May 15, 2012

Ms. Julia Philips, Chair HATF Subgroup on Reinsurance and Risk Adjustment

RE: Comments on the Impact of ACA Provisions on Health Risk-Based Capital

Dear Julia:

We appreciate the opportunity to provide our comments on the recommendations your group has tentatively identified as possible ACA provisions changing the risks to insurers. We support the position taken for the majority of the items you have identified as having “no impact” or an “immaterial impact” on the Health Risk-Based Capital (RBC) requirements of insurers and therefore not to be studied. However, below we include several items identified as “no impact” that could be included in studies of the changing risk as we believe they have the potential to reduce the solvency risk. Where we are in agreement with your group’s tentative position, we will provide no comment to shorten this letter.

We have three general notes before the detailed review:

1. We believe that those ACA provisions addressing Medicare Advantage or Medicaid coverage should be separated from those that affect the more traditional comprehensive medical coverage since many of these components of ACA only impact one of these three separate types of coverage. Even for comprehensive medical coverage, not all of the ACA changes apply to all health risks. Since many different types of coverage under the current RBC formula apply the same factors, the potential for change from each type should be compared with the overall effect of the other types.

2. It is also probable that several items from the list should be considered together, recognizing the potential for some aspects of certain ACA provisions to offset the risk from other impacts. In our discussion below, we have noted groupings that we think fall into this category. For example, we note that the list does not include the reinsurance, risk corridors and risk adjustment provisions as a separate item, but they certainly need to be included as offsets to some of the increased risks identified as applicable to comprehensive medical coverage.

3. To the extent this review identifies a net increased risk, the changes to the HRBC formula should be done as simply as possible, recognizing that the Health Annual Statement is the source of the exposure values used in the HRBC formula. The ultimate goal of the RBC formula should not be changed - to identify companies with potentially insufficient capitalization.
Comprehensive Medical Coverage

Item 8: CHIP Funding limits – The subgroup suggested that this will increase risk if funding is stopped. To the extent that the ACA does increase the number of individuals and families with insurance, the coverage of additional children transferred from a reduced or discontinued CHIP will not be a material added risk. We suggest that the more appropriate position is “immaterial change to risk.”

Item 16: Consumer Operated and Oriented Plans – The subgroup suggested that this will increase risk if these CO-Ops offer very competitive premiums and companies subject to the HRBC formula offer products at a loss to compete. We believe that much of this risk is addressed by states’ review of premium rates for adequacy as well as reasonableness. All RBC development is based on an assumption that pricing is adequate given limited knowledge of the future. Statutory accounting already requires companies to establish premium deficiency reserves when it is determined that premiums are inadequate. This effectively decreases capital in the current year to eliminate losses in future years, reducing the risk of future insolvency.

Item 45: Young Adults Coverage – The subgroup suggested that continuing coverage of children through age 26 adds risk. As this provision has already been implemented, we do not believe that there was an increased risk when these additional lives are covered in 2010 much less any need to change the RBC formula in 2014. As such, we believe the more appropriate position is “immaterial change to risk.”

Complimentary or Offsetting Items to Review in Combination

Items 20, 28 and 36: The Rate Restriction provisions, MLR provisions and the Rate Review provisions will work together to make both companies and regulators more aware of the need for appropriate pricing. Since regulators have both a premium review responsibility and a solvency review responsibility (with the added information from increased reporting of annual experience), it is incumbent on them to allow premium increases that reflect reasonable assumptions for the future. The combined impact of these provisions on HRBC will also vary depending on the distribution or concentration of a carrier in a few or many states.

Items 6, 11, 13, 19, 22, 37 and 38: These provisions are designed to change the manner in which health care providers deliver treatment. From the increased use of preventive and primary care to the process from transition from in-patient to less costly care, all will have the effect of reducing the variance in care, even if you assume that the overall costs will increase.

Items 3, 4, 23, 24 and 43: These provisions change the market landscape and will modify the manner in which risks are addressed by health insurance companies. As noted in our opening
comments, there are offsetting aspects of ACA, both in terms of its potential effectiveness in increasing the number of healthy lives insured, but in the manner in which high variance risk is shared. This is particularly true during the period from 2014 through 2016.

**Medicare Advantage**

Items 6, 11, 13, 19, 22 and 39: Similar to the above reasons to study these for the traditional markets, these items should reduce the variance even if it increases the overall average cost.

Item 30: Payment Reductions will result in some reduction indifferences in coverage for Medicare Advantage versus Medicare Parts A and B. Past experience has shown that companies adjust their products and market areas so that premiums remain consistent with the risks. We recommend that the more appropriate position is “immaterial change to risk.”

**Medicaid**

Item 25: This provision would increase the number of people eligible for Medicaid coverage but should not change the risk profile in any adverse manner. We recommend that the more appropriate position is “immaterial change to risk.”

Items 6, 13, 19, 22, 26 and 27: Similar to the above reasons to study these for the traditional markets, these items should reduce the variance even if it increases the overall average cost.

We will be happy to address any questions your subgroup has about this letter. Please feel free to contact either Candy Gallaher at cgallaher@ahip.org, or Bill Weller at omegasquared@msn.com.

Sincerely,

Bill Weller  
Consultant to AHIP

cc: Eric King, NAIC HATF Staff  
    Candy Gallaher, SVP State Policy, AHIP