# **02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**031 BUREAU OF INSURANCE**

**Chapter 945: Annual Report Supplement for Health Insurers**

**Section 1. Purpose**

This rule establishes standards, procedures, and forms that health insurers and health maintenance organizations must use in filing the annual report supplement required by 24‑A M.R.S.A. § 423-D.

**Section 2. Authority**

This rule is promulgated by the Superintendent pursuant to 24-A M.R.S.A. §§ 212 and 423-D.

**Section 3. Applicability and Scope**

Except as provided in this section, the filing requirements contained in this rule apply to all health insurers and health maintenance organizations and to all insurers writing employee benefit excess (stop-loss) insurance as defined in 24-A M.R.S.A. § 707(1)(C-1) with respect to health benefit plans. The requirements apply to companies renewing existing policies, whether or not they currently offer those policies for new issue. The reporting requirements do not apply to the types of health insurance identified as an exception to the definition of health insurance in 24‑A M.R.S.A. § 704(2). Therefore, insurers engaged in only the following types of health insurance or any combination of the following shall file blank reports, providing only their contact information, but shall not otherwise be subject to this rule: accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement, or other limited benefit health insurance as defined in Rule 755.

**Section 4. Filing Requirements**

Health insurers and health maintenance organizations subject to this rule shall submit the annual report supplement to the Superintendent on or before March 1st of each year for the year immediately preceding. The reporting entity may submit a written request for an extension for good cause to the Superintendent prior to March 1st. The Superintendent shall evaluate and grant a request for an extension on a timely basis if good cause has been demonstrated.

Health insurers and health maintenance organizations shall use information consistent with that reported in their annual statutory financial statements and reconcile the annual report supplement to the applicable pages of their statements.

The annual report supplement shall be filed in an electronic format prescribed by the Superintendent.

**Section 5. Annual Report Supplement Contents**

Annually, the Superintendent shall provide the form in which the annual report supplement shall be prepared by health insurers and health maintenance organizations. Appendices A and B provide the forms and instructions for use for the reporting of calendar year 2009 information. The forms and instructions for subsequent years will be substantially similar accounting only for revisions to the National Association of Insurance Commissioners’ annual statutory financial statements.

Appendix A provides the forms and instructions for health insurers and health maintenance organizations with direct written health insurance premium in the State of Maine totaling more than $2,000,000 for the reporting year, excluding the types of health insurance identified in section 3 as being excluded from the filing requirements. Appendix B provides the forms and instructions for all other health insurers and health maintenance organizations subject to this rule. Insurers that had no health business of any kind in force at any time during the year or during the previous year do not need to file a report. Insurers that had health insurance in force during the year or during the previous year but had no business of the types subject to this rule in force at any time during the year shall file blank reports, providing only their contact information.

**Section 6. Public Information**

Filings made pursuant to this rule are “public records” under 1 M.R.S.A. § 402(3) and will be available for public inspection pursuant to 1 M.R.S.A. § 408.

**Section 7. Failure to File**

Any health insurer or health maintenance organization that fails to file the annual report supplement by the later of March 1st or a date of extension granted by the Superintendent pursuant to Section 4, violates this rule and may be subject to penalties as permitted under 24‑A M.R.S.A. §§ 12-A and 215.

**Section 8. Effective Date**

This rule is effective February 13, 2005, and requires filing of data for calendar years 2004 and later. The 2008 amendments are applicable to reports filed in 2008 and later for calendar years 2007 and later. The 2009 amendments (filing 2009-683) are applicable to reports filed in 2010 and later for calendar years 2009 and later.

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 18, 2025

APPENDIX A

2009 ANNUAL REPORT SUPPLEMENT and INSTRUCTIONS

HEALTH INSURERS and HEALTH MAINTENANCE ORGANIZATIONS WITH AT LEAST $2,000,000 of DIRECT WRITTEN HEALTH INSURANCE PREMIUM IN MAINE (See Section 5 of this Rule.)

1. Reports shall not include data for accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement, or other limited benefit health insurance as defined in Rule 755, Section 9. The filing requirements do apply to employee benefit excess (stop-loss) insurance as defined in 24-A M.R.S.A. § 707(1)(C-1) with respect to health benefit plans. The filing requirements also apply coverage issued under the Federal Employees Health Benefits Program and to short-term medical coverage as defined in 24-A M.R.S.A. § 2849-B(1).
2. The reporting entity shall report the information (hereinafter referred to as “line items”) indicated on the attached reporting forms. Statewide data is to be reported on Part 1. One copy of Part 2 of the form must be completed for each region, as defined in item 3 below, in which the entity has health business. The majority of the line items listed correspond to line items from the Statement of Revenue and Expenses, the Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses and the Exhibit of Premiums, Enrollment and Utilization, which are contained in the health annual statutory financial statements. For insurers completing life and accident and health (Life) or property and casualty (P&C) annual statutory financial statements, a portion of the information required is contained within Schedule H – Accident and Health Exhibit—of those annual statutory financial statements. Some line items may not tie directly to any exhibits in the Life or P&C statements. For these items, the reporting entity may look to the instructions for the health statement for guidance.
   1. Member and Contract Information. The reporting entity shall report the indicated information on member months and on contracts in-force and covered lives as of December 31.

* 1. Revenue and Expense Information. The reporting entity shall report the indicated information on revenues and expenses and shall use the definitions and guidance found in the National Association of Insurance Commissioner’s Annual Statement Instructions and Accounting Practices and Procedures Manual or their successor publications.
     1. Total cost containment expenses should be reported in the cost containment expense line item and should be equivalent to information contained in line 20 of the Statement of Revenue and Expenses if the insurer files a health annual statutory financial statement.
     2. Other claims adjustment expenses should be reported in total only and should be equivalent to information contained in line 20 of the Statement of Revenue and Expenses if the insurer files a health annual statutory financial statement.
     3. All other general and administrative expenses should be reported in the appropriate line items and should, in total, be equivalent to line 21 of the Statement of Revenue and Expenses if the insurer files a health annual statutory financial statement.
     4. Lobbying expenses are expenditures in connection with matters before legislative bodies or governmental officers or agencies, including general legislative lobbying and direct lobbying of pending and proposed statutes or regulations.
        1. All lobbying expenses should be included, whether paid directly by the reporting entity or paid by a parent, affiliate, or holding company on behalf of the reporting entity.
        2. Lobbying expenses paid by a parent, affiliate, or holding company on behalf of multiple entities within the corporate structure should be included in an amount reflective of an appropriate allocation to the reporting entity.
     5. Investment expenses should not be included in any of the expense line items.
  2. Utilization Statistics. The reporting entity shall report the indicated information on utilization and shall use the definitions and guidance found in the National Association of Insurance Commissioner’s Annual Statement Instructions and Accounting Practices and Procedures Manual or their successor publications.
  3. The following definitions and guidance apply to items not found in the NAIC health annual statutory financial statements.

Line 2: “Number of contracts 12/31” means the number of individual or group policies in force at the end of the reporting year. A single group policy counts as one contract regardless of the number of certificate holders.

Line 2a: “Number of contracts included in line 2 that were issued during the year” means the number of individual or group policies issued during the year and still in force at the end of the year.

Line 2b: “Number of contracts included in line 2a covering policyholders that were uninsured for the prior 90 days” means the number of individual policies issued to previously uninsured individuals and the number issued to small groups that did not have a previous health plan in the prior 90 days.

**Drafting Note:** This information should be available from applications since it is needed to administer continuity rights provided by 24-A M.R.S.A. §§ 2849 and 2849-B.

Line 3: “Number of subscribers covered as individuals (non-family) under group or individual contracts 12/31” means the number of individual policyholders or group certificate holders who have no covered dependents as of the end of the reporting year. For stop-loss coverage, this refers to the underlying employee benefit plan.

Line 4: “Number of families covered (individual + spouse, individual + dependent, individual + family) 12/31” means the number of individual policyholders or group certificate holders who have covered dependents as of the end of the reporting year. For stop-loss coverage, this refers to the underlying employee benefit plan.

Line 5: “Number of dependents 12/31” means the number of covered members other than policyholders and certificate holders. The total of lines 3, 4, and 5 must equal the number of covered persons as of the end of the reporting year. For stop-loss coverage, this refers to the underlying employee benefit plan.

Line 33: “Dirigo savings offset payments” are payments required by the Board of Directors of Dirigo Health pursuant to 24-A M.R.S.A. § 6913(2).

Line 33a: “Dirigo access payments” are payments required pursuant to 24-A M.R.S.A. § 6917.

1. Except as provided in item 4 regarding small cells, the reporting entity shall report the information required in Item 2 by geographic region and category of policyholder within the State of Maine. The five geographic regions are:
2. Zip codes beginning with 039, 040, and 041
3. Zip codes beginning with 042
4. Zip codes beginning with 043, 045, 046, 048, and 049
5. Zip codes beginning with 044
6. Zip codes beginning with 047

The six categories of policyholders are:

1. Fully insured large groups, meaning all group and blanket policies, including Federal Employees Health Benefits Program, other than small groups and Dirigo groups
2. Fully insured small groups (1-50 employees) as defined by 24-A M.R.S.A. § 2808-B, excluding Dirigo groups
3. Fully insured individuals, including short-term coverage and excluding Medicare Advantage plans and Dirigo individuals
4. Dirigo groups (issued pursuant to 24-A M.R.S.A. Chapter 87)
5. Dirigo individuals (issued pursuant to 24-A M.R.S.A. Chapter 87)
6. Stop-loss (employee benefit excess insurance as defined in 24-A M.R.S.A. § 707(1)(C-1))

The reporting entity shall report the information according to the geographic region as follows:

a. Information pertaining to individual policies shall be included in the geographic region in which the individual contract holder resides.

b. Information pertaining to employer groups and labor union groups shall be included in the geographic region in which the employer is located unless the employer is not located in Maine. If the employer is not located in Maine, information shall be included in the geographic region in which the majority of the Maine employees work. Information pertaining to coverage of employees working in Maine under group policies issued in another state should be included if it is reported on the Maine state page of the insurer’s annual statutory financial statement.

c. For other types of groups, including but not limited to association groups and trustee groups, information shall be reported as follows:

i. If coverage relates to employment, for example a policy issued to a multiple employer trust or to an association of employers to cover their employees, then information shall be included in the geographic region in which the employer is located unless the employer is not located in Maine. If the employer is not located in Maine, information shall be included in the geographic region in which the majority of the Maine employees work.

ii. If coverage does not relate to employment, for example a policy issued to an association of individuals that does not provide coverage to employees of members, then information shall be included in the geographic region in which the certificate holder resides.

1. If the segmentation by category of policy and geographic region required in item 2 would disclose claims data or utilization data relating to a very small number of individuals or employer groups such that confidentiality might be sacrificed, the data must be combined with a larger cell as follows:
   1. Data for a small cell, as defined below, must be combined with the corresponding cell for the geographic area reflecting experience for the largest number of individuals. The reporting entity shall describe clearly which cells were combined.
   2. A “cell” means data for one policy category in one geographic region,
   3. A “small cell” means a cell reflecting the experience of fewer than 25 individuals or fewer than two employer groups.
   4. If the reporting entity has fewer than 25 individual policies or two group policies in a policy category statewide, data for that category must be combined with a larger category. The reporting entity shall describe clearly which categories were combined.
2. The reporting entity shall distinguish reported amounts representing actual revenues and expenses from reported amounts representing an allocation of revenues and expenses for each line item on Part 3 of the reporting form. If a revenue or expense line item is a combination of actual amounts and allocated amounts, the reporting entity shall so indicate. The reporting entity shall provide an explanation of the basis used when allocating revenues or expenses. As an example, rent expense may be allocated across all reporting categories. In this case, the reporting entity would indicate that rent expense is allocated along with the method used to allocate the expense. Actual amounts must be reported for lines 6-13, 15-24, 26-28, 30, and 33 to the extent feasible. An exception to this requirement is that allocation by region is acceptable if the insurer has fewer then 1,200 member months in the region. Otherwise, if allocation is used for any of these lines, the reporting entity must provide an explanation of why it is not feasible to report actual amounts.

MAINE ANNUAL REPORT SUPPLEMENT for Year \_\_\_\_

This form is for companies with at least $2 million of premium – see Rule 945, section 5.

PART 1: Statewide Data

Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAIC Code \_\_\_\_\_

Name of person completing this form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  | Large Groups | Small Groups | Individ-uals | Dirigo Groups | Dirigo Individ-uals | Stop-loss | TOTAL |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Member and Contract Information** | | | | | | | | |
| 1 | Member months during year |  |  |  |  |  |  |  |
| 2 | Number of contracts 12/31 |  |  |  |  |  |  |  |
| 2a | Number of contracts included in line 2 that were issued during the year |  |  |  |  |  |  |  |
| 2b | Number of contracts included in line 2a covering policyholders that were uninsured for the prior 90 days | XXX |  |  |  |  | XXX | XXX |
| 3 | Number of subscribers covered as individuals (non-family) under group or individual contracts 12/31 |  |  |  |  |  |  |  |
| 4 | Number of families covered (individual + spouse, individual + dependent, individual + family) 12/31 |  |  |  |  |  |  |  |
| 5 | Number of dependents 12/31 |  |  |  |  |  |  |  |
| 5a | Covered lives 12/31 (lines 3-5) |  |  |  |  |  |  |  |
| **Revenue Information** | | | | | | | | |
| 6 | Direct premiums written |  |  |  |  |  |  |  |
| 7 | Direct premiums earned |  |  |  |  |  |  |  |
| 8 | Net premium income |  |  |  |  |  |  |  |
| 9 | Change in unearned premium reserves and reserve for rate credits |  |  |  |  |  |  |  |
| 10 | Fee-for-service |  |  |  |  |  | XXX |  |
| 11 | Risk revenue |  |  |  |  |  | XXX |  |
| 13 | Aggregate write-ins for other health care related revenues |  |  |  |  |  |  |  |
| 14 | Total revenues (lines 8-13) |  |  |  |  |  |  |  |
| **Expense Information** | | | | | | | | |
| 15 | Hospital benefits (not including emergency room) - inpatient only |  |  |  |  |  | XXX |  |
| 16 | Hospital benefits (not including emergency room) - outpatient only |  |  |  |  |  | XXX |  |
| 17 | Medical benefits (excluding hospital inpatient and outpatient above) |  |  |  |  |  | XXX |  |
| 18 | Other professional services |  |  |  |  |  | XXX |  |
| 19 | Outside referrals |  |  |  |  |  | XXX |  |
| 20 | Emergency room and out-of-area |  |  |  |  |  | XXX |  |
| 21 | Prescription drugs |  |  |  |  |  | XXX |  |
| 22 | Aggregate write-ins for other medical and hospital |  |  |  |  |  | XXX |  |
| 23 | Incentive pool and withhold adjustments and bonus amounts |  |  |  |  |  | XXX |  |
| 24 | Net reinsurance recoveries |  |  |  |  |  |  |  |
| 25 | Total medical and hospital expenses (lines 15-23 less line 24) (For stop-loss, just enter total) |  |  |  |  |  |  |  |
| 26 | Increase in reserves |  |  |  |  |  |  |  |
| 27 | Cost containment expenses |  |  |  |  |  |  |  |
| 28 | Other claims adjustment expenses |  |  |  |  |  |  |  |
| 29 | Salaries, wages and other benefits excluding cost containment expenses and other claims adjustment expenses |  |  |  |  |  |  |  |
| 30 | Commissions |  |  |  |  |  |  |  |
| 31 | Marketing and advertising |  |  |  |  |  |  |  |
| 32 | Taxes, licenses and fees, , excluding Dirigo savings offset payments and Dirigo access payments |  |  |  |  |  |  |  |
| 33 | Dirigo savings offset payments |  |  |  |  |  |  |  |
| 33a | Dirigo access payments |  |  |  |  |  |  |  |
| 34 | Charitable contributions |  |  |  |  |  |  |  |
| 35 | Lobbying expenses |  |  |  |  |  |  |  |
| 36 | All other expenses |  |  |  |  |  |  |  |
| 37 | Total claims adjustment and administrative expenses (lines 27-36) |  |  |  |  |  |  |  |
| 38 | Net underwriting gain or (loss) (line 14 less line 25 less line 26 less line 37) |  |  |  |  |  |  |  |
| **Utilization Statistics** | | | | | | | | |
| 39 | Hospital days (not including emergency room) - inpatient only |  |  |  |  |  | XXX |  |
| 40 | Physician encounters |  |  |  |  |  | XXX |  |
| 41 | Other professional encounters |  |  |  |  |  | XXX |  |
| 42 | Number of emergency room visits |  |  |  |  |  | XXX |  |

MAINE ANNUAL REPORT SUPPLEMENT for Year \_\_\_\_

This form is for companies with at least $2 million of premium – see Rule 945, section 5.

PART 2: Regional Data

Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAIC Code \_\_\_\_\_

Name of person completing this form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This report is for the following zip code areas (Check one):

039, 040, and 041 042 043, 045, 046, 048, and 049 044 047

|  |  | Large Groups | Small Groups | Individ-uals | Dirigo Groups | Dirigo Individ-uals | Stop-loss | TOTAL |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Member and Contract Information** | | | | | | | | |
| 1 | Member months during year |  |  |  |  |  |  |  |
| 2 | Number of contracts 12/31 |  |  |  |  |  |  |  |
| 3 | Number of subscribers covered as individuals (non-family) under group or individual contracts 12/31 |  |  |  |  |  |  |  |
| 4 | Number of families covered (individual + spouse, individual + dependent, individual + family) 12/31 |  |  |  |  |  |  |  |
| 5 | Number of dependents 12/31 |  |  |  |  |  |  |  |
| **Revenue Information** | | | | | | | | |
| 6 | Direct premiums written |  |  |  |  |  |  |  |
| 7 | Direct premiums earned |  |  |  |  |  |  |  |
| 10 | Fee-for-service |  |  |  |  |  | XXX |  |
| 11 | Risk revenue |  |  |  |  |  | XXX |  |
| **Expense Information** | | | | | | | | |
| 15 | Hospital benefits (not including emergency room) - inpatient only |  |  |  |  |  | XXX |  |
| 16 | Hospital benefits (not including emergency room) - outpatient only |  |  |  |  |  | XXX |  |
| 17 | Medical benefits (excluding hospital inpatient and outpatient above) |  |  |  |  |  | XXX |  |
| 18 | Other professional services |  |  |  |  |  | XXX |  |
| 19 | Outside referrals |  |  |  |  |  | XXX |  |
| 20 | Emergency room and out-of-area |  |  |  |  |  | XXX |  |
| 21 | Prescription drugs |  |  |  |  |  | XXX |  |
| **Utilization Statistics** | | | | | | | | |
| 39 | Hospital days (not including emergency room) - inpatient only |  |  |  |  |  | XXX |  |
| 40 | Physician encounters |  |  |  |  |  | XXX |  |
| 41 | Other professional encounters |  |  |  |  |  | XXX |  |
| 42 | Number of emergency room visits |  |  |  |  |  | XXX |  |

MAINE ANNUAL REPORT SUPPLEMENT for Year \_\_\_\_

This form is for companies with at least $2 million of premium – see Rule 945, section 5.

PART 3: Allocation Method

Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAIC Code \_\_\_\_\_

**Check appropriate boxes. Attach explanation regarding line items indicated as “Allocated” or “Combination.”**

|  |  | Allocation by Region | | | Allocation by Category  of Policyholder | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Actual | Allocat-ed | Combin-ation | Actual | Allocat-ed | Combin-ation |
| **Revenue Information** | | | | | | | |
| 6 | Direct premiums written |  |  |  |  |  |  |
| 7 | Direct premiums earned |  |  |  |  |  |  |
| 8 | Net premium income | XXX | XXX | XXX |  |  |  |
| 9 | Change in unearned premium reserves and reserve for rate credits | XXX | XXX | XXX |  |  |  |
| 10 | Fee-for-service |  |  |  |  |  |  |
| 11 | Risk revenue |  |  |  |  |  |  |
| 13 | Aggregate write-ins for other health care related revenues | XXX | XXX | XXX |  |  |  |
|  |  |  |  |  |  |  |  |
| **Expense Information** | | | | | | | |
| 15 | Hospital benefits (not including emergency room) - inpatient only |  |  |  |  |  |  |
| 16 | Hospital benefits (not including emergency room) - outpatient only |  |  |  |  |  |  |
| 17 | Medical benefits (excluding hospital inpatient and outpatient above) |  |  |  |  |  |  |
| 18 | Other professional services |  |  |  |  |  |  |
| 19 | Outside referrals |  |  |  |  |  |  |
| 20 | Emergency room and out-of-area |  |  |  |  |  |  |
| 21 | Prescription drugs |  |  |  |  |  |  |
| 22 | Aggregate write-ins for other medical and hospital | XXX | XXX | XXX |  |  |  |
| 23 | Incentive pool and withhold adjustments and bonus amounts | XXX | XXX | XXX |  |  |  |
| 24 | Net reinsurance recoveries | XXX | XXX | XXX |  |  |  |
| 26 | Increase in reserves | XXX | XXX | XXX |  |  |  |
| 27 | Cost containment expenses | XXX | XXX | XXX |  |  |  |
| 28 | Other claims adjustment expenses | XXX | XXX | XXX |  |  |  |
| 29 | Salaries, wages and other benefits | XXX | XXX | XXX |  |  |  |
| 30 | Commissions | XXX | XXX | XXX |  |  |  |
| 31 | Marketing and advertising | XXX | XXX | XXX |  |  |  |
| 32 | Taxes, licenses and fees, excluding Dirigo savings offset payments and Dirigo access payments | XXX | XXX | XXX |  |  |  |
| 33 | Dirigo savings offset payments | XXX | XXX | XXX |  |  |  |
| 33a | Dirigo access payments | XXX | XXX | XXX |  |  |  |
| 34 | Charitable contributions | XXX | XXX | XXX |  |  |  |
| 35 | Lobbying expenses | XXX | XXX | XXX |  |  |  |
| 36 | All other expenses | XXX | XXX | XXX |  |  |  |

APPENDIX B  
2009 ANNUAL REPORT SUPPLEMENT and INSTRUCTIONS  
HEALTH INSURERS and HEALTH MAINTENANCE ORGANIZATIONS WITH LESS THAN $2,000,000 of DIRECT WRITTEN HEALTH INSURANCE PREMIUM IN MAINE (See Section 5 of this Rule.)

Reports must not include data for accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement, or other limited benefit health insurance as defined in Rule 755, Section 9. The filing requirements do apply to employee benefit excess (stop-loss) insurance as defined in 24-A M.R.S.A. § 707(1)(C-1) with respect to health benefit plans. The filing requirements also apply coverage issued under the Federal Employees Health Benefits Program and to short-term medical coverage as defined in 24-A M.R.S.A. § 2849-B(1).

The reporting entity shall report the information (hereinafter referred to as “line items”) indicated on the attached reporting form on a statewide basis. The reporting entity shall report the indicated information using the definitions and guidance found in the National Association of Insurance Commissioner’s Annual Statement Instructions and Accounting Practices and Procedures Manual or their successor publications. The information should be on a basis consistent with the annual statement line indicated in the following table:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Health Blank: | Life Blank or P&C Blank |
|  | Source Exhibit: | Statement of Revenue and Expenses | Schedule H Part 1 |
| 1 | Net premium income | Line 2 | Line 2 |
| 2 | Total revenues | Line 8 | Line 2 |
| 3 | Total medical and hospital expenses | Line 18 | Line 3 |
| 4 | Total claims adjustment and administrative expenses | Lines 20+21 | Lines 4+7+8+9+10+11 |
| 5 | Increase in reserves | Line 22 | Line 6 |
| 6 | Net underwriting gain or (loss) (line 2 less line 3 less line 4 less line 5) | Line 24 | Line 12 |

Since all of the items on this “short form” are net of reinsurance ceded, companies having less than $2,000,000 of direct written health insurance premium in Maine **and** having 100% of the business reinsured should file blank reports providing only their contact information.

The six categories of policyholders are:

a) Fully insured large groups, meaning all group and blanket policies, including Federal Employees Health Benefits Program, other than small groups and Dirigo groups

b) Fully insured small groups (1-50 employees) as defined by 24-A M.R.S.A. § 2808‑B, excluding Dirigo groups

c) Fully insured individuals, including short-term coverage and excluding Medicare Advantage plans and Dirigo individuals

d) Dirigo groups (issued pursuant to 24-A M.R.S.A. Chapter 87)

e) Dirigo individuals (issued pursuant to 24-A M.R.S.A. Chapter 87)

f) Stop-loss (employee benefit excess insurance as defined in 24-A M.R.S.A. § 707(1)(C-1))

MAINE ANNUAL REPORT SUPPLEMENT for Year \_\_\_\_  
This form is for companies with less than $2 million of premium – see Rule 945, section 5.

Statewide Data

Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAIC Code \_\_\_\_\_

Name of person completing this form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Large Groups | Small Groups | Individ- uals | Dirigo Groups | Dirigo Individ- uals | Stop-loss | TOTAL |
| 1 | Net premium income |  |  |  |  |  |  |  |
| 2 | Total revenues |  |  |  |  |  |  |  |
| 3 | Total medical and hospital expenses |  |  |  |  |  |  |  |
| 4 | Total claims adjustment and administrative expenses |  |  |  |  |  |  |  |
| 5 | Increase in reserves |  |  |  |  |  |  |  |
| 6 | Net underwriting gain or (loss) (line 2 less line 3 less line 4 less line 5) |  |  |  |  |  |  |  |