Conference Call Meeting

HEALTH REFORM SOLVENCY IMPACT (E) SUBGROUP
Thursday, April 29, 2010
1:00 – 2:00 p.m. CT

Summary Report

The Health Reform Solvency Impact (E) Subgroup met April 29, 2010. During this meeting, the Subgroup:

1. Reviewed a draft blanks proposal that was intended for initial discussion purposes only. The Subgroup requested comments on the draft be submitted to NAIC staff, with the intent of further discussion during the Subgroup’s May 5 call. The Subgroup intends to expose the blanks proposal on that conference call, with the intent of obtaining and incorporating changes on a May 12 conference call. The Subgroup hopes this will allow the proposal, which will include a calculation for the medical loss ratio, to be finalized on the Subgroup’s May 19 call.

2. The following items were noted regarding the proposal:
   - The bill does not apply to Medicaid, Medicare or limited health service plans, such as dental or vision. Therefore, the current proposal includes coverage not included in the bill in the “Other Health” program. Discussion on the desire to report some of these lines separately might occur on a future call.
   - The proposal should choose a method of how premium should be allocated by the states. There was discussion regarding the need to use the location of the resident (or the policyholder), but the regulators generally agreed that it might be necessary for the allocation to be consistently applied across all states. Members of the industry expressed a desire for the allocation methodology to be consistent with the methods allowed under Schedule T, but at least one regulator noted that the new schedule might require only one method to be allowed. Participants were asked to provide comments on that issue.
   - The proposal includes lines for inclusion of state assessments for indigent care in premium, which might need to be renamed to be more descriptive of regulators’ expectations. Some of what is included in the current line might need to be part of the numerator as opposed to the denominator.
   - Some members of the Subgroup suggested separate lines for unearned premiums, contract reserves and other types of reserves for the beginning and end of year. It was later suggested that the proposal add a new section to detail the components of premiums earned and claims incurred to meet this request.
   - Language will be added to the proposal to clarify that those salaries and capitation payments would be included in incurred claims for staff model health maintenance organizations (HMO) consistent with current annual statement and risk-based capital (RBC) reporting.
   - Questions were raised from the industry about specific lines, including guaranty funds, regulatory fees and federal income taxes.
   - Issues were raised about the level of reporting, be it by legal entity or by plan. This was noted in response to comments that groups are typically offered coverage by one insurer through two distinct legal entities, one that provides out-of-network coverage under an insurance policy and another that provides in-network coverage via an HMO policy. Similarly, if the group is offered out-patient coverage by one insurer and in-patient coverage by another insurer.
   - Several questions were raised regarding quality of care and cost-containment definitions. It was noted that the current definition for these items in the blanks proposal uses items from the existing cost-containment definition. The chair noted that regulators were trying to draft language that defines “quality of care” more explicitly. The chair hopes to distribute such a definition by close of business May 5.