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Risk-Based Capital for Health Organizations

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Moderator: DONNA C. NOVAK
Panelists: JULIA T. PHILIPS
STEVEN N. WANDER
Recorder: DONNA C. NOVAK

Summary: Participants in the developing Risk-Based Capital standards for insurers, Health Maintenance Organizationss, and Preferred Provider Organizations discuss the status of activities by the National Association of Insurance Commissioners, states, and the American Academy of Actuary regarding risk-based capital requirements for health insurers, Health Maintenance Organizations, and Preferred Provider Organizations. Panelists present results of testing conducted by the National Association of Insurance Commissioners.

Ms. Donna C. Novak: The first speaker, Julia Philips, is the life and health actuary for the Insurance Division of the U.S. Department of Commerce of Minnesota, St. Paul. She's also the vice-chair of the Managed Care Organization Risk-Based Capital (RBC) Committee of the NAIC. And then I'm going to speak. I'm the chair of the American Academy of Actuaries' Federal Relationship Group and, as such, attended the physician services organization (PSO) solvency meetings held by the Health Care Financing Administration (HCFA). I'm going to talk about the solvency requirements on the federal level and then Steve Wander, the senior manager with Deloitte & Touche is going to discuss some innovative things he's doing with RBC with a few clients.

Ms. Julia T. Philips: The Insurance Division of the Department of Commerce regulates insurance companies, although in Minnesota, the Department of Health regulates HMOs. One of the key issues that insurance departments are concerned about is solvency of insurance companies. We know that we can't single-handedly prevent insurance companies from becoming insolvent, but when a company appears to be getting into the danger zone, we take regulatory steps, ask for action

plans, and monitor things. If a company seems to be inevitably headed for insolvency, we take over the company and try to wind things down.

The question that often arises is, "What is a reasonable amount of capital?" Managements of insurance companies have various ideas about this, most of which are in concert with what regulators think, but it's the companies on the edge that generally disagree about what constitutes an adequate amount of capital. In the early 1990s, the NAIC developed RBC standards for life and property/casualty insurance companies. It came up with a formula that had various categories of risk and the appropriate amount of capital to hold for each one, which eventually became a "model law." A model law does not have any force unless the states adopt it, but, in fact, 49 states have adopted the model law for RBC for life and property/casualty insurers because it is an accreditation standard at the NAIC.

Since it was adopted in 1993, the RBC has had a very simplistic formula in place for health insurance, which is a percentage of premium that varies by a couple things. So the NAIC set up a new working group to come up with something as accurate as could practically be done. Tens of thousands of hours were spent working on the theoretical underpinnings, not by the NAIC, but by the Academy of Actuaries. Then, of course, the NAIC couldn't just take it as it was so, we revised it for a couple years. And now we are close to final approval of what is being called the NAIC's Managed Care Organization (MCO) RBC Formula.

It was originally conceived as a formula that would be for all health insuring entities, but, as the political and practical realities came up, it became a formula that applies to entities licensed as HMOs or hospital, medical, dental insurers (HMDIs). We expect the formula to be adopted by the plenary committee of the NAIC some time this year, so it will be a requirement when HMOs and HMDIs fill out their annual statements for 1998.

One question I am frequently asked is whether there is any lead time for implementing this while waiting for the states to adopt the model law. The answer in this case is, no, you don't have any lead time because your state already has a law saying that licensed HMOs and HMDIs must complete the NAIC's annual statement blank, complete with instructions—and we're putting it in the instructions.

The health formula has four categories: (1) asset risk, which includes assets that are actually affiliates (H0) and other assets (H1); (2) underwriting risk (H2), which is the risk of unfavorable fluctuation in underwriting results; (3) credit risk (H3); and (4) business risk (H4). The formula for health companies is, in some ways, similar to that for property/casualty companies, especially on the asset side. The underwriting risk seems simple and basic to me, but that's because I've been studying it for three-

and-a-half years. People who look at it cold think it's very complex, but we simplified it a lot. Credit risk is the risk that creditors will default. And under general business risk, we have categories for administrative expense risk—the primary risk for ASO businesses—guaranty fund assessment risk, and excessive growth risk.

The total RBC is a cute little formula: If you have all your risk concentrated in one category, then the formula does nothing; if your risk is spread evenly, it cuts your capital requirement in half. It took me a long time to figure this out, so I'm sharing it with you. You take the capital required for each of the categories, square it, add up the four categories, and then take the square root of the whole thing. This will cut your capital requirement in half, but no more than that, depending on how you're distributed.

There is a model law for life and property/casualty insurers. There has not been any RBC requirement for HMOs or HMDIs, although more than a majority of HMDIs belong to the Blue Cross and Blue Shield Association which has its own internal private capital requirements that apply to those HMDIs. One item that was big news was that when we tested this formula, 22% of the HMOs that filled it out were below what we call company action level, the first triggering of action. It's not an authorized control level where the sirens go off and the red flags start waving, but it's the level at which the regulator is supposed to demand a business plan.

Twenty-two percent is a big number. But the working group decided that it was a valid number, that the HMOs that were below company action level seemed not to have sufficient capital by any measure. That doesn't mean that 22% of HMOs are in danger and we should be worried about them. Many had parent companies with plenty of capital that didn't want to put the capital in the subsidiary. It might be a technical thing. By comparison, only about 3% of the HMDIs were below company action level, possibly because many were under the Blue Cross and Blue Shield Association rules and already living by such a standard.

If you want to see copies of the formula and the instructions, there's an Excel spreadsheet and a Word instruction document on the Internet that you can download. Go to the NAIC Web site (www.naic.org), select "Financial Data Reporting," and then MCO RBC Survey Spring 1998. It's somewhat complicated if you're not used to it, but in a year or two, it'll look really nice and simple, just like the annual statement.

Mr. Jeffrey L. Smith: You said that this applies to HMOs and HMDIs; for those states who have passed the uniform licensure model act, and that, by default, it

applies to PHOs and all the other acronyms because they'll have to follow the same statement. Is that correct?

Ms. Philips: If they are using the HMO or HMDI statement, and the instructions for that statement say to put in your RBC results, then they'll have to.

From the Floor: Then a PSO can get a waiver?

From the Floor: Yes, nonwaivered corporate entities, which would include PHOs and all the other acronyms could get a waiver. But under uniform licensure at the state level, that brings in everybody, except those who get the federal waiver.

Ms. Philips: That's how regulators think. Two HMOs could be dramatically different, but to us it's an orange blank.

Ms. Novak: I'll give a little bit of background on the PSO waiver. Part of the Balanced Budget Act was that HCFA would, through a negotiated rulemaking process, develop solvency standards for hospital and provider and physician entities that are provider-sponsored organizations. This was a process for lower or different solvency requirements than that which states had in place. The idea was that if Medicare was contracting directly with provider organizations, it would decrease the cost to Medicare. So, Medicare wanted to encourage this and make it easy. The feedback from the American Medical Association (AMA) and American Hospital Association (AHA) was that states made it very difficult to get an HMO license, and so they wanted an easy way to get a federal waiver.

The federal waivers are three-year waivers that are only going to be given for the next three years, unless the program is very successful, in which case it could always be extended. Only the solvency requirements are waived. Other state requirements, such as market conduct, are not. This will mean dual regulation of many entities, and every state regulates PSOs slightly differently. Therefore, in some states, it could be very confusing for provider groups that want to go for the waivers.

Let's compare some of the factors in the PSO waiver with the MCO RBC (see Table 1 on page 5). As Julia mentioned, there are four risk categories in MCO RBC. The PSO waiver looks a lot like the HMO model act, which on an ongoing basis has a capital requirement of $1 million, 2%/1% of premium, or 8% of expenditures with a managed care credit. The managed care credit is very significant, depending upon how a provider organization is contracting with its subproviders. It's 100% for capitations paid to affiliated providers and 50% for payments to affiliated providers or capitations to nonaffiliated providers.

TABLE 1
COMPARISON OF FEDERAL PSO SOLVENCY
REQUIREMENTS AND MCO RBC

Minimum Net Worth (MNW)	PSO Solvency Standards	Authorized Control Level MCORBC	AAA Liquidity Test-Current Thinking
Initial Stage	$1.5 million	Same as ongoing	Not applicable
Ongoing	Greater of $1 million or 2% of first $150,000,000 premium and 1% thereafter; or 3 months of uncovered expenditures; or 8% of expenditures to non-affiliates with a 50% credit for con-capitated expenditures to affiliates or capitation to non-affiliates and 100% credit for capitations for affiliates	Formula measuring four risk categories (asset, insurance, credit, and business risks) with managed care offsets to underwriting risk, which in total equates to approximately 5% of claims or 4.5% of premium for managed care plans	Not applicable
Health care delivery assets-initial stage	100% GAAP book value	Statutory value	Not included as liquid
Intangible assets—initial stage	Up to 20% of minimum net worth, if $1 million of MNW is cash or cash equivalents or up to 10% of minimum net worth, if less than $1 million of MNW is cash or cash equivalents	Not admitted except as approved by the commissioner	Not included as liquid
Intangible assets—ongoing	Up to 20% of minimum net worth, if larger of $1 million or 67% of MNW is cash or cash equivalents or up to 10% of minimum net worth, if less than the larger of $1 million or 67% of MNW is cash or cash equivalents	Not admitted except as approved by the commissioner	Not included as liquid
Deferred acquisition costs—Ongoing	Not admitted		
Subordinated debt—Ongoing	Not included as liability	Included as liability	Not included as short-term liability if due after one year
Financial plan—Initial stage	Financial plan through 12 months after breakeven	Required in most states with application	Not applicable
Financial Plan—	Financial plan filed regularly	At company	DFCA* required

Minimum Net Worth (MNW)	PSO Solvency Standards	Authorized Control Level MCORBC	AAA Liquidity Test-Current Thinking
Ongoing, Prior to Breakeven	showing forecast through 12 months after breakeven	action level RBC	if safe harbor test (current ratio) falls below threshold *Dynamic Financial Condition Analysis
Financial reporting—Initial stage	Financial plan filed and approved	No RBC requirement, but states require a financial plan for licensing	Not applicable
Financial reporting—Ongoing, prior to breakeven	Financial plan updated regularly and Orange blank quarterly	NAIC blank annually with quarterly filing of some exhibits; financial plan at company action level or lower	Safe harbor test and DFCA, if required
Financial reporting—after breakeven	Orange blank annually or if the PSO does not have a net operating surplus file, orange blank quarterly and financial plan	NAIC blank annually with quarterly filing of some exhibits; financial plan at company action level or lower	Safe harbor test and DFCA, if required
Financial resources allowed to be used in financial plan—Initial stage	Guarantees acceptable to HCFA Irrevocable unconditional letter of credit Other instruments approved by HCFA	Statutory assets only	Formula is not drafted yet, but guarantees similar to those acceptable to HCFA may be included in safe harbor Irrevocable unconditional letter of credit may be included in safe harbor, and other instruments similar to those approved by HCFA may be included in safe harbor
Liquidity—Initial stage	Current ratio of 1:1 with	No requirement	DFCA required

Minimum Net Worth (MNW)	PSO Solvency Standards	Authorized Control Level MCORBC	AAA Liquidity Test-Current Thinking
	corrective action required for current ratio of less than 1:1 and with a minimum of $750,000		
Liquidity—Ongoing	Current ratio of 1:1 with corrective action for current ratio of less than 1:1 and with a minimum of the greater of $750,000 or 40% of minimum net worth	No requirement	Safe harbor test (may be a current ratio which would potentially exceed 1:1)

The people at the negotiation table were representatives of Health Insurance Association of America (HIAA), some large provider groups, AMA, AHA, and the Blue Cross and Blue Shield Association. One of the more heated discussions was the admission of intangible assets and what the federal waiver would include that state requirements do not. The PSOs are going to be allowed under the federal waiver to include some intangible assets, but there are limits. And the PSOs will not have to include deferred acquisition cost or subordinated debt to affiliated providers—in other words, withholds.

Not including subordinated debt is the way to quantify "sweat equity." Sweat equity means that if I'm a provider or a hospital, I have some equity from providing the service. Obviously, this does not show up on a balance sheet. But long as those withholds are subordinated to all other debt, they will not show up as liabilities on the balance sheet. That was a compromise between the hospitals and physician groups that said they shouldn't have any capital requirements and the Blue Cross and Blue Shield Association. HIAA said, "You're no different than we are."

For financial reporting, under MCO RBC, a financial plan is required at the company action level. As the AAA was developing the RBC formula, there was some concern expressed that this didn't ensure that there was liquid capital available to pay the short-term liabilities, so the NAIC asked the AAA to develop a liquidity requirement. And that liquidity requirement may have some financial plan requirements within it. If liquidity is not high enough, a Section 8-type opinion might be required. MCO RBC, of course, is tied to the NAIC's annual statement blank. Under the PSO waiver, a financial plan would have to be filed at the time the waiver was requested and updated regularly until the organization came to a breakeven point, which is anticipated to be two or three years. Or if the current ratio—which is the current or short-term liabilities to short-term assets—was less than 1:1, an orange blank will have to be filed with HCFA. A new health annual statement blank is being developed for 1999 filings that probably won't be orange.

For total adjusted capital, compare your RBC requirement to total adjusted capital determined by your statutory blank. Therefore, all the statutory accounting rules are in place. Liquidity could have additional requirements. Under the PSO waiver, there are some assets that would be allowed that are not allowed under statutory accounting. One is parental guarantees, as long as they are acceptable to HCFA, in an evergreen letter of credit. Again, this was very hotly debated. Many of the PSOs have parents that have capital, and they want to be able to use parental guarantees rather than actually moving the capital—the situation many HMOs have. So this was seen as a way for some large hospital chain to have a PSO subsidiary without actually having to move capital until it was needed.

The MCO RBC currently has no explicit requirement for liquidity. There are asset factors that vary depending on how liquid the assets are, so, it's taken into consideration in the capital requirement. But there's nothing explicit that says your assets have to be a certain percentage liquid. Corrective action would have to be taken if it fell below 1:1. There is also minimum liquidity of $750,000 or 40% of the minimum net worth. The HCFA act and requirements can be found on HCFA's Web site: www.hcfa.gov.

Mr. Steven N. Wander: I'm a health care actuary, and a lot of my clients are health care providers or HMOs. I've come across some uses of the health RBC formula that are somewhat nontraditional. Three interesting case studies show the dynamics of the formula.

Case study 1 involves a primary care physician (PCP) group that wanted to take a full-risk capitation because it thought the HMO was taking all the profits. The group's physicians thought if they took all this risk and managed it well, they'd be better off, so they hired us to prove their financial viability to the HMO. We thought that sounded like a good use of the RBC formula because if they could meet the requirement that an HMO would have to meet, then they'd probably be OK. I was a little skeptical, given that most primary care groups don't have a lot of capital, but this one surprised me.

One of the unique things about using the formula for a provider group is that all the administration is done by the HMO. This affects the risk factors that get applied for underwriting risk because there's a loss ratio that gets applied to the risk factor, and the PCP group basically has a 100% loss ratio because it's not doing any administration; everything is medical expense. The group has about 50,000 members, which is a fairly good size, and $60 million annual capitation revenue. One bad thing for this organization is that the group only provides primary care services. Everything else (86%) is fee-for-service. That increases the risk factors by

the fact that most of the service that they'd be paying for, outside of what they do themselves, would be on a fee-for-service basis.

Case study 2 involves a large nonprofit dental service corporation (DSC) that had a lot of capital. They hired us to investigate whether they should be investing some of that capital in other things. They had more than 600,000 fully insured members, more than $150 million annual fully insured premium, and more than $140 million annual premium equivalent from ASO policies.

Case study 3 is given as a comparison. It involves a huge, well run HMO client, with more than 1.3 million members and $2 billion annual premium.

Table 2 breaks out the RBC before covariance for the three case studies.

TABLE 2
DISTRIBUTION OF TOTAL RBC BEFORE COVARIANCE

	PCP GROUP	LARGE DSC	LARGE HMO
Asset Risk Affiliates (HO)	0%	0%	0%
Asset Risk Other (H1)	6	33	10
Underwriting Risk (H2)	89	61	64
Credit Risk (H3)	5	1	20
Business Risk (H4)	0	5	6
Total	100%	100%	100%

The primary care group didn't have a lot of assets or any affiliates. Most of their assets were in cash, which shows up under H1, and health care receivables, which actually shows up under H3, credit risk. The group had few invested assets and some health care delivery assets also that go into H1, but a majority of its risk (89%) is coming from H2. The group isn't doing any administration, so there's nothing in H4.

The DSC also didn't have any affiliates, but it had a lot of capital and invested assets. They also had a lot of administration because they have the ASO block of business. So, there's a lot under H4, which makes H2 a smaller percentage. Under H3, the DSC has a little capitation paid to intermediaries, and that falls under credit risk.

The HMO also has a fairly good amount of assets, but not nearly as much as the DSC. It also has a lot of capitation to intermediaries, so, that's why there's a big number on H3. Most of the capitation is paid to intermediaries, and the HMO also does the administration, so, it has the H4 business risk.

The way the covariance formula tends to work is, if you have one category that's big compared to everything else, the other categories disappear when you run them through, as illustrated by the PCP group. Before covariance, its RBC was 89% from H2, but after you divide it by the total after covariance, it's about 99% (see Table 3). The dental company had a lot more evenly distributed RBC among the categories, so the H2 is a lot smaller percentage of the total. And with the HMO, it's somewhere in between the two.

TABLE 3
H2 RBS BEFORE COVARIANCE AS A
PERCENTAGE OF TOTAL RBC AFTER COVARIANCE

PCP Group	99%
Large DSC	88
Large HMO	94

Table 4 shows a calculation of the weighted managed care discounts, and that gets applied directly to the H2 underwriting risk factor that's reduced by the managed care discount. The PCP group's internal activities were similar to a staff model HMO because the PCP group was paying its physicians on a salary structure, and there was a lot of risk-sharing. So, the PCP group gets a 75% managed care credit for that, but only gets a 15% managed care credit for the 86% that they do outside of the group on a discounted fee-for-service basis. Weighted together, it ends up as a 23% credit.

TABLE 4
WEIGHTED AVERAGE MANAGED CARE DISCOUNT

PCP Group	23%
Large DSC	18
Large HMO	44

The DSC had some capitation, but it was mostly fee-for-service at the 15% managed care credit, so, it ended up with a weighted factor of 18%. And the HMO was mostly doing capitation, plus a bunch of fee-for-service stuff, so they're at 44%.

Table 5 calculates the total H2 RBC as a percentage of total risk revenue. For an HMO, that would be premium; for the provider group, it's the capitation revenue. This illustrates how the factors can vary based on the size of the company and the types of risks they're taking. The factors are tiered. There's a certain percentage for the first so many million dollars of business, and then there's a lower percentage when you get above that amount. So, a larger company has a lower risk factor. Also, with the DSC, the factors are lower on the dental, which lowers its factor. Finally, you apply the managed care credit, which can reduce your total H2 RBC even more.

TABLE 5
H2 RBC AS A PERCENTAGE OF TOTAL RISK REVENUE

PCP Group	8.8%
Large DSC	5.8
Large HMO	4.3

The primary care group has the highest percentage of H2 RBC as a percentage of revenue, mainly because it has a 100% loss ratio, so they're not getting a reduction for that. It doesn't get a big managed care credit, and because of its small size, the PCP group is not getting up into the upper tiers of the risk factors. The DSC has the lower dental factors and a high managed care factor, so it has a fairly low number. And the HMO has the lowest, mainly because of its managed care credit and large size.

Table 6 shows the final results, arrived at by comparing the actual amount of capital the HMO had versus the authorized control level, which is the first level of action. The company action level is 200% of the authorized control level, so, the primary care group came out below the company action level but above the regulatory action level. It might be told to start planning to correct things, but would probably get the green light to do a full risk capitation. The PCP group's results are actually a lot better than that of many HMOs. I guess it isn't a conclusive test, but I was surprised that it would even be that high because most primary care groups don't have any capital.

TABLE 6
TOTAL ADJUSTED CAPITAL AS A PERCENTAGE
OF THE AUTHORIZED CONTROL LEVEL

PCP Group	161%
Large DSC	1,415
Large HMO	911

It's best to set capital at about 200% of the company action level, or 400% of the authorized control level. The DSC is at 1,400% so it has 1,000% to use in other investments. Maybe the HMO was a little overcapitalized, but it's probably not a bad thing.

From the Floor: You mentioned that the PCP group wasn't doing any administration and, therefore, didn't need a factor for administrative expense risk. Were they doing absolutely nothing from an administrative standpoint? And how were they monitoring their success under the capitation contract? If they weren't doing any of that, did that have any impact on the underwriting risk?

Mr. Wander: Traditionally providers do some type of administration, but it's not the same type that an insurance company does. For an insurance company that's

paying doctors on a fee-for-service basis, part of that payment goes to covering what the medical group calls "administrative costs," but for purposes of the RBC formula, I'm making a distinction between insurance-type administration, which is paying claims and marketing, versus health care administration, which is part of medical expenses in a traditional loss ratio.

From the Floor: I think the piece that I'm referring to would be more in line with the financial management aspect of the health insurer. The HMO is doing financial management of its book of business and managing the risk. Now that the PCP group is responsible for the risk, it needs to be arguably doing some of the same types of things. Yes, it's not claims payment administration or member services, but it is a piece of the administrative charge that the health insurer is getting. And the question is, what is the primary care group doing that is significantly different from what they were doing for their capitated primary care group risk?

Ms. Philips: You are absolutely right that there's a certain illogicality in that the formula treats certain expenses when done by the medical group as claim cost, and treats those exact same expenses as administrative costs when done by an insurance company or HMO. It doesn't make perfect sense, and it's not a perfect formula. It's an attempt to take reality and cram it in a box, and sometimes the corners get lopped off.

So, you're quite right. This whole issue of which dollars go into which bucket is actually a very tricky issue, and one thing we're dealing with in the State of Minnesota right now is that we have very stringent loss ratio requirements. And, to some extent, the insurance companies have complained that the things that they stick on the administrative cost side of the ledger HMOs get to stick on the medical cost side. Then the HMO can say, "We have a 92% loss ratio and are delivering far more value for your premium dollar," when, in some cases, that's not really true because they're counting the money in different ways. Whenever anybody talks to me about loss ratio, I always tell them to go back to basic principles and tell me exactly what they're talking about. Don't just say loss ratio to me because there's no defined meaning for that. Unfortunately, our legislature, decided that we had to publish loss ratios for all the HMOs and health plan companies in an annual report. So we published the first one with a caveat about the numbers and we're trying to get the HMOs and insurance companies to agree on which dollars to put on the claim cost side and which dollars to put on the administrative expense side.

Ms. Novak: Maybe to further complicate this—although I think it's intended to simplify it—some changes are taking place in the accounting for the expenses, and in codification. The attempt is to line up some expenses and claim costs so they're the same for HMOs as they are for indemnity carriers. However, every time you

change your accounting notes, it tends to complicate things more than simplify them.

Mr. Martin F. Gibson: Back to the PCP group again that's taking all the risk. Do you think that regulators will eventually look below the HMOs at these PCP groups taking on all this risk and apply something like an RBC formula to see if they really are solvent enough to take on risks like that? Is it happening in Minnesota now?

Ms. Philips: What seems to be happening nationwide, and the NAIC talked about this in a white paper on risk-bearing entities put out a year or two ago, is that the regulators are requiring the upstream entity, the HMO, to hold enough capital to cover all the risk on the licensed entities. If worse comes to worse, we can take away their license, but we have no grip whatsoever on the downstream PCP that is accepting the capitation. As long as we require the HMO to hold the complete capital for the entire risk, we feel fairly comfortable that if the PCP group goes down, the HMO will have enough capital to cover it.

Providers tell me that they are uncomfortable with this situation because when the HMO holds the capital, it also skims off the risk charges to develop that capital. So the PCPs feel like they're getting dumped with all the risk, but not getting the risk charges, which is a valid concern. But this whole thing is really in a state of flux. Some providers have formed HMOs. The American Association of Health Plans says about 27%-35% of its member plans are actually provider organizations. So, some providers have gone the licensing route. Some of them still contract downstream.

In Minnesota, we had a big group practice clinic that formed its own HMO. Five or six years later they were in court suing the HMO for inadequate reimbursement. I don't see any movement of the regulators to try to go downstream and separately require capital or ask "Are you upstream or downstream, and how much do you need to hold?" However, if the downstream entity chooses to become licensed, then there is a slot for them. One of the criticisms that I have heard of this RBC formula is that if you have two or three licensed entities in a row, and one is accepting risk from another, the total RBC that we require is more than it would be if it was one entity assuming all the risk. These critics assume that it should add up the same, but it won't.

Mr. Walter H. Hoskins: We're in Florida, and many of our clients are going through the process with the Department of Insurance on reserves. They're working on some unofficial requirements that say you have to hold one or one and a half times the monthly capitation or something like that as a claim reserve in addition to any kind of version of RBC. Is that standard? How are other insurance departments

handling that in terms of setting up a reserve, something in a claim reserve or an incurred but not reported (IBNR) claim, for global capitation or significant capitations?

Ms. Philips: In Minnesota, we would consider that a risk that the capital is intended to cover. We would not require reserves. The receivable from the providers is a receivable and would be counted as such, although, I'm not in the Health Department, which directly regulates the HMOs in my state. As far as the RBC formula goes, if a company was required to hold a reserve for a month or a month and a half of capitation, it would clearly be double counting also to hold capital against that risk. We have it in the credit risk portion of the formula that if you have receivables from a downstream entity, and we have several levels of credit risk depending on how closely you're tied to that entity, or if that entity has given you guarantees, there's a higher charge if there are no guarantees, and a lower charge or none with guarantees.

Ms. Novak: You bring up an excellent point about the interrelationship between the reserves and the RBC. When we developed the RBC formula at the Academy, there were certain assumptions about the reserves that were set up and that they were adequate. But there could be a lot of discussion about this. Premium deficiency reserves are getting a lot of focus right now. The interplay between RBC and the reserves is that if you ask for more reserves, then you should ask for less RBC. If you don't have adequate reserves set up, you're going to have to have more RBC, and it's something the regulators are going to have to work through with entities.

From the Floor: Again, in this case, it's unclear that there's a receivable because it's in retrospective for capitation paid for a service period that's already been closed at the end of the accounting period. It's unclear that there's any receivable there. It's already been paid. It's only if the downstream group defaults on paying and someone comes back against the health plan, that risk arises, and it's not even clear what the risk is sometimes. But they're saying that if you have a global cap, you have to set up a claim reserve equal to some number that could change at any time. They're trying to do the right thing, but it's hard to see where it all interrelates, especially since the RBC isn't fully in place as of today. I think they need some help on it and it probably should be discussed in context with the RBC.

Ms. Novak: Not to do any damage to anybody's blood pressure, but the Financial Accounting Standards Board (FASB) is actually talking about setting up reserves on a disease basis. So, as soon as you know that somebody has a disease, you would have to set up the reserve, irrespective of the contract coverage. There's also discussion about setting up a reserve as soon as somebody goes into the hospital.

Depending on your claims processing process, some companies might already be doing this. The idea is, that as soon as an individual goes into the hospital, whichever entity is covering him or her at that point in time—even if it's on a monthly capitation—has to cover the person for the hospital stay, so a reserve should be set up.

There is a lot of discussion about exactly what reserves should be set up and at what point in time. The one thing that has almost universally been agreed upon, though, is that a monthly cap isn't the last of your claim liabilities. There are other liabilities associated with that monthly cap, but how to quantify them and exactly what they are remain unclear. I think what Florida's trying to do is maybe the easy way out—to say we know what these liabilities will be, and we think this will cover it.

Mr. Wander: One comment I wanted to add is that I do a lot of reserve work in states other than Florida, and I haven't seen anyone else require a claim reserve for capitated business. Generally, if stuff is capitated, there's no claim reserve, but as an actuary who does the certification, you're supposed to get their provider contracts, review them, and make a comment in your opinion that you have reviewed them. If you find anything that could justify setting up a liability, you're supposed to do that, but it's not real clear what you're supposed to do there.

Mr. Hoskins: Again, Florida says that they have authority under the unauthorized reinsurer. They treat any passing of risk to a downstream organization as an unauthorized reinsurer, and say you have to hold reserves as if you had the entire risk still within your organization. You can't take any reserve relief against that if it's going downstream. So, you basically have to set up the entire IBNR as if you fully had it and that the downstream relationship didn't exist. They feel there is justification for this. To try to quantify it, they're using a certain factor, a multiplier of the capitation amount.

From the Floor: I've seen some things along those lines. I also have a related question. I think there's a difference between a capitated contract, where the health insurer pays a group in advance for risk for services that it may or may not be providing, and the capitated contract, where the health insurer holds the premiums, pays the claims, and then performs a settlement at some later date. And, often, there's no transfer of funds to the capitated group up front, and the capitated group doesn't end up paying the claims, etc. Is there any difference in how those types of contracts, where the funds are not transferred from the health insurer, are treated relative to a pure capitation, where the group is paid in advance for all the care and is responsible for disseminating the funds?

I also have a comment. My experience has been that if the funds are not transferred, I advise my clients and the plans that I've worked for to hold all the reserves because they are responsible to the policyholder for paying the claims regardless of whether the provider group lives or dies. Members ostensibly have no knowledge of the risk arrangement at any point in time. Their procedures for getting coverage and health care doesn't change on the basis of the risk arrangement, except for the fact that they might be channeled by the provider who's at risk to other facilities in the provider network. On the provider side, we're also looking at what kind of IBNR they need to have up and if it balances out through some sort of a receivable relationship on the back end.

Ms. Philips: As actuaries, we have to go back to basic principles when faced with any of these problems. Nonactuaries are always asking me to give them my rules of thumb. They think I have a little notebook where I write down claim reserves, but I'm still trying to figure out what's right. That's the real answer to the question, What do you hold? You hold a reasonable estimate of what you expect you will need to pay out plus a reasonable margin to protect yourself against any expected fluctuation.

From the Floor: If you're in a fully capitated contract where you're getting a monthly capitation for your members, it makes sense that you want to book that as revenue. But if you're in a risk contract on a percent of premium basis where the health insurer is paying the claims—again, you're providing 14% of the services—and at the end of 180 days somebody's going to send you a bill or a check, do you book revenue in claims or do you book net? How do you handle that, and whose books do the dollars go on?

Ms. Novak: We have considered percentages of premium as capitations for RBC. When you say you withhold and settle up at the end, depending on that formula, you usually have a withhold or a bonus situation. And depending on what's written in the contract with the provider—the maximum and minimum amount you're going to pay—to determine your withhold or bonus. But you're talking about not paying it all up front?.

From the Floor: Yes. I've run into situations where provider entities are taking a capitation, and they want to book as revenue all the capitated revenue, and they're not receiving it. They never see that money because they're getting their primary care capitation. The health insurer's paying all the fee-for-service claims—the other 86% of the dollars—to providers in the health insurer's network, and then netting the claims against those revenues. And, in some cases, the providers want to put the revenue and the claims on their financial statements. In other instances, the revenue's already in the insurer's financial statements as premium and claims. The

providers want to put it in as premium and claims. And that doesn't necessarily make sense to me.

Ms. Novak: For one thing, sometimes you have a real disconnect when you're talking about providers and insurers because providers are often on a cash basis. But if you're talking accrual accounting, then the providers would book whatever is due to them as either premium paid, premium due, or revenue. They wouldn't call it premium in their case, but revenue.

Mr. Wander: We had a side project to help the PCP group determine how to set up claim reserves. Basically, for the services they provide themselves, there's no need for a claim reserve. If those services theoretically bring in more than what they would have received on a fee-for-service basis, they're not actually paying any money out of their pocket. They just have to work a little harder. On the stuff that's done outside of the group, where they have to pay claims when it's settled up at the end, they needed to set up claim reserves.

Ms. Philips: I have another example of how important it is to go back to basic principles and at the same time think outside the box. We had a situation in Minnesota where the administrator of our high risk pool was paying providers on a fee schedule. The fee schedule averaged out to be some percentage discount of what they would pay retail, and everybody was happy, except the patients because they would go in and have their tonsils out, and in some cases their health plan would pay 10% more than the retail charge. This was atypical, of course, because it averaged out to be something less, but there were several hundred hopping-mad people who thought their health plan was paying the doctor more than retail. So the carrier decided to pay the doctors discounted retail during the year and then settle up at the end of the year. And they set the discount so that in the overwhelming majority of cases, they would owe the doctor money.

This was convenient and useful, and everybody was happy, except perhaps the doctors who wanted the float. However, it threw off the claims analysis for the high-risk pool. The committee of actuaries that set claim reserves for the high risk pool was going on the discounted retail claims. When the administrating carrier threw in another million dollars of claim cost at the end of the year, everybody flew into a tizzy. This is why there is no such thing as a rule-of-thumb. The only way to have anticipated this would have been for the provider group to take the pessimistic view and assume they're going to have to pay a reasonable amount.

Mr. Hoskins: Let's go back to that Florida handling of the global capitation again as sort of a minicase study. You were already booking the capitation going out. The premium comes in; the capitation goes out. You've already booked it as an

expense, and then you have to set up an additional expense equal to one-and-a-half times that. Then you're saying, this actuary's going back to first principles. What risk are we trying to set up a reserve for? It's almost a solvency type risk. If this group disappears, you have to say, "What is the probability that they will default and then the health plan will have some kind of a liability? And how much would it be? Would it be on a runout on a tail that wasn't paid?"

The health plan has no knowledge whatsoever of any of this because the global capitation goes out, and there's no reporting back. They then pay their providers for their services on a ratio of fee-for-service or however they want to divide it up. So, as an actuary trying to go back to first principles, you're still left with the same question: What is the risk to the health plan? Do you say there's a 5% chance they're going to go out, so you take 5% of that? (That's not nearly what the state is saying.) So you have an analysis problem in trying to determine the risk that you're setting up for.

The other part of the problem is, when you're setting up the premium, how do you certify that the premiums are adequate if you don't know how they're going to distribute their money? You pay out the premium, and, theoretically, as long as they stay in business, you know what your losses are because it's a fixed percentage of premium. The only variable is if they go out of business and the health plan has some liability. And there are no good numbers for that. You can't show a study that says: x% of health plans go out of business, the resulting liability was *y*, and, therefore, *z*% of capitation should be held in addition. Now reserve is being mixed up with RBC again.

Ms. Philips: There are countless situations in which state regulators misuse information, take shortcuts, and, generally, lean toward being overly conservative. It's much more likely that they'll require you to pay out the capitation first and then hold a liability equal to it, than not because they can't think far enough ahead to say, "If we make a mistake in this direction, then the company won't go down." The only downside is that the company will be forced to hold too much capital and too much reserve. This may be a big deal to the investors, but not to us, whereas, if the company goes down, we're in real hot water. And that does happen a lot.

But we're not the only guilty parties. I've seen a lot of goofy stuff about HMOs from rating organizations. People will take the RBC and really stretch it on their statements. RBC was developed by regulators for regulators. We almost wish that it was totally private and nobody else could see it, but that's not the way it works. It's a tedious process to educate legislators and develop alternatives to make it a good, even playing field where different entities are not held to different standards of reserves and capital.

Ms. Novak: When the AAA looked at RBC, we looked at what managed care credit should be given for capitation. We discussed what your liability would be if you had a capitation provider that became unable to provide those services and played around a little with the credit. Then when the NAIC came up with a credit risk, and there was a lot of discussion about how to determine that type of risk. We considered requiring HMOs to get certified annual statements from all of the providers with which they capitate, but that seemed like overkill. So, this is not an issue with an easy solution. The State of Florida, the NAIC, and the AAA, are all wrestling with it. We know there's something out there that's bigger than a bread box, but we don't know how big it really is.

Mr. Wander: I agree with the State of Florida that there is risk associated with the capitation. But I think the appropriate place to take account for that risk would be in RBC, not in reserves.

Ms. Novak: On the other side of things, there are a lot of reserves that aren't being set up right now by HMOs for deficient premiums and IBNR. It's catching up with them in the balance sheet, and the FASB and NAIC are very concerned about reserves being set up, so you're going to hear a lot more about this.

From the Floor: Is there something from the NAIC that offers some guidance on reserves? The instructions for the HMO blanks say, "Set up actuarial reserves that are required," and the AAA issued a standard of practice that says, "Follow whatever the state regulations are." And, to a great extent, there aren't any.

Ms. Novak: There are really three things we have going on. One is codification that has some language in it that would imply some reserves. Two, there's a recent change to the Minimum Reserve Model Act (MRMA) that speaks to some reserve situations that have come up with health insurance because of HIPAA and guaranteed renewability issues that would force some changes in the way we do reserves. And, three, the Academy of Actuaries has suggested that the NAIC create a guidance manual to go along with the MRMA and we're charged with coming up with the first draft.

Ms. Philips: It's somewhat of a misstatement to say that the Actuarial Standard of Practice (ASOP) just says to follow state law. In my recollection, it says consider A, B, C, and D in doing this, but also follow state law. So, if there's no state law, that kind of leaves you free to follow the actuarial standards.

From the Floor: Where I see the biggest gap right now is having a clear definition of the scope of the actuarial opinion, particularly in the HMO blank instructions. And that essentially was continued in the ASP.

Ms. Philips: You're right, and that bothers regulators also. When we look at Schedule H development and see inadequate reserves, we don't have any basis on which to go to an actuary and say, "You screwed up! You better shape up and get some adequate reserves here." It's all judgmental and vague, so the actuary can say, "I did the best analysis I could at that point in time."

From the Floor: Not to belabor the point, but, as an actuary, my questions are: What is it? How far do I need to go? Are deficiency reserves required? Is that within the scope of my opinion? Those should be easy questions to answer, but, as the regulations and the guidance exist today, they're not. And, as an actuary within my organization, I don't have any influence, absent specific regulation, to say definitively, "In my state, for an HMO these are required, and they are within the scope of my opinion."

Ms. Philips: There are significant areas where reserves are not required that make me very uncomfortable. For example, in Minnesota, we have community rating for Medicare supplement insurance, and there are no active life reserves required for this. So, a new company comes into our medicare supplement, and we force them to charge a 65-year-old rate because we have loss ratio requirements. Fifteen years later, they're charging maybe a 72-year-old rate because their average age has drifted upward. Twenty-five or thirty years later, they're charging an 85-year-old rate because that's all they have left. So the established company that has a big block and a steady population can't compete with the new company who's charging the 65-year-old rate. What I would like to see is a requirement that companies hold active life reserves for their community rated blocks. If they don't, I'm stuck with these continual demands for 20% and 25% annual rate increases because of aging and antiselection, which I have a great deal of trouble either approving or denying.

Ms. Novak: The standards of practice are not very specific now because they are written by people who would like to leave a little room for creativity in the actuarial science. There is also a large group of people that would like more guidance. If we don't set up some of these rules, I think the AICPA will set them up for us, so, this is a decision that the profession has to make. And I encourage all of you to weigh in on it.