NATIONAL HEALTH CARE REFORM AND SOLVENCY RISK
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Introduction

Health insurance companies hold uncommitted assets, called surplus, for a number of reasons. In some cases, surplus is used to finance planned but unobligated capital expenditures such as information technology. But more fundamentally, companies hold surplus as financial protection against insolvency in the event of potential but unforeseeable costs, including rare events (such as an unusually harsh flu season) or unpredictable macroeconomic changes (such as the banking crisis that occurred in 2008). Surplus is distinguished from reserves, which are held against anticipated claims and related commitments.

The minimum amount of surplus that a company must hold is determined by state regulation, which most states have based on the NAIC Health Organization Model Act.² This model act requires health companies to calculate their risk-based capital (RBC) position based on consideration of five components of risk:

- The risk of default of assets for affiliated investments—including risk associated with downstream insurance subsidiaries as well as a risk factor for other affiliates not subject to RBC rules.
- Risk associated with the valuation of assets—including fixed income and equity instruments and adjusted for asset concentration, if any.
- Underwriting risk—principally the risk that medical expenses will exceed premiums collected. The calculation of this component is adjusted upward for small blocks of business (which generally experience less stable claims experience than large companies), and it is adjusted downwards for managed care arrangements (with provider contracts that make their loss experience more predictable).
- Credit risk—that is, the risk of default on accounts receivable from customers, providers, reinsurers, or others. Over time, credit risk has generally diminished with the development of credit bureaus, credit rating agencies, and accounting standards.

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¹ The author sincerely thanks Timothy Jost for inviting this paper and offering valuable background research and comments, as well as Jill Bernstein, Joe Ditré, Sally Duran, Cheryl Parcham, and Barbara Yondorf for their careful reading and insightful comments. Of course, any errors of fact or interpretation that might remain are the sole responsibility of the author.

Business risk, including the variability of operating expenses and the collectability of payments for its third-party administrator business, as well as guaranty fund assessment risk and excessive growth risk. These latter risks recognize the potential for the company to experience unanticipated medical losses when enrollment grows faster than expected.

The RBC calculation incorporates the company’s assessment of each of these risk components in a prescribed formula. Thus, regulators and analysts can compare a company’s overall risk and surplus positions from year to year, and from company to company, based on a consistent set of risk components and method of aggregating them.³

The NAIC is considering whether, in light of the ACA, the current calculation of RBC should be reconsidered. This issue brief considers the major provisions of the ACA affecting health insurers’ commercial business and discusses their potential impacts on health insurers’ overall risk of insolvency. Issues related to RBC calculation for insurers’ Medicare and Medicaid businesses are not addressed here. While the ACA has potential implications for each of those lines that may vary depending on where the insurer is writing the business, the law’s implications for commercial business are almost entirely uniform from state to state and within states. State implementation of the ACA might vary in smaller details, but these are unlikely to have significant implications for either the calculation of RBC or the amount of surplus an insurer should hold. In general, this issue brief also omits consideration of grand-fathered plans.⁴ With the possible exception of some large group plans, insured grandfathered plans are widely considered unlikely to survive in significant numbers much after 2014, when the major provisions of the ACA become effective.

The following sections describe ACA provisions that affect insurers’ risk related to their commercial lines and the ACA’s “risk leveling” programs intended to help insurers manage, in particular, the underwriting risk that they may face as they undertake the changes necessary to write the “essential coverage” that

³ The NAIC model law establishes the actionable level of surplus at 200 percent of RBC. Regulators become concerned as surplus drops toward 200 percent of RBC, and will intervene at 200 percent of RBC to avert insolvency. However, most companies hold substantially more than that amount. Surplus levels of 500 percent to 900 percent of RBC are common, especially among Blue Cross Blue Shield plans whose trade association encourages larger amounts of surplus (specifically, not less than 375 percent of RBC). Only a few states (including Pennsylvania and the District of Columbia) have regulation in place that constrains the maximum amount of surplus an insurer may hold.

⁴ Under the ACA, grandfathered plans are exempt from certain requirements as long as the plans do not increase cost-sharing requirements beyond certain limits (relative to the plan’s design in early 2010) or reduce benefits. Employer-sponsored plans may lose grandfathered status if the employer’s contribution to premiums is significantly reduced. The grandfathered plans do not have to comply with the following provisions: (1) offer an essential benefit package in the individual and small group markets and exchanges starting in 2014; (2) report on quality improvement activities; and (3) guarantee access to emergency, pediatric, and ob-gyn services. Grandfathered plans may, without losing grandfathered status, increase the number and type of benefits offered, make changes to comply with state or federal regulations, voluntarily adopt other consumer protections of the ACA, or make modest adjustments in benefits, cost-sharing, and premiums.
will satisfy the law’s individual mandate, whether or not they offer plans in the new health insurance exchanges. The ACA provisions that affect risk are discussed in two categories: limits on rating and provisions that will affect the volume of enrollment and average loss experience of health plans. A short discussion of major points is provided in the concluding section.

**ACA Provisions that Affect Risk**

The ACA introduces a range of consumer protections intended to make health insurance more accessible and affordable to individuals and small groups. These protections will limit how insurers may set premiums, issue coverage, and design benefits. Insurers have long experience with similar provisions in the small group market: federal law has required guaranteed issue to small groups and prohibited practices that discriminate within groups based on health status since the 1990s. However, the ACA offers stronger protections to small groups and extends the same protections to individuals. It also extends these protections to somewhat larger firms, with up to 100 employees. Finally, the ACA establishes new standards for “qualified health plans” with “essential benefits” that satisfy the law’s individual mandate, and it requires the formation of health insurance exchanges for individuals and for small groups to encourage greater competition on both price and quality.

The following sections consider ACA provisions that, respectively affect rating, enrollment, and benefit design. In each category, potential implications are discussed for the risk components that comprise insurers’ calculation of RBC.

1. **Limits on Rating**

The ACA limits the factors that an insurer can consider when establishing rates for individuals or small groups—a provision called adjusted (or modified) community rating. Specifically, insurers may consider only four factors:

- Self-only or family enrollment;
- Rating area as specified by the state (typically by county or zip code);
- Age (by no more than a 3:1 ratio across standardized age rating bands); and

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5 The Health Insurance Portability and Accountability Act of 1996 (HIPAA; Public Law 104-191, 110 Stat. 1936) was enacted in 1996; Title I of HIPAA became effective in 1997. Title I requires insurers to guarantee issue to small groups with 2 to 50 employees, limits restrictions on benefits for preexisting conditions, and prohibits insurers and employers from denying individual employees eligibility for benefits or charging them more for coverage because of any health factor. However, an insurer may take the health status of individual employees (or their dependents) into account when establishing aggregate rates. HIPAA’s guaranteed issue protection applies to individual coverage only when an individual is transferring from group to comprehensive individual coverage with no significant break in coverage. Unless constrained by state law, insurers typically rate HIPAA individuals as a separate block of business.
• Tobacco use (by no more than 1.5:1 ratio).

Unless prohibited by state law, insurers may maintain separate individual and small group product lines, and can rate identical products separately in each line. However, within each product line, insurers must charge the same adjusted premiums for the same product, regardless of whether it is offered in an insurance exchange or in the market outside the exchange.

These provisions become effective in a new environment that casts a high beam on how insurers set premiums, with both regulatory and consumer scrutiny of premium increases. The ACA requires regulatory review of premium increases. At this writing, HHS has deemed all but six states and two territories as having “effective rate review” with respect to most or all of their markets, with the statutory authority and technical capacity to review proposed rate increases. In all states, insurers seeking rate increases of 10 percent or more for non-grandfathered individual or small group products must publicly disclose the proposed increases and the justification for them. In states without effective rate review, those proposed rate increases receive federal review. In addition, HHS makes expert actuarial review available to all states (including effective rate review states) if they lack that capacity. An HHS website for consumers posts details by state on the outcome of all reviews for proposed rate increases at or above 10 percent.

The ACA also establishes minimum medical loss ratios for all individual and group insurers, aggregated across all plans offered in its individual, small group, and large group lines, respectively. For comprehensive products sold to individuals and small groups, the amount the insurer pays out for claims, quality improvement, or fraud detection cannot be less than 80 percent of premiums (net of taxes and fees); for large groups, the percentage cannot be less than 85 percent. In effect, this provision limits insurers’ available funds for administrative expenses as well as profit or surplus. Any premiums collected above these ratios must be rebated to policyholders.

These provisions put considerable pressure on insurers to constrain rates by limiting the administrative expenses they build into premiums as well as the factors they build in for profit or contribution to surplus. Although at least one insurer has cited rate review as contributing to underwriting risk—


7 Starting September 1, 2012, states may ask to replace the 10-percent threshold with a State-specific threshold that will reflect each state’s own insurance and health care cost trends; at this writing, only Alaska and Wisconsin have requested State-specific thresholds. States with effective rate review systems will conduct the reviews, but if a state lacks the resources or authority to conduct actuarial reviews, HHS will conduct them on behalf of the state. In addition, HHS will continue to make resources available to states to strengthen their rate review processes.

8 Separate rules govern “mini-med,” student health, and “ex-pat” plans that, respectively, offer very limited benefits or serve individuals who temporarily reside outside the United States.
specifically, that regulators might arbitrarily hold rates below levels warranted by projected medical costs—this concern appears to be unfounded. Historically, many states have reviewed rates without jeopardizing the financial solvency of insurers. As an analyst for the insurance industry has observed, regulators have responsibility for both review and solvency review, and they have information from increased reporting with which to ensure that premium increases reflect reasonable assumptions for the future. In addition, it is clear that insurers can reserve against a potential medical loss ratio rebate, and at least some large insurers reported holding such reserves on their 2011 annual statements. This new reserving practice hedges the underwriting risk that some might view as arising from the ACA’s regulation of medical loss ratios. Thus, there appears to be no reason that either the rate review or medical loss ratio provisions would warrant change in the measurement of RBC or the amount of surplus an insurer should hold.

2. Changes in Enrollment and Plan Experience

At least six provisions of the ACA might significantly change the number of insured enrollees, especially in individual and small group health insurance plans, as well as the risk profile of those who enroll. Specifically, the ACA:

- Requires insurers to guarantee issue to individuals—that is, they cannot deny coverage to any applicant. Previously, only five states (Maine, Massachusetts, New Jersey, New York, and Vermont) have required guaranteed issue to individuals.
- Requires most individuals to maintain qualified coverage if it is deemed affordable. This provision is commonly known as the individual mandate.
- Extends the definition of employers who will benefit from federal small-group protections from 2-50 employees to 2-99 employees, in effect requiring insurers to pool risk across a larger category of small groups. States may adopt this definition by 2014, but all small group provisions will apply to larger small groups not later than 2017.
- Requires that all states have an individual health insurance exchange that will offer comparable price, quality, and benefits information to help individuals choose among health plans offered in the exchange. New nonprofit “navigators” will educate consumers and help them select

9 In 2010, the District of Columbia’s Blue Cross and Blue Shield plan (an affiliate of CareFirst, Inc.) cited risks associated with the ACA that Milliman actuaries had identified as potentially warranting higher surplus. The first of these was “[a]dditional rate review at both the local and national level, with the potential for rate restrictions based on arbitrary caps on the level of change rather than appropriate analyses of actuarial rate requirements.” See: Group Hospitalization and Medical Services, Inc. Supplemental Report on Effects of Federal Health Care Reform. September 3, 2010 [www.disb.dc.gov/carefirst hearing, accessed May 15, 2012].


coverage in the exchange, augmenting the activities of brokers and agents. Subsidies will be available in the exchanges to assist low-income individuals to afford coverage, including many that may transition to or from Medicaid.

- Establishes new health insurance options for consumers—offering federal low-interest loans to help establish new non-profit Consumer Operated and Oriented Plans (CO-Ops) and requiring that the Office of Personnel Management (OPM) establish multi-state qualified plans along the lines of the health plans that serve federal employees. All exchanges must offer both the federally-approved CO-OPs and the regional plans established in their market area.

- Requires that all states have a Small Business Health Option Program (SHOP) exchange, in addition to the individual exchanges. The SHOP exchanges will offer employees choice among health plans within any of four plan tiers (defined by a common actuarial value within each tier) and may allow small employers to offer employees choice across tiers as well.

For each provision, potential implications for insurer solvency under the current RBC formula are discussed below.

a. Guaranteed issue to individuals

The ACA’s requirement that coverage to individuals (as well as small groups as has been required under prior federal law) be guaranteed issue is one of several provisions intended to help individuals with health problems obtain adequate and affordable coverage. Since September 23, 2010, the ACA has prohibited group plans and individual plans (if not grandfathered) from denying coverage to children under age 19 because of pre-existing conditions. Other provisions of the ACA will ultimately prohibit rating on health status or use of exclusions or waiting periods for coverage of preexisting conditions, preventing insurers from using rating or benefit design to avoid embracing guaranteed issue.

While insurers are generally wary of guaranteed issue, there is no reason to expect that they cannot predict risk and adjust premiums appropriately in response to this requirement. All insurers that now underwrite to deny coverage understand the various medical conditions of applicants that they are turning away; they also understand the cost of those medical conditions among insured lives and can factor these risks into their calculation of expected medical costs and premiums. The current RBC formula already increases RBC for insurers with low volume, where the high cost of the marginal applicant could increase underwriting risk. Moreover, the ACA’s “risk leveling” provisions, discussed later, will largely if not entirely indemnify individual carriers from unanticipated high risk for at least three years, as they gain experience with the large number of adults who historically have been unable to afford private coverage but are expected to enter the exchanges with subsidies.

Broader considerations suggest that health insurance markets are likely change, whether or not in response to guaranteed issue, in ways that improve insurers’ ability to predict medical costs—including the marginal cost of a high-risk enrollee. For example, the ACA encourages the development of bundled
payments and Accountable Care Organizations for Medicare enrollees, as well as broader enrollment in managed care for Medicaid enrollees. Earlier initiatives such as these (dating to the introduction of diagnosis-related groups to pay hospitals for inpatient care) have induced industry-wide changes, with insurers introducing new products and practices related not only to Medicare or Medicaid enrollees but also to privately insured individuals and groups.

Guaranteed issue may only reinforce such trends. For example, in New York State, most insurers moved most if not all of their business to preferred provider organizations and other forms of managed care immediately with the introduction of guaranteed issue and pure community rating (a provision much more restrictive than required by the ACA). However, in more concentrated (and less competitive) insurance markets such changes may occur more slowly, and they may be impractical in frontier or other very rural areas with few medical providers.

b. The individual mandate

Many individuals who are currently uninsured are expected to buy individual coverage in 2014. To support broad compliance with the individual mandate, premium tax credits and reduced cost sharing will be available to low-income individuals who buy coverage in an exchange, if not eligible for Medicaid or other qualified affordable group coverage. These provisions of the ACA are generally regarded as favorable to insurers, increasing their volume of business and bringing into the market many individuals with little or no immediate need for care. Conversely, those with the greatest need for care likely will be enrolled in Medicaid, under that program’s greatly expanded eligibility for low-income adults.

While the individual mandate potentially could affect both underwriting and business risk (the latter due to unanticipated enrollment growth), there is no reason to anticipate that the current RBC components and formula would not adequately account for both. Many if not most states have conducted analyses of their uninsured populations, many with federal grants, to support planning for ACA implementation. Those analyses are widely available to inform actuarial estimation of number and medical cost of now-uninsured individuals likely to enroll in 2014. Moreover, experience in Massachusetts (the only state with experience of an individual mandate) suggests both that insurers can anticipate enrollment growth in response to a mandate sufficiently to avoid increasing business risk and, in any case, that the current treatment of business risk in the calculation of RBC is sufficient.


c. Small groups with fewer than 100 employees

Analogous to the individual mandate, the ACA’s extension of the small group market to groups with fewer than 100 employees is expected to increase the volume of insurers’ small group business and, also help stabilize the market. In any case, this provision is unlikely to represent unknown risk for insurers and, therefore, necessitate a change in the components or calculation of RBC. Insurers that currently underwrite mid-sized groups are aware of the risk those groups represent and can set premiums accordingly. In general, there is no reason to expect that many mid-sized small groups will either change carriers when introduced into the small-group market or leave insured coverage.\textsuperscript{14} And while employees eligible for coverage but now uninsured may newly take up coverage in response to the individual mandate, the ACA’s risk-leveling provisions are intended precisely to help insurers accommodate this risk while gaining sufficient experience to price small-group coverage accurately.

d. Health insurance exchanges

The development of exchanges is expected to help consumers shop for and enroll in private coverage. However, for insurers, more transparent and competitive markets potentially carry new risk. By encouraging individuals to comparison-shop more aggressively, the exchanges could motivate consumers, when able, to switch among health plans in greater numbers than has occurred historically. In addition, the premium tax credits and lower cost sharing available to low-income individuals when they enroll through an exchange is expected to close the gap between Medicaid eligibility and enrollment in private coverage. As a result, the exchanges are exposed to the vagaries of state Medicaid eligibility rules and are expected to serve a large number of individuals who transition to or from Medicaid from month to month as their incomes change.

For insurers who offer coverage through an exchange, the exchanges represent a significant departure from their past experience. Historically, insurance products and prices have been difficult for consumers to compare, and very few insurers have substantial experience serving the large numbers of low-income adults who will enter individual coverage, whether or not from Medicaid.

Nevertheless, there are reasons to expect that these risks are calculable. First, in comparable situations where consumers can switch coverage, rates of shifting have ordinarily been low. For example, a 2004 analysis of Medicare Advantage plans found that fewer than 5 percent of plan enrollees switched either

\textsuperscript{14} There is some concern that some small groups—especially those with more than 50 employees and that now enjoy favorable rates related to the age and health status of employees—will choose to self-insure rather than accept higher premiums under the ACA’s constraints on rating small-group coverage. One recent simulation analysis suggests that impacts on the market may be small (Elbner, Christine, et al. Small Firms’ Actions in Two Areas, and Exchange Premium and Enrollment Impact. Health Affairs 31(2), February 2012: 324-331). However, others familiar with the industry maintain that self-insured small group plans are a significant threat to the market. At this writing, the NAIC’s ERISA subcommittee is considering the issues raised by stop-loss insurance.
between traditional Medicare and a Medicare HMO or among Medicare HMO plans in a given year.\footnote{Gold, Marsha et al. Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage. Report to The Robert Wood Johnson Foundation, August 2004 [http://www.mathematicampr.org/publications/PDFs/monitor.pdf, accessed May 16, 2012].} Among Medicare enrollees enrolled in Medicare Part D, only about 6 percent switch plans.\footnote{Estimate cited in: Jost, Timothy. Unpublished draft memorandum on Experience with Issuer Switching submitted to the NAIC HATF Medical Loss Ratio Subgroup, March 21, 2012. This estimate excludes low-income subsidy members, who may be auto-enrolled in a new plan when their current plan increases premiums, but can switch again if they are unhappy with that plan.} Plan switching in the Federal Employee Health Benefits Plan also is uncommon: according to one expert, only 5 to 10 percent of FEHBP enrollees change plans each year, often only within plans offered by the same carrier (BCBS).\footnote{Massachusetts Health Connector. Commonwealth Care Quarterly Update, Board of Directors Meeting, October 14, 2010 [https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2010/2010-10-14/October%25202010%2520CommCare%2520Qtrly%2520Update%2520-%2520FINAL.pdf, accessed May 16, 2012].} In Massachusetts, switching in Commonwealth Care (a subsidized program for low-income adults offered in the Connector) has been similarly low: 1.5 percent of enrollees voluntarily switched plans in 2009, and 3.1 percent voluntarily switched in 2010.\footnote{Massachusetts Health Connector. Commonwealth Care Quarterly Update, Board of Directors Meeting, September 8, 2011 [https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2011/2011-9-8/5.Sept2011CommCareUpdate.pdf, accessed May 16, 2012].} Plan switching in Commonwealth Care generally coincided with large and visible premium increases or differentials, or to a significant narrowing of a plan network.\footnote{See: Lako, Christiaan J., Pauline Rosenau, and Chris Daw. Switching Health Insurance Plans: Results from a Health Survey. Health Care Anal (2011) 19:312–328.} Analyses of switching in other countries with markets that resemble those anticipated in the exchange find similarly low rates of switching, especially after an initial acclimation period for both consumers and health plans.\footnote{Lako et al., Ibid.} In addition, available research suggests that individuals who are most likely to switch are relatively well-educated and in good health—and thus likely to represent a favorable cost experience for the plan they enter. This pattern bears out in international studies\footnote{Ji, L., and F. Liu. HMO versus Non-HMO Private Managed Care Plans: An Investigation of Preswitch Consumption. Health Care Management Science 10(1), 2007: 67–80.} as well as in studies of Medicare enrollees.

Thus, it seems reasonable that insurers can expect low rates of switching—and much lower rates than the proportion of individual enrollees who allow their coverage to lapse in the current market, some
because they find group coverage. Consumers might move opportunistically between the exchange and the market outside the exchange, but insurers that offer a plan in the exchange are likely also to offer it outside the exchange—and if so, the ACA requires that they charge the same premium in both venues. Thus, it seems more likely that insurers will need to learn how to cope with greater stability in their insured populations, not high rates of switching, and with greater stability the possibility that any initial favorable risk selection might erode over time.

For plans that might gain or lose many Medicaid enrollees month to month, however, the problem of anticipating underwriting risk is potentially greater, and there is little experience from which to project these enrollees’ medical cost. Experience with enrollment in the Massachusetts Commonwealth Care program indicates that low-income individuals who left private coverage, often because they become eligible for Medicaid, were in poorer health than those who remained—suggesting that individuals moving to Medicaid might improve insurers’ average loss experience. Conversely, those who are likely to enter private coverage from Medicaid have, by definition, experienced an increase in their incomes—in most cases, likely due to new or increased employment; such individuals would seem likely to be in better health than the average Medicaid enrollee of the same age.

Whether or not such expectations are reasonable, the absence of direct experience with low-income populations who will enter and leave coverage in the exchange as their Medicaid eligibility changes is problematic. The ACA’s risk-leveling programs will be essential in protecting insurers for this unknown risk.

e. New insurance options

Under the ACA, HHS offers federal low-interest loans to promote the formation of CO-Ops. At this writing, seven organizations in twelve states have received such loans, with the goal of launching one

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23 For example, from January 2010 through January 2011, 50 percent of enrollees in Anthem’s non-grandfathered Basic plan in California lapsed within 12 months of enrollment; nearly 26 percent lapsed within 6 months. Twelve-month lapse rates in its high-deductible and standard products varied from 32 percent to 41 percent. Galasso, James P. Actuarial Services & Financial Modeling, Inc. report to Anthem Blue Cross Life and Health Insurance Company Regarding Individual Rates to be Filed with the California Department of Insurance For Non-Grandfathered Health Care Plans with Effective Dates of May 1, 2012 and July 1, 2012. November 12, 2011 [http://www.insurance.ca.gov/0250-HlthRateFilings/upload/PF201102237IndActCert.pdf, accessed May 25, 2012].


25 A number of states also have experience with expanding Medicaid or other subsidized coverage to low-income adults. However, these programs have operated without an individual mandate and generally accept applicants whenever eligible. As a result, they likely have experienced much less favorable risk selection than the exchanges would with an individual mandate.
CO-OP in every state by 2014.\textsuperscript{26} In addition, OPM will contract with at least two insurers (including at least one nonprofit entity) that will offer multi-state health plans in the exchanges in at least 60 percent of the states by 2014 and in all states by 2017.

In every state the CO-Ops will represent new competition for insurers already in the market, and in many states the multi-state plans will also be new competition. The multi-state plans, perhaps especially, offer the potential for significant market restructuring. This prospect may underlie, in part, the increase in surplus held by large BCBS plans since enactment of the ACA, potentially allowing them to weather the new competition by offering lower premiums.\textsuperscript{27}

While surplus accumulation in anticipation of new competition might be a matter of concern to state insurance regulators (and possibly to federal anti-trust regulators), it does not suggest that new competition will pose unknowable new risks for insurers and, therefore, that the current measurement of RBC is inadequate. While the new plans might attract disproportionate enrollment among individuals who are now uninsured, it seems unlikely that they will succeed immediately in luring large numbers of consumers from plans in which they are already enrolled, especially if their current plans offer comparable value. Indeed, the challenge of gaining consumer confidence (as well as potentially also negotiating de novo with providers) is an important reason that there has been so little new market entry historically.

\textbf{f. SHOP exchanges}

SHOP exchanges will also pose new challenges for the insurers that participate in them. Federal regulation requires that the SHOP exchanges enable employee choice among all plans within a tier, and may enable employee choice across tiers. This kind of competition, where individual employees may sort readily among health plans, is a new environment for most insurers. Historically, if insurers have offered employees plan choice at all, the choice has been limited to a suite of their own products. But rarely have they offered even this choice to employees in small groups.

Employee choice among plans will cast the SHOP exchange in much the same mold as the individual exchange: individuals will select among plans, if their employer allows, in nearly all cases annually. Thus, the opportunity for plan switching at renewal will be similar—but without significant enrollment from or exit to Medicaid.


\textsuperscript{27} McDonald, Carl, and James Naklicki. Managed Care: Once the Game Is Over, the King & the Pawn Go Back in the Same Box: 2011 Blue Cross Non-Profit Financial Analysis. Citi Equities, May 21, 2012 [https://ir.citi.com/Dq4boEGUYtP2lp3CACdJmUH7Yo5zutRmAIYJtnLVOnebN26LfA3iA%3D%3D, accessed May 25, 2012].
While employee choice is potentially an important innovation of the SHOP exchanges, it may not pose unknowable risks for insurers. Those that now offer some choice to mid-sized or large groups (although likely more limited choice than envisioned in the SHOP exchanges) have direct experience to help them understand the potential for unfavorable selection in some products and set premiums accordingly. In addition, two of the three risk-leveling provisions of the ACA (including the states’ permanent risk adjustment programs) apply to small groups, helping to protect insurers from unanticipated high medical costs whether or not employees are offered plan choice. Especially because insurers are well-protected in the initial years, as they gain experience with the SHOP exchanges, there seems no reason that change in the measurement of RBC is needed to accommodate the new environment of SHOP exchanges.

### Benefit design

The ACA eliminates lifetime limits on coverage, phases out annual limits, eliminates cost sharing for recommended preventive services, and in 2014 prohibits insurers from imposing exclusions and waiting periods for pre-existing conditions for adults as well as children. Some of these provisions—the elimination of lifetime limits, coverage of preventive services without cost sharing in group plans (if not grandfathered), and prohibitions on preexisting condition exclusions and waiting periods for children—became effective in 2011. In addition, the phasing down of annual limits began in 2011, with at least some plans reported to have removed annual limits immediately. For the vast majority of health plans, these early provisions are expected to have very little impact on premiums, suggesting no need for changes in the measurement of RBC. Although the prohibition of waiting periods and exclusions for children apparently motivated some insurers to close their child-only products, the decision did not obviously relate to their levels of surplus.

The ACA also establishes benefit standards for qualified health plans effective in 2014. Federal regulation allows each state to specify the content of the essential benefit package within outlines established in the ACA. This approach to defining essential benefits is likely to help small group insurers,

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28 When accepting applications for annual waivers, HHS anticipated that plans with low annual limits (e.g., $10,000) would be the most likely to need waivers to prevent a significant increase in premiums or decrease in access to coverage to comply with the current limit of $750,000. For plans with higher annual limits, HHS estimated that the increased annual limit of $1.25 million would neither increase premiums significantly (less than one percent) nor decrease access to care, and that increasing annual limits from $1.25 million to $2 million the following year would have a similarly small impact on premiums. See: HealthCare.gov. Annual Limits Policy: Protecting Consumers, Maintaining Options, and Building the Bridge to 2014 [http://www.healthcare.gov/news/factsheets/2011/06/annuallimit06172011a.html], accessed May 25, 2012.

29 For example, Regence BlueCross BlueShield of Oregon, a company with ample surplus, was among those that abandoned child-only products. For a more general discussion, see: Georgetown University Health Policy Institute, Center for Children and Families. Frequently Asked Questions: Enrollment in Child-Only Plans Under ACA Requirement Prohibiting Pre-Existing Condition Exclusions, undated [http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/health%20reform/faq_kid-onlyplansfinal92710.pdf], accessed May 18, 2012.
especially, transition to products that constitute essential coverage in 2014 with relatively little change in the services they cover.

Among the many provisions of the ACA that require insurers to make changes, it may be easiest for them to anticipate the cost consequences of the provisions affecting benefit design. Insurers now process claims and calculate allowable cost and payments, and can easily estimate the consequences of changes in cost sharing for covered services. They also have actuarial tools at their disposal to estimate the cost of essential benefits that they may not currently cover at all. Thus, there appears to be no argument that these provisions would necessitate a change either in the RBC calculation or in the level of surplus that insurers should hold.

**Risk Leveling Provisions of the ACA**

The ACA provides for three “risk leveling” programs that are intended to protect insurers against risk selection and uncertainty variously in the individual and small group markets, and in turn ensure the viability of the Exchange and the larger market (see Figure 1). Two of these programs, reinsurance and risk corridors, are temporary and will end in 2017. The risk adjustment program will be permanent.

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1. **Reinsurance**

Section 1341 of the ACA establishes a reinsurance program to help non-grandfathered individual plans with unusually high claims—whether sold in an exchange or in the market outside the exchange. ACA allows (but does not require) states to establish a reinsurance program; HHS will perform the reinsurance functions in states that do not establish a reinsurance program. The stated goal of the reinsurance program is to stabilize premiums in the individual market during the first three years that the health insurance exchanges are operational.
The ACA reinsurance program payments to non-grandfathered plans in the individual market will be subsidized by group plans, including those that are self-funded or grandfathered. In part due to this broad financing base, the effect of the reinsurance program on premiums is expected to be minor.  

2. Risk adjustment

A state that elects to operate an exchange must also establish a risk adjustment program. In states that do not elect to operate an exchange for individual and small group insurers, HHS will perform the risk adjustment function. The risk adjustment program will apply to non-grandfathered individual and small group plans both inside and outside of the state health insurance exchanges; it will assess charges to insurers with enrollment that reflects below-average risk and transfer those dollars to insurers with enrollment that reflects above-average risk. Risk adjustment is expected to stabilize the experience of private plans by reducing the effects of adverse selection between plans. However, if low-risk groups and individuals disproportionately choose not to purchase coverage from any health plan, risk adjustment cannot offset the effects of adverse selection against the market as a whole.  

3. Risk corridors

The ACA calls for HHS to operate a temporary risk-corridor program for individual and small group plans in the health insurance exchanges. This program will limit the extent of insurers’ gains or losses in the Exchange that exceed 3 percent (plus or minus) of the insurer’s target medical cost. The risk corridors will serve insurers during the first years of a new program, until they accumulate experience with health spending by individuals who will become newly insured under the ACA. As insurers develop experience with this population, they will be able to set premiums more accurately, eliminating the need for risk corridors. This program will help insurers in the event that there is initial, unanticipated adverse selection across plans in the exchanges.

Discussion

Whether the current measurement of RBC—both the risk components that it considers and the formula used to aggregate measures of those components—remains adequate in light of the ACA is fundamentally a question of whether the ACA changes unknowable risk for health insurers. To the extent that the changes required by the ACA pose risks that insurers can anticipate based on experience


31 American Academy of Actuaries, Ibid.

32 Specifically, Insurers with medical costs that are within (plus or minus) 3 percent of the target they establish will bear the loss or keep the gains. Outside of that corridor, the reinsurance program will pay a share of the insurer’s losses and take a share of the insurer’s gains.
or available data, the impacts of those changes can (and should) be reflected in premiums. They should not necessitate change in either the measurement of RBC or in the surplus that insurers hold.

Nearly all of the provisions of the ACA that affect insurers’ commercial business pose knowable risk. That is, insurers have either direct experience or there are available data to estimate medical losses with reasonable precision. Of the provisions reviewed here, the weakest experience and data relate to the numbers and medical risk associated with enrollees in the health insurance exchanges who are likely to enter or exit from or to Medicaid. Not only will frequent enrollment and disenrollment by this population increase insurers’ administrative cost, the absence of experience with this population could increase insurers’ underwriting risk.

For this risk and to calm health insurance markets more generally, the ACA requires that three risk-leveling programs—reinsurance, risk adjustment, and risk corridors—be in place by 2014, when most of the ACA provisions become effective and the individual and SHOP exchanges open for business. All of these programs will have a role in protecting insurers in the exchange—including those that may enroll disproportionate numbers of low-income individuals likely to gain or lose Medicaid eligibility. But, because the state risk adjustment programs are permanent, it may be particularly important that these programs focus on potential transitions to and from Medicaid when developing and testing their risk adjustment formulas, at least until insurers are able to gain sufficient experience with these enrollees.

However, the ACA’s risk-leveling programs will help protect insurers with respect to other provisions of the law as well. Such protection may be especially important for smaller insurers that lack sufficient experience to anticipate accurately how enrollment and medical costs will change when the major provisions of the law come on line. The risk-leveling programs will allow all insurers to gain three years of experience on which to base individual and small group premiums in a new environment. Permanent risk adjustment will help those that experience unfavorable risk selection, whether or not anticipated in premiums. Especially in light of these programs, there is no compelling argument that the measurement of RBC should be changed to accommodate the ACA.