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Risk-Based Capital—An Update

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Summary: At the beginning of 1999, a new model regulation is expected to be approved by the National Association of Insurance Commissioners and will regulate risk-based capital for managed care organizations. Panelists describe the regulation and offer insights into the why, wherefore, and whereto. They consider the potential impact of the new regulation on the current life insurance company risk-based capital regulation that governs traditional health carriers.

Mr. Burton D. Jay: This session deals with the health insurance phases of risk-based capital (RBC). The session will address the new managed care organization (MCO) RBC formula and certain changes that were made to the life risk-based capital formula to be consistent with the MCO formula for the same health products.

I'm the financial actuary at Mutual/United of Omaha Insurance Company. I am a member of the Academy's Health Practice Council and chair of the Academy's Task Force on Health Organizations Risk-Based Capital. I am also chair of a working group that is looking at new factors for disability income, long-term care, stop-loss, and limited benefit plans, both for the new MCO formula, which does not cover those products now, and for the life RBC formula.

We have three other panelists today. Bob Cumming will describe the new MCO RBC formula. Bob is a principal with the Minneapolis office of Milliman & Robertson. His area of expertise is managed health care programs. He has assisted clients in areas of product development, network evaluation, experience analysis, health care management, actuarial cost projections, and regulatory filings.

Our next speaker is Peter Perkins, who will describe the work that was done by the AAA a couple of years ago that led to the formula that we now have for MCOs. He will tell you the differences between what the Academy recommended and what the final formula ended up to be. Peter is a senior vice-president and chief actuary at Trigon Blue Cross/Blue Shield. He is currently a board member of the AAA and a member of the Academy's Health Practice Council. Peter worked on the original Academy Task Force on Health Organizations Risk-Based Capital and chaired the task force during efforts to simplify the first set of recommendations.

Our final speaker will be Donna Novak. Donna will discuss the new federal provider-sponsored organization (PSO) solvency standards and how they compare with the standards for RBC for MCOs. Donna is a senior manager with Deloitte & Touche. She specializes in health care cost reduction, predicting the cost of heath care insurance reform, as well as measuring the financial health of insurers and other health care risk takers. She is currently working with state regulators and the NAIC to implement new insurance reform regulations. She also is working with the NAIC to develop liquidity standards for all organizations assuming the risk for health care costs. Donna is chair of the Academy's Committee on State Health Relationships. She is currently leading the Academy group responsible for creating an economic model to determine the effect of managed care benefit and funding alternatives. Donna has played a key role in the Academy's effort to develop MCO RBC. Prior to joining Deloitte & Touche, she worked for three major insurance companies, Blue Cross/Blue Shield, and two consulting firms. We will begin with Bob Cumming.

Mr. Robert B. Cumming: My topic today is RBC for MCOs. It's my job to tell you where we are today. The other speakers are going to tell you how we got here and where we're going in the future. I'm going to start by talking about the recently adopted NAIC Model Act on risk-based capital for health organizations. We'll then do a quick review of the current risk-based capital formula. We'll compare that to some of the existing requirements for HMOs, which tend to vary quite a bit from state to state. I'm going to wrap up with a discussion of the survey that the NAIC did. The NAIC has RBC calculations from a number of HMOs and Blue Cross plans throughout the country and has analyzed those results.

The NAIC has developed a model act on RBC for health organizations. I believe it was recently adopted at the September NAIC meeting, and it's now available to the individual states to adopt as they choose. The model act is very similar to the model acts for life and property/casualty companies. Those were developed by the NAIC in the early 1990s and have now been adopted in virtually all the states.

The model act specifies the regulatory action that's required, depending upon how a company's capital and surplus compare with the RBC calculation, but it does not actually specify the formula itself. The RBC formula is specified by the NAIC through a separate process, and it's not in the model act. That allows the NAIC to refine it over time and change it without all the states having to adopt a new law each time.

As I mentioned, the life and property and casualty (P&C) formulas are adopted in virtually all the states. One of the reasons for that is that it's required for the accreditation process through the NAIC. The model act for RBC for health organizations may not see the same level of adoption for a variety of reasons. One is that there's currently no plan to make it part of the accreditation process. Also, for some states, it would be a big change from their current requirements.

The model act applies to health organizations, and those are defined to include HMOs and hospital, medical, dental, indemnity or service corporations (basically, Blue Cross and Delta Dental types of plans) and other MCOs that the commissioner might specify. A state-licensed provider-sponsored organization could be thrown in under this umbrella.
It doesn't include life and P&C insurers, and that can be an issue, because many Blue Cross plans are licensed as life insurance companies or property and casualty companies and file those blanks. There's currently no direct requirement for them to file these formulas, but there is a note in the model act that says the commissioner should consider whether some of those companies should file the managed care formula. I think the original intent was to have all organizations that write mainly health insurance subject to the same RBC forms.

As you go through the formula, you develop the ratio of your company's total adjusted capital and surplus to the recruit of the RBC calculation. Depending upon that ratio, different actions may be available to, or required of, the commissioner of insurance. If the ratio falls below 1.0, the commissioner may require the company to file an action plan. If it falls even lower, the commissioner is authorized and then becomes required to take over the company. If the ratio is between 0.75 and 1.0, it falls in the company action level, and in that scenario, the commissioner can require the company to file a corrective action plan. That would identify its business problems and how it's going to fix its capital condition, and the plan also includes a three-year financial projection.

The next level down is the regulatory action level. In that scenario, the commissioner is also authorized, if he or she desires, to hire external firms to go in and look at the company—look at its business, its assets, its liabilities. If the ratio falls below 0.5, this is the authorized control level. The commissioner is authorized

to come in and take control of the company if he or she thinks it's in the best interest of the policyholders.

The worst level is the mandatory control level, and at that level, the model act would require that the commissioner come in and take control. So the model act specifies when and under what circumstances the commissioner can go in and take control of the company, but it doesn't say what to do once the commissioner has gone in and taken over. That's typically part of a separate statute or regulation in each state.

What I thought we'd do now is briefly review the RBC formula (Formula 1):

$$\text{RBC AFTER COVARIANCE} = \text{RBCAC}$$
$$= H_0 + \sqrt{H_1^{\,2} + H_2^{\,2} + H_3^{\,2} + H_4^{\,2}}$$

Where

H_0 = Asset Risk–Affiliates
H_1 = Asset Risk–Other
H_2 = Underwriting Risk: claims experience fluctuation
H_3 = Credit Risk: reins, capitations, & receivables
H_4 = Business Risk: admin expenses, guarantee fund, & excessive growth

There are five different components, each one representing a different type of risk. The first component, the H component, is capital for subsidiaries. If you own a life insurance company or an HMO subsidiary, you simply do the RBC calculation for that subsidiary separately and add it into the capital requirements. All the other components are subject to the covariance adjustment.

The H component is asset risk—basically, investments that you may have. The RBC requirement there is just a percentage of the asset values—depending upon the type of asset, somewhere between 0% and 30% of the asset values.

H is the underwriting risk. That's the risk that you may have a fluctuation in your claim levels that you haven't accounted for in the pricing. The capital requirement there is a percentage of your incurred claims with adjustments or credits if you have negotiated reimbursement arrangements with your providers.

H is the credit risk. That's basically the risk that you're not going to be able to collect the money that's due to you either from reinsurers or other types of receivables.

H is the business risk. That includes the risk that the administrative expenses may be higher than what you've priced for. The capital requirement there is, generally, a percentage of your administrative expenses.

The capital calculation tends to be dominated by the underwriting risk for most companies. There are two parts to the underwriting risk requirement. It's composed of the experience fluctuation risk calculation and an amount for other underwriting risk.

Experience fluctuation risk is the bulk of it. There is a minimum to it, so it's the greater of the alternative risk charge or a factor that's applied to, in essence, your incurred claims. For the experience fluctuation risk, you take your underwriting risk revenue times a claims ratio, times a risk factor. While a lot of the numbers are driven off of revenue or premium in the calculation, in essence, the factors are applied to incurred claims. The other underwriting risk is for things such as rate guarantees. Also included there is the capital requirement for the Federal Employees Health Benefits Program.

The experience fluctuation risk is a percentage of your incurred claims. The percentage varies by type of coverage. There are five different categories, including comprehensive major medical, medical only (which means the professional medical services only), and Medicare Supplement, dental and, finally, other coverages such as long-term care and stand-alone prescription drugs.

The factors step down as your revenue increases. The process is to look at how much revenue you have. You then use that revenue to calculate a weighted average factor, but you still take that factor and apply it back to incurred claims.

There is a credit for different types of provider reimbursement arrangements. If you have cost controls through your provider reimbursement arrangements, you get a different level of credit. There are five categories of reimbursement arrangements.

Category 0 is no credit. That would apply if you're paying on a straight fee-for-service basis or if you have a usual, customary, and reasonable payment schedule.

Category 1 is where you have, basically, a fixed-fee schedule. The amount you're going to pay for service is fixed ahead of time, so if you pay hospitals on a diagnosis-related-group basis or a per-diem basis, if you have fixed-fee schedules for your physicians, all those claims get a 15% credit.

The category 2 business is for claims that are subject to bonuses or withholds. The level of credit there depends on how much withhold is actually kept back and how

much of that has been returned in past years. The assumption is that if you kept money back in past years, but you haven't returned any of it, basically, it's not available. There is a claim buffer or a claim fluctuation reserve. But if you've returned that money, you do get a credit for that amount.

Category 3 is capitated payments. There is a 60% credit or reduction in your RBC for that type of payment arrangement. That's one area where there have been some changes from the original Academy recommendations. The highest category is if you basically own your facilities, or you have salaried physicians as employees. For that type of business there's a 75% credit or reduction in the RBC.

This new requirement is a dramatic change for most HMOs in terms of minimum capital requirements. The actual requirements that are in place today vary dramatically by state, even though the NAIC has developed a model act on HMOs covering licensing of HMOs and that specifies some net worth requirements. The NAIC model act, or something similar to it or related to it, has been adopted in roughly half the states.

This model act requires that an HMO has at least $1.5 million, initially, of capital, and thereafter, it's the greater of four components: (1) a fixed $1 million, (2) a relatively low percentage of revenue that steps down, between 1% and 2% of revenue, (3) three months' uncovered health care expenditure, and (4) which can typically be the largest (and many states have not adopted or picked up that part of the formula), is, generally, somewhere between 4% and 8% of the claim payments, set aside as the minimum of capital.

As I mentioned, the actual requirements vary dramatically by state. Only half of the states have adopted something similar or related to this legislation. Even of those that adopted something similar, a lot of them left out parts of that capital requirement. A lot of them left out the percentage-of-claim requirement, which tended to be the most significant, and just kept in the $1.5 million, initially, and then, thereafter, the greater of $1 million or a small percentage of revenue.

Some other states have requirements, currently, for HMOs that are as low as $300,000. Some states just say you need to demonstrate adequate capital. They don't give an objective requirement. Some states will require a deposit. New Hampshire is probably one of the highest states or the highest state in terms of current requirements. It currently requires the greater of $6 million or 7.5% of premium as its capital requirement for HMOs.

The NAIC has collected some results from different companies—companies that have gone through the RBC calculation and submitted those results voluntarily to

the NAIC. Those results have been compiled. They are results based on 1997 financial statements, and the NAIC collected about 300 calculations. About two-thirds of those were for HMOs, and the results are pretty dramatic. A fairly high percentage of the HMOs required some type of action level. Almost 25% of the HMOs there, given their capital structure in 1997, required some type of action by the commissioner. It was a much lower percentage for the Blue Cross-type plans. About 6% or so of the Blue Cross plans required some type of action.

Whether this is going to be seen again at the end of 1998 is not completely clear. Many of these HMOs are part of a holding company where the parent may keep a lot of the capital. They tend to keep a lot of the capital in the holding company or in the parent, and that is one of the reasons why the HMOs look as if they have very low capital levels. What's going to happen toward the end of the year is that some of these holding companies and parents will probably be funneling money down to the actual HMO itself and fixing a lot of these problems.

The results are pretty easily explained by just looking at your premium-to-surplus ratio. When the NAIC looked at the portion of companies that failed or triggered some type of action based on their premium-to-surplus ratio, it found that almost half of the companies that had a ratio of greater than 10 triggered some type of action level. So if your HMO or Blue Cross plan has surplus equal to 10% or less of the annual revenue, almost half of those plans triggered an action. However, if you have surplus greater than 10% of your revenue, less than 3% of those plans triggered an action. There was also a dramatic difference in the amount of surplus on average that was held by the HMOs and the Blue Cross plans. The Blue Cross plans on average had about 30–35% of their revenue in surplus, whereas for HMOs it was around 12%.

There were some slight differences between the HMOs and Blue Cross plans in terms of the RBC as a percentage of premium, but they weren't that dramatic. For HMOs, the RBC requirement, as a percentage of their premium, turned out to be pretty close to 8%. For the Blue Cross plans, it was a little bit higher; it was right around 9%. Most of that was explained by the difference in the managed care credit. As you might expect, the HMOs tended to have a slightly greater managed care credit than did the Blue Cross plans (26% versus 15%), and that reflected the fact that they had slightly more claims in the capitated and salaried employee types of managed care arrangements.

That's basically where we're at today. Now I will turn it over to Peter, and he'll tell you how we got here.

Mr. Peter Lynn Perkins: I'm going to give you a history lesson, and as Burt said, I worked on the original RBC work group and then worked on the simplification work group. You might say, "Peter, let go! Health RBC has been passed, and just let go of the past." The reason I wanted to do this was to tell you a little bit about how we got here, so that when you look at the formula that's in place, you can understand why some things are the way they are. Let's first talk about the history of the Academy involvement.

It's interesting to note that it was almost five years ago that the NAIC first sent a letter to the AAA requesting that the Academy help it develop an RBC formula for health organizations. Now, originally, that request included the desire to come up with an RBC formula that would be used for all carriers that provide health insurance. So whether a carrier was licensed as an HMO, a life company, or a P&C company, or whether the carrier wrote disability insurance, cancer policies, or medical coverage, the same formula would be in place for all of those companies.

The Academy took that request and looked to get some data from the industry and do some independent modeling to model probabilities of ruin. It submitted a report and came up with some estimates of probability of ruin and proposed RBC levels. The proposed levels flushed out some other people who wanted to take part in providing data and providing input. And with that additional input, the Academy developed a refined set of data and was able to produce a final report in December 1994.

Now, the NAIC was suitably impressed with the complexity of the formula that the Academy developed. The formula was very specific to different kinds of products and the managed care credits that Bob went through. It also was very specific to business that was written on a direct, an assumed, or a ceded basis. In effect, it was almost three different formulas.

With that complexity the NAIC said, "That's a nice formula, but can you simplify it? In your simplification we'd like you to retain as much of the specificity as you can in terms of benefit types. We'd like you to use auditable information, that is, information that comes from annual statements or from other audited sources. And finally, where audited information isn't available, we'd like you to use data that any HMO or MCO would have available." The Academy took that request and submitted another formula.

About the time the Academy submitted that formula, the Medicare organizations, HMOs, and PSOs were on the horizon, and the NAIC saw that it needed to get a formula done sooner rather than later. The NAIC pared back the scope of the assignment and said, "Let's focus on MCO, and let's focus on medical coverage."

And as a result of this focus, disability insurance, long-term care, and some of the other health insurance categories were left out of the formula.

The NAIC took the simplified formula and picked and chose what would be appropriate for a medical-focused RBC formula. The Academy, during this time frame, provided comments and highlighted for the NAIC places where, if you took one thing, you had to take another. The Academy also provided explanations of why certain RBC elements were there.

Now that an MCO RBC formula has been approved, I think you'll find that Burt's Task Force on Health Organizations Risk-Based Capital is going to take on the same role that the life and the P&C task forces of the Academy have. That is, it will provide ongoing technical support to the NAIC as the new formula matures. So, you can look to Burt and his group to get involved in that activity.

Now, let's talk about some of the differences between the NAIC and the Academy formulas. The first item of difference is the structure of the formula itself. The Academy took a slightly different approach than did the NAIC on small HMOs. That approach established a fixed minimum RBC level regardless of size that represents the risk of any HMO, and then you add to that. Both formulas have the same purpose in mind, that is, to have an extra amount of surplus for very small entities. They simply go about it in different ways.
The second thing I would highlight is the combination of coverages in the MCO formula. As I mentioned, the Academy formula was very specific to cancer policies, accident only, etc. The MCO formula puts these products together in an "all other" category.

As for managed care credits, their sizes may differ. The MCO formula gives this capitated managed care credit to a carrier, regardless of whether the capitated entity directly provides care, directly provides medical services, or is an intermediary. An intermediary would be perhaps some kind of health delivery organization that might have providers under salary or under a capitated contract, but it might also have fee-for-service arrangements with providers.

The Academy recognized that there's some risk associated with taking a credit for capitated care when the entity that's being capitated might, in fact, be paying on a fee-for-service basis. Additionally, the Academy looked to some of the other NAIC regulations that relate to reinsurance where a carrier gets credit for reinsurance when it reinsures with an authorized reinsurer. So, the Academy's formula said credit for capitation is given when the capitation is paid to a regulated entity.

The other difference that I would draw your attention to is the premium stabilization reserve credit. Obviously, the percentages are different, but the maximum in the Academy formula was put there to try and recognize the following situation.

Let's say you have a group where you've accumulated a $3 million premium stabilization reserve. Let's also say that if you do the calculation of RBC for that particular group, it might come up with $1 million of RBC. If that group were all your business, you'd have a $1 million RBC amount. The Academy questioned why you would get credit for more than what's at risk for a group, so there was a maximum placed on that credit. In its quest for simplification, the NAIC took the maximum limit out.

Another item that merits attention is the stop-loss coverage. I think the difference is largely a reflection of the relative risk assessment by the Academy, which said that for stop-loss coverage there is a higher risk than for regular medical coverage, so it should have higher RBC factors applied to it. The MCO formula, in effect, says no, stop-loss coverage is medical coverage, and it has the same factor.

Finally, there is a difference in the treatment of administrative expenses. In looking at the data and looking at past insolvencies, the Academy felt that administrative expenses weren't a significant source of risk to HMOs and MCOs. The NAIC felt differently about that, so the MCO formula has a factor applied to administrative expenses.

The next set of differences that I'd like to speak to is the valuation adjustment. As the Academy worked through what drives risk and what protects insolvency, there was a lot of discussion around companies that set incurred but not reported claims and other reserves very conservatively. Aren't they more protected against insolvencies than companies that don't? The obvious answer is yes, they are, but how do you quantify very conservative or extra reserves? This is very difficult to quantify objectively. So the Academy formula said that if you can't quantify it, you can at least have some confidence that if a balance sheet has, or the reserves have, an actuarial opinion related to them that speaks to their adequacy, then that probably gives some certainty that those reserves are at least adequate.

If that actuarial opinion isn't there, it doesn't necessarily mean that the reserves are inadequate, but by using the Academy formula felt there was at least a possibility that the risk was higher that they might be moderate. So the Academy formula said that if you don't have one of those opinions, then it would apply a 20% load to your RBC factor. The NAIC felt that some of the other rules associated with setting up reserves were adequate, and you'll not find that factor in the MCO formula.

As for the rating filing adjustment, the Academy looked at the experience and said that when a carrier has coverages that are subject to lengthy regulatory review for rate actions, the length of time between when the carrier can observe experience and when it can actually implement rates adds to the risk of setting rates. As a result, the Academy formula said that for a business that is subject to regulatory review, there will be a higher factor applied. As a matter of fact, in the life RBC formula, there's a higher factor for individual versus group, and there's at least a feeling that part of that is reflective of this regulatory risk. This didn't make it into the MCO formula, illustrating the different opinion as to the risk associated with rate review.

The last difference that I would highlight would be the credit risk. Now, if you go back to some of the other credit components that the MCO formula has, such as the capitation and the premium stabilization reserve, some of those carry with them some credit risk. So to offset some of the RBC credit, the NAIC included this credit risk in the MCO formula.

The difference in treatment of asset risks is kind of interesting. The MCO formula has asset factors and categories that are consistent with the P&C RBC formula. These differences reflect a different jumping-off point. The Academy's formula started with the life RBC formula, largely because most of the carriers of health insurance are life companies. The MCO formula probably starts with the P&C factors because the person who was leading the managed-care-focused RBC formula is knowledgeable on the P&C side, so that's what he or she was familiar with, and that's where it started.

All right, so that's the history lesson. Now, what are the potential impacts of these two different formulas? They can be sorted into four categories.

The first category of differences are those that have just limited impact. They have limited impact for a variety of reasons. The first reason for limited impact is that there's just not much noncancellable HMO coverage. The second reason is the administrative expenses. These have limited impact due to covariance adjustment in the formula. The covariance formula that Bob put up has the effect of canceling out a lot of different risks when one risk is significantly greater than the others. In the case of most MCOs, the underwriting risk is clearly the largest one. So while there is a difference in this administrative expense, the Academy formula didn't have any reflection of that. It's not a big impact, because it is minimized by the covariance formula.

As asset risk isn't really a significant part of an HMO's risk, the differences there aren't great. Also, most HMOs and managed care organizations that will be subject

to this don't have a lot of cancer policies and accident only, so there is no significant impact there. The credit risk has small factors. Finally, the valuation adjustment difference is small, since actuaries are more and more involved in HMOs and so there is probably an actuarial statement associated with most HMOs.

There are places where the MCO formula has a higher reflection of risk than the Academy formula: dental and Medicare supplement, credit for affiliate guarantees, treatment of subsidiaries, and the Federal Employees Health Benefits Program. I think it's a reflection of where the NAIC and the Academy felt they wanted to place some emphasis. On the Academy side, there's an increased reflection of risk in things such as capitations and staff models, rate-filing adjustment (primary individual products), growth, business risk (covariance and variability in assessments), stop loss, and self-insured products. I think to the extent that the MCO formula doesn't reflect some of these, it's either a reflection of judgment or of simplicity. Either of those, as we watch this formula mature, may be revisited.

In regard to situational impact, depending on the size of your company, the factor of tiered versus fixed plus percentage, along with premium stabilization reserve (PSR) credit, are going to have a different impact on your RBC amount. And that PSR credit, if you don't have a lot of it, obviously is not going to play big into your RBC calculation.

There are some opportunities for gaming or manipulation. Capitation paid to intermediaries is one. There's a possibility that a carrier could set up a separate company that, in effect, paid mostly fee for service downstream. But, if the separate company is paid in a capitated manner, the carrier may be able to take credit for the capitation in the managed care credit.

The decision to not make a distinction for stop-loss coverages is an area where some gaming may take place. The example would be if a carrier sets a low aggregate stop-loss limit for its coverages. For example, if a carrier has a 101% aggregate stop-loss coverage, then almost all of the premium can be considered self-insured, so the RBC factor gets applied to just that risk element that would be charged for that coverage.

In regard to the premium stabilization reserves, if a carrier were able to have a large reserve for one particular group, it would add to the credit that the carrier would receive, even if the amount at risk for that group were not as big.

Lastly, because of how things get rolled up between the subsidiaries and parent companies, there's probably some opportunity to determine what gets rolled and

what doesn't, as well as where a carrier places certain risks and certain assets. So we also want to keep an eye on those areas for some manipulation.

Mr. Jay: I will begin with a quick overview of the changes that were made in the life RBC formula, which will be effective for 1998 statements. Before the change for individual medical business, the charge was 25% of the first $25 million of premium and 15% after that. The change involved taking the MCO approach. Now group and individual are combined, with a 20% charge being applied to the individual premiums; then the RBC component is 15% of the premium up to $25 million and 9% of the premium in excess of $25 million, with two adjustments. One of the adjustments is to multiply this amount by the average loss ratio for the health product. In effect, this means that the factor is applied to claims instead of premium, which reduces the RBC requirement. The other adjustment is a factor of 1 minus the average managed care credit. These are the same managed care credits that are contained in the MCO formula. There is also a minimum amount of two times the maximum annual claim with a cap of $1.5 billion. There is also a business risk component that will be covered later.

No change was made in the treatment of stop loss, although a change is being studied for a future time. For the Medicare supplement, the change is to adopt the MCO RBC approach, that is, 10% of claims times the managed care adjustment for the first tier and 6.7% for the second tier.

For a life insurance company that sells a lot of health insurance, this change will have a fair amount of impact on its RBC requirement. The changes discussed provide a quick way to calculate what that impact might be.

Changes in the life formula were made only for medical coverages, dental coverages, and Medicare supplement. These are the same products that are specifically covered in the MCO formula. No changes were made for the other products.

Something new in the life formula is the credit risk, which is comparable to the credit risk component in the MCO formula (Formula 2):

FORMULA 2
TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

$$\text{C-0+C-4a+Square Root of } [(\text{C-1+C-3a})^2+(\text{C-2})^2+(\text{C-3b})^2+(\text{C-4b})^2]$$

The credit-risk component is the C-3b component, which is a new component for the life formula. Note that there were no changes made for reinsurance ceded. For capitations paid to providers, there is a charge of 2% of the amount paid, and for

capitations paid to intermediaries, the charge is 4% of the amount paid. For other receivables there is no change from the current formula. The charge is part of the C-1 component. In the new formula the two new terms, C-3b and C-4b, both go inside the radical, which means their impact will practically disappear in most situations.

In the business risk, there is a Guarantee Fund assessment component, which will now be called C-4a. Previously, this was the C-4 component. The charge for excessive growth was not brought over from the MCO formula into the life RBC formula. For nonrisk business, the charge is 2% of administrative expenses and 1% of payments on administrative service contracts. The most significant charge is a weighting of 7% of the first $25 million of premium and 4% for the excess times the amount of administrative expenses. This has come over from the MCO formula to the life formula.

A task force is now looking at the additional health coverages that were in the original Academy proposal but not yet addressed. These coverages are disability income, long-term care, stop loss, and what we call limited benefit plans. Limited benefit plans include cancer, hospital indemnity, and accident-only coverages.

The NAIC would like the task force to come up with a proposal early in the year so that it can adopt something at the March meeting. If the task force is able to use the work that was done originally by the Academy, the previous recommendations could be used with some minor adjustments. The subgroups that are into the work that was done for disability and long-term care think there has been enough change that new work will be necessary.

Disability is the most important of these products for most life insurance companies. Long-term care is important for the MCO formula as well as for the life formula.

The coverages for long-term care have changed since 1995, and the results from the simulation work done earlier on long-term care were so inconsistent that they were not used. The previous long-term-care recommendation was to use the disability income factors. If the task force must offer something in early 1999, a Delphi process may be used to come up with something that is more consistent with the other factors that are in the life formula now.

For disability it is more likely that some of the older work can be used. Currently noncan is treated differently from guaranteed renewable and differently from group. Session 157OF, Proposed Changes to the Statutory RBC Requirements, takes a closer look at the actual model that we would use to do the new work.

Ms. Donna C. Novak: No discussion would be complete without at least mentioning what's happening with the federal waiver of solvency requirements for Medicare PSOs. As Peter mentioned, one of the things that gave RBC for health organizations or for MCOs a shot of adrenaline was the threat of federal regulation of PSOs and some solvency waivers.

The Health Care Financing Administration (HCFA) led a negotiated rule-making process over a five- or six-month period to design a waiver of state license requirement for Medicare PSOs, as required by the Balanced Budget Act (BBA). The representatives "at the table" included a number of hospital associations, provider groups, the Blue Cross/Blue Shield Association, the Health Insurance Association of America (HIAA), and the American Association of Health Plans. The federal waivers as defined by the BBA will be three-year waivers, and they'll be available for the next three years. So any PSO that is getting a waiver now will have a waiver for three years. Any PSO that gets a waiver three years from now will have that waiver up until six years from now, and then the program will be over unless it is extended. Only the state solvency requirements are waived, not the other market conduct types of issues, so many of these entities have the potential of having dual regulation: the federal regulation plus the regulation of either the state's Department of Insurance or the state's Department of Health.

I think that the most important thing that came out of the exercise was the interaction between actuaries and providers. There were two actuaries at the table representing the entities that I mentioned. I represented the AAA, and there were numerous actuaries advising people at the table. We got an opportunity for the actuarial profession and the provider community to understand each other more.

The actuarial issues included capital requirements and a definition of catastrophic risk. We're all familiar with the tails of risk testing. For some of the provider community this was a new concept.

Financial planning, from a provider perspective, included the concept of "sweat equity." I'll talk later about how sweet equity gets into the actual solvency requirements, but the providers felt that since they are providing the care directly, they don't need capital. Many provider groups were not on an accrual accounting basis and were used to a cash accounting basis. They therefore felt that if they had people to provide the services, they didn't need solvency requirements. As I say, it was a real education on both sides.

The providers getting federal waivers are eventually going to have to meet this state requirement if they're going to stay in the business as a PSO provider for Medicare. More important, a PSO has a business capital requirement dictated by the needs of

the Medicare contract. There was a lot of discussion around the business plan and the importance of estimating elements such as enrollment, premium rate, and cost of care. These estimates are actuarial exercises. They certainly are not estimates that a PSO should have its marketing department do. So one of the things that we did accomplish was to have written into the regulations the importance of using actuaries and members of the AAA to help with the HCFA filings, specifically, the business plan.

We'll compare the MCO RBC and PSO waiver requirements. MCO RBC has four risk categories, with authorized control levels at about 5% of claim expenditures or 4.5% of premium. This results in a company action level of approximately 8–10%, depending upon the amount of managed care. The level used in the discussions with HCFA was the authorized control level.

The actual PSO waiver requirements came out looking very much like the HMO model act that Bob explained earlier, with some pretty significant credits for managed care. As Bob said, it's really the 8% of claims or expenditures that drives the PSO waiver, but depending upon the managed care level, this can be reduced to almost 1–2% of premium. This is a significant reduction in the net worth requirement.

Where some of the big differences come in is when you start looking at what is included in the capital or surplus part of the requirement. Currently, Medicare risk HMOs include some items that aren't admitted on a statutory accounting basis, such as intangible assets. HCFA therefore included these as part of the waived requirement, with some limitation.

For waived PSOs, withholds from providers for services that have been performed are subordinated to other claims and will not be included as a liability on the balance sheet. This is really how sweat equity became quantified and included in capital. So if providers argue that since they can provide the services, they don't have to have money in the bank, then they can translate this commitment into dollars by waiving their fees until HCFA is happy with their solvency and liquidity levels. This is how sweet equity was included to meet solvency requirements.

Financial reporting was very similar to state requirements. HCFA will require an orange blank to be filed for HMOs or PSOs, even those that would normally not have to file with the NAIC. If anything, there are going to be more filing requirements for waived PSOs because of the requirements to file a business plan until either the PSO breaks even or until liquidity reaches a ratio of 1:1.

For liquidity, there's no explicit requirement in MCO RBC, although the Academy is developing a liquidity formula for the future. For the HCFA-waived Medicare PSOs, there is a requirement to stay at a 1:1 current ratio or provide a corrective action plan. So if a PSO falls below the 1:1 ratio, it can still keep its waiver, it can still contract with HCFA, but it would have to provide a corrective action plan, as well as a detailed business plan.

There's a slight difference in insolvency situations between a PSO with a state HMO license and a PSO with a federal waiver. If there was an insolvency, instead of being in state receivership, a federally waived PSO would go through a federal bankruptcy court.

As of a month ago, there had been three PSOs that had applied for these waivers—not exactly the landslide that some anticipated or predicted. It looks like one of the PSOs will get the waiver. One other actually had not filed appropriately with the state, and in order to get a waiver, you have to prove that you filed with the state and they weren't responsive. So that PSO is going to have to go back and file with the state. And the third application was denied.

So it doesn't look like there is going to be a big effect in the marketplace. Although we haven't seen a lot of PSO waivers, we've seen a number of provider groups deciding to go the extra step and get an HMO license, since that's what they're going to have to do in three years anyway. So the HCFA waiver process may have generated or forced some decisions that were sitting on the back burner. We may have seen a number of entities filing for HMO licenses out of the decision process generated by the PSO waiver.

Mr. William F. Bluhm: Do any of you know any reason why a fee-for-service carrier, if subject to the MCO formula, would not want to immediately set up a bogus intermediary to pay itself on a globally capitated basis, so that it can have that intermediary pay the fee-for-service fees and thereby get a credit of 75% of the RBC factor?

Ms. Novak: Many indemnity carriers who have more than adequate capital don't really have a challenge meeting the RBC level. And although it improves the RBC ratio to some extent, the expense of setting up a bogus subsidiary wouldn't be worth it. That's one possibility.

Mr. Perkins: I don't know why not. Good question.

Mr. Cumming: Also, I think that in the future, the NAIC is going to be looking at those types of gaming issues. To the extent they occur significantly, I'm sure the

NAIC would take some actions to put some limits on that, so it might be a very short-lived situation.

Mr. Perkins: It may only work for a little while.

Mr. Frank J. Robertson: Why would the intermediary itself not be subject to the RBC?

Ms. Novak: If the intermediary is not regulated by the Department of Insurance, and it can be set up so that it isn't, it wouldn't be subject to RBC requirements.

From the Floor: Nationwide.

Mr. Jay: Nationwide, thank you.

Mr. Roy Goldman: I just had a question for your comment about the assets that PSOs may include. You say that one of these items is how they brought sweat equity into the formula. Could you explain in more detail what you mean by that?

Ms. Novak: Even though a PSO is called a "provider service organization" or "physician hospital organization," typically, the contracting entity is a separate entity that pays the hospital or providers on some type of contractual basis—often discounted fee for service—so the providers are paying themselves, the hospital is paying itself, or the provider groups are paying themselves.

The entity that's contracting with HCFA can set those payments up as owed to the provider, but subordinated to all other debt. Then the entity doesn't have to set up a liability for those payments to the providers and, therefore, doesn't have to take a reduction in its surplus for the amount that's owed to the providers. Again, this is a method to quantify sweat equity. Obviously, if you're including sweet equity on financial statements, you have to quantify it some way. You can't just say, "Well, trust us, we'll provide the care," and have that be worth enough to meet the federal solvency requirement. Is that clear?

From the Floor: Basically you're saying that they bought into the argument that there is sweat equity, and by now requiring them to reduce their surplus for the amount of care that was provided is owed to them in dollars, so they really bought the argument.

Ms. Novak: You could look at it that way. You could consider the fact that services were being provided and provider fees were being left in the organization as an investment.

Mr. John D. Stiefel III: I'm an independent actuary. I work with the American Medical Association and formulated a physician paper on sweat equity, so could you give me a little bit of the dynamics that led to what I think is a very good compromise as to how it is recognized?

Ms. Novak: A number of actuaries like yourself advised the provider organizations. Actuaries representing Blue Cross/Blue Shield Association and HIAA worked with the PSOs in a number of sessions, which were not always open to the public. In these sessions they came up with that compromise by focusing on balance sheets, business plans, and income statements versus the philosophy of "Trust us, we'll provide the care." I thought it was a good compromise. It was a very enlightening discussion from both sides, as I said.

Mr. Sanford B. Herman: I had a technical question on calculating H , the 15% credit for negotiated fee levels. Do those have to be fixed levels, or can they be percentage off of bill?

Mr. Cumming: Not percentage off. If it's some percentage off of bill and it would be category 0, there would be no credit then.

Mr. Herman: Okay, what if you have a PPO that has a situation? I think that with a lot of them like that, you negotiate with the hospital, and you have a fixed per diem. However, there's certain stop losses on catastrophic, where they revert to a percentage of bill, and then you have the doctor part, which may be percentage of bill? Do you go to the lowest level, or do you somehow split that by the percentage of risk that you have in the PPO?

Mr. Cumming: There are a lot of questions still remaining about how to categorize a lot of the different reimbursement arrangements. I don't think all those have been answered at this point.

Ms. Novak: The one thing that helps a little bit is that the credit is founded on paid amounts, so if a dollar is paid, say, under a capitation, then it goes under "capitated." If you've exceeded the capitation and go into a stop-loss situation, then that dollar is being paid in another category.

From the Floor: What are some of the market dynamics that are going into providers taking risk, and historically, how does that fit into how that may play out in the future? It seems like some of them have gone into it willingly and then pulled back because they weren't aware of the capital intensity, as well as some of the administrative burdens that it had. How do you see that playing out in the future?

Ms. Novak: I guess there were a number of questions. One is, What's driving it? I think from a provider perspective, there are a number of things driving it. One is that they're being asked to take more and more risk from carriers and from payers, and so they're saying, " If I'm taking this risk, I want to have as much control over it as possible." And many large provider groups feel that what actuaries do is pretty simple, and they want insurance companies to do it pretty simply. And they feel that insurance companies are taking quite a bit of money for performing those services, and that the whole health care could be delivered a lot less expensively if you didn't have that middleman. And that's, of course, what's driving a lot of what Medicare's doing. Everybody's job looks simple until you start doing it. I think that might answer your second question about why some of them are pulling back. They're realizing what can happen in the tails and that if you don't have enough enrollment to spread the risk over, you can get caught in those tails.

From the Floor: Where is it going in the future?

Ms. Novak: Any opinion I state is not the Academy's or my employer's. I think some very good things are being driven by managed care and by providers taking risk. I see hospitals that are coordinating care over a whole continuum of care for a patient, whereas previously, you had a specialty come in at 9:00, another specialty come in at 10:30, and they never talked to each other. I see a lot more community-focused health care being generated out of it. And I hope that some of the downside of managed care doesn't mean that we lose some of the real benefits that are happening in the marketplace as a result of providers taking on risk and, therefore, the management of the care, because somehow the dollars and the actual management of the health care go together. It's hard to manage one without managing the other.

Mr. Cumming: Yes, in a number of markets we're always seeing a backlash against some of the risk-sharing arrangements and the capitation arrangements. A lot of them—the HMOs and other insurance organizations—I think entered into it because they could significantly lower their reimbursement payments, and the providers were scrambling to get into managed care and taking risk and didn't fully understand the impact of some of these capitation and percentage-of-premium arrangements. So in a number of markets where we're working, there are already some providers moving back away from those types of arrangements now that they have had some adverse financial results, and I think that will continue to some degree. But there does definitely seem to be a movement toward providers taking a greater interest in the risk and controlling the costs.

In Minnesota, we have some direct contracting that's going on with some large business coalition, where providers, in essence, have agreed to a per-month per-member target, and their fee schedules float up or down depending upon how well they manage care. And that's a very interesting experiment. People seem very happy with it, and it might be something that flows out to other areas as well.

Mr. Harry L. Sutton, Jr.: Just a short, simple question. The accounting rules for HMOs require setting up premium deficiency reserves in the event you have a major client, at least where you underpriced it and you're losing money. For example, you could have a major client like a Medicare contract, and it could be underpriced, and you could be losing money. How does the RBC account for the fact that you set up this sizable reserve to cover the losses of the following year?

Mr. Perkins: I think I'll let the other panelists answer that, too, but I think that the RBC is on top of any additional required reserve established because you have a deficiency situation.

Mr. Cumming: As far as I know, it doesn't address that issue. It doesn't address how conservative or unconservative your reserving practices are. There's nothing that takes that directly into account at this point. One related issue, though—and I'm not sure where this is going to end up—is the possibility now that the Academy will be working jointly with the NAIC in developing a health reserving practice manual. This manual may, hopefully, start to eliminate some of the different reserving practices—the variation that we see in health reserving practices across companies—eliminate some of that variation and bring it closer to the mean or median.

Mr. Jay: The basic assumption of the RBC formula for all of the types of entities is that the reserves are consistently calculated and represent a consistent level of adequacy. I think that the new manual should help for health companies.

Ms. Novak: That brings up an excellent point and an insight that I don't know that many people have realized. That is the connection between the reserves and the RBC. We see that the codification project at the NAIC to codify statutory accounting has a potential of changing the way we do reserves, along with other changes that are being recommended by the AICPA. This would mean that we should go back and recalibrate RBC to take these changes into consideration, because algebraically the formula still has to stay calibrated at the level that the NAIC intends.

Mr. Michael Jay Sipos: Isn't there an additional business risk associated with revenues falling in future years?

Mr. Cumming: Yes, if you have physicians or facilities that are employees, your expenses are somewhat fixed, and if you don't get the business volume you need, you could have dramatic losses. The following came up in a recent conference call with some of the NAIC people. One of the NAIC people mentioned that the level of credit on that type of category business is one thing that they're considering looking at next year and perhaps thinking that maybe 75% was too high; maybe it should be more like 60% or something like that, I think for the reason you just mentioned. So that's something that they may be looking at; maybe on their short list for next year is determining that level of credit.

Mr. Jay: I think that is a good point. Of all the categories, the 75% is being questioned the most.

Mr. Sipos: I was just going to add an additional comment to that prior question. It's probably worth noting that when we did the original testing for the Academy group, everything except that one factor, the staff model factor, was all done based on modeled claim costs, which would take that into account, I think.