

Texas Department of Insurance



HMO SUPPLEMENT

for filing

2025 Annual

Financial Analysis Section

TEXAS DEPARTMENT OF INSURANCE
2025 Annual
HMO SUPPLEMENT INSTRUCTIONS

1. HMO Supplement – Exhibits I – V:

In addition to the NAIC annual statement blank, HMOs licensed in Texas are required to file HMO Supplemental Exhibits I through V with the Texas Department of Insurance (the Department). Separate instructions for completing Exhibits I - IV are provided on the pages preceding the exhibits. Please read carefully because some **exhibits and instructions have been amended**.

Exhibits I and II have been developed to closely compare to the 2025 NAIC quarterly statement blanks, but some deviation does exist. Please note that “Fee-for-service” revenues are to be reported on line 6, column 8 (for non-risk business) with the medical and hospital expenses associated with this “fee-for-service” revenues are to be reported on line 11 in column 8 and any administrative expense associated with “fee-for-service” revenues on line 15 in column 8.

Exhibit I (Projected Revenues and Expenses For The Following Year), Exhibit III (Contracts between Primary HMOs, Provider HMOs, and ANHCs), and Exhibit V (Supplemental Information) are to be submitted **only with the annual statement**.

Exhibit II (Actual Revenues and Expenses by Major Specified Lines) and Exhibit IV (Supplemental Interrogatories) are required to be submitted with **both the annual and quarterly statements**.

2. Annual and Quarterly Statements – Exhibit of Premiums, Enrollment and Utilization & Schedule E – Part 3 - Special Deposits:

Exhibit of Premiums, Enrollment and Utilization:

Separate exhibits are **required** to be filed for **each** Texas and out-of-state division. A consolidated corporate exhibit is also required. Membership reflected in the primary Exhibit of Premiums, Enrollment and Utilization should include direct business, only. Neither provider HMO business nor non-risk business should be included within the primary Exhibit of Premiums, Enrollment and Utilization. **Before** completing the Exhibit of Premiums, Enrollment and Utilization form, page 30, make copies of the form. A copy of this form shall be completed with Provider HMO business and filed as a supplemental exhibit labeled, “Provider HMO Premiums, Enrollment and Utilization Exhibit” under which the HMO shall report risk revenue, enrollment and utilization (relating to services under contract with Primary HMOs and ANHCs). Number the separate supplemental exhibit as Page 30 (a). At the HMO’s option, a copy of the form may also be either fully or partially completed for non-risk business and labeled as such, numbered Page 30 (b). Divisional reports should be numbered Page 30 (1) or Page 30 (a)(1), when a breakdown of direct business or provider HMO business is indicated.

Schedule E – Part 3, Special Deposits

This schedule, which is included with the annual statement filing, must also be included with the quarterly statement filing as an additional supplemental schedule. Instructions on completing this schedule for the quarterly filing are the same instructions used for the annual filing. When reporting deposits in this schedule, a detailed description should include the specific line each deposit is reported on page 2 of the financial statement.

3. Annual Statement -General Interrogatories, Part 2- Health Interrogatories Interrogatory #6:

Covered Expenses/Liabilities

If any liabilities or expenses are reported as covered in the annual statement, disclosure should include the basis or reason by which liabilities or expenses are considered covered.

HMO SUPPLEMENT INSTRUCTIONS (CONTINUED)

Guarantees

If a guarantee of any debts or expenses of the HMO exists, disclosure and explanation in General Interrogatories, Part 2 - Health Interrogatory #6, and if needed, continuing on Overflow Page for Write-ins, page 42, shall include the following:

- the name of the guarantor;
- the number and amounts of other guarantees such guarantor has issued;
- the guarantee's fiscal year; and
- the period covered in the guarantor's most recent audited financial statement filed with the Department.

4. **Annual and Quarterly Statement "Notes to Financial Statements" (Regarding Note #10 and Note #11 of the NAIC Annual Health Statement Instructions):**

Note #10

- List all subordinated and unsubordinated lines of credit with **parent or affiliated** companies in Note #10, including the following:
 - the total amount of each line of credit;
 - the name and affiliation of the lender;
 - whether the line of credit is subordinated or unsubordinated;
 - the total amount advanced to the HMO as of the statement date;
 - the remaining balance not advanced as of the statement date; and
 - the amount of any known advances subsequent to the statement date.

Note #11

- List all subordinated and unsubordinated lines of credit with **unaffiliated** companies not listed elsewhere under Note #11 and including the following:
 - the total amount of each line of credit;
 - the name of the lender;
 - whether the line of credit is subordinated or unsubordinated;
 - the total amount advanced to the HMO as of the statement date;
 - the remaining balance not advanced as of the statement date; and
 - the amount of any known advances subsequent to the statement date.

5. **Definition of Claims:**

Amounts reported under the term "claims" include amounts paid or to be paid on a capitation, per diem, or fee-for-service basis for medical, hospital, and other health care services.

Reserves for capitation not paid, because a physician or other provider was not selected by an enrollee, shall be reported as Incurred but not Reported Claims (IBNR).

6. **Electronic Data Filing:**

- Pursuant to Title 28 of the Texas Administrative Code, §7.68, all HMOs licensed in Texas are required to file electronic data containing quarterly and annual statement data with the NAIC. Electronic data filed with the NAIC must be completed in accordance with the current NAIC Annual Statement Filing specifications for HMOs.
- In addition, for annual and quarterly filings, the Department shall furnish each HMO formatted data forms and instructions for Texas-specific filings. These Texas-specific electronic forms shall be filed with the **Department only**. Instructions should be closely followed and no changes made to the forms except as instructed. For instructions related to such electronic data filing, contact Richard Dunlap at (512) 676-6461.

7. Other Instructions:

In addition to the guidance provided by these instructions, all health entities, including HMOs, licensed in Texas should follow the directions found in the NAIC Annual and Quarterly Statement Instructions for health entities. Also, the March 2025 version of the NAIC Accounting Practices and Procedures Manual should be used in the preparation of the annual and quarterly statements.

INSTRUCTIONS FOR EXHIBITS I AND II

EXHIBIT I
Indicates the HMO’s projected revenues and expenses for the following calendar year.
Must be completed on a total dollar amount basis only . Projected enrollees and projected member months must be reported on lines 1 and 2, respectively. Non-risk enrollees and member months are required only if a type of business represented lends itself to maintenance of an enrollee count. Examples of non-risk business are “Administrative Services Only” and “Fee-for-Service”.
Amounts budgeted for each Division’s Exhibit must add to the amounts reported in the Consolidated Exhibit.
EXHIBIT II
Separate pages are required to break out Current Quarter information from Year-to-Date information for each exhibit submitted.
DEFINITION OF A DIVISION
A division is an operation that meets at least one of the following conditions: <ol style="list-style-type: none"> 1. <i>A separate geographical area</i> whereby the geographical location of an enrollee or a group contract holder is used in determining charges or rates; or 2. <i>A service area that crosses state lines</i> or international boundaries is considered to have a separate divisional operation in each state or country and requires separate cost centers and reports. <p><i>For EXAMPLE, at a <u>minimum</u>, service areas for Dallas/Ft. Worth, Austin/San Antonio, Houston/Galveston/Beaumont, Corpus Christi/Rio Grande Valley, El Paso, and Lubbock/Amarillo shall each require separate divisional reporting. For HMOs writing Medicaid business, divisional reporting shall be, at a <u>minimum</u>, according to service areas defined by the Texas Health and Human Service Commission.</i></p>
GENERAL INSTRUCTIONS
A separate form is required for the Consolidated and for each Division.
Additional information, by specific type of business, may be requested at any time throughout the reporting year. The HMO should be prepared to report its financial condition at this level of detail when requested.
Disclosure must be made in the Management’s Discussion & Analysis (MDA) stating how indirect costs are apportioned among lines of business and divisional operations .

HMO DEFINITIONS
Commercial risk is defined as all business generated under HMO coverage contracts directly issued to individuals or groups, whether single service HMO coverage, limited-service HMO coverage, or basic service HMO coverage, with the exception of Medicare and Medicaid premiums paid by the Federal Government or the State of Texas and the CHIP program. Medicare supplement premiums paid by an individual or on that individual’s behalf by an employer would be included in “Commercial risk business.”
Medicare business to be reported in this exhibit pertains to premiums paid by the Federal Government for coverage under the Medicare program. This business is to include premiums paid directly to the HMO by the Federal Government and supplemental charges as allowed by the Federal Government to be charged to Medicare enrollees as a part of Medicare risk coverage but is not to include indirect Medicare business obtained through another HMO. Medicare business is divided into Basic, Medicare Advantage and stand-alone Medicare Part D Prescription Drug Coverage.
A Point-of-service rider is defined in Texas Insurance Code, §843.108.
Assumed risk pertains to indirect business obtained from other HMOs (or Approved non-profit health corporations) for a set capitation and which places the reporting HMO at risk. In this instance, another HMO is the direct writer of business and the reporting HMO obtained this business as a provider. Assumed risk includes Medicare and Medicaid business obtained from another HMO.
Children’s Health Insurance Plan is to include all business generated under the Children’s Health Insurance Plan.
Non-Risk & Other HMO: Non-risk business pertains to business without underwriting risk. Examples of this type of business include “Administrative Services Only” plan, Administrative Services Contract (ASC) plan, fee-for-service revenues, whether directly from the public at large or from another carrier for services provided to beneficiaries of that carrier, and management or administrative fees received for managing or administering operations of another company. The reporting of non-risk enrollees and member months that lends itself to maintenance of an enrollee count is optional.
NON-HMO: other products (e.g., PPO, Life, P&C) Non-HMO business includes Life and/or P&C business for companies that carry “dual license” to do HMO and Life (or P&C). This column also includes PPO business provided by the HMO.

EXHIBIT I (Filed Annually)
PROJECTED REVENUES AND EXPENSES FOR THE FOLLOWING YEAR

Annual Projections

	1. TOTAL	2. COMMERCIAL RISK (Omit Provider HMO Business)	3. MEDICARE (Omit Provider HMO Business) BASIC ADVANTAGE PART D			4. MEDICAID (Omit Provider HMO Business)	5. POINT OF SERVICE RIDER COVERAGE	6. ASSUMED RISK (as a Provider HMO)	7. CHILDREN'S HEALTH INSURANCE PLAN	8. NON-RISK & OTHER HMO*	9. NON-HMO
1. ENROLLEES AT THE END OF REPORTING PERIOD											
2. MEMBER MONTHS											
3. Direct premium income							XXXXXX				
4. Net premium income											
5. Change in unearned premium reserves and reserve for rate credits...											
6. Fee-for-service (gross revenues)		XXXXXXXX					XXXXXX	XXXXXX	XXXXXX		
7. Risk revenue		XXXXXXXX				XXXXX	XXXXXX	XXXXXX			
8. Aggregate write-ins for other health care related revenues.....											
9. Aggregate write-ins for other non-health revenues.....											
10. TOTAL REVENUE (Lines 4 to 9)											
11. Hospital and medical benefits											
12. Net reinsurance recoveries.....											
13. TOTAL HOSPITAL AND MEDICAL (Lines 11 minus 12)											
14. Claims adjustment expenses											
15. General administrative expenses.....											
16. Increase in reserves for accident and health contracts.....											
17. TOTAL UNDERWRITING DEDUCTIONS (Lines 13 to 16)											
18. NET UNDERWRITING GAIN/(LOSS) (Lines 10 minus 17)											
19. Net Investment Gains/(Losses).....											
20. Aggregate write-ins for other income or expenses											
21. INCOME /(LOSS) after cap. gains tax before FIT Items (Lines 18 to 20)											
22. Federal and foreign income taxes incurred.....											
23. NET INCOME (LOSS) (Lines 21 minus 22)											
24. Medical Loss Ratio											

* Non-Risk & Other HMO: identify product(s): e.g. ASO, Non-Risk Business. (Note: PPO should be reported under NON-HMO.):

EXHIBIT II (Quarter/Annual)

Indicate Reporting Period:

ACTUAL REVENUES AND EXPENSES BY MAJOR SPECIFIED LINES

Current Quarter: ____ Year-to-date: ____

1. TOTAL	2. COMMERCIAL RISK (Omit Provider HMO Business)	3. MEDICARE (Omit Provider HMO Business) BASIC ADVANTAGE PART D	4. MEDICAID (Omit Provider HMO Business)	5. POINT OF SERVICE RIDER COVERAGE	6. ASSUMED RISK (as a Provider HMO)	7. CHILDREN'S HEALTH INSURANCE PLAN	8. NON-RISK & OTHER HMO*	9. NON-HMO
1. ENROLLEES AT THE END OF REPORTING PERIOD								
2. MEMBER MONTHS								
3. Direct premium income					XXXXXX			
4. Net premium income.....								
5. Change in unearned premium reserves and reserve for rate credits								
6. Fee-for-service (gross revenues)	XXXXXXXX			XXXXXX	XXXXXX	XXXXXXXX		
7. Risk revenue.	XXXXXXXX		XXXXX	XXXXXX		XXXXXXXX		
8. Aggregate write-ins for other health related revenues.....								
9. Aggregate write-ins for other non-health revenues								
10. TOTAL REVENUE (Lines 4 to 9).....								
11. Hospital & medical benefits								
12. Net reinsurance recoveries								
13. TOTAL HOSPITAL & MEDICAL (Lines 11 minus 12).....								
14. Claims adjustment expenses								
15. General administrative expenses.....								
16. Increase in reserves for accident and health contracts								
17. TOTAL UNDERWRITING DEDUCTIONS (Lines 13 to 16).....								
18. NET UNDERWRITING GAIN/(LOSS) (Lines 10 minus 17).....								
19. Net Investment Gains / (Losses)								
20. Aggregate write-ins for other expenses or income.....								
21. INCOME /(LOSSES) after cap. gains tax before FIT Items (Lines 18 to 20).....								
22. Federal and foreign income taxes incurred.....								
23. NET INCOME / (LOSS) (Lines 21 minus 22)								
24. Medical Loss Ratio.....								
25a. NON-TAXABLE COMMERCIAL RISK ENROLLEES		(Examples of non-taxable enrollees are State of Texas enrollees & Federal employees.)	*Non-Risk & Other HMO: identify product(s): e.g., ASO, Non-Risk Business. (Note: PPO should be reported under NON-HMO.): _____					
25b. NON-TAXABLE COMMERCIAL RISK MEMBER MONTHS								

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

STATEMENT AS OF _____ OF THE _____

REPORT FOR DIVISION: _____
(Location)

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Dental Only	6 Vision Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Credit A & H	11 Disability Income	12 Long-Term Care	13 Other Health	14 Other Non-Health
		2 Individual	3 Group											
Total Members at end of:														
1. Prior Year	0													
2. First Quarter	0													
3. Second Quarter	0													
4. Third Quarter	0													
5. Current Year	0													
6. Current Year Member Months	0													
Total Member Ambulatory Encounters for Year:														
7. Physician	0													
8. Non-Physician	0													
9. Total	0													
10. Hospital Patient Days Incurred	0													
11. Number of Inpatient Admissions	0													
12. Health Premiums Written	0													
13. Life Premiums Direct	0													
14. Property & Casualty Premiums Written	0													
15. Health Premiums Earned	0													
Property/Casualty														
16. Premiums Earned	0													
17. Amount Paid for Provision of Health Care Services	0													
18. Amount Incurred for Provision of Health Care Services	0													

**TEXAS DEPARTMENT OF INSURANCE
HMO SUPPLEMENT - ANNUAL**

INSTRUCTIONS FOR EXHIBIT III

Exhibit III – Part 1 For HMOs or ANHCs Acting as Provider HMOs and ANHCs:

1. List each and every Primary HMO and ANHC from which Risk Revenue (Capitation) was earned during the year. Also, list each and every Primary HMO and ANHC from or to which a receivable or payable is recorded, even if no risk revenue was earned during the year.
2. Under column 2, the type of health care service or lines of business which the Provider HMO is furnishing the Primary HMO must be listed. An example of health care service could be: Dental, Vision, Pediatric, or Therapeutic, etc. Lines of business could be: Medicare, Group business, Medicaid, or even all business within a smaller service area.
3. Column 3 is for reporting Primary HMO Enrollees covered under contract by the Provider HMO or ANHC. These enrollees are to be reported by the Primary HMO as well as the Provider HMO or ANHC.

Exhibit III – Part 2 For Primary HMOs and ANHCs Contracting with Provider HMOs and/or ANHCs:

1. List each and every Provider HMO and ANHC to which Capitation was paid during the year. Also, list each and every Provider HMO and ANHC from or to which a receivable or payable is accrued, even if no capitation was paid during the year.
2. Under column 2, “Status”, indicate “L” to represent an ANHC that is **licensed** and holds a Certificate of Authority in Texas under §844.051, formerly Article 21.52F, Texas Insurance Code. Indicate “U” to represent an ANHC which is **not licensed** (does not hold a Certificate of Authority under §844.051, TIC) in Texas. Provider HMOs operating in Texas are assumed to hold licenses issued by the Texas Department of Insurance, but if one does not hold a license, please indicate with the initials UHMO. If the contracted responsibilities of the provider HMO/ANHC are exclusively for operations outside the state of Texas, please indicate by the initials F, or if the contracted responsibilities partially concern Texas enrollees and partially concern operations outside the state of Texas, please indicate with a P.
3. Under column 3, the type of health care service or lines of business for which the Provider HMO is furnishing the Primary HMO must be listed. An example of health care service could be: Dental, Vision, Pediatric, or Therapeutic, etc. Lines of business could be: Medicare, Group business, Medicaid, or even all business within a smaller service area.

TEXAS DEPARTMENT OF INSURANCE HMO SUPPLEMENT - ANNUAL

EXHIBIT III

CONTRACTS BETWEEN PRIMARY HMOs/ANHCs AND PROVIDER HMOs/ANHCs

FOR THE PERIOD ENDING _____ OF THE _____
 (Name of Company)

EXHIBIT III - PART 1 (To be completed by: HMOs or ANHCs Acting as PROVIDER HMOs and ANHCs)

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
NAME OF PRIMARY HMO AND/OR ANHC	HEALTH CARE SERVICES TO BE PROVIDED	ENROLLEES AT YEAR END	MEMBER MONTHS FOR YEAR	RISK REVENUE RECEIVED DURING YEAR	RISK REVENUE EARNED DURING YEAR	COMPENSATION OTHER THAN RISK REVENUE RECEIVED DURING YEAR	COMPENSATION OTHER THAN RISK REVENUE EARNED DURING YEAR	AMOUNTS PAYABLE	AMOUNTS RECEIVABLE
				XXXXX	XXXXX	XXXXX	XXXXX		
				XXXXX	XXXXX	XXXXX	XXXXX		
				XXXXX	XXXXX	XXXXX	XXXXX		
				XXXXX	XXXXX	XXXXX	XXXXX		
				XXXXX	XXXXX	XXXXX	XXXXX		
				XXXXX	XXXXX	XXXXX	XXXXX		
9999999 TOTALS		XXXXX	XXXXX						

EXHIBIT III - PART 2 (To be completed by: PRIMARY HMOs and ANHCs Contracting with Provider HMOs and/or ANHCs)

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
NAME OF PROVIDER HMO AND/OR ANHC	STATUS	HEALTH CARE SERVICES TO BE PROVIDED	ENROLLEES AT YEAR END	MEMBER MONTHS FOR YEAR	CAPITATION PAID DURING YEAR	CAPITATION ACCRUED DURING YEAR	COMPENSATION OTHER THAN CAPITATION PAID DURING YEAR	COMPENSATION OTHER THAN CAPITATION ACCRUED DURING YEAR	AMOUNTS PAYABLE	AMOUNTS RECEIVABLE
9999999 TOTALS			XXXXX	XXXXX						

HMO SUPPLEMENT - ANNUAL and QUARTERLY

STATEMENT FOR THE PERIOD ENDING _____, OF THE _____

**EXHIBIT IV
Supplemental Interrogatories**

1. Complete information below for each line of business.

	(1)	(2)	(3)	(4)	(5)	(6)
	Ending Enrollment	Member Months	Premiums Earned	Medical & Hospital Expenses Incurred*	Administrative & Other Expenses Incurred**	Net Income/ Loss
Direct Business:	<i>(Total Year-To-Date)</i>					
a. Medicare						
b. Medicaid						
c. CHIP						
Commercial:						
d. Large group						
e. Small group						
f. Individual						
ACO Business						
Assumed Risk:						
g. Medicare						
h. Medicaid						
i. CHIP						
Commercial:						
j. Large group						
k. Small group						
l. Individual						

* Medical & Hospital Expense also means "benefit" expense.

** Administrative & Other Expenses include claim adjustment expenses as well as administrative and all other non-benefit expenses.

2. Does the HMO participate in the State of Texas Employee Retirement System's Uniform Group Insurance Program (write coverage for Texas state employees)? **YES / NO**

If "YES", then in relation to the Uniform Group Insurance Program coverage what are the:

- a. number of enrollees _____
- b. number of member months _____
- c. premium revenue _____
- d. medical and hospital expense _____
- e. loss ratio _____
- f. net income/loss from business _____
- g. major metropolitan area(s) covered _____

TEXAS DEPARTMENT OF INSURANCE

HMO Supplemental Information - Annual

EXHIBIT V

ANNUAL STATEMENT FOR THE YEAR _____

OF _____
(Name of Organization)

- 1. Texas premiums received from the Federal Government for Title XVIII (Medicare), Federal Social Security Act _____
 - a. Texas enrollees that pertain to above premiums at the end of the:
 - 1st Quarter (3/31) _____
 - 2nd Quarter (6/30) _____
 - 3rd Quarter (9/30) _____
 - 4th Quarter (12/31) _____
 - b. Texas member months during year that pertain to Line 1 premiums. _____
- 2. Premiums on HMO Contracts Applicable to the Texas Employees Uniform Group Insurance Program (State employees) _____
 - a. Texas enrollees that pertain to above premiums at the end of the:
 - 1st Quarter (3/31) _____
 - 2nd Quarter (6/30) _____
 - 3rd Quarter (9/30) _____
 - 4th Quarter (12/31) _____
 - b. Texas member months during year that pertain to Line 2 premiums. _____
- 3. Premiums on HMO Contracts Applicable to Federal Employees located in Texas. _____
 - a. Texas enrollees that pertain to above premiums at the end of the:
 - 1st Quarter (3/31) _____
 - 2nd Quarter (6/30) _____
 - 3rd Quarter (9/30) _____
 - 4th Quarter (12/31) _____
 - b. Texas member months during year that pertain to Line 3 premiums. _____
- 4. Other non-taxable premiums (specify source and reason):

_____ _____
 - a. Texas enrollees that pertain to other non-taxable premiums at the end of the:
 - 1st Quarter (3/31) _____
 - 2nd Quarter (6/30) _____
 - 3rd Quarter (9/30) _____
 - 4th Quarter (12/31) _____
 - b. Texas member months during year that pertain to Line 4 premiums. _____
- 5. Total Non-taxable Premiums (1 to 4) _____

TEXAS DEPARTMENT OF INSURANCE

HMO Supplemental Information - Annual

EXHIBIT V-CONTINUED

ANNUAL STATEMENT FOR THE YEAR _____

OF _____
(Name of Organization)

6.	Texas premiums received from the State for Welfare Benefits		
a.	Medicaid	_____	
b.	CHIP	_____	
c.	Total of both CHIP and Medicaid		_____
d.	Texas enrollees that pertain to above premiums at the end of the:	<u>Medicaid</u>	<u>CHIP</u>
	1 st Quarter (3/31)	_____	_____
	2 nd Quarter (6/30)	_____	_____
	3 rd Quarter (9/30)	_____	_____
	4 th Quarter (12/31)	_____	_____
e.	Texas member months during year that pertain to Line 6 premiums.	_____	_____
7.	Texas Subscribers at Year End (A Subscriber is the holder of an individual policy. In the case of a group contract, a Subscriber is the holder of an individual certificate.)	_____	
8.	Gross Reinsurance Premiums Paid on all business (do not net reinsurance recoveries)	_____	
a.	Gross Reinsurance Premiums Paid on Texas business only (do not net reinsurance recoveries)	_____	
9.	Net Premiums in Force*	_____	
a.	Net Premiums in Force on Texas business*	_____	
10.	Uncovered Health Care Expenses Incurred in Texas	_____	
11.	Total Taxable Premiums written in Texas during year (include Medicaid & CHIP).		_____
a.	Total Taxable Enrollees in Texas (include Medicaid & CHIP) at the end of the:		
	1st Quarter (3/31)	_____	
	2nd Quarter (6/30)	_____	
	3rd Quarter (9/30)	_____	
	4 th Quarter (12/31)	_____	
b.	Total Taxable Member Months in Texas during the year (include Medicaid & CHIP)	_____	
12.	Does the HMO participate in the Affordable Care Act? If "YES", then in relation to the ACA Program coverage what are the:	YES / NO	
		<u>Exchange</u>	<u>Off-Exchange</u>
a.	Number of enrollees	_____	_____
b.	Premium revenue	_____	_____

*Net premiums in force constitute the premiums written which resulted in coverage being in force for the reporting date, net of any reinsurance expense pertaining to a reduction or limitation of risk retained by the company/HMO on the reporting date.

13. Does the HMO have a Dual License with the Texas Dept of Insurance?

If "YES", then in relation to the license, what are the:

- a. Individual
- b. Group
- c. Medicare Supplement
- d. Dental
- e. Vision
- f. FEBHP
- g. Medicare
- h. Medicaid
- i. Credit A&H
- j. Disability Income

YES / NO	Texas	Texas Premiums
	Premiums -	- Non-HMO
	HMO	
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0
	0	0