INSURANCE DIVISION
MEMORANDUM

Date: January 25, 2010

To: A&H companies, including HMOs and dental plans

From: Russell Latham and Annette Boyce

Subject: Guidance for Reporting Minimum Premium Plans

Issue

The Oregon Insurance Division is aware of inconsistencies among Oregon domestics in reporting premiums, losses and enrollment for Minimum Premium Plans.

The Division has reviewed how income, expenses, obligations, and membership under these policies should be reported for statutory accounting purposes, market analysis purposes, the health insurance assessment and the Insurance Division funding assessment.

Definition

A Minimum Premium Plan ("MPP") is a plan where an employer and an insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services. These plans include both an uninsured and insured component.

Contract Provisions

Common elements of a MPP include:

1. Employer funds fixed costs, often on a per member per month basis, to pay for plan administration, premium tax and assessments, insurer profit and commissions.

2. Employer funds anticipated claims at a pre-determined level.

3. Insurer is obligated for claims in excess of a predetermined level, typically referred to as the "maximum claims liability". Contract may provide that insurer can recoup losses in future years if contract is renewed or continues. The risk to the insurer is that the claims may exceed the "maximum claims liability."

4. The contract may provide that the employer maintain funds to pay claims or the insurer may hold funds to pay claims.

The amounts received in #1 and #2 are considered the uninsured portion of the contract. The amount covering the risk exposure described in #3 is the insured portion of the contract. The amount of liability to the insurer may change each contract year due to contract experience or accumulation of funds at the reporting date.

Accident and health plans, including MPPs, are considered "health" insurance as defined in the Insurance Code. The funding arrangement described in #4 does not alter a plan's classification as health insurance, but may affect how the plan is reported in the statutory financial statements.

Statutory Accounting

In applying statutory accounting principles ("SAP"), the contract provisions dictate which accounting principles apply. The insurer's risk for any of the obligations under the contract must be accounted for in accordance with appropriate statutory accounting principles. Statutory accounting principles that provide guidance on how to classify and record accident and health contracts are generally included in SSAP 47 (Uninsured Plans), 50 (Classifications and Definitions of Insurance or Managed Care Contracts in Force), 54 (Individual and Group Accident and Health Contracts), and 55 (Unpaid Claims, Losses and Loss Adjustment Expenses). Additional SSAP guidance is included in SSAP 61 (Life, Deposit-Type and Accident and Health Reinsurance) and SSAP 66 (Retrospectively Rated Contracts).

SSAP 47 (Uninsured Plans) provides definition and accounting and disclosure requirements for uninsured plans and partially insured or combination plans. An uninsured accident and health plan is a plan for which an insurer, as an administrator, performs administrative services such as claims processing for a third party that is at risk. The insurer assumes no insurance risk in such an arrangement. Contract provisions must provide that all costs are to be reimbursed to the insurer, with no risk to the insurer, including upon termination of the contract. Partially insured or combination plans exist that are treated as two plans: an insured plan and an uninsured plan. The components related to uninsured plans shall be accounted for using the guidance for uninsured plans in SSAP 47; the components related to insured plans shall be accounted for as accident and health insurance.

Insurers should ensure that contract provisions clearly set forth the uninsured and insured portions of combination plans.

Financial Statement Presentation

The funding of claims by the employer should be shown on the balance sheet as either an asset that is set up when payments are made by the insurer prior to being funded by the insured (amounts receivable relating to uninsured plans) or a liability when funds have been received

from the insured in advance of the insurer's payment of claims (liability for amounts held under uninsured plans).

When the amount of claims incurred exceeds the maximum claims liability, it then becomes an obligation of the insurer. The insurer must therefore record claims expense determined on an incurred basis and record a liability.

Other aspects of revenue and expense recognition for MPPs must be reported consistent with SSAP 47.

Market Analysis Reporting--Enrollment

The MPP health contracts meet the definition of a health benefit plan per ORS 743.730(19), therefore, are subject to mandates and regulation. Any report required of a carrier that pertains to health benefit plans shall include those lives (members and dependents) covered under a MPP.

These reports include, but are not limited to, the Quarterly Health Enrollment Report, Health Benefit Plan Report (ORS 743.748), Prompt Pay Report (OAR 836-080-0085), and the Patient Protection Reports.

Health Insurance Assessment

The health insurance assessment is based on gross health premiums earned by the insurer. MPPs fall within the definition of health insurance. Therefore, both the insured and uninsured portions of these plans are subject to the health insurance assessment (includes amounts covering the items listed in items 1, 2 and 3 above). The assessment reporting program provides for the insurer to indicate the uninsured amount received under these plans since it might not be included in premium in the insurer's annual statement.

Insurance Division Funding Assessment

ORS 731.804 and OAR 836-009-0011 generally provide that the funding assessment be levied on direct premium, including premium derived from providing health insurance. Therefore, both the insured and uninsured amounts received under these plans are subject to the funding assessment (includes amounts covering the items listed in items 1, 2 and 3 above).