OHIO DEPARTMENT OF INSURANCE

ANNUAL REPORT OF OHIO HEALTH INSURANCE BUSINESS

This is an annual health insurance report required by the Ohio Department of Insurance. This report is due by April 1st of each year. ***The contact person will receive an annual e-mail notification that the application is available for submission (approx. 2nd week in March).***

Purpose of this report

This report will provide:

- Statistical information regarding health insurance coverage on Ohio citizens.

General Instructions

Follow these instructions when completing this report:

- Report only Ohio health insurance business
- Use data that reflects the previous calendar year ("Reported Year")
- Read all instructions and the DEFINITIONS section of this Help file carefully before completing this report. *The "Type of Business" definitions provided are specific to this report.*
- Eliminate discrepancies by correcting the data or by providing an explanatory comment.
- After completing all *"Type of Business"* links that apply to the company, the following four links must be completed and saved by **all companies** before submitting the final report: ***(regardless of the type of products reported)***
  - ✓ Subrogation Recoveries
  - ✓ Aggregate Administrative Expense and Open Enrollment Data
  - ✓ Health Plan Benefit Specific Information
  - ✓ Company Statement

- ***Data is validated against the Direct Earned Premium and Direct Claims Incurred reported on the company's annual statement. All discrepancies will be displayed and require correction and re-submission or a detailed explanation of any differences. An automated e-mail confirmation will be sent to the contact person confirming that the report was submitted successfully. If an e-mail confirmation is not received, either all links have not been completed properly or the dollar amounts do not balance with the annual statement data reported by the company.***

Ohio Health Reinsurance Program Data ***SUSPENDED THROUGH DEC 2017***

HEALTH INSURANCE ANNUAL REPORT DATA WILL BE USED TO DETERMINE THE ASSESSMENTS FOR ALL REINSURANCE POOLS.

- Ohio offers the reinsurance mechanisms described below:
  - Open Enrollment pursuant to Ohio Revised Code Section 3923.58, mandating participation of insurers issuing individual policies of sickness and accident insurance;
  - Federal Open Enrollment pursuant to Ohio Revised Code Section 3923.58.1 and 1751.15(L) for carriers providing individual or non-employer group coverage; and
  - Small Employer Reinsurance pursuant to Ohio Revised Code Section 3924.07, a voluntary vehicle for carriers writing small employer groups of 2-50 lives.

- Ohio Revised Code Sections 3923.58, 3923.58.1, 3923.59 and 3924.01 through 3924.14 describe reinsurance pool mechanisms and small employer health care reforms.

* Pursuant to Section 3 of Substitute Senate Bill 9 of the 130th General Assembly, during the period beginning on January 1, 2014, and expiring January 1, 2018, the requirements related to the Ohio Open Enrollment Program and the option for conversion of a health insurance contract or policy are suspended.

THIS TEMPLATE CAN BE PRINTED FOR USE AS A WORKSHEET IN COMPLETING THE REPORT

(IMPORTANT! SEE DEFINITIONS SECTION FOR SPECIFIC INSTRUCTIONS.)

INFORMATION RELATED ONLY TO BUSINESS IN OHIO

For the Year Ending December 31, 2015

DEFINITION NUMBER	TYPE OF BUSINESS	Currently Marketing or Available (A)	Number of Policies (B)	Number of Lives (C)	Member Months (D)	Direct Premium Earned (E)	Direct Claims Incurred (F)
I. INDIVIDUAL POLICY – HEALTH INSURANCE:							[DEFINITIONS]
MEDICAL							
1	Major Medical Health Benefit Plan:						
1a	Individual Health Benefit Plan, On Exchange						
1aa	On Exchange Platinum						
1ab	On Exchange Gold						
1ac	On Exchange Silver						
1ad	On Exchange Bronze						
1ae	On Exchange Catastrophic Plan						
1af	On Exchange Non Employer Group						
1ag	Individual Health Benefit Plan, Off Exchange						
1ah	Off Exchange, Platinum						
1ai	Off Exchange, Gold						
1aj	Off Exchange Silver						
1ak	Off Exchange Bronze						
1al	Off Exchange Catastrophic Plan						
1am	Off Exchange Non-Employer Group						
31	Grandfathered Health Plan						
32	Transitional Health Plan						
36	Other Health Plans						
2	Franchise/Blanket Accident & Sickness						
3	Short Term Medical						
28	High Deductible Products **(HSA Qualified)**						
SUPPLEMENTAL COVERAGE **(IMPORTANT! SEE SPECIFIC DEFINITIONS)**							
4	Dental, On Exchange						
4a	Dental, Off Exchange						
5	Hospital/Surgical/Outpatient Indemnity						
6	Long Term Care						
6a	Long Term Care **(Partnership Qualified)**						
7	Prescription Drug						
8	Short Term Care						
9	Specified/Named Disease/Intensive Care/Organ & Tissue Transplant						
10	Vision						
FEDERAL GOVERNMENT PROGRAMS							
11	Federal Employees Health Benefit Plan						
12	Health Coverage Tax Credit (HCTC)						
14	Other Federal Government (See Definition)						

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INFORMATION RELATED ONLY TO BUSINESS IN OHIO

For the Year Ending December 31, 2015

DEFINITION NUMBER	TYPE OF BUSINESS	Currently Marketing or Available (A)	Number of Policies (B)	Number of Lives (C)	Member Months (D)	Direct Premium Earned (E)	Direct Claims Incurred (F)
SENIOR COVERAGE							
15	Medicare Advantage						
17	Medicare Supplement:						
17a	Standard Medicare Supplement						
17b	Pre-Standardized Medicare Supplement						
17c	Medicare Select						
29	Medicare Part D						
DISABILITY							
18	Credit Disability						
19	Disability Income - Long Term						
20	Disability Income - Short Term						
MISCELLANEOUS							
21	Accident Only (Incl. Student)/ AD&D/ Travel						
22	Student Policies - Accident & Health						
30	Involuntary Unemployment Insurance						

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INFORMATION RELATED ONLY TO BUSINESS IN OHIO

For the Year Ending December 31, 2015

DEFINITION NUMBER	TYPE OF BUSINESS	Currently Marketing or Available (A)	Number of Policies (B)	Number of Lives (C)	Member Months (D)	Direct Premium Earned (E)	Direct Claims Incurred (F)
II GROUP/BLANKET POLICY - HEALTH INSURANCE:							[DEFINITIONS]
MEDICAL							
1	Major Medical Health Benefit Plan:						
1b	Small Employer Group (1-50), On Exchange						
1aa	On Exchange Platinum						
1ab	On Exchange Gold						
1ac	On Exchange Silver						
1ad	On Exchange Bronze						
1ba	Small Employer Group (1-50), Off Exchange						
1ag	Off Exchange, Platinum						
1ah	Off Exchange, Gold						
1ai	Off Exchange Silver						
1aj	Off Exchange Bronze						
1c	Large Employer Group (> 50)						
31	Grandfathered Health Plan						
32	Transitional Health Plan						
36	Other Health Plans						
28a	Small Employer Group (1-50) High Deductible Products **(HSA Qualified)**						
28b	Large Employer Group (>50) High Deductible Products **(HSA Qualified)**						
23	Small Employer Health Care Alliance						
23a	Alliance – Employer Members w/ <2 Lives						
23b	Alliance – Employer Members w/ 2-50 Lives						
23c	Alliance – Employer Members w/ >50 Lives						
2	Franchise/Blanket Accident and Sickness						
3	Short Term Medical						
SUPPLEMENTAL COVERAGE **(IMPORTANT! SEE SPECIFIC DEFINITIONS)**							
4	Dental, On Exchange						
4a	Dental, Off Exchange						
5	Hospital/Surgical/Outpatient Indemnity						
6	Long Term Care						
6a	Long Term Care **(Partnership Qualified)**						
7	Prescription Drug						
8	Short Term Care						
9	Specified/Named Disease/Intensive Care/Organ & Tissue Transplant						
10	Vision						
FEDERAL GOVERNMENT PROGRAMS							
11	Federal Employees Health Benefit Plan						
14	Other Federal Government (See Definition)						
SENIOR COVERAGE							

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INFORMATION RELATED ONLY TO BUSINESS IN OHIO

For the Year Ending December 31, 2015

DEFINITION NUMBER	TYPE OF BUSINESS	Currently Marketing or Available (A)	Number of Policies (B)	Number of Lives (C)	Member Months (D)	Direct Premium Earned (E)	Direct Claims Incurred (F)
15	Medicare Advantage						
17	Medicare Supplement						
17a	Standard Medicare Supplement						
17b	Pre-Standardized Medicare Supplement						
17c	Medicare Select						
29	Medicare Part D						
DISABILITY							
18	Credit Disability						
19	Disability Income - Long Term						
20	Disability Income - Short Term						
MISCELLANEOUS							
21	Accident Only (Incl Student)/AD&D/Travel						
22	Student Policies - Accident & Health						
24	Excess/Stop Loss						
30	Involuntary Unemployment Insurance						

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(IMPORTANT! SEE DEFINITIONS SECTION FOR SPECIFIC INSTRUCTIONS.)

INFORMATION RELATED ONLY TO BUSINESS IN OHIO

For the Year Ending December 31, 2015

DEFINITION NUMBER	TYPE OF BUSINESS	Currently Marketing or Available (A)	Number of Policies (B)	Number of Lives (C)	Member Months (D)	Direct Premium Earned (E)	Direct Claims Incurred (F)
III. INDIVIDUAL – HEALTH INSURING CORP. (HMO PRODUCTS):							[DEFINITIONS]
MEDICAL							
1	Major Medical Health Benefit Plan:						
1a	Individual Health Benefit Plan, On Exchange						
1aa	On Exchange Platinum						
1ab	On Exchange Gold						
1ac	On Exchange Silver						
1ad	On Exchange Bronze						
1ae	On Exchange Catastrophic Plan						
1af	On Exchange Non Employer Group						
1ag	Individual Health Benefit Plan, Off Exchange						
1ah	Off Exchange, Platinum						
1ai	Off Exchange Gold						
1aj	Off Exchange Silver						
1ak	Off Exchange Bronze						
1al	Off Exchange Catastrophic Plan						
1am	Off Exchange Non Employer Group						
31	Grandfathered Health Plan						
32	Transitional Health Plan						
36	Other Health Plans						
28	High Deductible Products **(HSA qualified)**						
SUPPLEMENTAL/SPECIALTY PLANS **(IMPORTANT! SEE SPECIFIC DEFINITIONS)**							
4	Dental, On Exchange						
4a.	Dental, Off Exchange						
7	Prescription Drug						
10	Vision						
25	Mental Health/Substance Abuse						
FEDERAL GOVERNMENT PROGRAMS							
11	Federal Employees Health Benefit Plan						
12	Health Coverage Tax Credit (HCTC)						
13	Title XIX – Medicaid						
14	Other Federal Government (See Definition)						
SENIOR COVERAGE							
15	Medicare Advantage						
16	Medicare Cost						
29	Medicare Part D						

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(IMPORTANT! SEE DEFINITIONS SECTION FOR SPECIFIC INSTRUCTIONS.)

INFORMATION RELATED ONLY TO BUSINESS IN OHIO

For the Year Ending December 31, 2015

IV GROUP – HEALTH INSURING CORP. (HMO PRODUCTS): [DEFINITIONS]

DEFINITION NUMBER	TYPE OF BUSINESS	Currently Marketing or Available (A)	Number of Policies (B)	Number of Lives (C)	Member Months (D)	Direct Premium Earned (E)	Direct Claims Incurred (F)
MEDICAL							
1	Major Medical Health Benefit Plan:						
1b	Small Employer Group (1-50), On Exchange						
1aa	On Exchange Platinum						
1ab	On Exchange Gold						
1ac	On Exchange Silver						
1ad	On Exchange Bronze						
1ba	Small Employer Group Plan, Off Exchange						
1ag	Off Exchange, Platinum						
1ah	Off Exchange Gold						
1ai	Off Exchange Silver						
1aj	Off Exchange Bronze						
1c	Large Employer Group (> 50)						
31	Grandfathered Health Plan						
32	Transitional Health Plan						
36	Other Health Plans						
28a	Small Employer Group (1-50) High Deductible Products **(HSA Qualified)**						
28b	Large Employer Group (>50) High Deductible Products **(HSA Qualified)**						
23	Small Employer Health Care Alliance						
23a	Alliance – Employer Members w/ <2 Lives						
23b	Alliance – Employer Members w/ 2-50 Lives						
23c	Alliance – Employer Members w/ >50 Lives						
SUPPLEMENTAL/SPECIALTY PLANS **(IMPORTANT! SEE SPECIFIC DEFINITIONS)**							
4	Dental, On Exchange						
4a	Dental, Off Exchange						
7	Prescription Drug						
10	Vision						
25	Mental Health/Substance Abuse						
FEDERAL GOVERNMENT PROGRAMS							
11	Federal Employees Health Benefit Plan						
13	Title XIX – Medicaid						
14	Other Federal Government (See Definition)						
SENIOR COVERAGE							
15	Medicare Advantage						
16	Medicare Cost						
29	Medicare Part D						

HEALTH PLAN BENEFIT SPECIFIC INFORMATION PAGE:

THIS DATA PAGE IS REQUIRED FROM COMPANIES WITH TYPES OF BUSINESS LISTED UNDER THE SECTIONS TITLED "MEDICAL". **If information does not apply, 0 must be entered for each field and saved.**

- Provide an estimate of the total number of lives for all Health Plans (see definition 1) listed under the Medical sections that are covered for Dental, Prescription Drug, or Vision benefits.

- Do not include lives listed under the Supplemental Coverage or Supplemental/Specialty Plans sections.

Individual – Health Insurance	**# Lives**
*Total Number of Lives - Dental	
*Total Number of Lives – Prescription Drug	
*Total Number of Lives - Vision	
Group / Blanket – Health Insurance	
*Total Number of Lives - Dental	
*Total Number of Lives – Prescription Drug	
*Total Number of Lives - Vision	
Individual – Health Insuring Corporation (HMO Products)	
*Total Number of Lives - Dental	
*Total Number of Lives – Prescription Drug	
*Total Number of Lives - Vision	
Group – Health Insuring Corporation (HMO Products)	
*Total Number of Lives - Dental	
*Total Number of Lives – Prescription Drug	
*Total Number of Lives - Vision	

SUBROGATION RECOVERY INFORMATION PAGE:

THIS DATA PAGE MUST BE COMPLETED BY ALL REPORTING COMPANIES.

- For purposes of this reporting, "subrogation recovery" is defined as recovery of medical expenses on behalf of an insured, where those medical expenses were subsequently reimbursed to the insurer by another lawfully liable party.

- Provide the total annual $ amount of subrogation recoveries for medical claims expenses.

- Report one combined total for all product types, **excluding** all Disability products and Excess/Stop Loss.

- If there are no subrogation recoveries for medical claims expenses to report, enter **0**.

Does your company pursue subrogation for Medical Claims Expenses?	
YES	☐
NO	☐
Provide the total annual $ amount of subrogation recoveries for medical claims expenses. Must enter an amount. 0 is permissible *(required field).*	
$_____	

Ohio Department of Insurance

Annual Health Insurance Administrative Expense and Open Enrollment Data Reporting

Instructions and Information

Background:

Ohio Am. Sub. H.B.1, that, for most sections, became effective 10/16/2009, requires additional annual reporting by health insurers of aggregate administrative expense and open enrollment data. Please review the regulations that apply to each of these categories from the links provided below:

- **Aggregate Administrative Expense Reporting** – ORC §3923.022(C)(1)-(2), (G) http://codes.ohio.gov/orc/3923.022

*****SUSPENDED THROUGH DEC 2017*****

- **Open Enrollment:**
  - OAC Rule 3901-8-12(D) http://codes.ohio.gov/oac/3901-8-12
  - Non-FEI: ORC §3923.58 http://codes.ohio.gov/orc/3923.58
  - FEI: ORC §3923.581 http://codes.ohio.gov/orc/3923.581

Instructions:

- General
  - All carriers that are required to submit the Annual Report of Ohio Health Insurance Business must complete the Aggregate Administrative Expense and Open Enrollment reporting page. Carriers may certify that the statutory requirements for either or both categories are not applicable to their business by checking the appropriate certification check box provided on the page.
  - All numeric data fields must be completed in each applicable category. If a numeric field is not relevant, enter a zero (0).
  - Numeric data fields accept numbers only with or without commas. Use a minus sign (-) to indicate negative amounts.

- Aggregate Administrative Expense Reporting:
  - All taxes, fees, costs and expenses should be reported on an incurred basis.
  - The application will automatically calculate the Aggregate amount for each row of data.
  - When the "Save & Validate" button is clicked at the bottom of the page, the application will save all data entered and perform a validation check of amounts reported on Lines 4 through 12 using the following formula:

	LINE #	FIELD NAME
+	4	Earned Premiums Less Reinsurance Costs
-	5	Claims Paid Less Reinsurance Reimbursements
-	6	Claims Incurred But Not Reported (IBNR) Current Year

+	7	Claims Incurred But Not Reported (IBNR) Prior Year
-	8	State Fees and State & Federal Taxes Incurred
-	9	Commission Costs Incurred
-	10	Fraud Prevention Costs Incurred
-	11	Managed Care Costs Incurred
=	12	Administrative Expenses Incurred (net)

- If the validation check fails, an error will be displayed in the upper portion of the page. Data must be corrected and pass the validation check, or a comment explaining the exception must be entered in the field provided on Line 13.

- Reporting of aggregate administrative expense data also requires certification by an authorized officer of the carrier (in compliance with ORC §3923.022(C)(1)). The certification is accomplished through this application by completion of Lines 14 through 15a.

- Open Enrollment Reporting: ***SUSPENDED THROUGH DEC 2017***
  - Accuracy is important -- data should reconcile, where applicable, to data reported elsewhere in this application.

  - Open Enrollment data reported in this application will be used by the Superintendent in formulating market-wide average medical loss ratios that will determine open enrollment capacity and premium rate limits to be effective beginning January 1, 2012, in compliance with:
    - Non-FEI: ORC §3923.58(E)(2) and (G)(1)(b) http://codes.ohio.gov/orc/3923.58
    - FEI: ORC §3923.581(E)(2) and (J)(1)(b) http://codes.ohio.gov/orc/3923.581

FAQs

- **Administrative Expense FAQs**

1. What health products are to be reported in this section?

   - All "Sickness and accident insurance business," as defined in ORC 3923.022(A)(3).

2. Please provide definitions of Individual, Small Group, and Large Group columns.

   - Individual: refers to "Individual business," as defined in ORC 3923.022(A)(4).

   - Small Group: employer group plans where the number of employees is 50 or less.

   - Large Group: employer group plans where the number of employees is over 50.

3. Does Gross Earned Premium have the same definition as the term Direct Earned Premium used for reporting elsewhere in the Annual Health Report?

   - Yes. Gross Earned Premium means, prior to reinsurance, premiums collected and

attributable to the reported calendar year (including direct premiums unearned for the year prior to the reported calendar year, and excluding direct premiums unearned for the year following the reported year) for each category of business.

4. Define Reinsurance Costs. Is the definition the same for "Earned Premiums Less Reinsurance Costs" and "Reinsurance Costs (Incurred)?"

- Reinsurance Costs refers to the amount of premiums paid to a reinsurer and any related costs, to transfer all or a portion of the risk for a block of business. The term has the same meaning in both fields. The amount reported as "Reinsurance Costs (Incurred)" is the amount that would be used in calculating "Earned Premiums Less Reinsurance Costs."

5. Define Reinsurance Reimbursements.

- Any portion of Gross Claims Paid that is reimbursed by a reinsurer.

6. Have the definitions of types of administrative expenses changed under the revised regulation?

- The definitions have not changed. Expense categories to be reported (e.g., State fees, taxes, commission, fraud, and managed care costs) should be determined in the same manner as they would have been under the previous regulation.

7. Please define "Administrative Expenses (net)" – this is the amount that is required to be 20% or less of earned premiums; it represents the amount of administrative expenses after all exclusions permitted under the regulation.

- **Open Enrollment FAQs**

*****SUSPENDED THROUGH DEC 2017*****

1. What is the difference between the table of data for reporting Administrative Expenses and the Open Enrollment table of data and how are they related?

- The Administrative Expense data table includes reporting of defined sickness and accident insurance business, broken down only by individual, small group, and large group markets. The Open Enrollment data table includes only individual market data and breaks that data down in more detail. It would be expected that some individual market data reported in the Administrative Expense section would closely correlate to data reported in the Open Enrollment section; however, definitions of individual market business differ slightly between the applicable regulations.

2. Are the definitions of premium and claim data (e.g., Gross Earned Premiums) the same as those for the same terms in the Administrative Expense section?

- Yes.

Aggregate Administrative Expense and Open Enrollment Data Page

THIS PAGE MUST BE COMPLETED BY ALL REPORTING COMPANIES, EITHER BY ENTERING THE DATA REQUESTED, OR BY CERTIFICATION WHERE INDICATED ON THE PAGE THAT THE COMPANY IS NOT SUBJECT TO THE REPORTING REQUIREMENTS.

- Ohio Revised Code ("ORC") Section 3923.022 requires additional annual reporting by health insurers of aggregate administrative expense relative to "sickness and accident business. The data to be reported has been added to this application on a new reporting page under the category link titled **Administrative Expense**.

- As defined in ORC Section 3923.022(A)(3), "**Sickness and accident insurance business**" does not include coverage provided by an insurer for specific diseases or accidents only; any hospital indemnity, Medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than six months, or other policy that offers only supplemental benefits; or coverage provided to individuals who are not residents of this state."

- The template below can be used as a worksheet to prepare your data for reporting; however, the **Instructions & Information** document that is provided from a link on both the **Contact Page** and the **Administrative Expense** reporting page of the application should be reviewed to ensure that you are reporting data on the basis specified.

- The "Aggregate" column of the Administrative Expense Reporting is displayed on this worksheet for your convenience in preparing data for reporting. However, this column will be automatically calculated and displayed in the application.

- All taxes, fees, costs and expenses should be reported on an incurred basis.

Administrative Expense Reporting				
	Individual	Small Group	Large Group	Aggregate
Gross Earned Premium				
Earned Premiums Less Reinsurance Costs				
Gross Claims Paid				
Claims Paid Less Reinsurance Reimbursements				
Claims Incurred But Not Reported (IBNR) Current Year				
Claims Incurred But Not Reported (IBNR) Prior Year				
State Fees + State & Federal Taxes (Incurred)				
Reinsurance Costs (Incurred)				
Commission Costs (Incurred)				
Fraud Prevention Costs (Incurred)				
Managed Care Costs (Incurred)				
Administrative Expenses (net)				

Federal Payment Reporting Page

		Number of Policies for which payments are received from the Federal Government	Number of Lives Covered under such Policies	Total Dollar Amount Received from the Federal Government for enrollees in Ohio	Estimated Dollar Amount to be Received from the Federal Government for enrollees in Ohio
33	Cost Sharing Subsidy				
34	Premium Tax Credit				
35	Reinsurance Payments				

DEFINITIONS FOR
ANNUAL REPORT OF OHIO HEALTH INSURANCE BUSINESS

For purposes of this report:

- *Do not include Self-Insured or Administrative Services Only (ASO) business.*
- *The risk-bearing entity issuing the insuring contract (policy, certificate of coverage, etc.) is the entity responsible for reporting that business.*
- *If a policy fits into more than one category, please pick the most appropriate category.* ***DO NOT REPORT A POLICY IN MORE THAN ONE CATEGORY.***

REQUIRED DATA FIELDS (COLUMN HEADINGS)

(A) **Currently Marketing or Available (Y/N)** – indicate whether the type of business is currently being marketed or available for purchase by the company or individual. ***(Example - A company that has products available for purchase due to statutory requirements should report "Y" in this field for that product).***

(B) **Number of Policies** - the number of policies in force at 12/31 of the Reported Year for each type of business***. **The number of policies should reflect the "actual number of certificates" for both individual and group products. Do not provide a count of group master policies for group products.***

(C) **Number of Lives** - the number of lives insured, including dependents, at 12/31 of the Reported Year for each type of business.

(D) **Member Months** - determine the total number of lives insured each month of the Reported Year on a pre-specified day of each month. Add the total for each month to determine the member months for each type of business.

(E) **Direct Earned Premium** – prior to reinsurance, premiums collected and attributable to the Reported Year (including direct premiums unearned for the year prior to the Reported Year and excluding direct premiums unearned for the year following the Reported Year) for each type of business.

(F) **Direct Claims Incurred** – prior to reinsurance, claims paid during the Reported Year, plus estimated unpaid claim liabilities (reported and unreported) at the end of the current Reported Year, less estimated unpaid claim liabilities (reported and unreported) at the end of the year prior to the Reported Year for each type of business.

TYPES OF BUSINESS (ROW HEADINGS)

1. **Major Medical Health Benefit Plan** – any hospital or medical expense policy or certificate or any health plan, provided by a carrier, that is delivered, issued for delivery, renewed, or used in Ohio.

Note that the following products are not considered "major medical" for purposes of this survey and must be reported separately in their appropriate category:

i. Services offered as a supplemental or specialty policy covering only: (Accident, Credit, Disability Income, Short Term Care, Long Term Care, Hospital/Surgical/Outpatient Indemnity, Medicare Supplement, Specified Disease/Intensive Care/Organ & Tissue Transplant, Dental Care, Vision Care, Mental Health/Substance Abuse or Prescription Drugs)

ii. Any other category of services offered separately, and not in combination with other services or as part of a comprehensive health plan

iii. Medicaid (Title XIX), Medicare, Federal Employees Health Benefit Plans, plans offered under the Health Coverage Tax Credit (HCTC) program and other Federally regulated health benefit programs

1a. **Individual Health Benefit Plan, On Exchange ~~(total)~~** - a qualified health plan as defined by section 1301(a) of the Affordable Care Act (ACA) and offered through the Exchange as described in sections 1311 and 1321 of the ACA. Enter data in the corresponding lines 1aa through 1af.

1aa. **On Exchange, Platinum –** designed to provide benefits actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan and offered through the Exchange as described in sections 1311 and 1321 of the ACA**.**

1ab. **On Exchange, Gold –** designed to provide benefits actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan and offered through the Exchange as described in sections 1311 and 1321 of the ACA**.**

1ac. **On Exchange, Silver –** designed to provide benefits actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan and offered through the Exchange as described in sections 1311 and 1321 of the ACA**.**

1ad. **On Exchange, Bronze –** designed to provide benefits actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan and offered through the Exchange as described in sections 1311 and 1321 of the ACA**.**

1ae. **On Exchange, Catastrophic –** A health plan defined in section 1302(e) of the Affordable Care Act that is offered only to eligible individuals in the individual market, and generally does not provide benefits for any plan year until the individual has incurred certain cost sharing expenses that is offered through the Exchange as described in sections 1311 and 1321 of the ACA**.**

1af. **On Exchange Non Employer Group** - any group hospital or medical expense policy or certificate, or any health plan, that is not sold in connection with an employer group health benefit plan and that provides more than short term, limited duration benefits. Do not include Conversion, Open Enrollment, or Small Employer Health Care Alliance plans.

1ag. **Individual Health Benefit Plan, Off Exchange ~~(total)~~ –** individual health benefit plan. Includes non-employer group and association plan coverage. Do not include Small Employer Health Care Alliance plans. Enter data in the corresponding lines 1ag through 1am.

1ah. **Off Exchange, Platinum -** designed to provide benefits actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan or policy.

1ai. **Off Exchange, Gold –** designed to provide benefits actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan or policy.

1aj. **Off Exchange, Silver –** designed to provide benefits actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan or policy.

1ak. **Off Exchange, Bronze –** designed to provide benefits actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan or policy.

1al. **Off Exchange, Catastrophic -** A health plan defined in section 1302(e) of the Affordable Care Act that is offered only to eligible individuals in the individual market, and generally does not provide benefits for any plan year until the individual has incurred certain cost sharing expenses.

1am. **Off Exchange, Non Employer Group –** any group hospital or medical expense policy or certificate, or any health plan, that is not sold in connection with an employer group health benefit plan and that provides more than short term, limited duration benefits. Do not include Conversion, Open Enrollment, or Small Employer Health Care Alliance plans.

1b. **Small Employer Group, (1-50) On Exchange ~~(total)~~ -** a qualified health plan as defined by section 1301(a) of the ACA and offered through the Exchange as described in sections 1311 and 1321 of the ACA. Enter data in the corresponding lines 1aa through 1af.

1ba. **Small Employer Group, (1-50) Off Exchange ~~(total)~~** - group plans where the number of employees is 1-50. Do not include Small Employer Health Care Alliance plans. Enter data in the corresponding lines 1ag through 1aj.

1c. **Large Employer Group (> 50)** - group plans where the number of employees is greater than 50. Do not include Small Employer Health Care Alliance plans.

2. **Franchise/Blanket Accident and Sickness** - an individual insurance contract for accident and sickness issued to either of the following:

- **Franchise Accident and Sickness** – (1) five or more employees of any corporation, co-partnership, or individual employer, or of any governmental corporation or agency or a department thereof; or (2) ten or more members of any trade or professional association, or labor union, or any other association having had

an active existence for at least two years where such association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance.

- **Blanket Accident/Sickness** - a health insurance contract that covers all of a class of persons not individually identified in the contract (see Ohio Revised Code section 3923.13).

3. **Short Term Medical** – a one-time-limited-duration policy of no longer than six months designed to provide coverage during a "gap" in coverage.,

4. **Dental, On Exchange** – a policy or contract providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw and offered through the Exchange as described in sections 1311 and 1321 of the ACA. Do not include coverage provided under a major medical health benefit plan (see definition 1).

4a. **Dental, Off Exchange -** policy or contract providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw. Do not include coverage provided under a major medical health benefit plan (see definition 1).

5. **Hospital/Surgical/Outpatient Indemnity** - a supplemental insurance contract that pays a fixed dollar amount without regard to the actual expense incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition (see Ohio Revised Code Section 3923.37).

6. **Long Term Care** – a policy or contract designed to provide coverage for not less than 1 year for medical and other services provided in a setting other than an acute care unit of a hospital. Do not include coverage provided under a major medical health benefit plan (see definition 1).

6a. **Long Term Care (Partnership Qualified) –** a product established under division (b) of section 1917 of the "Social Security Act," 42 U.S.C. 1396p that offers a way for people to buy long-term care insurance, receive policy benefits and protect a matching amount of assets if they need to apply for Medicaid.

7. **Prescription Drug** – a policy or contract providing benefits only for prescribed medications. Do not include coverage provided under a health benefit plan (see definition 1).

8. **Short Term Care** – a policy or contract designed to provide coverage for no longer than six months for medical and other services provided in a setting other than an acute care unit of a hospital. Do not include coverage provided under a health benefit plan (see definition 1).

9. Include the following types of contracts. Do not include coverage provided under a major medical health benefit plan (see definition 1):

- **Specified/Named Disease** - a contract that only pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits may be paid as expense incurred, per diem, or as a principal sum.
- **Intensive Care** - a contract that provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits not to exceed a stated dollar amount per day.
- **Organ & Tissue Transplant** - a contract that provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day.

10. **Vision** – a policy or contract providing benefits for eye care and eye care accessories. Benefits often include stated dollar amounts for annual eye examinations, glasses and contacts, and may include treatment/surgical benefits for injury or sickness associated with the eye. Do not include coverage provided under a major medical health benefit plan (see definition 1).

11. **Federal Employees Health Benefit Plan** - business allocable to the Federal Employees Health Benefit Plan (FEHBP) premiums that are exempted from state taxes or other fees by Section 8909 (f) (1) of Title 5 of the United States Code.

12. **Health Coverage Tax Credit (HCTC)** – policies issued under state qualified health plans pursuant to the Trade Act of 2002 (Public Law 107-210) that created a federal tax credit for the purchase of private health insurance for displaced workers certified to receive Trade Adjustment Assistance (TAA) benefits and individuals receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

13. **Title XIX – Medicaid** – business where the reporting entity charges a premium and agrees to cover the full medical costs of eligible Medicaid subscribers.

14. **Other Federal Government** - business allocable to other federally regulated health benefit programs (e.g., Champus/Tricare Supplement). Do not include managed care contracts under Title XIX Medicaid, Title XVIII Medicare contracts, coverage offered through the Exchange as described in section 1311 and 1321 of the ACA or Health Coverage Tax Credit.

15. **Medicare Advantage** – managed care and fee-for-service contracts with CMS offering comprehensive medical care to Medicare beneficiaries that reside within a specified service area. *(Previously called Medicare + Choice)*

16. **Medicare Cost** – contracts with CMS to provide services that are paid on a pre-determined monthly amount per member based on a total estimated budget. Beneficiaries are permitted to use out-of-network providers.

17. **Medicare Supplement** - a contract between a Medicare beneficiary and an insurer that has contracted to provide a variety of Medigap type services to beneficiaries.

17a. **Standard Medicare Supplement** – a policy providing benefits according to standard plans A – J or high deductible plans F and J.

17b. **Pre-Standardized Medicare Supplement** – a policy issued before 1992 (not subject to standard plan A – J requirements).

17c. **Medicare Select** – a policy that provides the same benefits as one of the standard plans A – J or high deductible plans F and J, with provider network restrictions.

18. **Credit Disability** – a policy or contract that makes monthly loan/credit transaction payments to the creditor upon the disablement of an insured debtor.

19. **Disability Income - Long Term** - a group disability contract where the maximum benefit period commonly extends to retirement or age 70 or an individual disability income insurance policy where the maximum benefit period is greater than 5 years, commonly extending to age 65 or for the insured's lifetime. Group Long-term disability usually specifies a maximum benefit period of at least one year.

20. **Disability Income - Short Term** – an insurance contract that provides a benefit for a short disability. Individual short-term disability insurance specifies a maximum benefit period of from one to 5 years. Group short-term disability usually specifies a maximum benefit period of less than one year.

21. **Accident Only (Incl. Student)** - an insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents. Include the following types of business:

- **Student Accident** - a health insurance contract that covers a class of students not individually identified in the contract for accident only benefits.
- **AD&D** - an insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.
- **Travel** - a limited benefit expense policy that provides benefits for loss incurred while traveling generally outside a 100-mile radius of the US borders. May extend to domestic as well as foreign travel. May provide both sickness and injury benefits. May include loss of baggage benefits. May include air transportation services for emergencies. Benefits not to exceed a stated dollar amount per day, per month or trip duration.

22. **Student Policies - Accident & Health** - a health insurance contract that covers a class of students not individually identified in the contract for both accident and health benefits.

23. **Small Employer Health Care Alliance (Alliance)** – an organization that is authorized under Ohio Revised Code Section 1731.01, to sponsor a program to assist small employer members to obtain coverage for their employees under one or more health benefit plans.

23a. **Alliance w/ <2 Lives** – individual members and member employers with fewer than 2 lives.

23b. **Alliance w/ 2-50 Lives** – member employers with at least 2 but fewer than 51 lives.

23c. **Alliance w/ >50 Lives** – member employers with more than 50 lives.

24. **Excess/Stop Loss** – an insurance policy or contract that may be extended to either a health plan or a self-insured employer plan to insure against the risk that any one claim or an entire plan's losses will exceed a specific dollar amount.

25. **Mental Health/Substance Abuse** – a contract providing coverage for mental health services, and/or medical or psychological treatment and referral services for alcohol and drug abuse or addiction. Do not include coverage provided under a major medical health benefit plan (see definition 1).

28. **High Deductible Products / Individual - Health Savings Account (HSA) Qualified** - a high deductible health insurance plan (HDHP) that is qualified to combine with a Health Savings Account, which is an investment account where pre-tax dollars are deposited that can be used tax-free for qualified future medical and long-term care expenses or premiums.

28a. **High Deductible Products / Small Employer Group (1-50) - Health Savings Account (HSA) Qualified -** HSA qualified HDHP group products offered to member employers with at least 1 but fewer than 51 lives.

28b. **High Deductible Products / Large Employer Group (> 50) - Health Savings Account (HSA) Qualified -** HSA qualified HDHP group products offered to member employers with more than 50 lives.

29. **Medicare Part D –** a standalone prescription drug product available to all Medicare eligible individuals.

30. **Involuntary Unemployment Insurance –** a product covering credit card payments for an insured while unemployed.

31. **Grandfathered Health Plan** – group health plans and health insurance coverage in which an individual was enrolled on March 23, 2010 that has not made any changes causing cessation of grandfathered status as set forth in 45 CFR 147.140.

32. **Transitional Health Plan** – non-grandfathered health insurance in the individual and small group markets that would otherwise have terminated or required modification as a result of the federal health insurance market reforms required under the ACA, but was renewed pursuant to CCIIO's November 14, 2013 or March 5, 2014 transitional policy.

33. **Cost Sharing Subsidy** – financial assistance provided by the federal government that reduces eligible enrollees' out-of-pocket costs for health care services, such as deductibles, copayments, and coinsurance, for insurance plans purchased through the Exchange as described in section 1402 of the ACA.

34. **Premium Tax Credit** – financial assistance provided by the federal government that reduces eligible enrollees' monthly payments for insurance plans purchased through the Exchange as described in section 1401 of the ACA.

35. **Reinsurance Payments** – payments received by eligible individual insurance plans from the federal government when the plans' cost for an enrollee reaches a specified attachment point as described in section 1341 of the ACA.

36. **Other Health Plans** – health insurance coverage that does not fit into any of the above listed categories. When reporting, provide an aggregate total for the number of policies, lives, months and premiums for all plans reported in this category. Additionally, provide a description of each plan type in the comments section.