Health Actuarial (B) Task Force’s Risk and Reinsurance (B) Subgroup Response to Health Risk-Based Capital (E) Working Group Charge

The Subgroup conducted seven open conference calls with interested regulators and interested parties to discuss the charge (below) from the Working Group.

"By June 1, 2012, identify and communicate to the NAIC’s Health Risk-Based Capital (HRBC) Subgroup those aspects of the Affordable Care Act (ACA) that have or will have significant effects on the risks assumed by U.S. health insurers. The communication to the HRBC Subgroup should identify qualitatively the specific sources and nature of the changes in risk, but the HCRAWG Risk Adjustment and Reinsurance Subgroup should not attempt to quantify the changes or the implications on HRBC requirements."

The discussions initially were about which provisions of the ACA would possibly need to be addressed in the HRBC formula. The list below is the result of these discussions.

1. Affordable Insurance Exchanges – ACA Section 1311
2. Prohibition of annual limits on insurance coverage – ACA Section 1001/PHSA Section 2711
3. Fraud, waste, and abuse offenses – ACA Section 1303
4. Prohibition of use of gender or health status in rating - ACA Section 1201/PHSA Section 2701
5. Independent Payment Advisory Board – ACA Section 3403
6. Individual mandate to obtain basic health insurance coverage – ACA Section 1501
7. Individual tax credits for purchase of basic health insurance coverage – ACA Section 1401
8. Requirement of commercial individual and small group health plans to cover certain preventive care services - ACA Section 1001/PHSA Section 2713
9. Requirement of Medicare to cover certain preventive care services – ACA Section 4104
10. Tax credits to small businesses for providing health insurance to employees – ACA Section 1421

The Subgroup’s evaluation of the qualitative effects of these ACA provisions is as follows:

1. Affordable Insurance Exchanges: In its June, 2012 report (Attachment 1), Milliman has projected that the total individual health insurance market will almost triple by 2017. Exchange business is expected to grow much faster than non-exchange business due to the premium subsidies only available through exchanges. Many of these new insureds will be those who are currently uninsured. To what extent will these new insureds be individuals for whom employers have dropped employer-provided coverage or self-insured with limited benefits?
The effect of the exchanges should be increased competition with regard to both price and quality. Competitive information will be more transparent to all market participants, including companies. Concentration of market power in certain regions will decrease. Rapid growth will increase business risk. Increased competition will depress margins and drive out marginal competitors.

Deborah Chollet stated in her report (Attachment 2) “…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.” She went on to say that she believes that these risks are calculable. She pointed to research that puts the switching rates at 5-6% per years with those switching tending to be more highly educated and healthier.

2. Prohibition of annual limits on insurance coverage: This provision will increase the cost of insurance, but depending on related reinsurance agreements, it may not impact the risk to insurers.

3. Fraud, waste, and abuse offenses: While this provision is likely to impact overall costs of commercial insurance, it is not likely to have a significant impact on volatility.

4. Prohibition of use of gender or health status in rating: The Chollet report (Attachment 2) does not specifically address rating limits. The report makes a general comment that because the risk is knowable, no changes need to be made to the RBC formula.

The Milliman report (Attachment 1) states that "plans in states that are moving from relatively less restrictive rules...are projected to have more need for the risk mitigation mechanisms." It goes on to say that modeling shows possible "need for premium rate actions that are higher than past experience would support, at least in 2014 and 2015. Potentially higher rate increases may be needed in 2017 after the reinsurance and risk corridor programs terminate."

The Subgroup’s conclusion is that the new rating limitations will have very different effects in different states, and may lead to significantly increased risk to insurers due to adverse selection.

5. Independent Payment Advisory Board: While this provision is likely to impact overall costs of commercial insurance, it is not likely to have a significant impact on volatility.
6. **Individual mandate to obtain basic health insurance coverage**: While the intent of the mandate is to decrease the underwriting risk associated with guaranteed issue and modified community rating, the question concerning the strength and effectiveness of the mandate remains.

Deborah Chollet (Attachment 2) stated: “These provisions (the individual mandate) 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.” She further stated that there is no reason to believe that current RBC requirements would not handle the increased business risk and underwriting risk.

However, if the individual mandate is ineffective due to the low level of penalties as contrasted with the cost to individuals of buying qualified insurance, then the degree of anti-selection averted would not be as great as expected. This could lead to much higher risk corridor payments during 2014-2016 and disorder in the marketplace. To the extent that the individual mandate is considered weak, the risk to health insurers would increase.

7. **Individual tax credits for purchase of basic health insurance coverage**: While the intent of the tax credits is to increase participation in the individual insured pool, the questions remain about the effectiveness of the individual tax credits and the health of the current uninsured population.

Similar to the comments on the individual mandate, if the tax credits are ineffective in reducing anti-selection, then the resulting market disorder would increase the risk for health insurers.

8. **Requirement of commercial individual and small group health plans to cover certain preventive care services**: While this provision is likely to increase the overall cost of commercial insurance in the short-term, in theory it will put downward pressure on long-term commercial insurance costs. In any event, it is not likely that this provision will significantly impact long-term volatility. This provision may result in a slight increase in volatility during the early years of the program; however, such increase in volatility would be more than offset by the various risk mitigation programs that will be in place (i.e., The Risk Adjustment, Risk Corridors and Reinsurance programs).

9. **Requirement of Medicare to cover certain preventive care services**: This provision is not expected to have a significant impact on the volatility of commercial insurance costs.
10. Tax credits to small businesses for providing health insurance to employees: While the intent of the tax credits is to maintain and even increase the number of small group employees covered under group programs, the question regarding the effectiveness of the small group tax credits in the decision-making process of the small employer versus the other options of self-insurance or letting the employees purchase individual health insurance remains.

If the small group market shifts significantly to self-insurance and/or employees being left to purchase insurance in the individual market, then the SHOP exchange will not be as significant as the individual exchange in the landscape of health insurance purchasing decisions.

If the small business tax credits are ineffective, then the risks of anti-selection in the individual market are increased with the possible consequences noted above, with consequent greater risk to health insurers.

Attachment 1:


Attachment 2: