viability of the health plan.
- Item C: The purpose of Item C is for the health plan to report donated materials or services. This information is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to enrollees.
- Item D: The purpose of Item D is for the health plan to report forgiven debt or obligations. This information is necessary for the Department to accurately assess the health plan's financial stability and ability to provide care to enrollees.

**Supplemental Information for TNE and POS Calculations. TNE (1) and (2) and POS (1) and (2).** These items appear in the Annual Report, Quarterly Report, and Monthly Report.

Rule 1300.76 of the CCR implements, interprets, and makes specific Health and Safety Code section 1376, which requires health plans to comply with Department rules regarding minimum capital or net worth, and limitations on indebtedness, for the purpose of protecting health plan enrollees by ensuring a health plan's financial stability.

Pursuant to Rule 1300.76, subdivisions (a) and (b), health plans must maintain a certain minimum financial reserve known as tangible net equity (TNE). Point-of-Service health plan contracts have specific TNE requirements described in Health and Safety Code section 1374.64. Therefore, the Department must evaluate TNE for all health plans as part of its yearly review of health plan financial stability and it must review Point-of-Service contracts specifically to ensure compliance with the requirements for those contracts as described in 1374.64.

- TNE (1), Item E: The purpose of this item is to identify the calculation of TNE and Required TNE to assist the health plan in reporting its subordinated debt with interest and its unsecured affiliate receivables. It also refers the health plan back to Report#1 as a reference for applicable line items. This information is necessary to enable the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.
- TNE (1), Item F: The purpose of the Calculation of Percentage of Administrative Costs to Revenue Obtained from Subscribers and Enrollees is to assist the health plan in calculating the year-to-date percentage for its report. This information is necessary to enable the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.

- TNE (1), Item G: The purpose of the Calculation of Percentage of Health Care Expenses for Non-Contracting Providers is for the health plan to report its payments to providers that it does not contract with. Health and Safety Code section 1377 contains specific fiscal requirements related to health plans that reimburse non-contracting health care providers for services provided to the health plan's enrollees. This calculation is necessary to assist health plans in reporting the required information. This information will enable the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.
- TNE (1), Item H: The purpose of the Calculation of Percentage of Premium Revenue Earned from POS contracts is to inform the health plan how to report compliance with TNE for POS contracts and provides the calculation for such information. This information will enable the Department to accurately assess the health plan's financial stability and ability to provide care to its enrollees.
- TNE (1), Item I: The purpose of the Calculation of Percentage of Total Health Care Expenditures incurred for out-of-network services is to enable the health plan to report its expenditures for out-of-network care costs it incurred for those enrollees who received care from out-of-network hospitals or providers. This information is necessary to assist the Department in accurately assessing the health plan's financial stability and ability to provide care to its enrollees.
- TNE (1), Item J: The purpose of the Calculation for the POS Deposit Requirement is to inform the health plan what items it is to calculate in order for the Department to determine whether the health plan complies with the required provision of Section 1374.68. This information is necessary to assist the Department in accurately assessing the health plan's financial stability and ability to provide care to its enrollees.
- TNE (2): The purpose of the TNE calculation required for Full Service Plans and Specialized Plans is necessary to provide the health plan with the variables it must use in order to determine the health plan's TNE requirements established in Rule 1300.76. In addition, the item is necessary to ensure all health plans are calculating the same variables. The Department must ensure all calculations are consistent and accurate in order to adequately assess health plan financial viability and protect enrollees from potential health plan insolvency.

For health plans that offer Point-of-Service (POS) products, the health plan must all complete POS TNE (1) and POS TNE (2). A health plan may enter "NA" for this section if it does not offer POS products.

- POS TNE (1): The purpose of this item is to clarify for the health plan what variables it must include when calculating its TNE, as required in Health and Safety Code section 1374.64 and Rule 1300.76. The item is necessary to ensure

all health plans are calculating the same variables. The Department must ensure all calculations are consistent and accurate in order to adequately assess health plan financial viability and protect enrollees from potential health plan insolvency.

- POS TNE (2): The purpose of this item is to clarify for the health plan what variables it must include when calculating its TNE, as required in Health and Safety Code section 1374.64 and Rule 1300.76. The item is necessary to ensure all health plans are calculating the same variables. The Department must ensure all calculations are consistent and accurate in order to adequately assess health plan financial viability and protect enrollees from potential health plan insolvency.

**Overflow Page for Write-ins.** Overflow pages for write-in appear in the Annual Report, Quarterly Report, and Monthly Report.

The purpose of overflow pages is to provide space for the health plan to report additional information to the Department in connection with all prior write-in sections of the Annual Report, Quarterly Report, and Monthly Report. Overflow pages are necessary because the health plan may need additional room to explain its financial statements to the Department and to supplement any information provided in write-in sections of the report the health plan submits to the Department.

[End of Forms.]

#### **IV. SPECIFIC PURPOSE AND BENEFITS OF THIS FINANCIAL REPORTING REGULATION PACKAGE**

##### **Specific Purpose and Benefit of Proposed Rules and Incorporated Documents**

###### **Amendment of Rule 1300.84.06 and Renumbering to Rule 1300.84.1**

Health and Safety Code section 1384, subdivision (c), requires that health plans submit an annual financial report to the Department. The contents of the report are specified in greater detail in Rule 1300.84.06. The current text in Rule 1300.84.06(a) specifies the health plan is required to submit a “DMHC Annual Financial Reporting Form;” however, the referenced form is now obsolete and is being replaced with the “Annual DMHC Financial Reporting Form” (Annual Report) incorporated by reference in proposed Rule 1300.84.1(a). Further, current Rule 1300.84.06(b) describes supplemental information that must be included in the Annual Report. The purpose of the amendment to Rule 1300.84.06 is to clarify requirements for the Annual Report to ensure health plans are accurately submitting the required financial information. Accurate information aids the Department in monitoring and examining a health plan’s financial stability to protect health plan enrollees from potential health plan insolvency. The changes will benefit health plans by eliminating confusing and redundant language and ensure that health plans submit the correct forms with the annual report required by this Rule.

Proposed subdivision 1300.84.1 will specify that the Annual Report should include the comprehensive “Annual DMHC Financial Reporting Form,” as incorporated by reference in this rulemaking package. The Department is also changing the numbering in this section from 1300.84.06 to 1300.84.1 to better align with the section numbering of the Quarterly Report and the Monthly Report. The purpose of these amendments is to ensure health plans understand which form to submit in their annual reporting and to allow for ease of reference by renumbering the Rules. The anticipated benefit of updating the form title is that it will provide greater clarity and simplicity for health plans for their annual reporting requirement. In addition, the benefit of renumbering the section is that it will make it clearer to health plans that the Annual Report is related to the Quarterly Report and the Monthly Report.

#### *Amendment to Rule 1300.84.2*

The purpose of the regulation amendment is to aid the Department in monitoring and examining a health plan’s financial stability and to protect health plan enrollees from potential health plan insolvency. Title 28, Rule 1300.84.2, sets forth a quarterly financial reporting requirement for health plans, specifying the required documentation that the report must contain. It is necessary to amend Rule 1300.84.2 to eliminate a reference to an obsolete form and replace it with the Department’s “Quarterly DMHC Financial Reporting Form” that is being incorporated by reference in this rulemaking package. The change will result in the benefit of greater clarity regarding the Department’s expectations of health plans for quarterly financial reporting.

In addition, the Department is revising subdivisions (a) and (b) of the Rule to better describe for health plans what financial information needs to be reported to the Department, how the documents should be submitted, and when the Quarterly Report should be submitted. The information in the existing provision (a)(1)-(7) is being incorporated into the actual reporting form itself for the purpose of avoiding redundancy and consolidate the information into one document. The benefit of the revisions is to better identify for the health plan when the health plan is required to submit the quarterly report, what information is required, and how the health plan should report the information to the Department.

#### *Amendment to Rule 1300.84.3 and Adoption of Rule 1300.84.03*

Under title 28, Rule 1300.84.3, health plans are subject to conditional monthly financial reporting requirements. Rule 1300.84.3 contains general requirements and specific monthly reporting requirements. In order to provide clarity and distinguish between the general and specific requirements, the Department is proposing the adoption of a new Rule 1300.84.03. The purpose of the adoption is to make clear to health plans the general requirements for advising the Department if internal review of health plan finances suggest the health plan will be unable to meet its financial obligations.

The Department moved current subdivision 1300.84.3(a) into newly proposed subdivision 1300.84.03(a) because the specific purpose is to ensure health plans have sufficient financial security to cover enrollee claims for health care services. The addition of Rule 1300.84.03 is beneficial to health plans to assist them in understanding notice requirements, and it is beneficial to ensure the provision of health care services to health plan enrollees.

Rule 1300.84.3 currently sets for conditional monthly financial reporting requirements for health plans, including separate requirements in subdivisions (b), (c), and (d). The purpose of the amendments is to eliminate the reporting requirement in subdivision Rule 1300.84.3(b) because it has become obsolete and has proven to be confusing to the regulated health plans because of its length and wordiness. Further, the Department is able to track any increase in payments owed to providers in the financial statements themselves and therefore, subdivision (b) has become repetitive. These amendments are beneficial because they eliminate redundancy in requirements and provide clarity of what is required.

Existing subdivision 1300.84.3(c) is amended and revised as newly proposed Rule 1300.84.03. The purpose of the revision is to separate this general requirement in existing subdivision (c) of the Rule from the specific monthly reporting requirements in (d) of the Rule. The separation of the general requirement and more specific monthly reporting requirement will result in the benefit of a simpler and more understandable regulation.

The amendment to Rule 1300.84.3 will better effectuate the statute's purpose of ensuring health plan financial stability and enrollee protection. The anticipated benefits of this amendment are greater clarity due to the fact that the reporting requirement will be consistent with other reporting requirements, and that it will result in timelier reporting to the Department. This change will result in the Department's improved ability to monitor, examine, and respond to reports regarding a health plan's financial stability.

Therefore, as described in the paragraphs above, the ultimate benefits of these amendments include the protection of the public health and safety, as well as increased transparency in business and business practices.

#### *Specific Purpose and Benefit of Documents Incorporated by Reference*

##### DMHC Financial Reporting Forms Instruction Manual

The purpose of the Instruction Manual is to provide health plans with detailed instructions and explanations of what items are necessary for financial reporting depending upon which report the health plan is submitting to the Department. The Instruction Manual is beneficial because it describes the exact information required for each reporting requirement. The Instruction Manual also ensures the information health plans are reporting are true and correct which allows the Department to accurately assess health plan financial viability. Enrollees benefit because accurate reporting

ensures they will receive health care services they are paying for. Enrollees and members of the public can view health plan financial status before choosing a health plan.

#### Annual DMHC Financial Reporting Form

This Form contains all of the financial reporting requirements a health plan must submit to the Department in order to allow the Department to assess health plan viability. Health and Safety Code section 1384 requires health plans to submit yearly financial statements to the Department to allow the Department to assess and evaluate the financial viability of a health plan. The purpose of this Form is to clarify the exact financial information a health plan must report to allow the Department to assess financial viability. The Form is beneficial because it allows for consistent and accurate reporting across health plans. Accurate reporting is beneficial for enrollees of health plans because it ensures their health plan is financially stable and able to provide the necessary health care services. In addition, members of the general public can view a health plan's financial status before choosing a health plan.

#### Quarterly DMHC Financial Reporting Form

This Form contains all of the financial reporting requirements a health plan must submit to the Department in order to allow the Department to assess health plan viability on a quarterly basis. The Quarterly DMHC Financial Reporting Form is a subset of the Annual DMHC Financial Reporting Form and requires the health plan to submit certain financial statements in order for the Department to assess the financial viability of the health plan on a quarterly basis. The purpose of this Form is to clarify the exact financial information a health plan must report to the Department on a quarterly basis allowing the Department to assess financial viability during the fiscal quarter. The Form is beneficial for health plans because it describes the exact information required to report quarterly financial information to the Department and allows for consistent and accurate reporting across health plans. Accurate reporting is beneficial for enrollees of health plans because it ensures their health plan is financially stable and able to provide the necessary health care services. In addition, members of the general public can view a health plan's financial status before choosing a health plan.

#### Monthly DMHC Financial Reporting Form

This Form contains the items the health plan must file with the Department if it is required to submit monthly financial reports. The proposed text in Rule 1300.84.3 and Rule 1300.84.03, describe the instances in which a health plan is to file monthly financial information to the Department. The purpose of this Form is to clarify the exact financial information a health plan must report to the Department allowing the Department to assess financial viability during the preceding month. The Form is beneficial for health plans because it describes the exact information required to report monthly financial information to the Department and allows for consistent and accurate reporting across health plans. Accurate reporting is beneficial for enrollees of health



plans because it ensures their health plan is financially stable and able to provide the necessary health care services. In addition, members of the general public can view a health plan's financial status before choosing a health plan.

## **V. DOCUMENTS INCORPORATED BY REFERENCE**

The Department is incorporating by reference the following documents:

- Annual DMHC Financial Reporting Form (Form No. 10-072)
- Quarterly DMHC Financial Reporting Form (Form No. 10-071)
- Monthly DMHC Financial Reporting Form (Form No. 10-070)
- Annual, Quarterly, and Monthly DMHC Financial Reporting Forms Instruction Manual (Eff. Date, OAL insert)

## **VI. DOCUMENTS RELIED UPON**

- Health and Safety Code sections 1346, 1348.95, 1375.1, 1376, 1377, 1382, and 1384.
- Title 28, California Code of Regulations, Rules 1300.76, 1300.77.2, 1300.82.1, 1300.84.06, 1300.84.2, and 1300.84.3.
- Financial Accounting Standards Board (FASB), Accounting Standards Codification: <https://www.fasb.org/home>

## **VII. REASONABLE ALTERNATIVES TO THE REGULATION**

No alternatives were considered by the Department. The Department will consider all reasonable alternatives submitted by members of the public during the comment period.

## **VIII. ECONOMIC IMPACT**

The Department has determined that the regulation amendments will not have a significant statewide adverse economic impact directly affecting businesses.

As mentioned previously, the health plans have been required to report financial status since the inception of the Knox-Keene Act. For over 20 years, the health plans have been required to file the annual report, the quarterly report, and the monthly report. The amendments proposed by this regulation package align with previous reporting requirements and existing practices for the health plans and the Department. Further, as existing businesses in the state of California, health plans have financial information readily available. All reporting elements are essentially the same and do not require reporting that is outside the scope of the Knox-Keene Act and its implementing regulations.

For the reasons stated above, the Department anticipates negligible costs associated with training staff for minor changes proposed by this regulation. The Department anticipates health plans will spend approximately \$500.00 in discussing the proposed

changes with staff and possibly conducting minor training. There are approximately 125 full-service and specialized health plans that are licensed to offer medical and specialized services to California consumers. Licensed health plans are required to comply with financial solvency laws in the Knox-Keene act. Therefore, the Department anticipates total costs for business subject to the proposed regulations to be \$62,500.

The Department does not anticipate any ongoing health plan costs.

## **Economic Impact Analysis**

### **Creation or Elimination of Jobs Within the State of California**

The proposed amendments clarify and make specific existing law for the health care industry and impacted enrollees. The Department has determined that these amendments will not significantly affect the creation or elimination of jobs within the state of California. On the contrary, the amendments will benefit persons with jobs in the impacted industry in California by updating obsolete provisions and making clear what is required under the current law.

### **Creation of New Businesses or the Elimination of Existing Businesses Within the State of California**

The proposed amendments clarify and make specific the updated laws for the health care industry and impacted enrollees; therefore, the Department has determined that the amendments will benefit persons with jobs in the impacted industry in California by updating obsolete provisions and making clear what is required under the current law and will not impact the creation of new businesses or the elimination of current businesses within the State of California.

### **Expansion of Businesses Currently Doing Business Within the State of California**

Because the amendments only clarify and make specific the updated laws for the health care industry and impacted enrollees, the Department has determined that the amendments will not impact the expansion of business within the State of California but in fact will benefit the impacted industry in California by updating obsolete provisions and making clear what is required under the current law.

### **The Benefits to the Health and Welfare of California Residents, Worker Safety, and the State's Environment**

Because the amendments only clarify and make specific the updated laws for the health care industry and impacted enrollees, the Department has determined that this amendment will not significantly affect California residents, worker safety or the state's environment.

### **Benefits to the Health and Welfare of California Residents**

The anticipated benefit to the health and welfare of California residents of the proposed amendments is that health plans will maintain financial viability and enrollees can ultimately have greater access to health care. The changes to the annual, quarterly, and monthly reporting forms will result in the benefit to the health and welfare of California residents by providing greater clarity regarding the Department's expectations of health plans for financial reporting; thereby ensuring that health plans remain viable and enrollees may access health care. The benefit of incorporating the instruction manual by reference is to ensure consistency of health plan reporting across health plans. Therefore, as described in the paragraphs above, the ultimate benefits to the health and welfare of residents of California from these amendments is increased protection of the public health and safety, as well as increased transparency in business and business practices.