HEALTH RISK-BASED CAPITAL

MS. DONNA C. NOVAK: I am with Deloitte & Touche, and Bill Weller is from the Health Insurance Association of America (HIAA). We will be speaking today about risk-based capital (RBC). Bill and I have been involved in this process for a number of years now, and it looks like it's coming to an end, at least with the NAIC process prior to implementation. We will do a short review, and then spend most of this session on the current issues. I'd like to see a show of hands to find out how many different organizations there are in the audience. How many of you are from multi-line companies that write all lines? It looks like the majority. How many of you are from HMO provider organizations? Maybe 5-10%. How many are from health insurers that write primarily just health? Quite a few also. I'm sure we also have a good representation of consultants that work with all of the above. We have a little bit of everything and that's good because this does affect everyone who writes health insurance from the hospitals that are starting to take on risks through the multi-line carriers where health lines represent a percentage of the total business. Bill is going to start off with some history of risk-based capital, specifically health risk-based capital. He'll start with a discussion of the formula. Then I'm going to speak on some additional aspects of the formula and some of the emerging issues.

MR. WILLIAM C. WELLER: The risk-based approach to minimum capital basically came about because it was recognized that the normal requirements that existed before risk-based capital for the minimum level were strictly a flat-dollar amount that varied by state and not by the level of risks. Particularly in the life situation, there were some very large life companies that were taking some very different risks, particularly in the asset area. The NAIC started there saying it would do something similar to what the banks did and come up with a risk-based capital standard that starts off using the information in the statement. The Life and Health Annual Statement was the first one that was done. It started in 1990, and because it was looking at life and health (L&H) companies, it related to all types of health insurance: disability income, supplemental products, and major medical. Some of the other formulas have not done all types of health. The L&H RBC formula

currently applies to the health lines of property and casualty (P&C) insurance carriers, if over 5% of their premium is in health coverages.

As we go through our discussion, we will note the components of the co-variance formula. The idea of the covariance formula was to recognize that the risks were, to a certain extent, independent, and there was an assumption made that certain ones were independent and certain ones were not independent. The current formula for life and health is:

$$C_0 + \sqrt{(C_1+C_3)^2 + (C_2)^2 + C_4}$$

C-0 represents risks for the investment portion of the assets that are related to affiliates. Prior to 1996, this was just part of C-0, so it was underneath the radical, and that caused some problems for some regulators, particularly when one company that wrote a lot of health insurance was the subsidiary. Health insurance is primarily a C-2 risk, and when it's in a subsidiary, you change it from C-2 to C-1 for the parent. The NAIC decided to move it outside the radical and get rid of that problem. C-1 is the nonaffiliated asset risk. How many of you have done a risk-based capital calculation for either L&H or P&C? If so, you know the degree of detail to which the formula applies to assets. It breaks down bonds into the various classes within the annual statement. It breaks down preferred stocks. There are factors for common stocks, and various types of asset risks, and they are all in the C-1 component.

C-2 is the obligation risk. There are factors for life, as well as for the various types of health insurance. C-3 is an interest change risk. Right now it is a relatively small amount applied to some types of annuities, but the American Academy of Actuaries is in the process of looking at C-3 and translating the RBC risk into something that works off data from the actuarial opinion that is based on asset adequacy analysis.

Finally, C-4 is a very small amount for business risk. The principal things that regulators were looking at in this formula were the C-1 risk, to really affect the types of assets that life insurance companies hold and to require relative amounts for larger exposure to C-2 risks.

That was so successful that in a very short period of time the NAIC went to the P&C Annual Statement and developed a P&C risk-based capital formula. The L&H formula was done at a time when much of the information was not in the statement and they didn't care that it wasn't in the statement. Consequently, when you do the risk-based capital formula and you look at the workbook, you'll find that a lot of the life information still comes from company records. When the NAIC completed the P&C RBC formula, they used the lines of business that were in the P&C statement. It had line-of-business data from a number of years. All companies were reporting them in much the same way, and so, to a much greater extent than the L&H formula, the NAIC used the information that was in the P&C statement.

Within the P&C formula, health business is not separated if health is less than 5% of total premium. If the premium is between 5% and 100%, then you use the L&H factors for the health portion, but the asset portions and everything else within the formula is the P&C formula. If health is 100% as it is for some companies that file the P&C blank, in that situation, you actually calculate using only the L&H formula.

The P&C covariance formula expanded the radical a little bit as shown below. Again, the affiliated asset risk is separate. They split the asset risks into fixed income versus equity, so the preferred stock and real estate are in a different section here. They have considerably higher credit and reinsurance risk factors. If you recall, much of the focus in developing risk-based capital formulas tends to come from what the regulators remembered as the problems. For the L&H RBC formula, it was Executive Life and the asset problems. For the P&C RBC formula, it was the Mission and Transport insolvencies that were reinsurance problems. There is a significant factor in the P&C formulas with regard to reinsurance risks.

$$R_0 + \sqrt{(R_1)^2 + (R_2)^2 + (R_3)^2 + (R_4)^2 + (R_5)^2}$$

R_0 = Affiliated Asset Risks
R_1 = Fixed Income Asset Risks
R_2 = Non-affiliated Equity Risks
R_3 = Credit/Reinsurance Risks
R_4 = Reserve Understatement Risks
R_5 = Premium Risks

The obligation risk was split into two parts. One (R-4) looked at the degree to which reserves may be understated relative to the average for the industry, and the R-5 factor looked at the risk related to premium, something like the combined ratio. If you are running at a combined ratio over 100%, then the R-5 factor would go up a little bit. Most of the asset risk followed the L&H formula. All of the breakdowns were essentially the same, but they used some different factors, particularly in common stock and mortgage obligations.

The development of the health factors in the L&H formula was done on a relatively simple basis. It was done looking at only two categories, the group major medical products and the individual disability income market. Other factors were developed relating to those based on perceived differences in risk. When the NAIC wanted to develop a formula that was more extensive and discriminating for health organizations, it went to the American Academy of Actuaries. During this period, the NAIC was not relying upon industry technical support and working groups to the extent it was in 1990; instead, they asked the Academy to do a couple of things. One was to modify the health C-2 factors in the L&H formula to put them all on a consistent basis. The other was to increase the differentiation in the risks for certain variations. Managed care was recognized as something that could considerably change the risks to an organization's continued solvency. In addition, there were other coverages like dental, long-term care, and supplemental coverages that had not been specifically addressed. There was also a desire on the part of the Academy to recognize that premiums may not be a good basis for risks when you're talking about the ranges from some supplemental products that may have a 50% loss ratio to a large group, which may have a 90% or higher loss ratio.

One of the things the Academy did was to refocus the exposure base by looking at this as claims. It also wanted to use a single model which hadn't been done in the L&H formula. The last thing was

that the Academy's model would look at both the effect of claim variability that was caused by the size of the exposure -- the statistical variation -- as well as the impact of what we considered in the first formula, which was primarily trend miss or other misestimations.

The formula was complicated and detailed which, when it got to the NAIC, proved to be a problem. The NAIC wanted it simplified, so the Academy did some simplification and after it did its simplification, the NAIC said, "We thought you were going to simplify it to our level." So the NAIC started with the Academy's formula, and at the beginning of this year, they worked on simplifying it so that they could get it approved this year.

The expectation is that the NAIC will adopt a formula for managed care organizations (MCOs) that file the HMO, Hospital, Medical & Dental Indemnity (HMDI) blank, or Limited Health Service Organization (LHSO) blank. It was based upon the Academy's work. The NAIC did not go back and try to create a new formula, but it did simplify the formula. It is limited to certain types of health insurance. Because the NAIC was trying to get a MCO formula, and it needed to have it done by the end of 1997, it wanted to deal only with coverages written by MCOs. They don't write disability income, so the NAIC won't look at the disability income. They don't write long-term care, so it won't look at long-term care. Other than Medicare supplement, the NAIC didn't look at any of the supplemental products like accident or hospital indemnity. It was strictly looking at the major medical, dental, and Medicare supplement lines. It had another category just in case an MCO did write something not in one already mentioned.

Again there is a covariance formula. It is very similar to the formula that is in the P&C formula in that the credit risk is there as a separate factor, and the business risk is under the radical. The only thing that is outside is the affiliated asset risk.

$$H_0 + \sqrt{(H_1)^2 + (H_2)^2 + (H_3)^2 + (H_4)^2}$$

With regard to the asset risks, they followed the P&C formula, which means they have a lower factor for common stocks than the life companies do. They do not have any breakdown for various types of mortgages. In a new area, they looked at health care delivery assets. From the beginning, we recognized that these were going to be something that we had to look at. When you start talking about health care delivery assets or any business-operations-based assets, one of the things that we ran into over the last year was the Codification Project that was also going on. This project was the NAIC setting out in writing the conceptual framework of statutory accounting. How health care delivery assets would fit into that conceptual framework is an unresolved problem. To the extent that the health care delivery assets are in there, they are treated as real estate with a 10% factor.

In the credit risks factors, the reinsurance factor uses the L&H credit risk as opposed to the P&C factor, and that makes an enormous difference. The factor is a half of a percent in the L&H formula versus the P&C formula where it is 10%. That was a big difference. The NAIC came up with the idea of intermediary risk as an offset to managed care credits. I'll let Donna explain those because it is related to how you address the managed care credit, which Donna is going to deal with.

In the business risk factors, again they tried to do some of the things that had been done in the P&C formula. The P&C used a combined ratio. They didn't want to use a combined ratio, but they felt that there was some degree of risk with regard to the expense levels -- those you had assumed in your pricing versus what your actual expenses were. The L&H formula has no factor for expenses. When the L&H formula was developed, the assumption was that the company had capable management that was able to price and had done a good job of pricing. The issue was the variability and the risk inherent in what management didn't know. The assumption was that management would have a good idea of what their expenses were. That is not true in the MCO formula. There is a specific factor for expenses. There is a specific factor for administrative services business, and this is significantly higher in some circumstances than what's in the L&H formula which is a half of one percent.

There's an excessive growth risk. We had originally thought that this was a risk when we developed the L&H formula and actually had suggested that there be a factor relating to something like the increase in premiums. The concern was that it was complicating the formulas, especially for health insurance. Every increase in premium did not mean an increase in exposure; in fact, you could have a decline in premium and actually have a very large change in the amount of your exposure, lose a lot of business that you had before, have a lot of new business, and the risk is that the business that is the basis for your rates isn't the business that you actually keep or insure.

We didn't have a good answer for this, so it was dropped out of the L&H formula. The P&C formula includes a factor for excessive growth that looks at the level at which the RBC is increasing. The NAIC put a growth risk factor into the MCO/RBC formula. Unfortunately, what they put into the MCO/RBC formula is based on the degree to which the growth in your RBC exceeds the growth in your premium. I'm not sure that makes a lot of sense. If all you are doing is changing the managed care credit, I'm not sure that that is a type of excessive growth.

MS. NOVAK: What I'm going to first be looking at is the H-2 or underwriting risk, and then I'll go through some of the issues of the different risk categories, except for the asset risk, which as Bill said, we've been working on separately and he'll be discussing.

The NAIC has the formula, as well as the instructions out on the Internet. It's under NAIC.ORG and you have to trace through the menuing there. You can also find the formula on a diskette that has been sent out to the HMDI and HMO carriers. It will include some corrections to errors in the instructions and diskette. All of this is out on the Internet in a great amount of detail.

Underwriting risk is broken into four major categories. You could see it as five, and it is five columns right now, where medical and medical only are separated, but have the same factors. Medical only is defined as covering physician services without hospitalization. The reason that medical only is separated out is because of recognition that some provider groups would want to offer a capitated type product or a risk bearing type product that only included medical services.

There have been a couple of studies done to support the position of the AMA that there is a lower variability with that type of product, and therefore, it should have a lower factor now, which it doesn't. The level of catastrophic risk, which another part of H-2 addresses, is the minimum capital requirement, and it should be lower for medical only coverage. There might still be some consideration of having a different factor for medical only.

FROM THE FLOOR: Are factors used against claims or premiums?

MS. NOVAK: The dollar amounts are premiums. The way the formula works though is you multiply premium by a loss ratio, and you actually have the factor against claims, but the dollar amounts for the factor are premiums.

FROM THE FLOOR: Is vision care under "Other?"

MS. NOVAK: Vision care is under "Other" right now.

FROM THE FLOOR: Prescription drugs?

MS. NOVAK: It is under "Other." If it's part of a comprehensive medical product, it would be under medical. A stand-alone prescription drug is prescription drug part and vision is included in the formula under "Other." As Bill mentioned earlier, in an attempt to simplify the formula, the NAIC took all of the noncomprehensive medical and put it in "Other."

FROM THE FLOOR: Are premiums net of reinsurance?

MS. NOVAK: Yes, premiums are net of reinsurance.

FROM THE FLOOR: They assumed that most HMOs didn't write stop-loss and they were thinking a bit for HMOs.

MS. NOVAK: Much of the simplification was based on the fact that the NAIC was just addressing HMOs originally, and that later the formula would be expanded to HMDI carriers. Currently, premiums for the comprehensive medical are on a net basis.

Medicare Supplement has a different set of factors. Dental and "Other" is a straight 13% factor. Notice that there is not a difference between individual and group factors, unlike the life formula. The NAIC is currently reviewing changes to the life formula to include health H-2 risk categories and structure. Some of the NAIC Life RBC working group members would like to rethink the possibility of having two factors. In order to retain the level playing field, those types of changes should be effective for all filing entities.

The factors that we discussed are adjusted by a managed care credit. The managed care credit is broken into four credit categories. A fifth managed care category is zero, which gets a credit of zero. Contractual arrangements get a 15% managed care credit. Withholds and bonuses are split between payments that would not have received a managed care credit and those that would have received a category one managed care credit. The withhold and bonus credit is based upon the amount of withholding bonus available compared to what was paid in the previous year. If there is a withhold, and less than 50% of that withhold is actually paid to the providers, there's a decrease in that credit. The decrease and the resulting credit depends upon the underlying agreement.

A category zero which would not have been eligible for a credit without the withhold or bonus should be given a credit between zero and 25%. Arrangements that would have been eligible for a category one, would, minimally, retain the 15% credit, resulting in a 15-25% credit of net claims, including the withhold and/or bonus.

All of the managed care credits are on a paid claims basis, versus a premium basis. This makes sense, since one premium dollar can sometimes be spread over a number of different arrangements. If you capitate specialists and not primary care physicians (PCPs), your capitated payments to the

specialists would give you a 40% credit and your fee for service to the PCP would usually give you a 15% credit because there would be some type of contractual arrangement.

FROM THE FLOOR: What is the credit for PPOs?

MS. NOVAK: When you say PPOs, if you have a discount arrangement with a PPO that is eligible for that 15% credit, you get it. The category is determined based on the arrangement. I'm being very careful answering because there is a little bit of a discrepancy between the NAIC's interpretation of how these work and how the American Academy of Actuaries had defined them. Obviously the NAIC's definition will be used in the formula. We have sent a number of questions to the NAIC, and they're answering them more liberally than the Academy originally defined the formula. The salaries are staff model HMO salaries to providers. There are a number of pending questions, such as, are bonuses to salaried providers included?

Bill alluded to the fact that the managed care credit is affected by the intermediary risks. These managed care credits are reduced, if the payment is made to an intermediary. If you capitate to an intermediary and that intermediary is on a cash (versus an accrual) basis and they do not have audited statements, then some of this managed care credit is taken back through a credit risk. When the American Academy of Actuaries originally modeled the managed care credit, the modeling indicated a higher factor. When it came to actually recommending a managed care credit, it was felt that because you can have a capitation to an entity that could have a business failure and, therefore, not be able to fulfill their obligations, that they didn't deserve quite the credit that the modeling would indicate. Therefore, the credit was reduced to the 40%. Through the NAIC, they again thought that because of the potential of the failure of an intermediary, the managed care credit should be reduced based upon the strength of the intermediary. The NAIC is using as a caveat for strength intermediaries indicators, such as, do they have their own risk-based capital? Are they on a cash or accrual basis? Do they have audited statements, etc?

I mentioned earlier that medical only coverage was also getting special treatment in the minimum RBC levels. The H-2 underwriting risk is subject to minimums based on the size of the organization. The minimum is the maximum of two times the individual risk retained, or the retained risk or the alternate risk. For comprehensive medical, the minimum is $1.5 million. For medical only, the minimum is $750,000. This preferential treatment is being given to medical only coverage because of the studies that I mentioned earlier. Medicare supplement minimum is $50,000, dental is $50,000, and other is $50,000.

FROM THE FLOOR: Is the minimum $1.5 million or two times the maximum individual risk?

MS. NOVAK: It's whichever is lower. It's the minimum of those two. This is important for start-up operations or start-up lines of business. It's two times retained risk up to these levels for each one of these lines of business.

There are other underwriting risks. There are additional risks for rate guarantees. Rate guarantees for 15 to 36 months is 2.4% of direct earned premiums, and over 36 months is 6.4% of direct earned premium. The Federal Employees Health Benefits Program (FEHBP) is 2% of premium equivalence for FEHDP. This is significantly higher than the recommendation from the American Academy of Actuaries, which had actually been a full risk charge less a rate stabilization reserve down to base of a half of percent of premium.

FROM THE FLOOR: How are rate guarantees defined -- by original guarantee or number of months remaining?

MS. NOVAK: It's not number of months remaining, it's the number of months of the whole contract. If you're two years into a three-year guarantee, you still have a risk charge for the three-year guarantee.

There is also the question, does this include rate guarantees that include an increase for trends? Say you're guaranteed a maximum of 5% rate increases, rather than a flat guarantee. The NAIC does not consider this a rate guarantee. I don't think that this is the answer that the Academy would have given.

I want to go back to some of the issues with the H-2, as well as some of the other aspects of this formula that are coming up, now that we are testing it. First, with the managed care credit, there is, as I mentioned earlier, a difficulty in getting the data to support the formula with some organizations, actually identifying a dollar paid and withhold credits. Some organizations are not currently set up to track these data.

There has always been a difference between managed care entities and indemnity carriers, in that expenses paid for utilization review and medical management are seen as expenses in the indemnity carrier, and are often seen as medical expenses in the HMO because the primary care physician does a lot of this work. There is some disagreement of how these expenses should be handled when external medical management organizations are contracted with for managed care services. The terms that we're all using now, sometimes inconsistently, weren't even in existence three years ago, and more and more arrangements are popping up all of the time.

As Bill pointed out, the terms staff model and group model aren't even used in the instructions. It just says salaries paid to providers. This has also caused some confusion because of the definition of intermediary. If you are paying a capitated fee to providers, it's usually not to Dr. Wilson, it's usually to Wilson Clinic & Associates. So there's usually a legal entity other than the provider, even in the case of provider partnership. When you look at these definitions, I think the bottom line is that they are confusing and they will have to be improved going forward in order to identify the different payment arrangements.

Speaking of our intermediaries, the definition of an intermediary, especially when there's a partnership or a clinic or a legal entity, is the provider that you're paying. Even in the simplest case,

it can be confusing. It's even more confusing when you start asking for financial statements from the intermediaries and asking if the accounting is on a cash basis, which it normally is, or an accrual basis. HMOs are picturing themselves asking providers to switch accounting practices so that they can get a larger credit. Many HMOs know they're not going to get very far there. Just getting the statements is probably going to be troublesome, much less encouraging provider groups to change their accounting basis for a risk-based capital purpose.

Looking at business risk, business risk includes risks for expenses, which was not originally included in the Academy formula. Risks, as measured by the Academy and others, is a measure of variability and lack of control. The more something is variable and not under your control, the more risk there is. The NAIC has done some studies on the variability of expenses, but that still leaves the formula under your control, even though you can go back and show a pattern of variable expenses. The fact that you replaced that computer system when you did, or made other capital expenditures, is often within your control. There's still debate as to the appropriateness of the level and the appropriateness, in general, of including expenses in this risk category. ASC, FEHBP and ASO fees have been given a 2% factor, which many companies feel is too high.

That's a summary of H-2. Many issues are coming out of the testing of this formula on H-2, H-3 and H-4. Bill's going to go back and talk to the asset part of the formula and some of the issues there, which are very specialized.

MR. WELLER: One of the critical issues for HMOs that was raised very early is that they have a significant investment in the health care delivery assets -- specifically the land and buildings for hospitals, the unique medical equipment that is in those hospitals, as well as the other equipment that's in those hospitals, such as the furniture and fixtures. In many situations, as the HMOs were developing within the states, there was an agreement that a number of these assets would be accepted as admitted assets for statutory statements subject to certain limits. But those limits varied, just as a lot of invested asset limits vary all over the place. There were also situations that, in spite of the fact that the state was following the NAIC model, the state was permitting a practice so that a carrier

could include more in admitted assets than what would have otherwise been allowed. This was also going on in life and P&C companies. There was a lot of variation in the accounting treatment so that when you looked at a statement and a particular line and a particular item in it, you couldn't necessarily have any confidence that you knew what was behind that or that you could compare one company to another company if it was domiciled in a different state.

As part of the whole accreditation process, the NAIC decided that statutory statements should be subject to audit as part of the accreditation standards for states. After most of the states passed that accreditation standard, the AICPA said it didn't know what statutory accounting is and in fact, there wasn't any basis for it because there were so many of these different practices all over the place. A letter was sent to all the members of the AICPA telling them that they could not sign a clean opinion on a statutory statement and they would have to qualify the opinion because it did not follow GAAP standards. The NAIC did not want that as the end result so there was a period of negotiation between the NAIC and the AICPA. An agreement was reached that the NAIC would develop a system for statutory accounting, and that once it was codified, the AICPA would then be able to treat it as what they call Another Comprehensive Basis of Accounting (ACBOA).

The NAIC began that process but decided to deal with L&H and P&C first, just like they did with RBC. As the regulators developed statutory position papers, one of the first things they did was come up with a series of concepts. One of the key items in that series of concepts was a definition of an asset. They said an asset had to meet two criteria. It had to be readily marketable, and it had to be available to fulfill the obligations to the policyholders. When you look at health care delivery assets, they clearly meet the second one. They are there to fulfill the obligations that you have to your policyholders in terms of delivering health care. The problem is whether they are readily marketable.

There was a considerable amount of concern with regard to whether or not health care delivery assets would be included. The NAIC said, "Don't worry about that, we'll deal with health after we get through the Life and the P&C." The industry and the Academy were working on risk-based capital

with the assumption that somehow the NAIC was going to deal with this issue. The Codification Project is almost complete with regard to L&H and P&C companies. They have begun to look at health-specific issues, especially health care delivery assets.

For the work to date, the NAIC had one of the major accounting firms working with them to develop issue papers strictly from a regulatory point of view, and then they would put out specific issue papers and the industry and others could respond to those issue papers. The NAIC had a number of public meetings to discuss comments. Regarding the health issues, the accounting firm said that wasn't part of the arrangement and they were not going to develop the health papers. The NAIC came to the industry and asked it to look at the papers that have already been developed and determine where they needed to be changed. They also asked if there were some papers that needed to be written specifically for health organizations. That was done over the last three or four months. One of the proposed papers has to do with health care delivery assets. At this time, the paper is being drafted by an industry group that includes the HMOs, indemnity carriers and providers. The paper is almost to the point where it can be sent out.

As it stands, there are four categories of health care delivery assets. The first is land and buildings, and they are all to be admitted assets. We think that the NAIC will accept this approach on land and buildings. The second category is medical fixtures and equipment. Examples of this are diagnostic equipment, hospital beds, and examining tables -- things that are clearly necessary in order to provide health care. They are typically set up on your books as an asset and depreciated over a period of time. The assumption is that they are clearly assets, and we are arguing that they should be admitted assets.

The third category is medical supplies and pharmaceuticals. My own feeling is that we are getting into boggy ground here. This is not an asset that is set up on your books and depreciated. This is generally inventory that you count at the end of the year and you set up an asset based on that count. However, there are a number of states under current statutory accounting that are allowing this to be done. The argument has been made many times in comments on L&H and P&C that codification

isn't supposed to be changing what is being done; it is supposed to be putting it down in a set of consistent comments. There is a good argument that these pharmaceuticals, durable medical equipment, etc. are assets that are needed to provide health care.

The fourth item is property furnishing health care buildings and facilities. The examples that are given here are furnishings for patient rooms and waiting rooms. The draft states that this item is not to include furniture, equipment and fixtures for administrative facilities. The idea here is that you may not need these assets to directly provide the care, but there aren't too many hospitals that are going to survive on a long-term basis if the waiting room is a standing room. The argument is that these should also be admitted assets. They typically are set up on the books as assets and depreciated. The real issue is whether there is a significant enough difference between these assets and the furniture and equipment that is needed to operate an insurance company -- including the claim service offices of a large P&C company that is doing more at claim time than just cutting a check. In the normal insurance company, all of those are not admitted assets. The NAIC is going to have to deal with this issue of medical versus business.

There was a fifth item, electronic data processing (EDP) equipment, and it was decided that the draft would not ask that this be treated as a health care delivery asset. EDP equipment has a separate and unique situation within the L&H and P&C rules, and so we are using the same rules for EDP in the health or the MCO type of environment. That says that you get EDP equipment and operating software up to 3% of your capital and surplus and it does not matter what you use it for.

This gets us into the one area where the industry could not agree in preparing the draft. We are giving the NAIC two options. This has to do with the extent of use of a particular HCDA by the insured population. For example, a CAT scan machine is an asset of a provider service organization which is clearly a type of HCDA asset (medical equipment). It is being used to fulfill policyholder obligations when the members use it. The question is, what percentage of the time is it being used for the member and what percentage of the time is it being used by others (e.g., rented out to other clinics or used on a fee-for-service basis, etc.)?

There are two options that are being given. The first is that as long as they are used to some extent to fulfill policyholder obligations, then they need to be there. In this approach, an asset is an asset, so it is fully admitted. The second option is that essentially there needs to be some control that you don't go overboard and have assets well beyond what is needed to provide for the policyholders or members. The second approach provides that if the assets are used for anyone other than insured members in excess of 10% of the time, then you have to do an allocation of the asset (and only to the extent that it is used for members, is it a health care delivery asset and treated as an admitted asset under these rules)? To the extent that it is not used by insured members, then you find out what type of asset it would be, and you give it statutory treatment based on whatever rules apply to that type of invested asset. For example, let's say you allocate a hospital on the basis of the revenues. If 50% of the revenues are from insured members (say on a per-member/per-month basis), then 50% of the hospital is a health care delivery asset, and the other 50% would presumably be treated as investment real estate, subject to whatever the state laws are with regard to real estate. To the extent that there are too many real estate assets, you might run into a nonadmitted problem.

There are those who don't think that all four categories will be accepted as admitted assets within Codification. There are those who feel that there is a good justification for having them all admitted because in many states they are currently all allowed as admitted assets.

One other point is important in dealing with Codification. Industry, the L&H and P&C trades, have stated that "limits" are not a part of Codification. Examples of limits are the percentage of a type of asset that can be admitted or the interest rate for reserve valuation. This is something the states decide. For HCDA, it is entirely appropriate for a state to decide that some types (or all) HCDAs should not exceed a certain percentage of total assets. But that is for a state to decide -- it's not something to be defined by Codification. The state legislature would put it into the law. One state might not have any limits at all, in which case you could have 100% of your assets in health care delivery and that would be okay. This raises some important issues with regard to liquidity, and I think Donna will be getting to those.

There are implications of the MCO formula on the other formulas. As Donna mentioned, within the L&H formula, the factors for individual major medical business and all types of Medicare supplement business are significantly higher than those proposed for the MCO formula. In addition, the L&H formula factors apply to premiums as opposed to claims, and there are no managed care categories. Consequently, industry wants a level playing field. If this is the formula that MCOs use to define capital, life and health companies that write a lot of major medical business should not have a higher factor. The NAIC asked what the effect would be of changing the life and health formula. I tried to do some analysis of the potential effects. The analysis is somewhat difficult because we don't know what the loss ratios are for the group carriers on major medical business, we don't know what the managed care credits would be, and we don't know what the additional amounts would be for expenses. I developed a spreadsheet in which I tried to reproduce for certain levels of premiums what the C-2 RBC amounts would be. I also had to make some assumptions with regards to the minimum amount. I basically assumed that we would use the alternate minimum dollar amounts, specifically $1.5 million. For small group carrier (under $13 million in premiums), you would find that the $1.5 million minimum raises RBC. I suspect that a company with a large amount of group major medical business would probably not be able to effectively compete in that market without getting some managed care credit. If you assume that they get approximately the category one managed care credit of 15% on most of their business, the two formulas are fairly close for a company in the billion dollar premium range. Between those two, the MCO formula is generally lower.

For individual insurance, they don't ever get close together. As Donna mentioned, for the MCO formula, you add the individual and the group together. For the L&H formula, they are kept separate. For individual, the lowest number is 15% of premium. The NAIC asked for a certain level of information out of the current RBC database on companies with $10-$75 million of individual health premium. A review of those data show that there would be a significant drop for a fairly large number of companies; 15 to 20 companies would see a drop in their risk-based capital of somewhere between 30% and 50%. That is not many companies, but it is a big reduction for those few.

The last items are the Medicare supplement business where the factor would be dropping considerably for all types of companies and the addition of the expense component. The percentage reduction numbers that I gave you for the 24 companies studied under the MCO formula included both major medical and Medicare supplement.

For P&C, it is my understanding that they have asked the Academy to look at what should be done with the MCO formula. There are a number of alternatives being suggested. I expect that the most likely one is that they will say if the only health business that you write is MCO type and it is over 5% of your total premium, then use the MCO factors. If you write some other types of business that are not in the MCO formula -- such as disability income, long-term care and hospital indemnity -- then use the L&H factors.

That is a description of the implications for the other formulas. For the L&H formula, the results of my review will be presented at the NAIC meeting in Washington, D.C. Changes, if any, may be effective for 1998 for the types of coverages that are in the MCO. It will not be adjusted for the other types of coverages at this point in time, but they probably will look at those afterwards.

MS. NOVAK: I have some comments on general issues that are coming out of the testing. One of the first issues that's coming out of the testing is that this is a tremendous increase in capital requirements for some entities. You did hear Bill say that it's up to a 30% reduction for some entities. For some HMOs in states that have very low capital requirements, it's a 600% increase. That's an indication of where we're at today -- on a very unlevel playing field versus moving to a level playing field. Therefore, there are going to have to be some transition issues addressed in the formula.

The increase in capital is also being pointed to as evidence that there is not enough of a credit for the managed care aspect of different entities. It's possible that we'll see some debate concerning increasing the managed care credit. Also there is the issue of the special treatment for medical only, if that's appropriate. If it is appropriate, to what extent is it appropriate?

Bill mentioned earlier that the Academy formula was based upon the life RBC asset risk structure, which was supported by the life blanks. When the NAIC developed the P&C formula, it once again looked at the P&C blank to see what was already included. It used that as a basis of the risk-based capital categories. When reviewing the HMO blank, and trying to make modifications so that it will support the H-1 risk or asset risk, we see a significant amount of change needed to the HMO blank, and many HMOs are saying that there's no way they can be ready to supply the additional detail that will be required.

The NAIC simplification of the Academy formula eliminated the rate stabilization reserve (RSR) credit, which worked for FEHBP (although the factor of 2% may still be too high). It also eliminated the rate stabilization reserve for other lines of business. There are a couple of carriers who, in the original testing, did get a significant credit for the rate stabilization reserve. The RSR is a credit in the life formula. It's possible that there is some compromise of simplicity while also allowing a credit for rate stabilization reserves.

The current risk-based capital formula is on a per subsidiary basis. There was a comment made earlier about a line of business versus a separate subsidiary. Many companies create subsidiaries with a minimum amount of capital and later move more capital down as it's needed. Also, companies may have multiple subsidiaries with a minimum amount of capital allocated to each one, giving the parent the ability to move capital where it's needed going forward. With risk-based capital, each entity would have to pass the risk-based capital test, and capital would actually have to be moved to the subsidiaries. There may be further discussion as to the use of some type of formula that would allow a family of companies to be reviewed together.

We've mentioned liquidity risks a couple of times. Part of the development of the health risk-based capital formula almost immediately brought up a question. You have health care assets used for the delivery of health care, but how liquid are they to pay out-of-network claims and to cover the cash requirements? There is a separate liquidity standard being developed by the NAIC with help from the American Academy of Actuaries, which would be a companion requirement to risk-based capital.

It would fall within the same model law. Regulatory intervention could be triggered by a liquidity deficiency, as well as a capital deficiency. There will be meetings in October to start working on a separate liquidity requirement. There will be liquidity requirements for P&C and life insurance, but right now, other priorities are putting those on the back burner. Health insurance has a higher priority, especially with some of the discussion going on in Washington right now on PSO solvency requirements.

When will MCO/RBC be effective? From what I understand, this formula will not be passed at this session of the NAIC, but it will likely be passed in December, effective for 1998 filings that are filed in 1999 for HMOs and HMDI.

Bill has mentioned adding the health risk-based capital to the P&C and life formulas. These are two issues that are being considered by the NAIC group responsible for life RBC. One is a separate risk factor for individual insurance, which is one of the biggest discrepancies now, as well as an increased risk or increased capital requirement for prior rate approval. RBC would be incurred for products that require state prior rate approvals and for Medicare and Medicaid risk products. This was included in the original Academy project. The NAIC, as part of their simplification, dropped it from the formula and the life risk-based capital group.

To date, transition rules have been discussed, but no specifics as to what they would be have been set.

FROM THE FLOOR: Will actuaries have to provide an opinion on RBC in 1998?

MS. NOVAK: Risk-based capital is included in the annual statement filing, but it is not included in the opinion. The important aspect of being effective for 1998 is that there are much data that will have to be gathered starting in January (for example, claim payments and what categories they fall into for the managed care credits). You can't wait a year and a half to be prepared for this. We'll

have to be prepared in January. That gets into the transition rules, and if you can't track managed care categories, there will have to be a provision for some type of transition.

MR. WELLER: I would suggest that whether they do it in 1998 or 1999, clearly something along the lines of managed care credits is going to be included in risk-based capital. The definitions of the managed care credits, the wording in the instructions versus the wording of your contracts with providers, can have a significant difference on which category a payment falls into. It's worthwhile to review the provider contracts that you have and compare the language in them. A minor change in language that the providers are not going to consider would make it sure that it gets into one of those categories. That is a worthwhile effort at this point in time.

MS. NOVAK: A number of organizations have brought that up as part of their testing. Now they're seeing how to go back and make sure that their contract language is structured to guarantee that they get the appropriate credit.