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Surplus and the ACA

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INTRODUCTION

The passage of the Patient Protection and Affordable Care Act (ACA) introduced significant changes to the health insurance marketplace, including:

- Federal premium and cost-sharing subsidies
- Minimum loss ratio (MLR) requirements
- Individual and employer mandates
- Insurance market reforms
- Medicaid expansion.

These changes affected the dynamics of the individual and small group markets, in particular. For example, insurance market reform includes a guaranteed issue provision. As a result, several states eliminated their high-risk pools, placing individuals obtaining coverage through these pools into the individual market. A second example is the individual mandate. This provision of the ACA is intended to motivate uninsured individuals to obtain coverage. The question insurers had to answer was how many of the previously uninsured would actually enter the market and what the underlying risk of these individuals was. Further com-

plicating the market landscape are the “transitional” plans that were added to allow individuals to keep their pre-ACA policies. The impact of these examples—as well as the other provisions of the ACA affecting market risk, profitability and surplus—is still unknown.

The drafters of the ACA recognized the additional uncertainty issuers face, especially in the first years after enactment; thus they included the “3Rs”—risk adjustment, reinsurance and risk corridors¹—in order to help mitigate some of the uncertainty and level the playing field. However, issuers needed to include the impact of the 3Rs in their initial and subsequent pricing estimates. These impacts are difficult to assess. For example, in order to estimate the impact of risk adjustment, issuers have to estimate their own risk score, the risk score of the entire market, the average market premium, and the distribution of enrollment by plans in the risk pools. None of these were known at the time 2014 premium rates were filed nor are they known precisely even now. Given that the risk adjustment is needed for both pricing and accrual determination, an issuer could misjudge its net income in two ways.

As this demonstrates, the ACA increased the potential variability of the net income of an issuer. This increased variability raises the required surplus level.

RISK AND THE NEED FOR SURPLUS

Insurance is, by definition, a risky business. Health insurance issuers participate in a very competitive market with potentially small and unpredictable margins. Even prior to the ACA, health insurers faced a multitude of risks including:

- Asset risk (e.g., asset concentration, market returns, ownership structures, capital adequacy, etc.)
- Underwriting (e.g., cost and utilization trends, pricing accuracy, rational and sometimes irrational competitors, underwriting, etc.)
- Credit risk (e.g., reinsurance, capitation, etc.)
- General business risk (e.g., administrative expenses, growth strategy, legal and regulatory environments, mix of business)
- Other risk (e.g., reputation, market concentration, service area size, provider reimbursement rates, distribution systems, etc.).

Health insurers must be financially strong in order to withstand adverse financial situations resulting from these risks. Thus, the primary need for surplus is to prevent insurer insolvency. Surplus is intended to allow plans to withstand sustained periods of adverse financial conditions including

inadequate premiums, cash flow shocks, unexpectedly high medical claims, and adverse risk selection. Surplus also serves as a capital resource allowing companies to invest in infrastructure, technology—some of which is necessary to comply with regulations (e.g., the Edge Server and ICD-10), and growth.

Growth poses unique challenges. A growing organization with significant new membership most likely needs to hold surplus that is much higher than an organization in a steady state. They must consider expenses incurred prior to launch (e.g., technology, marketing/sales, etc.) and expenses incurred after launch (e.g., claims, reserves, systems, etc.). Possibly more importantly, they must also recognize that new business takes time to generate retained earnings.

Thus, a company’s target surplus is unique to each organization and its individual circumstances and business characteristics. Determining the appropriate surplus is complex, varies by the risks each individual issuer faces, and is also somewhat subjective.

DETERMINING TARGET SURPLUS

Surplus is basically the excess of assets over liabilities. Target surplus is the amount company management thinks it needs given the risk that the company is balancing and the interests of its investors, regulators and rating agencies. It can be a function of management’s risk tolerance (desired level of conservatism), risk-based capital (RBC) requirements and regulatory en-

vironment. It need not be 100 percent of a worst-case scenario.

There are several methods to determine and measure target surplus. One of the most straightforward methods is a fixed capital and surplus requirement. Under this method, issuers are required to hold a minimum amount of capital. This amount is typically dependent on requirements by a state in order to be licensed to write business. As insurers have grown and changed, this standard is not necessarily considered effective in providing sufficient cushion for many insurers.

A second method is “surplus as a percentage of revenue” (SAPOR). SAPOR measures capital and surplus (“surplus”) as a percentage of insured premium revenue net of reinsurance (“total revenues”). SAPOR enables the study of surplus from single to multiyear gains/losses that can occur during the underwriting cycle. Results can be translated to an RBC equivalent once the modeling is done.

A third, and probably the most common, method in measuring surplus is RBC. This is discussed in greater detail below.

RBC

After a string of large-company insolvencies in the late 1980s and early 1990s, the National Association of Insurance Commissioners (NAIC) established a working group to study the development of an RBC requirement for insurers. The result was an RBC construct intended to be an early warning system for U.S. insurance regulators and provide capital adequacy standards that are uniform across states. This construct has two main components: 1) an RBC formula establishing a hypothetical minimum capital requirement; and 2) an RBC model law that grants automatic authority to the state insurance regulator to take specific actions based on the level of impairment.

The purpose of the formula is to establish a minimum capital requirement based on the types of risks to which a company is

exposed. Since different insurance types (i.e., life, property/casualty, health and fraternal) face different economic environments and risks, separate RBC models have been developed for each.

The NAIC’s RBC health formula recognizes the unique and complex nature of health insurance coverage and takes into consideration an issuer’s size, structure and risk profile. The formula focuses on three major areas: 1) asset risk; 2) underwriting risk; and 3) other risk. The calculation produces an “RBC ratio” of the total adjusted capital (TAC) over the authorized control level (ACL).

There are four levels of action that a company can trigger depending on the RBC ratio: company action, regulatory action, authorized control and mandatory control levels. Each RBC level requires some particular action on the part of the regulator, the company, or both. These are described in Exhibit 1.

For a health insurer whose RBC ratio is between 200 and 300 percent, an additional test is performed to compare the plan’s recent RBC trends. The additional test compares the ratio of the insurer’s underwriting deductions to revenue and 105 percent. Failure of the trend test triggers a company action level event.

While RBC is a commonly accepted measure of surplus, it is not amenable to modeling. Therefore, health insurers will most likely need to use more than one method and be able to model target surplus over multiple time periods.

WHAT DRIVES DEMAND FOR SURPLUS

Various business factors drive higher or lower surplus requirements. For example, nonprofit plans may need higher surplus to offset specific operating constraints since they have less access to capital. They don’t have access to capital markets, and terms of borrowing funds are dependent on financial performance and stability. Thus they may have to hold more surplus in order to meet business needs. On the other hand, public for-profit plans tend to hold relatively lower levels of retained surplus. They may use surplus to buy back shares, thus improving their return on equity, and if they find they need more capital, they have access to equity markets.

Ownership structure is another example. If, for instance, the issuer is a provider-owned plan or its owner is a holding company, then some of the sur-

Exhibit 1
Risk-Based Capital Authoritative Action Outcomes

RBC Ratio (= TAC / ACL)	Action Level	Outcome
> 200%	—	No action is required.
150% to 200%	Company Action Level	The health care insurer is required to submit a business plan to improve financial strength.
100% to 150%	Regulatory Action Level	The health care insurer is required to submit a business plan to improve financial strength. Also, the regulator is authorized to perform a review of practices.
70% to 100%	Authorized Control Level	The regulator is authorized to take actionable steps to improve the financial strength of the health care insurer.
< 70%	Mandatory Control Level	The regulator is required to take actionable steps to control the health care insurer.

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plus may be moved “upstream” quickly with the minimum required amount being held by the issuer.

Different situations may require higher or lower relative surplus levels (see Exhibit 2).

ers may severely under-rate (or over-rate) their products as a result.

A second area of uncertainty is membership that will enroll with a particular issuer. Areas where an issuer may be off in its estimates include its total

merous products were developed with narrow networks and some form of risk sharing ranging from gain-sharing to full capitation. The impact to surplus depends on the type of contract and arguably the financial strength of the provider organization.

still be “cash-out-the-door” during the policy year. For example, say an issuer is expecting a risk transfer payment because it has a higher risk population. During the policy year, it will be collecting lower premium (since its premium should have been set to the market risk) and it will be paying higher claims. These will combine to create a cash flow issue that needs to be supported by higher surplus until the risk transfer payment is received.

Additional uncertainty is driven by the impact of the risk corridor, Medicaid expansion, and revenue that may be at risk due to performance guarantees. The estimated accruals associated with these and other ACA-related items could vary quite significantly from the actual amounts due to this uncertainty.

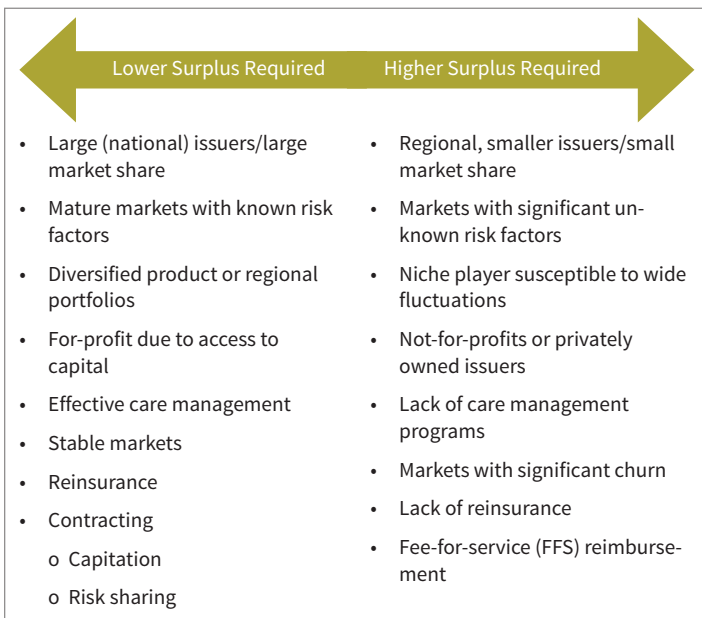
Finally, the timing of payments for the 3Rs should be considered. These will not be reconciled and paid to the issuer until several months after the close of the policy year for which they apply. However, the claims to which these apply will

CONCLUDING COMMENTS

The impact of the ACA on surplus will vary by issuer based on their individual circumstances. It may be relatively small for issuers that are large, offer a diversified product portfolio, or have very little exposure to the individual and small group markets, in particular. It could be quite large for a small, private or not-for profit issuer with a narrow product portfolio

Exhibit 2

Situations Requiring Higher or Lower Relative Surplus



IMPACT OF THE ACA

The ACA has increased the variability, and thus the risk, that health issuers face driving a need for increased capital and surplus. One of the first places this is evident is in premium rate setting. The underlying risk of the market used to determine the premium and an issuer’s share of that market is unknown at the time of premium rate development. Factors driving this uncertainty include Medicaid expansion, the individual mandate, churn caused by actions of employers and individuals, and the underlying risk of the entire market. Issu-

enrollment expected, the distribution by metallic level, and the estimation of its plan risk and risk-transfer payment. These may not greatly impact a dominant player in the market or a large multiline issuer. However, these could be quite significant for an issuer new to the market or who is not well-diversified. For example, if the issuer is small or new to the market and it has under-estimated its rates, then its enrollment could be so large as to create significant surplus strain.

A third area of uncertainty is provider contracting. Nu-



Risk Mitigation Program	Expected Timing of Transfers	Other Considerations
Risk Adjustment	Per the 2014 Notice of Benefit and Payment Parameters, issuers who are net payers are required to pay by July 31 in the year following the benefit year and net receivers will receive by Aug. 31 in the year following the benefit year subject to the funds collected to achieve a zero-sum program at a state and market level.	Subject to the 7.3 percent sequestration holdback, but the U.S. Department of Health and Human Services (HHS) has the authority to pay out the holdback amount in the next fiscal year.
Reinsurance	Not finalized but HHS indicated on a REGTAP call in February 2015 that issuers could expect the first installment of 2014 reinsurance payments to be paid around July 2015 with a second installment in the October/November time frame. A potential third installment could be made in December.	Subject to the 7.3 percent sequestration holdback, but HHS has the authority to pay out the holdback amount in the next fiscal year.
Risk Corridor	To be determined.	HHS intends to settle the risk corridors in a budget-neutral manner over the life of the program (2014-2016). Further, in September 2014, the Government Accountability Office (GAO) found that ACA section 1342 did not make an explicit appropriation of funds. Therefore the government must look to other sources of appropriations for risk corridor payments. GAO ultimately concluded that risk corridor payments would have been available for FY 2014 under the program management fund had risk corridor collections/payments occurred in the fiscal year. Future congressional appropriations will be required for risk corridor collections/payments to occur.

or large exposure to the individual and small group markets.

Issuers should consider not only the minimum surplus that is required; rather, their determination of the appropriate surplus should include balancing the long-term goals of their organization with the risks they face and the potential uncertainty posed by the ACA and market conditions. This requires a multiyear view and simulation of the variables, including premium rates and rate position, enrollment, product and plan distribution, and morbidity risk. ■

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Further readings recommended by the author are:

- Thomas D. Schnook, “Target Surplus Considerations for a Managed Care Organization”, © 2000 Milliman and Robertson, Inc.
- NAIC RBC article: http://www.naic.org/cipr_topics/topic_risk_based_capital.htm

ENDNOTE

¹ Risk adjustment is a permanent program. Reinsurance and the risk corridor are temporary programs ending in 2017.



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