AMERICAN ACADEMY of ACTUARIES

Feb. 7, 2013

Dennis Julnes
Chair, Health Risk-Based Capital Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Additional Changes to Health RBC Formula Regarding Risk Mitigation in ACA

Dear Mr. Julnes:

The Health Risk Based Capital Working Group asked the American Academy of Actuaries'[1] Health Solvency Work Group to review the list of risks identified by the Health Actuarial (B) Task Force's Risk and Reinsurance (B) Subgroup. These risks reflect the many unknowns, such as who will be covered and how effective the risk mitigation mechanisms in the Affordable Care Act (ACA) will be. After reviewing the list of risks, the work group does not anticipate that the effect of risk adjustment would be significant enough to warrant a change in the RBC formula.

The provisions in the ACA identified by Health Actuarial (B) Task Force's Risk and Reinsurance (B) Subgroup that add risk due to the unknowns they create for pricing actuaries are:

1. Affordable health insurance exchanges (Section 1311);
2. Prohibition of use of gender or health status in rating (Section 1201);
3. Individual mandate to obtain basic health insurance coverage (Section 1501);
4. Individual tax credits for purchase of basic health insurance coverage (Section 1401);
5. Tax credits to small businesses for providing health insurance to employees (Section 1421); and
6. Reinsurance, risk corridors, and risk adjustment (Sections 1341, 1342, and 1343, respectively).

Note that the reinsurance and risk adjustment mechanisms may decrease risk, but payments would be delayed. Further, risk adjustment may increase or decrease risk depending on the carrier's enrollment, but payment of receivables would be delayed beyond the point at which claims and administrative expenses have to be paid.

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

Although the net impact of these risks may be significant and could affect carrier profits and solvency, adjusting the Health RBC formula to incorporate them would not be effective for the following reasons:

1. Since it is retrospective, the RBC formula will not identify any negative result of these risks until the end of 2014, even if it could be changed by then. As such, the solvency of a company could be negatively affected by mispricing due to these factors; and
2. The risks are short term—only for two or three years. Making formula modifications for a short-term problem may not be feasible.

Insurance regulators should take special measures in 2014 (and probably 2015) to identify carriers that have deteriorating solvency strength due to misestimating the 2014 market. The 2014 risks are likely to be as much or more liquidity risks as they are solvency risks. Therefore, we recommend the following:

1. Monitoring carriers that have limited access to capital or that have low liquidity levels;
2. Monitoring carrier growth to identify those that may be growing faster than their capital would allow;
3. Monitoring underwriting experience and loss ratios to identify carriers that may have difficulty covering claims and administrative expenses based on current premium levels;
4. Reviewing quarterly estimates of health RBC based on quarterly financials to identify deteriorating RBC levels; and
5. Monitoring reinsurance and risk adjustment accruals to identify carriers that may not be adequately accruing liabilities, that may be over estimating receivables, or that may have a liquidity issue since payments will be delayed until final determinations can be made.

Several of the provisions identified by the Health Actuarial (B) Task Force's Risk and Reinsurance (B) Subgroup actually may decrease risk in the long term. Those include:

1. Fraud, waste, and abuse offenses (Section 1303); and
2. Independent Payment Advisory Board (Section 3403).

There are also a number of provisions that are not likely to cause actual risk in the marketplace, including:

1. Prohibition of annual limits on insurance coverage (Section 1001);
2. Requirement of commercial individual and small group health plans to cover certain preventive care services (Section 1001); and
3. Requirement of Medicare to cover certain preventive care services (Section 4104).

We would like to note another risk created by the ACA related to the medical loss ratio (MLR) rebate formula. This formula essentially prohibits years of losses to be offset by years of gains in which the MLR is less than the rebate threshold have to be returned. It also eliminates the

potential for poor performing blocks of business to be offset by other lines of business or blocks of business in other states. This could restrict carrier growth since profits may be insufficient to fund increased RBC requirements. Further consideration should be given to a potential modification to the RBC formula to account for the reduced ability to subsidize losses with gains from other blocks of business or profitable years.

Should you have any questions regarding the work group's concerns or analysis, do not hesitate to contact Tim Mahony, the Academy's state health policy analyst (202.223.8196; Mahony@actuary.org).

Respectfully,

Donna Novak, MAAA, FCA
Chairperson, Health Solvency Work Group
American Academy of Actuaries