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Risk-Based Capital According to the National Association of Insurance Commissioners (NAIC)

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Panelists: WILLIAM F. BLUHM
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Recorder: DONNA C. NOVAK

Summary: This session presents and discusses the NAIC's model bill for risk-based capital. This Model Bill has been released this summer. The panel will include members who were active in the formulation of the model bill, and they will present a general overview and some practical considerations for practicing actuaries.

Ms. Donna C. Novak: We will discuss the recent efforts to simplify Health Organization Risk-Based Capital (HORBC). After that, Bill Bluhm, Principal at Milliman & Robertson (M&R) in Minneapolis, will present HORBC decisions that are still outstanding. Bob Wilcox, Commissioner for the State of Utah and the Chairman of the Health Organization Risk-Based Capital Working Group for the NAIC, is going to talk about the regulatory perspective, where we're at with the formula, the implementation plan, and about the testing of the formula that's taking place right now.

Mr. Steven E. Lippai: When Donna asked me to speak on the topic of HORBC simplification, I agreed because I'd been working with the Academy's committee, and, after all, how difficult would it be to speak about simplicity? In the process of preparing this talk, I realized that I needed to address why simplification was important, and that would require conveying the complexity of the original HORBC formula.

When you go back to the original work, you find that at the request of the NAIC the first proposal was developed on a theoretically precise basis without any constraints on either the structure or the formula or the data elements that were used. This resulted in a formula that's described in about 13 pages of narrative text. Six pages describe medical coverage, the offsets for managed care, alternative funding methods (including specific and aggregate stop-loss, minimum premium approaches), and administrative services only and cost-plus arrangements. One page covered variations in valuation and guaranty fund assessments.

The nonmedical lines of business were covered in a little over two pages. Limitations on the ability to change rates were covered in a page, reinsurance was covered in two pages, claim reserves and liabilities took up a paragraph or two and, finally, credit for rate stabilization reserves, retrospective premiums, and dividends is a little over a page. All of these are important areas, and each, by itself, was not very difficult or complex.

However, some parts of the formula were based on claims, and other parts were based on premium. There's nothing inherently wrong in this. It would just make it difficult to determine if all of a company's business was included in the risk-based-capital calculation. If one index was used, for example, premiums, it would be possible to add up all the premiums used in the risk-based-capital calculation to see if that tied to the premiums being reported elsewhere. Certain parts of the formula graded the risk-based capital required based on the number of lives insured. Other parts of the formula graded based on the number of disabled lives. Again, there's nothing inherently wrong in this approach. However, many companies don't keep their records in quite that fashion and don't accumulate that data. Certain sections of the formula adjusted the risk-based capital developed in other sections based on, for example, the length of a premium guarantee. Again, there's nothing wrong with this. It just meant that the basic data would have to be split differently. To comply with current regulatory or management reporting requirements, most companies can easily get a one-dimensional split on their data, for example, splitting premiums by line of business or splitting premiums by renewal provision.

It's much more difficult to obtain the data in a two- or three-dimensional split, such as premiums by line of business, by renewal provision, and at the same time, by reinsurance agreement. Auditing information that is split this way also becomes increasingly difficult. Nothing in the formula was complex by itself. It was only the number of pieces, the lack of consistency between the pieces, and what's most important, the way those pieces interrelated that created the difficulty.

For these reasons and a few others, the NAIC asked the Academy State Health Committee to review the formula to see if it could be modified to minimize the cost

of implementation while maintaining reasonable precision. They requested that the data elements have three characteristics. They wanted the data to be specific, to be auditable, and to be available. To be specific means that a source can be identified as a specific place in some other report, such as a particular line of the annual statement or some supplemental required filing. This requirement of being specific should help create consistency between companies. It was recognized that not all of the necessary data elements would already be included in these various required filings. Part of the Academy's charge was to recommend additional data elements that would be necessary to accumulate in this information.

The second area, "to be auditable," meant that the data should be included in the annual statement information or supplemental reports that are electronically captured by the NAIC.

Risk-based capital serves as a warning light that a company is beginning to have serious financial problems. Data elements that need an extensive financial audit to be verified do not allow for the rapid regulatory response that is desirable in this type of situation. The third characteristic is requiring that the data be readily available, recognizing that there's a cost of obtaining information. It's very desirable to have data elements be gathered from existing reporting systems.

So at the NAIC's direction the committee reviewed its proposal, concentrating on the C–2 risk portion of the formula and looking for ways to consolidate segments, to improve consistency, and to use data that matched these three criteria. The committee also worked to provide both written instructions as well as an electronic spreadsheet version of the calculation.

Spreadsheet, in the singular, does not leave the proper impression of the group's work. There is actually a principal worksheet that would be filed with the states. I believe this is four pages when it's printed out. There's also supplemental back-up worksheets that will be retained at the company. If a company needed to use all of them, I believe that it would total to a couple dozen additional work pages.

The revised proposals contain quite a few modifications. The basis of all risk-based-capital calculations has been standardized to premiums. This eliminates the use of claims in certain sections and the use of risk-based-capital amounts that were computed in other sections. Not only does this improve the auditability, it should also eliminate the need for the multidimensional slicing of data.

Other modifications made the formula simpler to apply. At least two lines of business had formulas that graded down after having 5,000 lives in force. The incremental, extra risk-based capital that these 5,000 lives generated were

converted into a flat-dollar amount, in both cases $50,000. This amount would represent one or two large claims and not be so large that it would be prohibitively expensive for companies with very small blocks of business.

In addition, four lines of business were consolidated into two groupings. The revised formula has one accident-only grouping instead of two. This should eliminate a problem that companies could have in classifying the premium for what is a minor line of business for most companies. The hospital indemnity and specific disease lines were also combined because the formulas were very similar.

Other changes included removing elements that referenced very minor or nonexistent business, such as a distinction on dental deductibles greater than $2,500. The application of factors was also simplified by reducing the number of categories in many areas of the calculations, such as the stop-loss coverages and the rate guarantee periods. The risk-based-capital calculation for claim reserves were also modified to be graded based on the amount of reserves and not on the number of disabled lives. As you can see, there were quite a few changes in quite a few different areas.

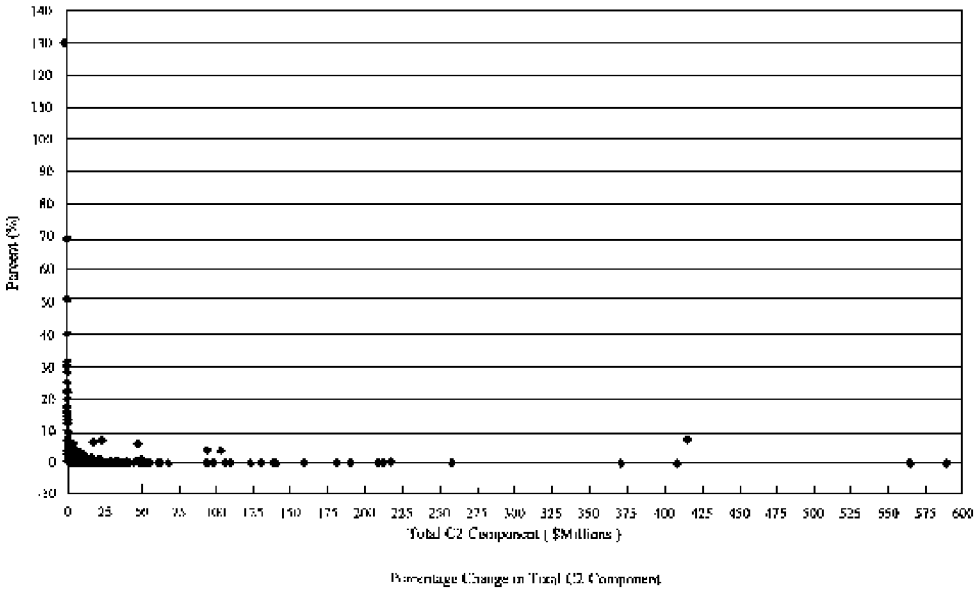
Whenever there was enough data, sensitivity testing was done. It was important that the simplification process did not dramatically change the C–2 component and affect the company's risk-based-capital results. These tests worked off of the actual risk-based-capital information that was filed with year-end-1995 statements. Before we received any of the data, all the identifying company labels were, of course, deleted. In a number of cases, in the process of doing this sensitivity testing, we needed to assume that 100% of the data on one of the current existing lines represented a certain type of business.

For example, Line 3 of the current formula contains the sum of the premiums for all the different types of limited benefit coverages that do not anticipate rate increases. When we were testing the accidental death and dismemberment (AD&D) simplifications, we assumed that 100% of the business on that line was AD&D business. When testing the hospital indemnity simplification, 100% of the same data was assumed to represent hospital indemnity business. In other words, we were testing under extreme situations. The analysis was extensive. We looked at listings of results sorted in several different ways. We looked at two-dimensional tables and numbers, and we looked at graphs to visually identify any unacceptable results.

I'd like to share with you some of this graphical analysis because I think it's the easiest way to convey a flavor of the work. Chart 1 shows the change in the total

C-2 component compared to the dollar amount. Dollar amounts are shown on the horizontal axis, and the change as a percentage of the total C-2 is the vertical axis. This is for companies up to $600 million of the C-2 component. As you can see in this particular test, very few companies had a change above 10%, and only those at a very small level of total C-2 component had that change.

CHART 1
PERCENTAGE CHANGE IN TOTAL C-2 COMPONENT
BASED ON INDIVIDUAL MORBIDITY—HOSPITAL INDEMNITY, AD&D,
AND OTHER LIMITED BENEFITS (LINE 3)



In Chart 2, we would just show the companies under $15 million. This is just the previous table with the first segment of data. You can see through the scatter diagram again that there's very little impact except for companies with very small amounts of risk-based capital or, in this case, small amounts of the C-2 component of risk-based capital.

Chart 3 shows the distribution of companies. The number of companies is shown on the vertical axis by the percentage change in total risk-based capital. You can see there were, again, very few companies that had any significant change whatsoever, with only a few above 10%.

If you look at Chart 4, you can see the dollar amounts of those changes. Again, there were not many companies with very significant amounts of change in total C–2 component. Similar types of graphs, scatter diagrams were used for additional sensitivity testing.

CHART 2
PERCENTAGE CHANGE IN TOTAL C-2
COMPONENT BASED ON INDIVIDUAL MORBIDITY—HOSPITAL
INDEMNITY, AD&D, AND OTHER LIMITED BENEFITS (LINE 3)

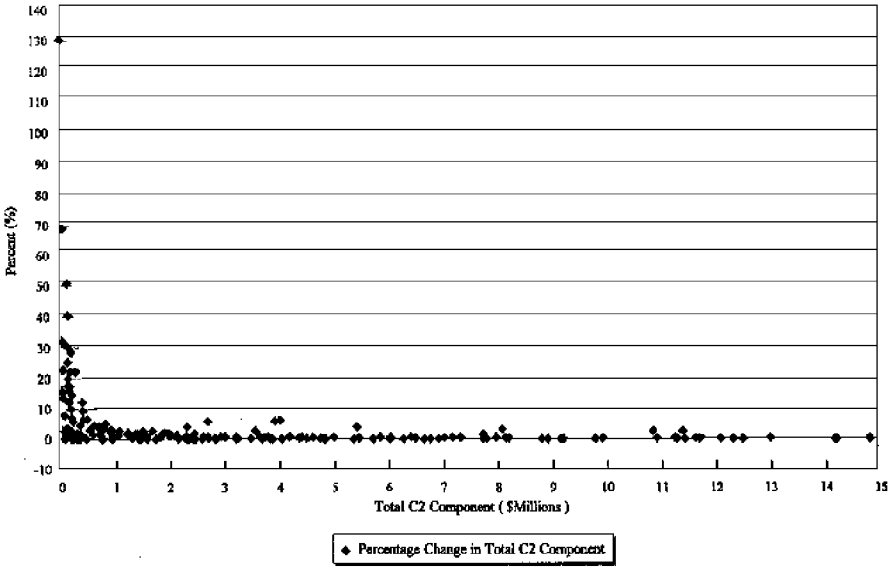


CHART 3
DISTRIBUTION BY PERCENTAGE CHANGE IN TOTAL C-2

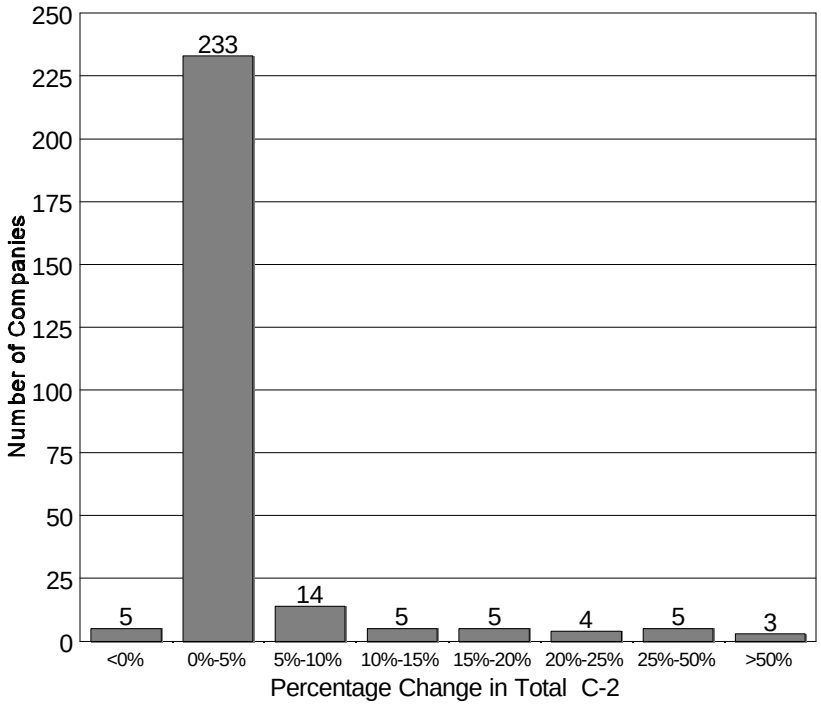


CHART 4
DISTRIBUTION BY TOTAL C-2 COMPONENT

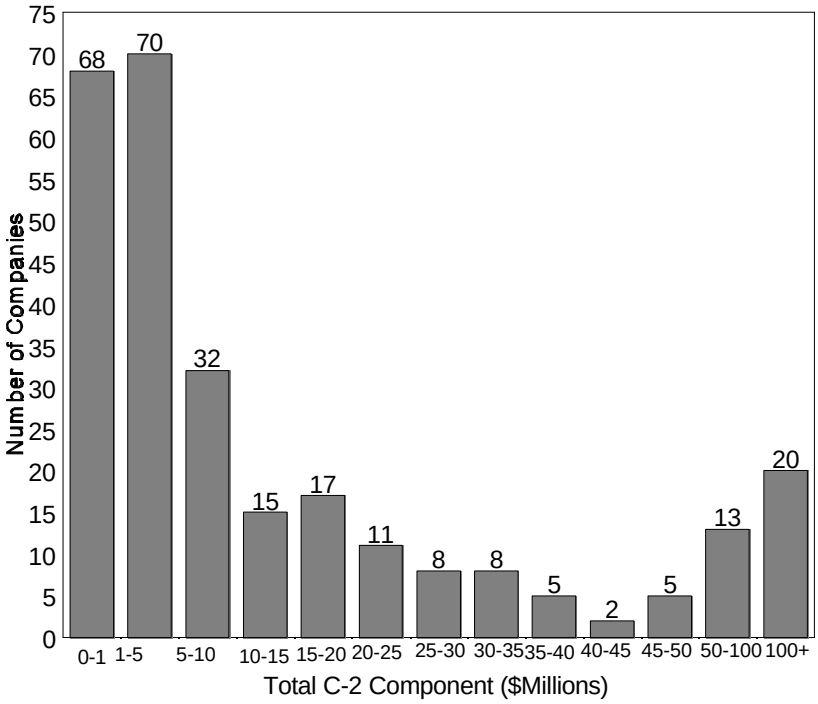


Chart 5 shows the percentage change in the company control level of total risk-based capital, rather than simply the C–2 component. Again, only a couple of companies, those with a small dollar amount of change or small amounts of company control level, have any significant impact.

The next table, Chart 6, again blows up the left-hand side of the chart, showing only the first $15 million. This simplification did not have any significant negative impact.

Chart 7 shows the distribution of change or percentage of change by companies. You can see that very few companies are affected to any significant degree. Chart 8 looks at the same distribution in terms of dollar amounts, again with the same result.

CHART 5
PERCENTAGE CHANGE IN 2×ACL
BASED ON INDIVIDUAL MORBIDITY—HOSPITAL
INDEMNITY, AD&D, AND OTHER LIMITED BENEFITS (LINE 3)

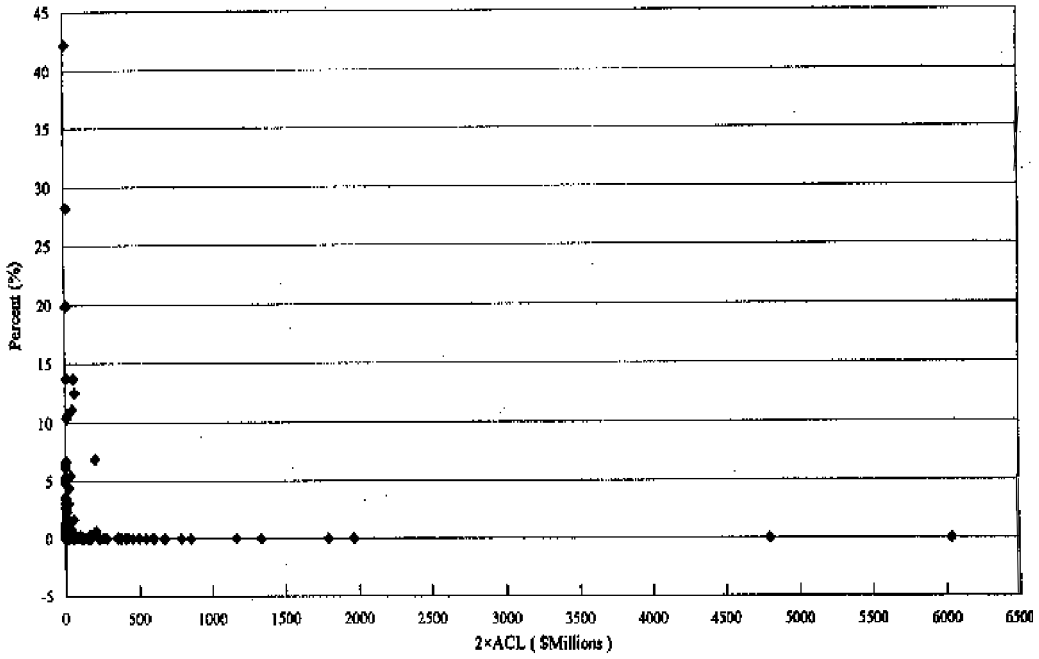


CHART 6
PERCENTAGE CHANGE IN 2×ACL
BASED ON INDIVIDUAL MORBIDITY—HOSPITAL
INDEMNITY, AD&D, AND OTHER LIMITED BENEFITS (LINE 3)

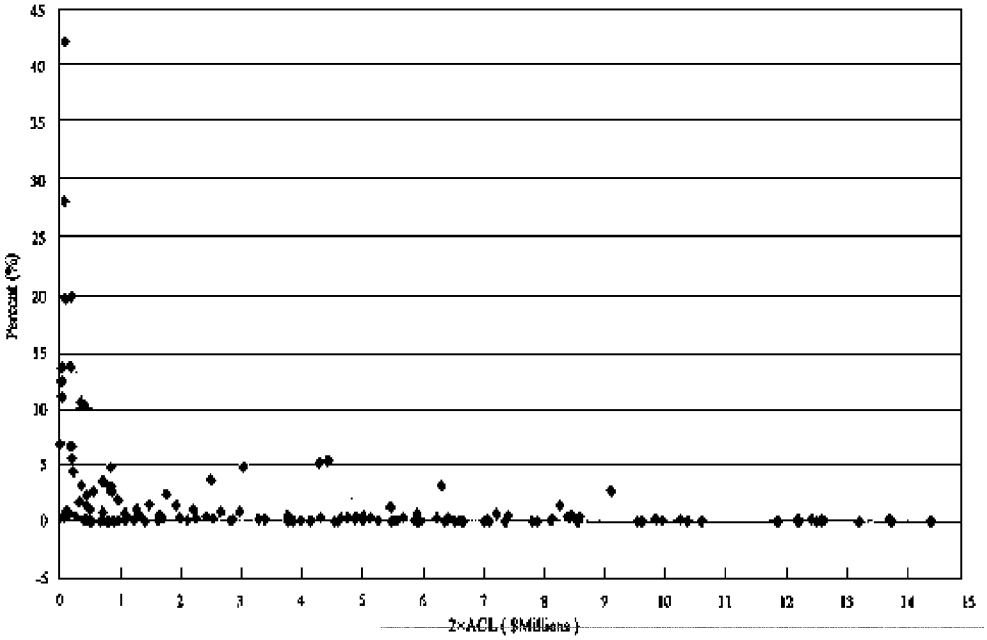


CHART 7
DISTRIBUTION BY PERCENTAGE CHANGE IN 2×ACL

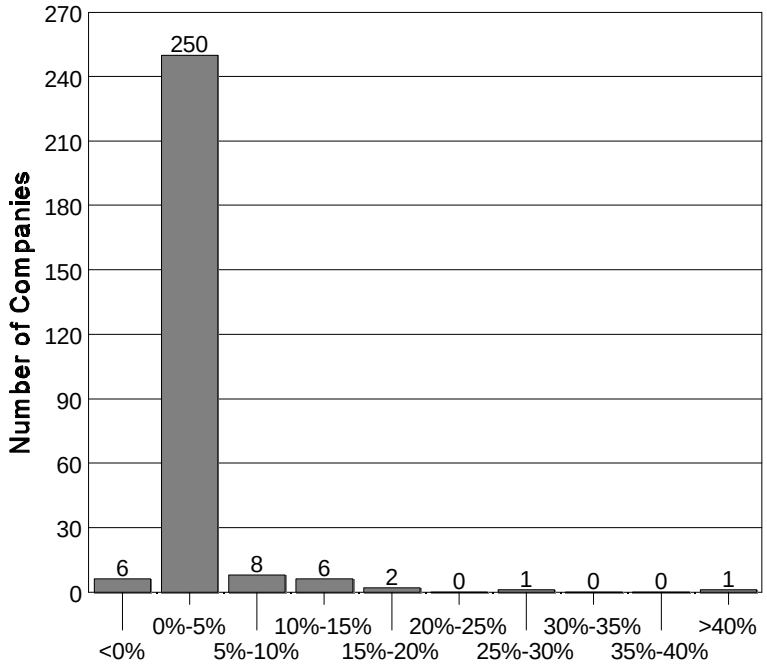


CHART 8
DISTRIBUTION BY 2×ACL

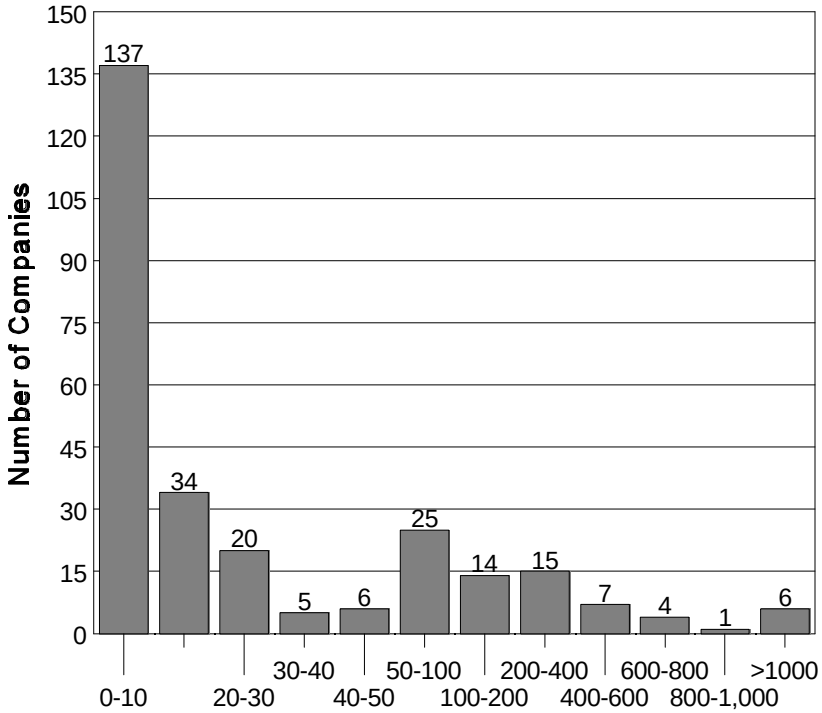
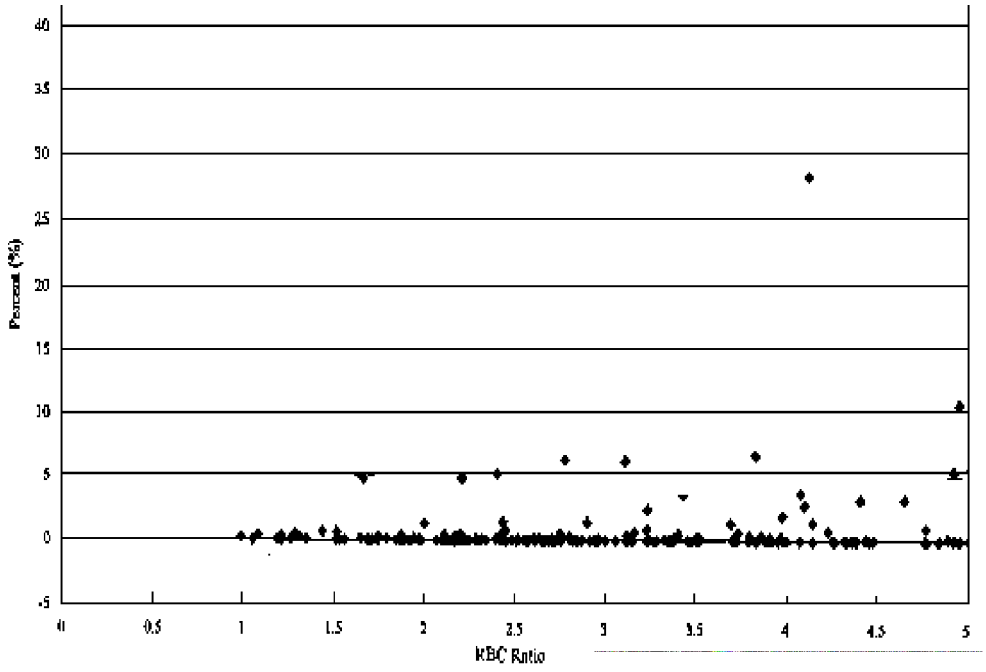


Chart 9 provided a different type of overview. You are looking at the percentage change in company control level versus the risk-based capital ratio that company

has. You can see that the companies with significant impact tend to be the companies with much higher risk-based-capital ratios.

CHART 9
PERCENTAGE CHANGE IN 2×ACL VERSUS RBC RATIO
BASED ON INDIVIDUAL MORBIDITY—HOSPITAL INDEMNITY
AND OTHER LIMITED BENEFITS (LINE 3)

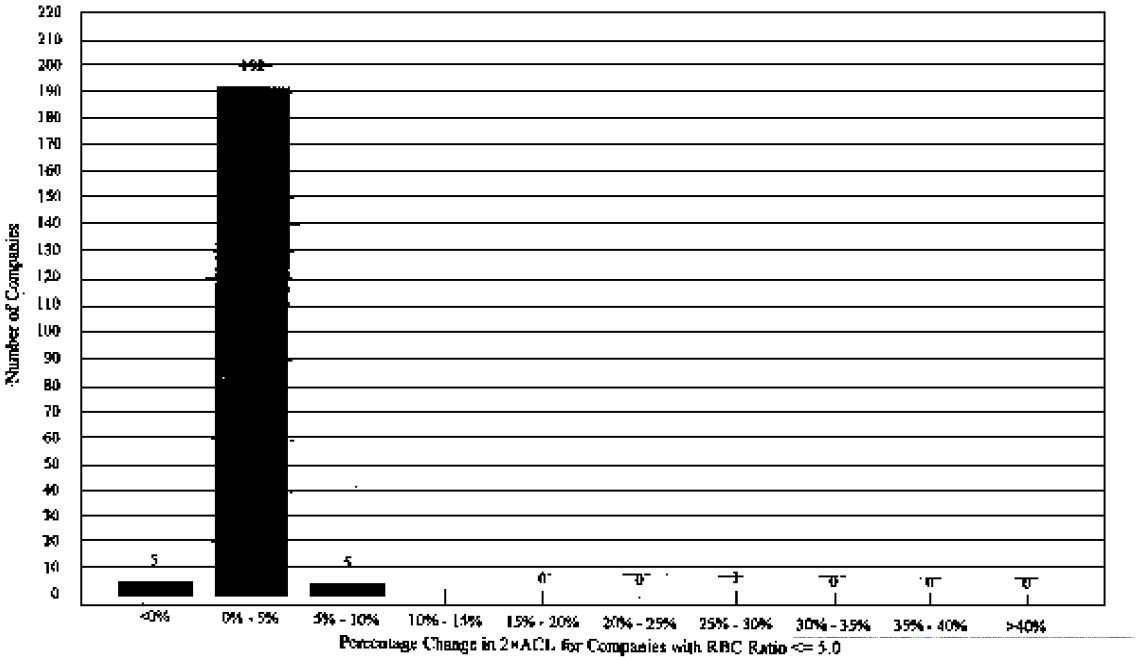


The last chart we'll show, Chart 10, shows the distribution of percentage of change in company control level by the number of companies. Again, very few companies have much of a significant change in the company control level.

This visual graphic approach was only one piece of the analysis. There were listings of data that used a variety of different characteristics, sorted in various ways. There were a variety of tables of data, two-dimensional tables that look at the impact of the changes at the various extremes in the assumptions. In the process of doing this sensitivity testing in our office, the ASA doing the work was convinced that if we continued to torture the data just a little bit longer, it would surely confess to any abnormality that we wanted it to.

That's a quick overview of the simplification process and the types of analysis that determined whether or not the proposed changes had any significant impact.

CHART 10
DISTRIBUTION BY PERCENTAGE CHANGE 2×ACL
FOR COMPANIES WITH RBC RATIO LESS THAN OR EQUAL TO 5.0



Ms. Novak: Next Bill is going to talk about some of the unresolved issues with the formula, so I'll turn it over to him.

Mr. William F. Bluhm: I'm going to talk about the impact the formula is expected to have or is having on HMOs. HMOs are subject to this type of formula for the first time. Those of you who work for life insurance companies probably recognize what a big paradigm shift it is for companies to use this formula, and HMOs are about to do it. There are many challenges for them, probably even more so than life companies had, because HMOs have not been financially regulated in the same way life companies have in the past. They've had different reporting requirements and different regulatory agencies (they aren't all regulated by insurance departments). Some of them are regulated by health departments. There are differences in the reporting and the standards. There needs to be changes in reporting to make HMOs consistent with statutory accounting for life insurers. There's one other major issue for a subset of the HMOs having to do with their assets. For the first time, covered under these risk-based-capital formulas is an organization that has a substantial part of its assets used to actually deliver care rather than to develop assets that are then going to be converted to cash to pay for care. That's where many of these issues are coming from.

I've worn a number of hats through this process. I was the chair of the original group that came up with the very complex formula that was up on the board earlier.

When that was done, my term as Chairperson of the Academy State Health Committee was up, so I also stepped down as chairperson of the Task Force. I have been working for a couple of different clients since then on these subjects. One client is the American Association of Health Plans, which had us do a study for them for the NAIC in response to some of these issues, to try to evaluate what the impact was of some of these asset questions on HMOs.

First, let me mention a couple of outstanding issues that are probably not quite as big as the asset issue from a whole market perspective. It may be more important for particular HMOs. One is the definition of managed care credits. As you recall, the formula has a managed care credit built into it, and based on what category of managed care your payments fall into, you get a different level of credit in the formula against risk-based capital. The concern is that they are being fixed and may not be flexible enough to reflect an evolving marketplace that's going to change the risks. There are a few statement issues that the formula has tried to make fit. HMOs have different statements, and there are different practices in reporting that aren't fully consistent with the life reporting, and those are being worked out now. The NAIC and the Academy will evaluate it in detail by using a survey, but it doesn't appear that there are huge issues involved right now. We don't know for sure yet.

Another issue that cropped up last year in a public policy area was the potential for provider service networks, really Physician Hospital Organizations (PHOs), depending on whether it was the Senate or the House version of the bill. It really was sort of a PHO. It was provider-sponsored insurance, although they didn't want to call it insurance, and there's a big issue now on the part of providers who are contracting directly with employers or with the public. How and to what extent the risk-based capital should apply to them is obviously of interest to their competitors. HMOs or PPOs and insurance companies would probably like to see a level playing field. In that regard, there has also been a study that we did for the American Medical Association that has proposed an amendment to the formula to modify it and allow for risk-based capital for the portion of risk that is attributable to physicians or to professional services because that portion is much less volatile. There's a higher frequency and lower average cost as well as a lower volatility in the historical variance.

The one remaining issue is the relative value, and that hasn't been the huge issue it sounded like it was going to be when we were doing the original formula. The original formula, you may recall, has many relative values built into it, and the Academy tried to avoid the fallout of the flak from that at the time by saying right now we're not talking about setting the final level. We're just constructing this very enormous set of relative values so that once the NAIC chooses an absolute level, it will fix all of those values in relation to each other. Over the couple of years since

that took place, it seems like most everybody has gotten pretty resigned to the level falling in the 9–10% range. That's my own evaluation of what I see happening, but it's not necessarily intended to be any sort of a lobbying statement.

Let me talk about the asset study, which is the major issue for HMOs. HMOs are the one insurer that has assets that are used to actually deliver care. There was a concern over what the impact would be of applying risk-based capital a la life and health risk-based capital to those HMOs. The life and health formula, if you're aware of it, is really heavily involved with the risk of assets, especially evaluating them and applying factors to them. It doesn't get into refining the assets having to do with home office or owned real estate issues, other than as invested assets. For life companies that's probably acceptable because there's not a huge part of the assets of a life company tied up with its home office; however, this can happen at an HMO. So one of the things we did to evaluate that aspect was to see just how big of an issue it was. We did a survey of a collection of 113 HMOs, which represent about 20% of the HMOs in the country. This was a fairly low percentage of the Individual Practice Association (IPA) models. It was an issue for 8.4% of the IPA models, for 42% of group models, for 30% of staff, and for 45% of network. We expected and found that the issue has a bigger impact for staff and group models who tend to be the sort of corporate structures that end up owning their own facilities. IPAs tend not to own their facilities; they're sort of capital unintensive in that regard.

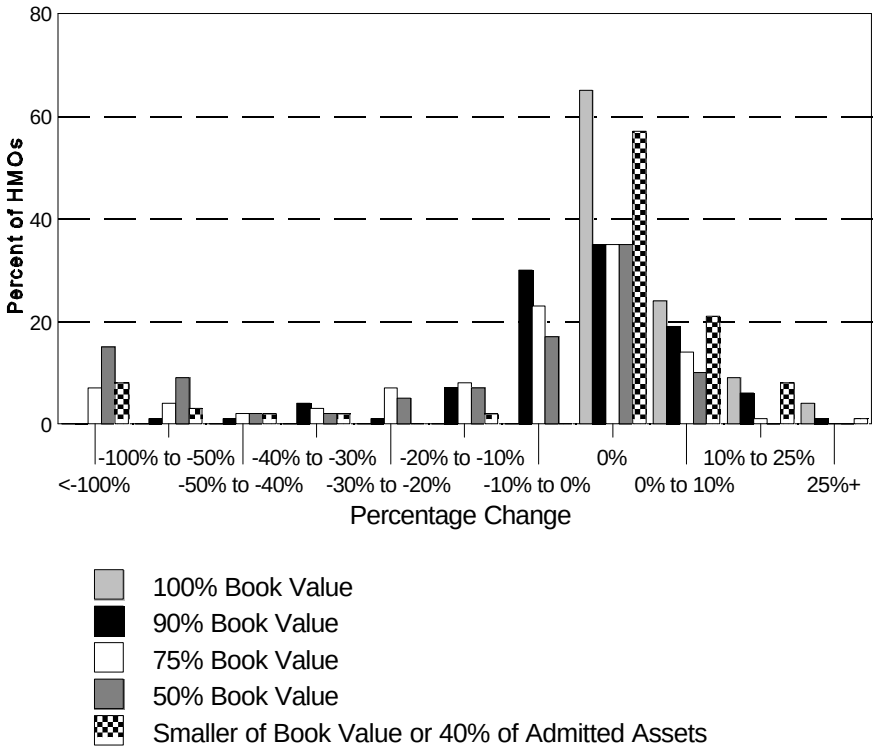
This characterizes the same data based on how big companies were, and how many millions of dollars they had in admitted assets. There were 15 of them in the survey who had assets of a quarter billion dollars or more, which is most or all of the HMOs in that category. It's disproportionately weighted to that end because those larger HMOs tend to be the ones who were better able to respond and willing to respond to the survey. Therefore, keep in mind that these probably tend to be the healthier HMOs and more representative of those heavy in assets and net worth. Again, there were 12 of them with a net worth of $100 million or more, but 71 of them with less than $25 million, which is probably not terribly meaningful by itself because the net worth is not shown as a percentage of assets, but it can give you some information.

Probably the most revealing piece of information is what percentage of the HMOs had assets locked up in these health care delivery assets and what proportion these were of total assets. What we found was that a little over 40% of them have none, and it was sort of a bimodal thing. At the 30% or more of assets range, there were close to 20% of the HMOs in the report. This seemed to imply that HMOs would tend to be of two types: those that don't have much locked up in health care

delivery and those that have a great deal locked up in the health care delivery assets.

Chart 11 shows what the impact is on the HMOs in the database if we were to vary the valuation basis under which the assets are allowed. There was discussion about how we'll let the HMOs admit these health care delivery assets, but we're not sure how we feel about them because we're not used to dealing with them. Or maybe we should not allow them fully; in fact, in some cases, that has already occurred. There are some limits in a few states as to how much is being allowed, and that is why you'll see that 100% of book value, which is more like a generally accepted accounting principles (GAAP) accounting value, will be higher for some HMOs than the admitted asset value.

CHART 11
CHANGE IN ADMITTED ASSETS/NET WORTH
FOR ALL HMOS INCLUDED IN THE DATABASE

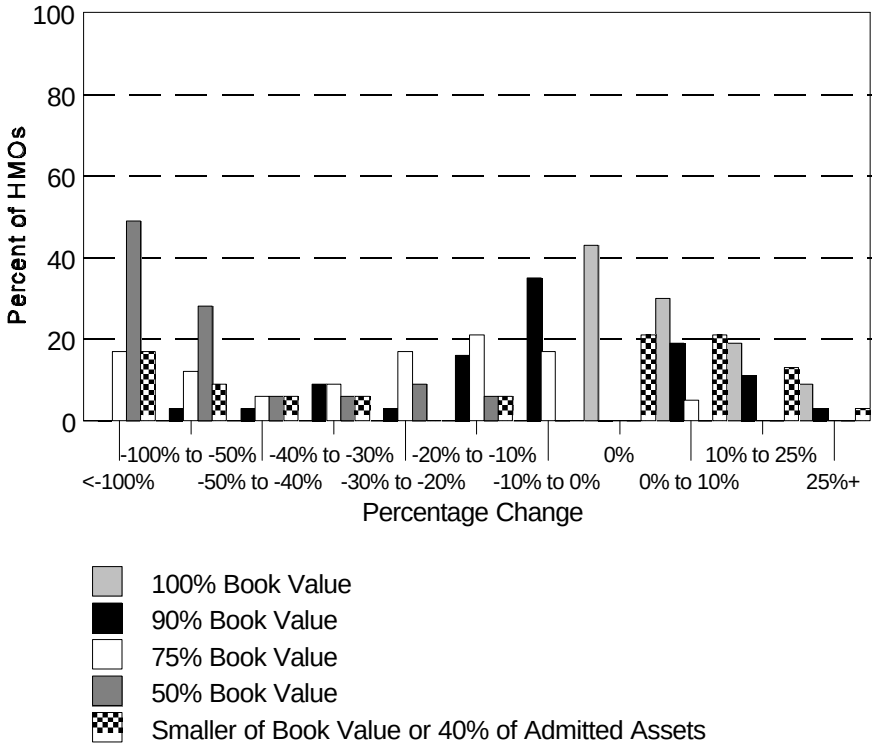


One hundred percent admitted asset value is the starting point. One hundred percent at line zero says, in going from the first column to the next column, nothing changed. The next one, which is 100% book value, compared to the first column, which is 65% of the HMOs in the study, still had no change in net worth when we moved to that valuation basis of 100% of book value. Twenty-three percent got an increase in their net worth of up to 10%, 9% increased to 25%, and 3% went over

that amount. What we've discovered is, through this process, anything that is less than the current admitted asset value or the book value has a significant negative impact on these HMOs who, by and large, tend to be the healthier HMOs. In fact, because of these limitations, it could end up triggering a great deal of regulatory action at times when we didn't want regulatory action to occur.

Chart 12 has the same results, but it's for that subset of the HMOs in the database who had a significant amount of their assets tied up in property and equipment assets. Significant is defined as 10% or more.

CHART 12
CHANGE IN ADMITTED ASSETS/NET WORTH
HMOS WITH SIGNIFICANT ASSETS INVESTED IN PROPERTY AND EQUIPMENT

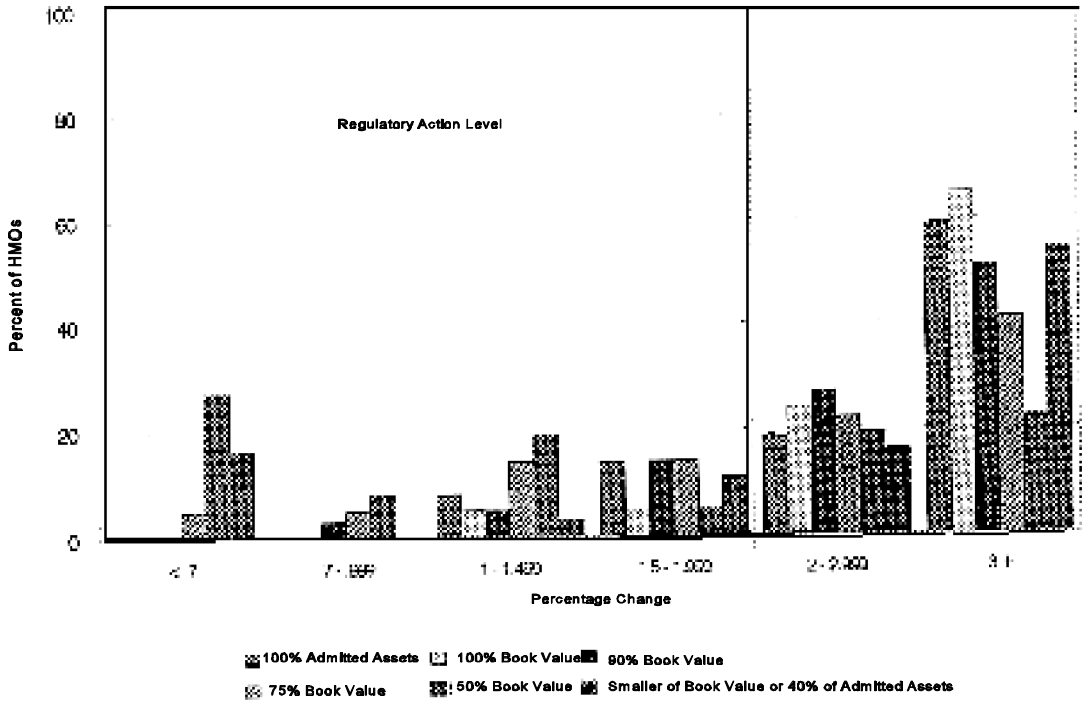


We didn't look at the ones that don't have any assets this way. Among those in this class that are considered that type of HMO who have those types of assets, the results were even more significant. If we moved from the 90% of book value to 75%, we would have been causing 16% of the HMOs in that category to have a negative net worth. They would have gone from their current, somewhat healthy financial status to negative net worth because of that valuation. Even at 90%, 14% of them lose at least 30% of their net worth. That's a fairly significant impact on that subset, and if that were to occur, it would imply some public policy issues, like not wanting those HMOs to be operating so much, or that the public needs to be

protected more from them than they have been. I don't think that's what the NAIC wants to do.

Chart 13 shows the distribution of the risk-based-capital ratios of HMOs under various valuation bases. It shows similar results as before, but they are shown in terms of how they cause regulatory action under the risk-based-capital formula. This involves simplifying assumptions because most of these HMOs in the database have not gone through the process of calculating their risk-based capital. They have never had to. They've never had to take their assets and figure out which class of assets they were and what type of reimbursement formulas they had and so forth.

CHART 13
DISTRIBUTION OF RBC RATIOS OF HMOS
UNDER VARIOUS ASSET VALUATION BASES
P&E C-1 FACTOR=10.0%, SIGNIFICANT ASSET HMOS



Based on the small number of HMOs that we knew had done that calculation, we made the assumptions that these HMOs were representative of the marketplace and, based on that, came up with risk-based-capital factors and measured their actual surplus against the risk-based-capital levels to model what the impact was of these changes in valuation bases. The results were that 22% of the HMOs would have some regulatory action if risk-based capital were applied, which it's not. If it went to 100% of book value, 10% of them would be subject to regulatory action. At

90% of book, it would be 22%, but not the same 22%, and the numbers get very large thereafter.

The conclusion is that limitation of the valuation basis would have a real significant impact on HMOs. Part of what the NAIC was trying to accomplish, I believe, in asking those questions was to evaluate the need for liquidity measures. There are issues related to those assets, not their value as long-term assets, but rather the liquidity issues connected with operating that business, that clinic, or that hospital. There has been a separate task force set up to do that and, at this point, it seems to make sense to separate that issue out and not treat it as a valuation basis issue for the HMOs.

Ms. Novak: Before we move to a discussion of the regulatory perspective, maybe we can pause to take any questions that we might have generated to this point. Any questions on either the simplification or the unresolved issues?

From the Floor: Your graphs mainly were on the hospital indemnity comparisons. I would assume there were other graphs that were compared on the other product lines.

Mr. Lippai: Yes. In almost every place where we had data we did a similar level of testing, using not only using those type of methods, but others as well. Almost all of the approaches had a similar lack of variability. There was at least one place where, after testing, we decided we didn't have the right simplification. We went back and modified it to something that had results similar to this. In general, that was the case. I'm trying to think if there's any exceptions, and I don't recall any that were really very significant. In one place we had to go back to some of the original work that was done to see if the underlying work also would verify it, but in general most of the end results were very similar to this; there were very few significant changes.

Mr. Robert E. Wilcox: I'm really going to take a little different approach than even I had expected to take originally when this subject came up, but I thought that we would have in the audience not only some people who have tracked through this with us from the beginning but some people who had not been involved, and it might be useful to step back, look at the big picture, and see how the risk-based capital fits into the overall concerns that we have with regard to the regulation of health care. So, I hope this makes sense as we go along.

In looking at that big picture, we can see some issues that we've been faced with that are important considerations. There are many new provider arrangements, new approaches to risk assumption, emphasis on managed care, unclear regulatory

requirements, outdated state laws, and differing backgrounds and skills of the people who are involved in what we're doing.

First, with regard to the new provider arrangements we're looking at, traditional commercial insurers are working with indemnity payments, managed-care, preferred-provider arrangements, and HMOs as lines of business within indemnity carriers. For health maintenance organizations there are different kinds of models, some of which Bill talked about in his discussion. There's the staff model, the group model, the network model, the IPA model, and the direct contract model. We're looking at preferred-provider organizations which, in general, do not accept risk, but sometimes they do, creating a need for solvency regulation. They generally use discounted fees or diagnostic-related groups (DRGs) in order to determine how they accept that risk. We have the point-of-service plans, which are hybrids of HMOs and indemnity plans. They sometimes are offered as an option under managed-care plans, sometimes they're freestanding. You have the provider-sponsored organizations, the physician/hospital organization, individual practice associations, and group practices.

The point here is that you're seeing a wide variety of different kinds of organizations that have come into being in just the last few years. We have to deal with the new approaches to risk assumption of these various organizations, such as discounted fee for service, bundled fee arrangements, withholds and risk pools, corridors of risk, capitation programs, bonuses and penalties, percentages of premiums, which all package the risk in a little bit different form, and make a difference in terms of how we need to regulate for solvency. An emphasis on managed care has blurred the lines between the different kinds of organizations so that sometimes the indemnity insurance companies look more like HMOs than HMOs, and HMOs look more like indemnity insurance companies than the insurers; the Blue Cross and Blue Shield plans shift back and forth in terms of how they appear in this.

The regulatory requirements in all of this have become unclear. The regulators are trying to catch up with what's happening, and I think that's understandable with the rapidity of change that's taking place. The differences that have previously made up much of the regulatory structure no longer make the same difference. So you'll find in the insurance code a chapter that establishes how you set up an indemnity carrier, another chapter on how you set up a hospital, medical and dental indemnity corporations (HMDIs), and another chapter on how you set up an HMO. All of these chapters have different requirements, and those differences in requirements no longer make the same sense that they once did when those chapters were first written. It is difficult in that environment to give clear guidance to the industry so that there is a clear path as to what the industry should be doing.

State laws are a step behind that in most instances. The statutory definitions are unclear, and they limit the ability of both the industry and the regulators to respond to these rapidly changing needs. So that's the environment in which we find ourselves trying to operate. Couple that with the fact that we find coming into this business people without any prior experience with this type of regulation.

I've tried to avoid most of the acronyms in this presentation, such as the PSNs, but the consolidated licensure for entities assuming risk is an acronym that has been developed for a project that is intended to accomplish five, general purposes: (1) to clarify what we mean by insurance, (2) to identify those that should be included within the regulatory universe, (3) to set some standards for health plan accountability, (4) to come up with some commonly defined terms so that we can speak a common language as we move between these different kinds of organizations, and (5) to provide financial standards that cross these various boundaries and provide consistency in model laws and regulations. Number five may be the most difficult of all because we're dealing with model laws and regulations in many different jurisdictions: 50 states, the District, and the territories. In a number of the states, the regulatory model involves multiple departments within the state; it's not always as straightforward as the Insurance Department having all of these laws and regulations within its grasp.

Now, if we go to the financial standards, which is our primary concern, there are many different areas that we need to be concerned about. The health organization risk-based capital, our primary purpose for being here, is at the top of the list, but there are a number of other requirements that have to fit within this, if you're going to have a comprehensive financial regulatory package, liquidity requirements are certainly an element. This is part of what Bill was talking about when we get into health care delivery assets and the analysis of how much liquidity you need. Also how do you provide that liquidity with health care delivery assets? What other kinds of assets do you need to have in order to provide the liquidity? What sort of depository arrangements need to be there to provide the consumer protection? Insolvency protections are an important aspect.

Another working group is involved in the process of looking at a consistent approach to guarantee mechanisms that cross these various boundaries. That's part of this interlocking arrangement of financial regulation, and that becomes one of the more challenging ones. As a matter of fact, because each of these different kinds of organizations have developed their own approaches toward consumer protection in the event of insolvency, it’s not easy to harmonize those and come to something that's consistent that crosses those boundaries and encompasses the new kinds of things that are being developed.

Statutory accounting practices is a difficult one. I hope you're all aware of the project that is well underway to codify statutory accounting for insurance companies. This has been a major undertaking. You'll see within the next few months a comprehensive document that brings all of the various issue papers that have been developed into a single comprehensive statement on statutory accounting. When that project was originally undertaken, health organizations were not included within the scope of the assignment. We have broadened that assignment now so that the work is now beginning on the pieces of statutory accounting that are unique to health organizations. Ultimately that will be brought within the scope of statutory accounting, a very necessary step and something that has never been done in a comprehensive way.

Let's discuss the reporting requirement. When we get into talking about the survey that's currently underway, you'll see that one of the fundamental problems is the rainbow of financial reporting forms that come from the different organizations. When you look at the various reporting blanks that health organizations report on, you'll find that it includes the blue book, the yellow book, the orange book, the brown book, and the white book, which are different forms that supposedly are reporting the business of health insurance on quite different structures. There are some similarities but a great deal of difference as well. One of the things that has to be encompassed in this is to move those reporting requirements into a single stream so that companies that do the same thing, whether they do it under an indemnity insurer umbrella or an HMO umbrella or some other kind of structure, report the same things in the same way. That's a very necessary step in this whole process.

Regarding investment requirements, this again ties into health care delivery assets, but there are other unique aspects of the assets associated with health care and the asset/liability matching association with health care that needs to be considered. Examination and enforcement authority need to be unified. Finally, you must know what to do when they get into trouble to bring supervision, receivership , and liquidation into harmony as well. So you see there are many pieces of which HORBC is only one.

The standards by which we look at these, the fundamental principles with regard to financial standards are, I think, built around these four items. First of all, it's fairness to consumers. The consumer expects, has reason to expect, and should expect the same level of protection from the regulators under each of these various kinds of licensed entities. The consumer shouldn't have to worry about buying from a certain kind of company and having a different kind of protection because they're subject to different regulations. The idea here is that the consumer ought to be able to expect the same level of protection for all of these kinds of organizations that are officially licensed. At the same time, we want an even playing field for the insurers,

and this is particularly important as the new players come into the field. We've seen the evidence that sometimes they can successfully lobby for their own set of laws and regulations that they hope will give them an advantage or some leg up on the overall system. The fair way to do this is to have an even playing field across the board so everyone comes in on the same basis.

We need to anticipate continuing change, and you'll see that the HORBC formula is built around this idea of adapting to continuing change. We tried to anticipate, as much as possible, the kinds of things that might happen in the future and include those events in the formula, but not with the intent of the change. It's not the function of regulation to point the change in a specific direction. I happen to believe that change is good. It's positive. That's how things get better. Things never get better by staying the same, so we want to encourage bright people who think clearly to come up with better ideas, new ideas, and ways to improve the situation, but it's not the province of regulation to drive those ideas or build in the advantages to steer things in particular directions as we're dealing with the financial regulation aspect of this.

Now, many of you are aware of the survey diskettes that went out recently. How many of you have had contact with those diskettes? Not everyone, but a significant number of you here have seen those diskettes. The mailing started in late September 1996 and was completed recently. Why the spread? It turned out that because of these diverse organizations, the mailing list had to be assembled from several sources, as you'll see in just a minute, so the last of the mailings went out only two weeks ago. Those that went out first have a November 1 return date. Those that went out last are supposed to be back by November 22. I would encourage you, even if you can't make the deadline, to still get it in. We're getting an abysmally low response rate. Normally, we expect on a survey like this to have a 40% response rate, and we expect to get about one-and-a-half phone calls for every survey we send out. We're not getting anywhere close to those responses so far.

Here's what we have so far. We mailed out 1,100 diskettes to life and health companies. We obtained a list through the American Association of Health Care Providers (AAHP), from which we obtained 650 HMOs. Another 225 HMOs did not come from AAHP. There were 80 HMDIs that came from Blue Cross/Blue Shield, and another 60 HMDIs were not affiliated with Blue Cross. Sixty percent were from limited health service organizations, and 45 fraternal were sent out. That's a total of 2,220 questionnaires. Some of you might be surprised to see fraternal in the survey. There are already three or four states, including Utah, that require risk-based capital of fraternal companies. The fraternal companies officially

asked last month to be included in the risk-based-capital requirements across the board. Most of the fraternal don't write health insurance, however.

So far we have received 100 responses from the 1,100 that we sent out for life and health insurers. Those were the first that went out, by the way. Seventy-five of them completed the diskette. Twenty-five sent it back not completed. I presume there are a few more that came in, and our experience is that most people send these in at the deadline and not before, but it's still a very low response. As for the AAHP HMOs, three have sent in completed diskettes and five have sent in uncompleted diskettes. None have come in from the other HMOs. We've received only two Blue Cross from the HMDI, and from the fraternal organizations we have received three. We haven't gotten any responses from the LHSO mailing list. In total, we've received 80 completed diskettes and 35 incomplete diskettes. We really need this to assess the formula to go forward. This is important, and I encourage you to make sure that the work gets done and the diskette comes back in.

I want to run through some of the frequently heard comments that have come in on these. HMOs complain that the survey uses insurance terminology that they do not understand. When we talk about arcane language, it's true for the HMOs, even though they've been around for a long time. Imagine where we are for the provider-sponsored organizations who have none of this background and experience. Many callers are unfamiliar with reinsurance jargon. Reinsurance presents many problems for them. A comment we received was that the instructions that were prepared generally tied into the blue book and not to the different statement blanks. I think that's a valid concern that obviously needs to be resolved when we get to something more final.

Another comment was that the survey looks daunting, but it's mostly wasted space because very little of it applies. The idea that one size fits all doesn't fit. They're saying that this is really three or four different formulas tied together in a single formula. Those who have developed it see the continuity between those, but those filling out the forms don't see the continuity between the different lines of business and the way they fit together.

Many life and health companies that declined to fill out the survey said they cede all the premiums to an affiliate, and since they don't retain the risk, it doesn't apply to them. That's their analysis of the situation.

There were many questions as to what goes where in the managed-care buckets. The managed-care descriptions seem to be giving people some problems.

How to classify reinsurance (proportional or nonproportional) is a subject that elicits many questions. When faced with filling in many reinsurance contracts (Mike indicated that there was a life and health insurer with more than 1,000 reinsurance contracts) the tendency is to lump them together. Simplicity is the rule. In summary, the reinsurance arrangements seem to be giving some problems because they're not well-defined and not well-understood.
There are many questions about maximum-retained risk after reinsurance. Some are trying to use an estimate or justify putting in something when no limit is theoretically the correct answer.

The concept of rate stabilization reserves seems to be foreign to many companies and again, the view is that there's a bias towards the life and health companies.

We're open to any questions that you might have, but again, I encourage you to get the responses in so that the survey becomes meaningful. It's important that we be able to go ahead with the HORBC formula, but in order to do that we need to know how it affects the industry, not just three or four people in the industry.

From the Floor: Do you have a target implementation date?

Mr. Wilcox: I would probably have moved it up much sooner if we were getting the survey information in that we need. I think that, because a number of states are being pressured by regulators and others to move forward with something, it's important that we finalize this formula as quickly as we can. I had hoped that we could make these changes so that we would get an official reporting at the end of 1997, but if we haven't adequately tested the formula, that will present some problems because we don't want to put it out without knowing the impact.

From the Floor: What happens to the companies that return incomplete surveys?

Mr. Wilcox: I'm sure that there's a black mark in a book someplace, but I don't know who keeps that book. Maybe it's one of those things that will show up as coal in your Christmas stocking.

From the Floor: Are you attempting to get them to complete it in time or is it just not done?

Mr. Wilcox: In this particular situation, with this broad survey, we will work with the information that comes in. Because 2,200 were mailed out, we're really not in a position to follow up with each individual company and hold someone's hand when filling it out. By the way, if you do have questions on the survey that you think others might have asked, please check the NAIC Web page on the Internet,

and you will find a summary of the questions that are coming with some answers that will be likely to be helpful to you. The Website is www.naic.org.

From the Floor: Can you discuss the impact that this has on life companies that currently file under the life risk-based-capital formula that write health insurance?

Mr. Wilcox: The expectation is that this will have some change in the C–2 risk portion of the formula and little change outside the C–2 risk, but the whole process that we've been going through is a more rigorous examination of what those risks are so that it's not only a more complex formula, but a more accurate formula to be used in the assessment of the underwriting risk.

Mr. Bluhm: It's probably worth noting that, at least at the moment, the value for RV that was chosen for testing purposes was the value that would result in the same amount of overall C–2 as that in the old formula. Since the relativities have changed materially, different companies will have impacts differently from the old formula, even though the industry in total probably shouldn't be as affected.

Mr. Wilcox: I think that there will be some minor differences in the industry as a whole, but probably some major differences in specific companies where the previous broad categories lumped some relatively high risks and low risks together. With a more precise measurement of those risks, the low risk is going to go down and the high risk is going to go up. So you'll see some marked differences between specific companies.

From the Floor: It seems to me that the low response is directly connected to the fact that HMOs, for example, don't understand the terminology that's more understood by regular health insurers. I'm wondering if it's at all possible, at this time, to ask the questions in a way they'll understand what is being requested?

Mr. Wilcox: I think that's a valid concern; hopefully we're getting that addressed, to some extent, by the industry. Donna, for example, is conducting a hands-on seminar for the Blue Cross people, to walk them through it and make sure that they understand what's expected, and AAHP is doing something similar for their members to help them get through it. I suspect, for example, that we'll get a whole rash of Blue Cross filings shortly after Donna does her seminar.

Ms. Novak: That's exactly right. We found that our question rate is much higher than the one-and-a-half per survey, which is what's being experienced by the NAIC. We've been getting a great deal of questions, and some of the plans are waiting until after the training session to finalize their surveys. Many of them waited until a couple of weeks before the deadline, assuming that this was a two-week project.

Because of some of the data required and the time needed to understanding the survey, it was not a two-week project. I think we're going to see many surveys right after the deadline. We are getting some very good questions and good feedback on what instructions need to be clarified going forward. It has been a worthwhile, albeit lengthy process.

Mr. Wilcox: Bill, do you know when AAHP is doing their training seminar?

Mr. Bluhm: It already took place a week ago. They asked me to sit in on it. It was done via a conference call, and I expect that there should be a good return from the larger HMOs who are struggling with many of these new things, but I think it may be difficult to expect the smaller HMOs to be able to figure it all out. It's sort of like taking a life insurance company and saying, we're going to apply Australian rules to it now, so have it back to us in six weeks. There may not be that great a response rate from those HMOs.

Mr. Wilcox: Do you think it's possible that consulting actuaries might go out and help these folks fill it out?

Mr. Bluhm: One could hope.

From the Floor: Bob, could you tell us how the HMOs are supposed to complete their forms? Of course, if it's only C–2, and it doesn't have assets in it, how are they supposed to report their assets to cover the questions that Bill talked about before?

Mr. Wilcox: It does have the life/health C–1 formula included, so we'll gather that information.

From the Floor: But they'll just assume it's admitted. They won't put limits on it will they?

Mr. Wilcox: We will get the same limits that currently apply under the accounting requirements that they're under, whatever those are, so that's going to present some lack of accuracy in the outcome.

Ms. Novak: Harry, we're requesting the data for nonadmitted and admitted so that we can see the effect of different limits. We're asking for more data than what is on the balance sheet.

From the Floor: I saw that disability income is not based on relative value. Is that still the case?

Mr. Bluhm: Right. The disability income was, for a variety of reasons, the one piece that was not put in as a relative value. As far as I know, it will not vary as the relative value factor is chosen. It's going to be fixed.

From the Floor: You said that the relative value that is currently being used was meant to fix the current C–2 risk equal to the current formulas.

Mr. Bluhm: The medical part, not the disability part.

From the Floor: That comment does not include disability income?

Mr. Bluhm: Correct.

Ms. Novak: Or the long-term care?

Mr. Bluhm: Correct.

From the Floor: Would the NAIC or its committees consider what C–1 factors should be used against certain classes of assets or whether that would change for medical assets?

Mr. Wilcox: This is a significant concern that I have. The nature of the risks associated with health insurance, except for disability income and long-term care, correspond much more closely to the principal lines of property and casualty coverage than they do to life coverage. However, there are some very long-tailed property and casualty coverages as well. Every time I think through this problem I come to the conclusion that, until you start assigning assets to liabilities so that you do the actual asset/liability matching and carry it over into the risk-based-capital formula, you don't get the right risk-based-capital analysis that you ought to have. That's due to the long-term nature of life insurance being quite different than the primary medical lines, although life insurance's long-term nature is very similar to disability income.

Mr. Bluhm: Let's add a little piece of history. That question has been dogging the Academy group for three years as they try to come up with a rationale for choosing that C–1 factor, and there have been no obvious answers at this point. One line of reasoning is that the home office real estate risk-based-capital factor is 10%, so perhaps it should be left at 10%. Another line of reasoning is that the financial data that was used to measure volatility already includes fluctuations in those asset values, so it should be zero because it's already included in the C–2 risk. Various other arguments that put it somewhere between 0% and 10%, but if anybody does

have a rationale and thinks they have a good way of pursuing it, I think the Academy would love to hear it.

Mr. Wilcox: I keep coming back to an answer that I think the industry is probably not ready for, which involves the allocation of assets to liabilities. If you think about the health care delivery assets, for example, hospital beds for an HMO that uses those hospital beds to deliver care have a very clear and identifiable value. Hospital beds that are not used to deliver care but held as an investment probably are about the least marketable investment that you could own, and the risk-based capital that ought to be assigned to those two categories is quite different. Until you assign the health care delivery assets to the liabilities that they match up with, how do you know which one to assign? I'm afraid that you keep coming back to the answer that you have to tie specific assets to specific liabilities in order to assign the risk-based capital, and still do that in the context that all of the company's assets are available to all the policyholders as we traditionally hold in insurance.

From the Floor: To some extent, they relate to looking at cash-flow questions on health insurance.

Mr. Wilcox: If we went to do dynamic solvency analysis across the board, then we could have much less concern about the assignment of risk-based capital requirements to specific asset categories, but until we do that and have the actuaries take on a whole new responsibility and authority within the insurance industry, we don't have that to fall back on.

Ms. Novak: The liquidity project that you mentioned is also examining many of these issues. There's some overlap between different measures that I think will be sorted out in such a way that all risks will be addressed in one test or the other and, in the end, we'll have a complete solvency requirement.

From the Floor: One of the questions dealt with sections on credits for reinsurance, both proportional but nonproportional, yet most HMOs buy nonproportional reinsurance. It's not exactly legal to buy proportional reinsurance. Is there any way of trying to equal the playing field between insurers that can quota-share insurance and HMOs that, in my view, can't quota-share legally?

Mr. Wilcox: Does that apply in just some jurisdictions?

From the Floor: I think it's general. I don't know anyone that permits it. When you have an insurance company who owns an HMO, it doesn't really make any difference. It all comes out in the bottom line.

Mr. Wilcox: Well, this is one of the areas where it doesn't make sense to permit one kind of company to do that sort of reinsurance and the other not to. It ought to be evened out so that what is available to one is available to all.

Mr. Bluhm: But that's not really an risk-based-capital problem.

From the Floor: No. The risk-based capital permits it and an HMO can't do that. We may need some capital relief.