Session 78 PD, Surplus considerations for health insurance issues

Presenter:
James T. O'Connell, FSA, MAAA
Surplus Considerations for Health Insurance Issues in Light of the ACA

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SOCIETY OF ACTUARIES

SOA Health Meeting
Atlanta, GA
Session #78

June 16, 2015

Presented By

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Principal and Consulting Actuary
Milliman, Inc.

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Topics

- Purposes of Capital and Surplus
- Identification of ongoing ACA-surplus related considerations
  - The 3Rs
  - The CSR Program
  - Pricing Uncertainty
  - Regulatory and Judicial Events Post-Pricing
- Industry Case Studies
Purposes of Capital and Surplus

- Protection against rating inadequacy
  - Adverse selection
  - Statistical fluctuation in claims experience
  - Epidemics and catastrophic events
  - Mis-estimation of claims trends
  - Greater operational and administrative expenses than budgeted
  - Lack of reliable experience data and dependency on market changes make pricing precision very difficult
Purposes of Capital and Surplus

- Post-pricing adverse regulatory and legislative developments
- Sales higher or lower than expected due to market competition
- Member lapses resulting in excess capacity not supported by premiums
- Mis-estimation of liability and receivable estimates in financial reports
- Litigation directly related to insurance risks
- Reputational risks
- Investment portfolio risks
Purposes of Capital and Surplus

- Operational risks
  - Employee malfeasance
  - Unexpected electronic and computer systems needs and maintenance of service operations
  - Other overhead and administrative expense recovery under adverse conditions
  - Regulatory and compliance issues requiring new investment in or revamping of systems, marketing and sales approaches, accounting and actuarial methodologies and reporting requirements, claim processing, member grievance arrangements, and other such items
  - Litigation related to non-insurance issues
  - Other business needs

- Growth opportunities
Characteristics related to surplus needs

<table>
<thead>
<tr>
<th>Diversification Characteristic</th>
<th>Less Surplus Needed</th>
<th>More Surplus Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lines of business (e.g., health, life, annuity)</td>
<td>Multi-line ↓</td>
<td>Single line ↑</td>
</tr>
<tr>
<td>Health insurance market segments (large group, small group, individual ACA, excepted benefits, supplemental coverages, Medicare, Medicaid, other)</td>
<td>Multi-segments ↓</td>
<td>Single segment, especially if individual ACA ↑</td>
</tr>
<tr>
<td>Membership size</td>
<td>Larger ↓</td>
<td>Smaller ↑</td>
</tr>
<tr>
<td>Geographic dispersion</td>
<td>Multi-state ↓</td>
<td>Single service area ↑</td>
</tr>
<tr>
<td>Financial robustness</td>
<td>Strong ↓</td>
<td>Weak ↑</td>
</tr>
</tbody>
</table>
### Characteristics related to surplus needs

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<thead>
<tr>
<th>Diversification Characteristic</th>
<th>Less Surplus Needed</th>
<th>More Surplus Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate structure</td>
<td>Publicly traded</td>
<td>COOPs and Mutuals</td>
</tr>
<tr>
<td>Regulatory environment</td>
<td>Business oriented</td>
<td>Consumer oriented</td>
</tr>
<tr>
<td>Number of plans offered</td>
<td>One</td>
<td>Many</td>
</tr>
</tbody>
</table>
Risk mitigation programs (3Rs)
- Transitional reinsurance – 2014 to 2016
- Transitional risk corridor – 2014 to 2016
- Permanent risk adjustment

Minimum medical loss ratio (MLR)

Cost-sharing reduction (CSR) program

30-day and 90-day grace periods

Pricing requirements and limitations
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ACA Risk Mitigation Programs

Surplus Risk Elements

- Mis-estimation of liabilities and receivables
- Cash flow payment delays
- Risk adjustment and reinsurance receivables are subject to sequestration (7.3% of amounts owed to health plans)
- Regulatory changes as to what is owed compared to what health plan expected when determining prices

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ACA Reinsurance Program

- Intended to mitigate large claims of primarily new entrants into the individual market (e.g. those entering from state and federal individual high risk programs)

- Funded by group and individual health plans
  - Both insured and self-funded plans using a third-party administrator (TPA) must contribute
  - Self-insured plans doing their own administration are exempt

- Benefits only available to ACA-compliant health plans sold in the individual medical market subject to single pool pricing rules

- Transitional program from 2014 through 2016 for funding (benefits can be paid through 2018 if funds have not all been paid out)
# The ACA Reinsurance Program Funding and Benefit Parameters

<table>
<thead>
<tr>
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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Total target claim funds</td>
<td>$10 billion</td>
<td>$10 billion</td>
<td>$6 billion</td>
<td>$6 billion</td>
<td>$4 billion</td>
</tr>
<tr>
<td>Total target to U.S. Treasury</td>
<td>$2 billion</td>
<td>$2 billion</td>
<td>$2 billion</td>
<td>$2 billion</td>
<td>$1 billion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual receipts (estimated)**</th>
<th>$9.7 billion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual contribution rate:</td>
<td>$63</td>
</tr>
<tr>
<td>Attachment point:</td>
<td>$60,000</td>
</tr>
<tr>
<td>Cap:</td>
<td>$250,000</td>
</tr>
<tr>
<td>Coinsurance:</td>
<td>80%</td>
</tr>
</tbody>
</table>

* HHS has revised the 2014 reinsurance attachment point due to an expectation of lower and less healthy enrollment in 2014

** Actual collections by HHS have been $8.7 billion through 3/31/2015. Expect $1 billion more by 11/15/2015

*** Self-administered, self-insured health plans would be exempt from paying the contribution rate in 2015 and presumably in 2016
Sunset of transitional reinsurance program

- 3-year program ending after 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Funding</th>
<th>Individual Marketplace</th>
<th>Group Market Assessments per Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Rate Reduction from 2013</td>
<td>Implied Rate Increase</td>
</tr>
<tr>
<td>2013</td>
<td>$0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2014</td>
<td>$10B</td>
<td>8% to 14%</td>
<td>-8% to -14%</td>
</tr>
<tr>
<td>2015</td>
<td>$6B</td>
<td>4% to 8%</td>
<td>4% to 7%</td>
</tr>
<tr>
<td>2016</td>
<td>$4B</td>
<td>2% to 5%</td>
<td>2% to 3%</td>
</tr>
<tr>
<td>2017**</td>
<td>$0</td>
<td>0%</td>
<td>2% to 5%</td>
</tr>
</tbody>
</table>

* Estimated – assumes 4% growth in membership over which assessment is made
** Residual funding not paid out in 2014-2016, if any, can be used in 2017 and 2018

- Double payments on high-risk claimants goes away
### The ACA Reinsurance Program
#### Key Administrative Dates

<table>
<thead>
<tr>
<th>Eligible Incurred Period</th>
<th>1/1/2014 – 12/31/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission Date to HHS</td>
<td>4/30/2015</td>
</tr>
<tr>
<td>Date HHS Recognizes Payable</td>
<td>6/30/2015</td>
</tr>
<tr>
<td>Date Payment is Made</td>
<td></td>
</tr>
<tr>
<td>- 1st remittance</td>
<td>7/2015 – 9/2015</td>
</tr>
<tr>
<td>- Sequestered amount</td>
<td>10/1/2015</td>
</tr>
<tr>
<td>- 2nd bifurcated remittance</td>
<td>12/2015 – 1/2016</td>
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The ACA Reinsurance Program

- If there is less than the target $12 billion collected for 2014 or $8 billion for 2015, the shortage will first be taken from the $2 billion earmarked for the U.S. Treasury, then health plan benefits will be ratcheted down
  - HHS estimates that it will only collect about $9.7 billion for 2014
  - That implies health plans will forego expected reimbursement if their claims collectively exceed the $9.7
  - The U.S Treasury will forego $2.0 billion if health plans have $9.7 billion in claims; Plans may need to forego $0.3 billion

- If there are more claims than the $10 billion available, payments will be ratcheted down on a pro-rated basis. Could mean expected receivable in financials is overstated.

- If there is excess money available, the 2014 benefit percentage will be increased up to 100% and any remaining excess will be carried over to 2015. Could mean reported receivables are less than actual will be.
The ACA Reinsurance Program Comments – Good for Surplus

- The enhancement of reinsurance benefits for 2014 by lowering the attachment point and possibly increasing the benefit percentage has mixed impact potential:
  - Change was made in response to what appeared to be less than expected exchange enrollment and the expected impact of the transitional program.
  - It will result in greater benefits being paid for each eligible claim.
  - It will result in the health plan getting subsidized for an increased number of insureds.
  - It provides some additional mitigation for non-QHP plans, which are not eligible for the risk corridor program.
  - This impact will vary by health plan.

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The ACA Reinsurance Program Comments – Bad for Surplus

- The enhancement of reinsurance benefits for 2014 by lowering the attachment point and possibly increasing the benefit percentage could result in lower benefits from the risk corridor program, particularly to the extent that the full $10 billion would not have been spent in 2014.

- Health plans need to wait at least 7 months, and as long as 24 months to receive reinsurance reimbursement.

- Reinsurance receivables are subject to sequestration.
  - CMS Position: Delays 7.3% of payments due until 10/1/2015.
  - Could possibly be a permanent cut (though not expected).

- MLR calculations will require reporting the full amount of the benefit, including the sequestered portion that will have not yet been paid.
The ACA Risk Corridor Program

- **Source:** American Academy of Actuaries fact sheet

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The risk corridor program

3-year program ending after 2016

Purpose is to provide protection to health plans in an uncertain pricing environment, resulting in more competitive premiums due to lower risk charges

Assumes pricing environment stabilizes by 2017

But did not anticipate various delays in ACA implementation

E.g. transitional program for retaining current coverage through much of 2017

Still not entirely clear how program will be administered

Budget neutral expectations by CMS

CBO projects government will reap payments from health plans

Many health plans believe significant payouts to health plans

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The risk corridor program

How intertwined is managed competition with the risk corridor program?

- Some health plans have been willing to risk having premium rates lower than those recommended by their actuaries
- Makes the lure of larger market share ever more tempting

Will aggressively priced health plans be able to survive without the risk corridor and reinsurance programs?

- May have challenges to get larger rate increases approved
- Fear of media attention if high rate increases are proposed
- Market compression in health plans offering coverage through exchanges is quite possible
- Survival of the fittest
The Risk Corridor Program

- Applicable to both the individual and small group markets
- Only QHPs are eligible for the risk corridor program
- Based on a complex formula
- Results dependent on knowing reinsurance and risk adjustment program transfers
- Results based on parameters set by CMS
  - Administrative expense cap – 20% in the 2014 payment rule
  - Profit allowance – 3% in the 2014 payment rule

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The Risk Corridor Program

- On March 5th CMS announced it would modify the 2014 parameters by developing an adjustment factor to account for the impact of the transitional program.
  - Results would vary by state based on whether the state allowed the transitional program to go into effect
  - The number of transitional members in the state relative to ACA-compliant plan members
  - The loss ratio experience of each health plan’s transitional business
- On April 17, 2015 CMS announced the adjustment factors
The Risk Corridor Program

- In its proposed Market Rule issued on March 21st CMS announced it would also modify the 2015 parameters, as follows:
  - Administrative expense cap – increased to 22% from 20%
  - Profit allowance – increased to 5% from 3%

- The risk corridor program is **not** subject to budget sequestration
  - Not clear why, especially considering this is the only program of the 3Rs that involves the possibility of government money being paid out
The Risk Corridor Program

- But CMS also announced its intent to administer the risk corridor program on a budget neutral basis
  - It would do this by setting the formula parameters greater or less than those it has announced
  - It would determine the budget neutrality over the 3-year period of the program
  - It has not disclosed how it would handle 2016 mismatches between payments to the government and those due from the government
  - CMS approach to budget neutrality could result in inequity by health plan depending on how it administers the program

- Could result in a mismatch between formula results which are to be reported in the MLR rebate calculation and actual payments received from the government

- The budget neutrality and sequestration issues add to the uncertainty of how to profitably price health plans
The Risk Corridor Program

- Some health plans priced their products with the expectation that they would be protected adequately by the risk corridor program.
  - As intended, the unbridled program as written in the law motivated health plans to price products with lower risk charges than they otherwise would have.
  - Some health plans priced aggressively in order to garner market share because of the presence of the program.

- An S&P risk corridor program study found that the aggregate risk-corridor payables recorded by U.S. insurers for 2014 are less than 10% of the aggregate risk-corridor receivables booked by insurers for the same year.
  - This does not bode well for health plans expecting a risk corridor receivable if budget neutrality is enforced, especially if on an annual basis.
  - Surplus may be needed to keep some health plans afloat.

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Most Insurers Keep From Accounting For ACA Corridors

- Insurers that didn’t record either (56%)
- Insurers that recorded a corridor receivable (30%)
- Insurers that recorded a corridor payable (14%)

© Standard & Poor's 2015.
The Risk Adjustment Program

- The risk adjustment program is intended to create a balance in the level of risks faced by each health plan due to risk selection by consumers.
- This is the only permanent program of the 3Rs.
- Applies separately to the individual and small group markets (except in states with a merged market).
- Applies to all insured members in the market’s single risk pool (i.e. both exchange and non-exchange members are included).
- Catastrophic plan enrollees effectively have their own risk pool for risk adjustment transfer purposes.
The Risk Adjustment Program

- Each insured member is assigned a risk score based on the person’s demographics, health conditions, and metal plan
- CMS determines risk score factors for each condition category
  - Based on 127 HCCs (hierarchical condition categories) – collapsed to 100
  - Separate factors for adults, children, and infants
  - Includes interaction factors for multiple condition members
- Uses 9 different adult age bands for each gender
- Uses different models for each metal plan
- Adjusts for higher utilization expected from CSR plans
- Average risk scores from each health plan are submitted to the government to determine the overall state risk score

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The Risk Adjustment Program

- As they determined premium rates for 2016, health plans still could only guess at how they will be impacted by the risk adjustment program, as was the case for 2014 and 2015 pricing
  - They don’t really know what the demographics and health status are of those who will enroll in 2016; the 2014 and 2015 experience will be helpful, but, given the transitional program and small group expansion to 100, much could change.
  - They also need to know the health status and demographics of all enrollees in the market by state, which in most cases is still unknown, even for 2014 experience
  - Plans rely on simulation analyses, voluntary collective data analyses, health status surveys, and various studies to set an estimate
The Risk Adjustment Program

- Program uses a concurrent methodology
- Only uses medical claims; does not include use of prescription drug claims
- This means results cannot be known until well after the calendar year ends
  - Claims to be used in the risk score calculation must be made available to HHS by April 30th of the year following the benefit year
  - State or HHS will notify health plan of their risk adjustment transfer by June 30th of the year following the benefit year
  - Results subject to audit in the future
The Risk Adjustment Program
Comments and Observations

- Risk adjustment is also subject to budget sequestration
  - Presumably, health plans receiving a transfer will receive 7.3% less
  - Again it is expected to be a cash flow issue – about 3-month delay

- Some health plans are using prescription drug histories on enrollees to get an early sense of what their risk scores may be

- Milliman’s Intelliscript practice provides this service for health plans

- As is done with Medicare Parts C and D, health plans will invest in maximizing their risk score calculations through improved coding practices

- Health plans will also analyze plans and geographic areas, as well as medical conditions that may result in larger positive transfers than might be actuarially warranted or for conditions that they feel they can profitably manage
The ongoing risk adjustment program

- By 2017, risk factor experience should give CMS ability to tweak factors for more balanced results
- Will help shape how health plans operate
  - Influence more accurate coding by healthcare providers
  - Introduce more care management and collaboration with healthcare providers
  - Will influence target marketing approaches – what conditions are most profitable? Least profitable?
- May result in plan design changes
  - Directed drug formularies
  - Services covered
  - Cost-sharing structures
  - Out-of-network coverage
Risk Adjustment

Risk Distribution Histogram

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Issues in Current Risk Adjustment Systems

- Context - current risk adjustment systems are designed and maintained to fit current healthcare systems
- Context – ACA risk adjustment applies to very different and diverse populations in a restrictive rating environment
- Models are not perfect
  - Overall predictive accuracy: only about 12% $R^2$ for Medicare HCC, <30% $R^2$ for prospective models, <60% $R^2$ for concurrent models
  - Payments may not track well with actual claims experience
  - Under and over-prediction for certain subpopulations
  - Health plans offering richer benefits may be both adversely selected and underpaid, but could also end up being overpaid
  - May never be perfect but always better than just age/sex adjustment
  - Can be improved with richer & better quality data, better designs, more practical considerations

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Issues in Current Risk Adjustment Systems (Cont.)

- Data issues – Importance of understanding the coding process
  - Coding persistency
  - Coding precision and specificity
  - Number of diagnosis fields captured
  - Need more transparency of risk drivers

- Operational issues
  - Communication and education about the risk adjustment model
  - Transparency – what’s driving risk?
  - Coding creep
  - Uncertainty and credibility in risk scores – is there a substantial difference between this year’s score vs. last year’s?
The Cost-Sharing Reduction (CSR) Program

- Involves estimates
- Exact method versus Simplified Method
  - The “simplified simplified” method shown to understate amounts due to health plans
  - CMS extended the method election date
- The CSR program can involve very significant money transfers for some health plans
- Amounts get trued up after close of the year
Market Competition

- Market competition played a key role in setting 2014 and 2015 rates, and continues to for 2016
  - Active buyer exchanges and proactive insurance commissioners wield pressure
  - Voluntary health plan strategy to be competitive
  - More optimistic than competitors about adverse selection
- Presence of risk corridor program seemed to encourage more aggressive pricing
- Insurers selectively competing by rating region, not necessarily statewide or nationwide
- Some carriers did not get the market share they hoped for which was needed to support expenses
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2014 Financial Results of Four ACA Health Plans

➤ In which plan would you invest?

<table>
<thead>
<tr>
<th></th>
<th>Company 1</th>
<th>Company 2</th>
<th>Company 3</th>
<th>Company 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC-ACL Ratio</td>
<td>18.8</td>
<td>9.6</td>
<td>5.5</td>
<td>5.0</td>
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</tbody>
</table>

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### 2014 Financial Results of Four ACA Health Plans

**In which plan would you invest?**

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<td>18.8</td>
<td>9.6</td>
<td>5.5</td>
<td>5.0</td>
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<tr>
<td>ACA Members</td>
<td>3,461</td>
<td>2,836,764</td>
<td>56,680</td>
<td>147,880</td>
</tr>
<tr>
<td>ACA Premiums*</td>
<td>$14</td>
<td>$10,830</td>
<td>$250</td>
<td>$624</td>
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<tr>
<td>Total Premiums*</td>
<td>$14</td>
<td>$27,686</td>
<td>$250</td>
<td>$2,340</td>
</tr>
<tr>
<td>Ratio</td>
<td>100%</td>
<td>39%</td>
<td>100%</td>
<td>27%</td>
</tr>
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</table>

* In millions

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<th>BLUE 1</th>
<th>COOP 2</th>
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<tbody>
<tr>
<td>ACA U/W Gains*</td>
<td>-$18</td>
<td>-$1,060</td>
<td>-$51</td>
<td>$19</td>
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<tr>
<td>Total U/W Gains*</td>
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<td>$2,461</td>
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<tr>
<td>Difference*</td>
<td>$0</td>
<td>$3,521</td>
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<td>$63</td>
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<tr>
<td>ACA U/W Gain as % of Premium</td>
<td>-128%</td>
<td>-10%</td>
<td>-20%</td>
<td>3%</td>
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</tbody>
</table>

* In millions

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</thead>
<tbody>
<tr>
<td>ACA Administrative Expenses</td>
<td>$12</td>
<td>$1,461</td>
<td>$34</td>
<td>$72</td>
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<tr>
<td>ACA Expense Ratio</td>
<td>87%</td>
<td>13%</td>
<td>14%</td>
<td>12%</td>
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*In millions*
# 2014 Financial Results of Four ACA Health Plans

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<th>BLUE 1</th>
<th>COOP 2</th>
<th>BLUE 2</th>
</tr>
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<tbody>
<tr>
<td>Total C&amp;S*</td>
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<td>$9,942</td>
<td>$65</td>
<td>$331</td>
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<tr>
<td>Unassigned Surplus*</td>
<td>-$33</td>
<td>$9,456</td>
<td>-$59</td>
<td>$149</td>
</tr>
<tr>
<td>Difference*</td>
<td>$68</td>
<td>$486</td>
<td>$124</td>
<td>$183</td>
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<tr>
<td>RBC-ACL Ratio</td>
<td>18.8</td>
<td>9.6</td>
<td>5.5</td>
<td>5.0</td>
</tr>
</tbody>
</table>

* In millions

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### 2014 Financial Results of Four ACA Health Plans

<table>
<thead>
<tr>
<th></th>
<th>COOP 1</th>
<th>BLUE 1</th>
<th>COOP 2</th>
<th>BLUE 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Reinsurance</td>
<td>$4</td>
<td>-$320</td>
<td>-$2</td>
<td>-$24</td>
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<tr>
<td>Receivable*</td>
<td></td>
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<tr>
<td>Net Risk Adjustment</td>
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<td>-$56</td>
<td>$0</td>
<td>$2</td>
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<tr>
<td>Receivable*</td>
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<td></td>
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</tr>
<tr>
<td>Net Risk Corridor</td>
<td>$3</td>
<td>$0</td>
<td>-$18</td>
<td>-$18</td>
</tr>
<tr>
<td>Receivable*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 3R Receivables*</td>
<td>$6</td>
<td>-$375</td>
<td>-$20</td>
<td>-$41</td>
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<tr>
<td>3Rs Receivables as %</td>
<td>17%</td>
<td>-4%</td>
<td>-31%</td>
<td>-12%</td>
</tr>
<tr>
<td>of Surplus</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* In millions

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Health Plans and Providers in an ACA Marketplace

Narrow networks – will deep discounts from health care providers be sustainable?

Will high-value networks proliferate?
- More coordination and collaboration between providers and health plans
- Pay for results rather than pay for services
- Increased reliance on care management
- Easier to assure accurate risk-score coding

Will accountable care organizations (ACOs) and provider-owned plans continue to increase?

Can these models be successful on a large scale?
Extension of small group rules to groups up to 100

- Extension effective in 2016
- The transition program may push much of this change into 2017
- Groups may self-select to avoid new requirements
  - Move to self-funding, PEO, or other alternative if healthier than average small group
  - Change to leaner coverage to avoid the “pay or play” penalty
- Likely to impact ACA small group community rates
- Not clear in what direction risks will move
What if King wins?

Threat to profitability and surplus highly dependent on subsidy transition timing
- 87% of 2015 FFM members get a premium subsidy
- 60% of 2015 FFM members qualify for a CSR plan

What happens to CSR policy contracts?
- The CSR program gets eliminated since it is dependent on members being eligible for premium subsidies (tax credits)
- But will insurers still have to honor the higher benefits of the CSR enhanced benefit plans?
- Should only effect 2015 if subsidy cutoff occurs during the year or if after beginning of 2016

Grace period impact
- All the terminations will qualify for 3-month grace period (health plan responsible for one month)
- Providers exposed for other two months; so look if provider agreements address grace period

Can premiums withstand expected adverse selection and reduced membership support expense structure?
For further information contact

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