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# ORSA 101 for Health Actuaries

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As health actuaries, we have sometimes been accused of marching to the beat of our own drum. Although actuaries all deal with their own discipline's unique risks and challenges, actuarial techniques related to medical insurance coverages tend to be less of what outsiders might think of when they hear "actuarial." We don't get to use international actuarial notation as often as our life colleagues do. And those of us whose work is touched by health care reform tend to spend a lot of our time reading, understanding and applying the myriad rules and regulations that affect our industry (arguably occupying as much of our day as more traditional "actuarial" tasks do).

One place in particular where we've had less focus than others is in the practice of enterprise risk management (ERM). We have also paid less attention to the implementation of Own Risk and Solvency Assessment (ORSA) regulations in many states. This could be due to thinking that the short-tailed risks associated with health insurance do not necessitate the need for ERM and ORSA to the extent needed for life and casualty insurance businesses, because of a lack of training, or through sheer inertia. Whatever the reasons, ERM processes have taken longer to pervade the health insurance industry than other areas. Many of you reading this may be doing so just to find out what an "ORSA" is, what is ERM, and why are they being talked about in *Health Watch*?

ORSA is something that may already be going on in your company, and it's very closely tied to the practice of ERM. As an actuary, this is something that you should, at a minimum, be aware of, and something that potentially should be one of your core activities. So, what is an ORSA?

## WHAT IS AN ORSA?

Before we start our discussion of ORSA in earnest, it is useful to remind ourselves what standards the National Association of Insurance Commissioners (NAIC) has set, and how they work. The NAIC is the umbrella organization for state insurance regulators (including regulators for the District of Columbia and U.S. territories). As health actuaries, we are acutely aware of two important ways that the NAIC influences our work—they provide the System for Electronic Rate and Form Filing



(SERFF) system that insurers (in most states) use for rate and form filings, and they develop the statutory financial statement templates that are used for insurance company annual and quarterly statements.

Another function of the NAIC is to draft model laws and regulations for states to adopt. For instance, nearly every state has the same laws governing the coordination of benefits when someone is covered by more than one health benefit plan. This didn't happen by accident, but because the NAIC promulgated a Coordination of Benefits Model Regulation,<sup>1</sup> which most states have since adopted. This model regulation was last revised in October 2013, although many states still have an older version of this on their books. This is because the NAIC cannot make laws or regulations by itself—it still requires action by each state to enact the laws and regulations that are promulgated by the NAIC. Some states do this more quickly than others, and not every state enacts the NAIC model text in an unaltered form.

The ORSA concept comes from another NAIC Model Act,<sup>2</sup> which was released in 2012, and which became effective in 2015 for the states that have adopted it. The ORSA Model Act is only six pages long,<sup>3</sup> and most of those six pages deal with the applicability rules and exceptions to ORSA. Only one page (or so) of the model act relates to what ORSA actually is, and what insurers have to do. So what do insurers have to do? At its core, the ORSA Model Act simply requires that insurance companies<sup>4</sup> implement and document an ERM program. ORSA and ERM are different things, but closely related. You can do ERM without conducting a formal ORSA, but a formal ORSA requires ERM.

ERM is an important activity for insurers to do, whether it's required or not. As such, the Society of Actuaries and the Casualty Actuarial Society focus on ERM practices in their CERA credentialing processes. In one sense, ORSA merely codifies a good risk management practice that should already be happening throughout the insurance industry. However, health insurers have lagged other disciplines in terms of implementing these processes into their organizations.

ORSA is an acronym, and as with many acronyms, it's useful to look at each letter separately, since each letter contains valuable insight into key ORSA principles.

- The first letter in ORSA is “O,” which stands for “Own.” A health insurer is supposed to conduct its own ORSA; although nothing prohibits getting help from outside parties, the ultimate responsibility of an ORSA falls upon the insurer. An ORSA is not something that a state regulator will do to you, or do for you. The term “own” also implies a certain level of flexibility in recognition that every company has a unique combination of goals and characteristics—with ORSA, there is not a prescribed formula or approach (unlike other exercises, such as risk-based capital (RBC) calculations).
- The “R” in ORSA stands for “risk.” Managing risk is the business that insurance companies are in (and also the specialty of the actuarial profession), so it may seem obvious what “risk” entails. However, we commonly see people (even health actuaries) misinterpret what “risk” means, both by mixing up expectations with variability and by not looking far and wide enough for risks that aren't obvious. Generally, “risk” means uncertainty. When conducting an ORSA, the insurer should be thinking about *variation* in future results, not just whether the most likely outcome would be a bad one. Something that has a certain bad outcome is not risky—it's just bad. Driving a car at 100 mph toward a riverbank with no bridge does not present the risk of a bad outcome; in this case, there's a certainty of a bad outcome. We don't need ERM to tell us that this is a bad idea. On the other hand, driving a car at 100 mph in the direction of a bridge that I believe to exist, based upon construction plans read one year ago, is a risky action. Perhaps the bridge was never completed, or the bridge was moved to a different location farther down the river. Or perhaps the bridge was completed according to the plans, and things will turn out OK.
- The “S” in ORSA stands for “solvency,” which is the focus of ORSA. As a health insurer, will you be able to satisfy the obligations of your policyholders, and what circumstances would make it so that you couldn't do so? “Solvency” refers to things that jeopardize the company, not merely the risk of disappointing shareholders or incurring a small loss.

Stress testing is a key part of an ORSA. This is not the place to assume bad things will never happen (just because they have a low probability); thinking about unlikely (but very bad) things is part of the point of an ORSA. The *ORSA Guidance Manual* states (multiple times) that the insurer should analyze risk exposures “under both normal and stressed environments.”

- Last but not least, the “A” in ORSA stands for “assessment.” An ORSA is not an equation, or a formula, or a test—it's an assessment. It's easy to compare and contrast this with RBC requirements—although there are certainly mathematical aspects of an ORSA, this assessment requires a lot more *qualitative* work than an RBC calculation requires. An ORSA requires you to think about things that are difficult to measure, and even for items where math is present, the rules are not spelled out as they are for an RBC calculation.<sup>5</sup>

If you prefer sports analogies, think gymnastics, not track and field. We can't use a stopwatch or tape measure to immediately determine the results, but instead need to look at the big picture and reach a judgment-based decision. ORSA is an assessment, not a measurement.

So that's what an ORSA is—it's a structured implementation of ERM processes. Health insurers have not typically focused on ERM. There is a tendency to view ERM as something pertaining to the banking industry or to other types of insurance. Many health insurers (especially those focusing on short-duration products) may not see ERM as important or useful, since it's easy to believe that the risks faced by health insurers are simple—problems occur when claims and administrative costs exceed premium collected, and that will happen if trends are higher than anticipated.<sup>6</sup> The reality, however, is that ERM matters for health entities, too. Many of the risks are somewhat different than in banking or life insurance, but they are still very real. They go beyond just looking at risks associated with claims and premium rate-setting.

## WHAT IS ERM?

As health actuaries, we focus on organizational risk as a matter of course—this makes us uniquely suited to drive ORSA development. Moreover, we know the risks health insurance carriers face have gotten significantly more complicated over the past few years. These risks are interconnected, and ERM is the perfect tool for a “whole body” risk analysis.

A basic purpose of ERM is to identify the risks that exist (or could emerge), decide how much risk an organization should take on and how to mitigate those risks, and to determine appropriate capital levels to support them.<sup>7</sup> ERM provides a framework to identify potential risks—one of the biggest shortcomings of risk management in any organization (including health

insurance) is that people give intense focus to things that have already happened, and wait for them to happen again, to the exclusion of focusing on what new risks may exist.

ERM looks at the entire enterprise—sometimes risks in different company segments offset one another. A classic example would be mortality risk in a life insurer, where an unexpected decrease in mortality is usually adverse with respect to annuity products but favorable with respect to term life products. On the other hand, there may be processes that pose only a small risk to any specific product line or division, but are much more serious when aggregated across an entire organization. For example, if different divisions make investment decisions independently, it is possible for each division to have a well-diversified bond portfolio across issuers and industries. But if each division's bond holdings in the energy sector are all from the same issuer, then the company as a whole could find itself with more issuer concentration than it would like.

ERM considers accumulations and combinations of potential risks—sometimes individual risks are not significant, but combinations can be devastating. For example, the risk from underpricing in the Affordable Care Act (ACA) markets in 2014 may be modest. Separately, the risk that the ACA risk corridors program would be underfunded in 2014 may be modest. As we've seen, the combination of these risks has been devastating to multiple health carriers.

## RISK IDENTIFICATION

Much of the ERM battle is identifying what risks are out there for a health insurer. It's not an easy task. Some risks arise from within the company, but others are external—for instance, general economic conditions could make it difficult for people to pay for your coverage (and some coverages allow for consumers to take their own premium holidays if they so desire).<sup>8</sup> Regulatory and legal changes can introduce challenges that are difficult to mitigate or anticipate; when President Obama decided to allow non-ACA-compliant policies to remain in the individual and small group commercial marketplace on Nov. 14, 2013,<sup>9</sup> health insurers were already offering ACA-compliant plans for 2014 whose premiums assumed otherwise. Some future risks may be truly unpredictable, but that doesn't mean that we shouldn't perform stress testing on potential calamities. Not all risks can be reinsured away, and not all risks can be mitigated through product line diversification.

We'll refer the reader to a 2006 *Health Watch* article for an enumeration of broad risk categories to consider.<sup>10</sup> As we all know, business changes, and the specific risks that health insurers face have evolved since 2006. However, these broad categories are still relevant a decade later.

To evaluate some of the categories that Clark lists, an actuary may have to (gasp!) talk to and work with people who are not actuaries. A simple example relates to claims processing. This is a significant area of operational risk (and perhaps legal or regulatory risk) for a health insurer due to the volume of claims coming in the door. Will claims be adjudicated under the terms of the policy, and does the method of claims adjudication align with the understanding of the actuaries who priced the product? As insurers come up with ever-more-clever and complicated benefit design structures for medical coverage, this risk becomes more pronounced. What processes and controls are in place to ensure accuracy? Much of this information lies outside the actuarial department, but actuaries are well-positioned to drive the assessment.

Another particular problem relates to strategic risk. Typically, those responsible for determining a company's strategy are the same as those ultimately responsible for evaluating a company's risk. It can be difficult to be objective. External points of view can be good for testing the "group think" that may exist within an insurer. Relatedly, it is easy to fall into the trap of only evaluating whether *actions* create a risk of significant financial loss. It is harder to evaluate whether *inactions* give rise to this risk, because one reason a company may not have taken a particular action is that it never occurred to anyone to do it. The *ORSA Guidance Manual* does ask for attention to risk mitigation activities that may not already be in place.

A challenge of conducting an OWN risk and solvency assessment is that it's easy to fall into the trap of considering only things that have caused problems for you or your company in the past, and not things that have happened to other companies (let alone things that haven't happened to anyone yet). Although the responsibility of an ORSA falls on the carrier, it can be useful to get help from others when analyzing what could lead to future catastrophic risk. Limited employee tenure and institutional memory can be serious problems in this effort. Suppose a company's business model gives rise to a 10 percent risk in any given year that a certain catastrophic event will take place. Many people would be uncomfortable living with that amount of risk. However, there is a 12 percent chance that the event *hasn't* happened in the past 20 years<sup>11</sup> (which may be longer than any current employee has been thinking about such things). This illustrates how easy it is for risks to be missed in the ERM process if there is not a concerted effort to try to identify new and emerging risks. It can be mildly disturbing to realize that 1 in 8 risks with this frequency of occurrence won't be personally remembered by anyone with less than 20 years of experience, especially when it's more likely than not that it will happen at some point in the next seven years.

## RISK ASSESSMENT

Once risks are identified as a part of an ERM process, they must be measured. How likely is the risk to occur, and what would be the magnitude of loss were it to occur? It's easy to focus only on risks that are easy to measure, but ORSA and ERM force you to think about things that are harder to quantify—in fact, a lot of these efforts will be speculative in nature. The *ORSA Guidance Manual* even calls out that “for some risks, quantitative methods may not be well established and, in these cases, a qualitative assessment may be appropriate.”

Risks need to be viewed in the context of the entire system—some risks offset one another; hypothetically, if legislation allowed for those of any age to enroll in Medicare, this would affect a purely commercial carrier differently than a carrier who offers both commercial and Medicare Advantage business. Other risks may magnify one another (as we showed earlier).

## RISK MANAGEMENT

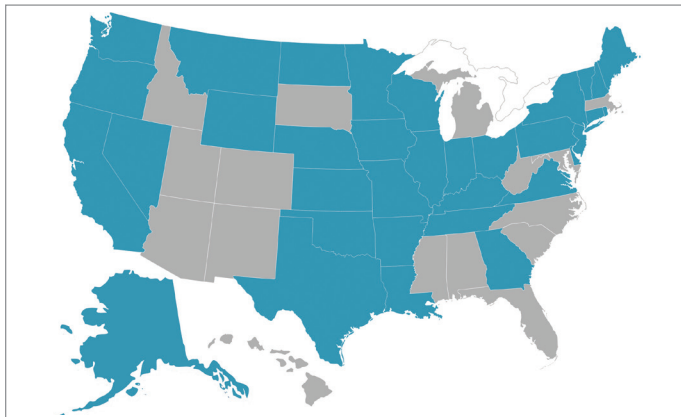
Of course, once risks are identified and evaluated, they must be managed (the “M” in “ERM”). Not all risks can be avoided, although perhaps their likelihood can be reduced or their impact mitigated. Alternatively, carriers can attempt to transfer the risk, or decide to live with it (as we know, “risk is opportunity”). Capital levels need to be large enough to support an insurer's activities and appetite for risk.

## WHO IS REQUIRED TO CONDUCT AN ORSA?

First and foremost, ORSA applies to insurers—not just health insurers; life and property/casualty insurers fall under the ORSA umbrella, too. Although the NAIC has published a model act, it has not yet been adopted in all states; only carriers domiciled in a state that has adopted the model act are required to conduct an ORSA.

Figure 1 shows the states where ORSA is in force, as of the end of 2015:<sup>12</sup>

Figure 1  
States Where ORSA is in Force



ERM matters for health entities, too. Many of the risks are somewhat different than in banking or life insurance, but they are still very real.

Blue shaded states are subject to ORSA, which now covers most of the country—a significant number of states (12) adopted ORSA during 2015 alone, and even if your state is not shown as an ORSA adopter in the map, it's possible that by the time you read this paragraph, it will have adopted ORSA. Most NAIC model regulations are eventually adopted by most states, so even if your state has not adopted ORSA, it would be prudent to expect that adoption is coming. Even if adoption never comes, the ORSA requirements are generally just a codification of good insurance practice.

The ORSA Model Act contains a size exemption for smaller insurers. ORSA applies to insurers (at the subsidiary level) with \$500 million or more in annual premium. ORSA also applies to members of an insurance group if the group has \$1 billion or more in annual premium. If a holding company has three subsidiaries, each with \$400 million in annual premium, then all three subsidiaries are subject to ORSA (by virtue of the group's exceeding \$1 billion). On the other hand, if one member of the group has \$600 million in annual premium, and the others have \$100 million apiece, then only the largest subsidiary is subject to ORSA (because it exceeds \$500 million).

Last but not least, divisions of insurance are allowed to ask for things that they want, and the ORSA Model Act specifically contemplates this. Even if your organization is below the size threshold discussed previously, the insurance commissioner still has the authority to ask for an ORSA. On the other hand, divisions of insurance may also grant exemptions to insurers who otherwise would need to conduct an ORSA.

ORSA is an annual requirement, although it could be necessary to be conducted more frequently if there are significant changes in an insurer's business (such as an acquisition or merger). The final work product of an ORSA is a summary report. Although there is an NAIC guidance manual<sup>13</sup> (separate from the model act) that discusses the contents of an ORSA in greater detail, this is a new requirement and there is still much variability from state to state as to what insurance commissioners are looking for in an ORSA summary report. We believe that having a healthy relationship with state regulators is a good idea in general; spe-

cifically, we recommend that carriers talk with their department of insurance (DOI) about what they are looking to see in an ORSA report.

### WHAT'S THE NEXT ORSATUNITY?

ORSA is a new and evolving opportunity for health actuaries. In the future, we may see more states adopt it (many states adopted ORSA just within the past year).

Since ORSA is relatively new, it's likely that some state insurance divisions don't yet know exactly what the "perfect ORSA report" looks like. There will likely be more details and direction, and perhaps specific regulations, as we move forward. These may be guided by the reports that are currently being filed, with the ones that states like the best forming the basis for future requests.

Actuaries have always served an important role in risk management for health insurers. With ORSA rules putting a fresh spotlight on ERM procedures in the insurance industry as a whole, health actuaries are well-positioned to make sure that risks related to health coverage get the attention they deserve. ■



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### ENDNOTES

- <sup>1</sup> <http://www.naic.org/store/free/MDL-120.pdf>, retrieved Feb. 16, 2016.
- <sup>2</sup> [http://www.naic.org/documents/committees\\_e\\_risk\\_management\\_orsa\\_adopted\\_120906.pdf](http://www.naic.org/documents/committees_e_risk_management_orsa_adopted_120906.pdf), retrieved Feb. 16, 2016.
- <sup>3</sup> There is also a longer (and helpful) *ORSA Guidance Manual*, which we discuss later in this article.
- <sup>4</sup> At this time only insurance companies and insurance groups meeting certain size thresholds are required to file an ORSA report. This is discussed in greater detail later in this article.
- <sup>5</sup> Another important difference between ORSA and RBC is that a company's RBC requirement is mainly calculated using historical data. For insurers issuing medical coverage and filing on the Orange Blank, the H2 (underwriting risk) component of the RBC formula is usually by far the most important, and that calculation (and hence an entity's regulatory capital requirement) is heavily driven by what last year's claims were. ORSAs, on the other hand, need to be forward-looking. An ORSA is arguably better suited to detecting problems for rapidly growing companies or companies operating in a rapidly changing marketplace.
- <sup>6</sup> Thomas Nightingale comments on this widespread perception among group insurers in "Enterprise Risk Management for Group Health Insurers," *Group Insurance* (6th ed.), ACTEX Publications, 2012, p. 781.
- <sup>7</sup> Of course, ERM is also useful to aid in strategic decision-making and to keep different segments of an insurer talking to one another about risk. Actuarial Standards of Practice Nos. 46 and 47 contain a definition of ERM: "The discipline by which an organization in any industry assesses, controls, exploits, finances and monitors risks from all sources for the purpose of increasing the organization's short- and long-term value to its stakeholders."
- <sup>8</sup> Michael Kolber and Hans Leida. 2014. "How Consumers Might Game the 90-Day Grace Period and What Can Be Done About It." *Health Affairs Blog*, Nov. 17, <http://healthaffairs.org/blog/2014/11/17/how-consumers-might-game-the-90-day-grace-period-and-what-can-be-done-about-it/>, retrieved Feb. 17, 2016.
- <sup>9</sup> <http://us.milliman.com/uploadedFiles/insight/2014/update-canceled-plans.pdf>, retrieved Feb. 17, 2016.
- <sup>10</sup> Kara Clark. 2006. "Enterprise Risk Management." *Health Watch* Issue No. 51, January, p. 14.
- <sup>11</sup>  $(1 - 0.10)^{20} = 0.122$ . This assumes that these events are independent from one year to the next, and that the event occurs at random without the probability of the event changing as a function of time since the last occurrence.
- <sup>12</sup> <http://www.naic.org/store/free/MDL-505.pdf>, retrieved Feb. 19, 2016.
- <sup>13</sup> [http://www.naic.org/store/free/ORSA\\_manual.pdf](http://www.naic.org/store/free/ORSA_manual.pdf), retrieved Feb. 17, 2016.