

Draft date: 10/31/23

Virtual Meeting

HEALTH RISK-BASED CAPITAL (E) WORKING GROUP

Wednesday, November 8, 2023

2:00 – 3:30 p.m. ET / 1:00 – 2:30 p.m. CT / 12:00 – 1:30 p.m. MT / 11:00 a.m. – 12:30 p.m. PT

ROLL CALL

Steve Drutz, Chair	Washington	Tish Becker	Kansas
Matthew Richard, Vice Chair	Texas	Danielle Smith/Debbie Doggett	Missouri
Wanchin Chou	Connecticut	Margaret Garrison	Nebraska
Carolyn Morgan/Kyle Collins	Florida	Michael Laverdiere	New York
		Diana Sherman	Pennsylvania

NAIC Support Staff: Crystal Brown

AGENDA

- 1) Consider Adoption of July 25 Minutes—*Steve Drutz (WA)* Attachment One
- 2) Consider Adoption of Proposal 2023-11-H (XR014 Fee-For-Service & Other Risk Revenue-Medicare & Medicaid)—*Steve Drutz (WA)* Attachment Two
- 3) Hear a Report from the American Academy of Actuaries (Academy)
 - Health Care Receivables—*David Quinn (Academy)* Attachment Three
 - H2 Underwriting Review—*Steven Guzski (Academy)* Attachment Four
- 4) Discuss Pandemic Risk—*Matthew Richard (TX)* Attachment Five
- 5) Provide Overview of Risk Evaluation Ad Hoc Group—*Thomas Botsko (OH)*
 - Areas of Concentration for Health
- 6) Discuss questions on the 2022 Health RBC Statistics—*Steve Drutz (WA)*
- 7) Discuss Any Other Matters Brought Before the Working Group—*Steve Drutz (WA)*
- 8) Adjournment

Draft: 8/10/23

Health Risk-Based Capital (E) Working Group
Virtual Meeting
July 25, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 25, 2023. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair, Aaron Hodges, and Caroline Choi (TX); Wanchin Chou and Sarah Mu (CT); Benjamin Ben (FL); Chut Tee (KS); Debbie Doggett (MO); Lindsay Crawford and Michael Muldoon (NE); and Tom Dudek and Matt Ryan (NY). Also participating was: Tom Botsko (OH).

1. Adopted its May 17 and April 17 Minutes

Drutz said the Working Group met May 17 and April 17. During these meetings, the Working Group took the following action: 1) adopted its Spring National Meeting minutes; 2) referred proposal 2023-01-CA to the Capital Adequacy (E) Task Force for exposure; 3) heard an update from the American Academy of Actuaries (Academy) on the health care receivables and H2-underwriting risk review projects; 4) discussed pandemic risk; and 5) exposed the proposal on the health test language for a 45-day public comment period ending June 30.

Chou made a motion, seconded by Doggett, to adopt the Working Group's May 17 (Attachment **xx**) and April 17 (Attachment **xx**) minutes. The motion passed unanimously.

2. Adopted its 2023 Health Risk-Based Capital Newsletter

Drutz said the 2023 health risk-based capital newsletter includes all proposals that the Working Group adopted for year-end 2023, along with editorial changes to the health risk-based capital (RBC) forecasting and instructions publication. He said the purpose of this adoption is to consider the content of the newsletter, and the format will later be revised. The adopted version of the newsletter will be posted to the Working Group's web page, with the final formatted version posted around Sept. 1

Dudek made a motion, seconded by Chou, to adopt the Working Group's 2023 health risk-based capital newsletter (Attachment **xx**). The motion passed unanimously.

3. Adopted its 2022 Health RBC Statistics

Drutz said the 2022 health RBC statistics were run July 5. There were 1,143 health RBC filings loaded onto the NAIC database, up from 1,095 in 2021. Twenty-eight companies triggered an action level in 2022, of which six were in a company action level, 10 were in a regulatory action level, and 12 were in a mandatory control level. There were 13 companies that triggered the trend test. The authorized control level and total adjusted capital amounts increased from 2021 to 2022. Chou said that the number of companies in an action level rose from 12 to 28 and asked if there were any significant reasons for the change. Drutz asked NAIC staff to review the companies at an action level and try to identify the cause of the action level. He said the Working Group could review this during its next meeting. Botsko said the number of companies that filed on the health blank grew by about 48 over the prior year and asked if it would be possible to identify how many new companies triggered an action level. Drutz agreed and said this was also something that could be investigated further. Jim Braue (UnitedHealth Group—UHG) suggested incorporating the operational risk component into the statistical report in future years. Crystal Brown (NAIC) said this could be added to the report beginning with 2023, but it would not include previous years because the report is run at a specific point in time, as the numbers can fluctuate due to

amendments and late filings. The Working Group agreed to incorporate this into the report. Botsko asked that it also be added to the life and property/casualty (P/C) statistics beginning with 2023.

Doggett made a motion, seconded by Dudek, to adopt the 2022 health RBC statistics (Attachment **xx**). The motion passed unanimously.

4. Exposed Proposal 2023-11-HI

Drutz said proposal 2023-11-H was developed to include Medicare and Medicaid fee-for-service and other risk revenue amounts in column (1), lines (4) and (10) on pages XR013 and XR014. This change creates consistency across column (1), lines (2), (3), (4), (7), and (10) since Medicare and Medicaid premiums and claims are already included in column (1), line (2), (3), and (7). Brown said that only page XR014 is referenced in the proposal because it references the annual statement pulls for the calculation used on XR013.

Hearing no objections, the Working Group agreed to expose proposal 2023-11-H for a 30-day public comment period ending Aug. 24.

5. Referred the Health Test Proposal to Blanks (E) Working Group

Drutz said the health test language proposal was exposed to all RBC working groups for a 45-day comment period that ended June 30. The Working Group received one comment letter from the New York Department of Financial Services (DFS). Ryan said the New York DFS believes any insurer that writes life business should file on the life blank and be regulated by the Life Bureau, and the Health Bureau agreed. He said the main concern is that the New York DFS has some domestics that cede a large portion of their life business. As a result, the net basis approach makes it appear that the company has a majority of health business when it actually has a significant amount of life business. He said that in those situations, they would want those companies to be filed on a life blank.

Drutz said the ad hoc group considered either an all-net or all-gross basis for the premium and reserve ratios due to the inconsistencies in the current calculation, where both net and gross basis amounts are included in the calculation of the reserve ratio. The ad hoc group also discussed lowering the 95% ratio to capture more companies. However, the group determined it best to leave the ratios at 95% and use an all-net basis. The group determined that if needed, it could re-evaluate in the future, given that more data is being captured on health business in the life blank and that the health blank includes the life supplement. Drutz said the ad hoc group intended to fix the ratio, but New York DFS' comments are strong arguments for using an all-gross basis. He noted that points have been made for both raising and lowering the ratio thresholds, and as a result, the group may need to consider revisions to the threshold in the future.

Doggett made a motion, seconded by Chou, to refer the health test proposal to the Blanks (E) Working Group. The motion passed unanimously.

6. Received an Update from the Academy on the Health Care Receivables Project

Kevin Russell (American Academy of Actuaries—Academy) said Other Health Care Receivables included in line 06xxxxx on Exhibit 3 are part of incurred claims. He said those and four additional types of health care receivables (pharmaceutical rebates receivable, claim overpayment receivables, capitation arrangement receivables, and risk-sharing receivables) enter the calculation of incurred claims on the U&I Exhibit Part 2 line 6. He said loans and advances to providers are another type of health care receivable, but they are excluded from incurred claims if not yet expensed. He said the Academy has concerns that some filing companies may be using the other health

care receivables line when another would be more appropriate—either a different type of health care receivable or some other type of receivable (one that is not a health care receivable). He said that because of differences in receivable factors, this is affecting the calculation of RBC. Russell said the Academy is looking at other health care receivables where the filing company provided a name of the debtor or a description of the receivable in that field. He noted that many filing companies do not provide a description of the receivable, so the Academy is grateful for those that did. Russell said the Academy is looking for the Working Group's approval for NAIC staff to contact the filing companies to ask questions related to the other health care receivable amounts. He said the expectation is that their answers will help guide improvements to the Instructions for filing or improvements to guidance. Russell said the Academy would provide recommendations on the questions to ask particular companies, and NAIC staff would contact the filing companies and compile their responses.

Drutz said the plan is to notify all states that the Working Group may be contacting some of their companies and is just looking for additional clarity and understanding of the reporting.

The Working Group approved the Academy's request to reach out to the filing companies. It directed NAIC staff to work with the Academy to begin reaching out to the companies for further clarification on the questions.

7. Received an Update from the Academy on the H2 – Underwriting Risk Review

Derek Skoog (Academy) said the Health Solvency Work Group is working on getting a better understanding of the definitions for claims and revenue in the health RBC formula. He summarized the Academy's letter regarding the nuances identified (Attachment xx). He said proposal 2023-11-H does help to address nuance 1 and 2. He said there are a couple of questions the proposal does not address, including: 1) how we should think about the fee for service revenue in the context of the RBC formula; and 2) whether the fee for service revenue should be netted. He said the annual statement instructions define the fee for service at a high level. He said the Academy noted that the reporting conventions appeared varied for those issuers who report a substantial portion of fee for service revenue. He said the Academy has looked at historical loss ratios by line of business, and a change to the calculation could result in a significant change.

Skoog noted one caveat is that few issuers report fee for service revenue, and it appears more unique to provider-sponsored plans. He said that when an issuer reports fee for service revenue, it tends to be a pretty material portion of the total revenue. He said the reason the Academy feels this is important is that there was a case where an issuer reported a substantial amount of fee for service revenue to its total revenue, and when it is netted out (fee for service revenue is not included in revenue nor claims), the observed loss ratio is very high. When it is not netted out, it is still high but has a more reasonable loss ratio.

Skoog said the Academy's view is to look at this on a gross basis and not net out the fee for service revenue. He said using Total Revenue (Line 7) in the Analysis of Operations would allow for a more simplistic approach to the calculation. He also noted that using line 7 would include aggregate write-in revenues (health and non-health). He said line 6 for aggregate write-in revenue for non-health was basically blank across the entire industry, and aggregate write-in revenue for health comprised a tiny portion of total revenue. He asked the medical loss ratio should use total revenue as the denominator or continue to use the nuanced view of net premium revenue plus unearned premium revenue plus fee for service revenue plus risk revenue but not include aggregate write-ins. Skoog asked if the Working Group preferred a net or gross-basis approach for total revenue. He said that from a results perspective, it does not appear to have too much of an impact.

Braue said the fee for service business is where the reporting entity is basically acting like a provider or provider intermediary. They are being paid directly for specific services, and it is not a prepaid sort of coverage like the

premium and other risk revenue are. He asked that given that, while it might be that the entity is reflecting the potential gains from that business in its pricing, in terms of potential fluctuation in the results (not an RBC concern), wouldn't there be a much different pattern of fluctuation for that fee for service business versus the prepaid business. Skoog said that is what the Academy was expecting. However, based on the filings, the results in practice did not match that intuition. He said that it appeared after looking at several issuers that there was some relationship where they were pricing this into the products, but it was not obviously clear without reaching out to the issuer directly.

Braue asked if some are reporting losses on the fee for service business itself. Skoog said it is hard to parse that out because the fee-for-service component is included in other lines, and one does not see a stand-alone amount for fee-for-service profit or losses. Braue said he thought that the entity was supposed to report the number of claims netted against the revenue on that line. Skoog said companies are not doing that particularly well.

Drutz suggested meeting in regulator-to-regulator session to discuss specific companies to address the Academy's questions and possibly contacting specific companies to request additional clarification on the reporting.

The Working Group agreed to move forward with a regulator-to-regulator meeting and to expose the Academy letter for 30 days.

Hearing no objections, the Working Group agreed to expose the Academy letter for a 30-day public comment period ending Aug. 24.

8. Adopted its Updated Working Agenda

Drutz said its working agenda was revised to incorporate the following changes: 1) line X1 was updated to reference the adoption of proposal 2022-16-CA; 2) line X3 was updated to reference the adoption of proposal 2023-01-CA; 3) line X4 was updated to include the work with the Academy on the health care receivables; and 4) lines X5 and X10 were deleted because these items have been completed.

Dudek made a motion, seconded by Chou, to adopt its revised working agenda (Attachment). The motion passed unanimously.

9. Received an Update on the Excessive Growth Charge Ad Hoc Group

Drutz said the Excessive Growth Charge Ad Hoc Group has continued to meet and move forward on its work of evaluating the existing health RBC excessive growth charge. He said the group has performed an extensive analysis of various data pieces, and based on the analysis to date, it appears that the current excessive growth charge is working at a reasonable level in identifying companies that incur an underwriting loss in the following year after revenue growth in excess of 10% is reported in the current year. He said there seem to be some limitations with the current charge in that it has a very narrow focus because the trigger is based on the RBC charge and does not seem to identify all companies that incur an underwriting loss in the following year. The group continues to meet generally monthly to determine the best approach to move forward. The group will continue to provide the Working Group with updates.

10. Discussed Pandemic Risk

Drutz said the Working Group has discussed pandemic risk and its effect on the health RBC formula in the last several meetings. During its April 17 meeting, the Working Group discussed some of the questions to think about, and some suggestions were made to look at any work done by the Society of Actuaries (SOA) on the COVID-19

public health emergency (PHE) and evaluate the RBC filings from 2020 to 2022. He suggested asking NAIC staff to: 1) reach out to the SOA on any work it has done on pandemic risk; 2) reach out to modeling firms to see if any model pandemic risk; 3) look at the templates for the calculation used by Solvency II; and 4) review the RBC filings from 2020 to 2022 to see if there are any discernable differences from year to year. Chou suggested also looking at the exposure by the Life Actuarial (A) Task Force on the historical mortality index, which included a discussion on pandemic risk.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/CADTF/2023-2-Summer/HRBCWG/7-25-23 minutesTPR.docx

Capital Adequacy (E) Task Force

RBC Proposal Form

- | | | |
|---|--|---|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input checked="" type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p style="text-align: right;">DATE: <u>7-12-23</u></p> <p>CONTACT PERSON: <u>Crystal Brown</u></p> <p>TELEPHONE: <u>816-783-8146</u></p> <p>EMAIL ADDRESS: <u>cbrown@naic.org</u></p> <p>ON BEHALF OF: <u>Health Risk-Based Capital (E) Working Group</u></p> <p>NAME: <u>Steve Drutz</u></p> <p>TITLE: <u>Chief Financial Analyst/Chair</u></p> <p>AFFILIATION: <u>WA Office of Insurance Commissioner</u></p> <p>ADDRESS: <u>5000 Capitol Blvd SE</u> <u>Tumwater, WA 98501</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-11-H</u> Year <u>2024</u></p> <p style="text-align: center;">DISPOSITION</p> <p>ADOPTED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
---	---

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life and Fraternal RBC Blanks |
| <input checked="" type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The purpose of this proposal is to include Medicare and Medicaid amounts in Column (1), Line (4) – Other Health Risk Revenue and Line (10) – Fee For Service Offset of page XR013. Column (1), Lines (4) and (10) on page XR014 will be updated to reflect the Columns 8 & 9 in the annual statement reference.

Additional Staff Comments:


The proposed change will create consistent treatment of Medicare and Medicaid amounts throughout Column (1) of page XR013.

**** This section must be completed on all forms.**

Revised 2-2023

† Annual Statement Source

		(1) Comprehensive (Hospital & Medical) - Individual & Group	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(1)	Premium	Page 7, Columns 2 & 3, Lines 1 + 2	Page 7, Column 4, Line 1 + 2	Page 7, Columns 6 & 5, Line 1 + 2			Page 7, Column 14, Lines 1 + 2	
(2)	Title XVIII-Medicare	Page 7, Column 8, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 8, Lines 1 + 2
(3)	Title XIX-Medicaid	Page 7, Column 9, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 9, Lines 1 + 2
(4)	Other Health Risk Revenue	Page 7, Columns 2 + 3 + 8 + 9, Line 4	XXX	Page 7, Columns 6 & 5, Line 4			XXX	
(7)	Net Incurred Claims	Page 7, Columns 2 + 3 + 8 + 9, Line 17	Page 7, Column 4, Line 17	Page 7, Columns 6 & 5, Line 17			XXX	
(10)	Fee-For-Service Offset	Page 7, Columns 2 + 3 + 8 + 9, Line 3	XXX	Page 7, Columns 6 & 5 , Line 3			XXX	
(17)	Maximum Per-Individual Risk After Reinsurance	Gen Int Part 2, Lines 5.31 + 5.32	Gen Int Part 2 Line 5.33	Gen Int Part 2 Line 5.34			XXX	XXX

 Denotes items that must be manually entered on filing software.

Health Care Receivables (HCR) Current and Proposed H3 Factors

David A. Quinn, MAAA, FSA
Member, Health Care Receivables Factors Work Group
American Academy of Actuaries

Presentation to the National Association of Insurance Commissioners (NAIC)
Health Risk-Based Capital (E) Working Group
November 8, 2023

About the Academy



- The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues.
- The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

For more information, please visit:

www.actuary.org


Additional Information

- The presenters' statements and opinions are their own and do not necessarily represent the official statements or opinions of the Actuarial Board for Counseling and Discipline (ABCD), Actuarial Standards Board (ASB), any boards or committees of the American Academy of Actuaries, or any other actuarial organization, nor do they necessarily express the opinions of their employers.
- The Academy operates in compliance with the requirements of applicable law, including federal antitrust laws. The Academy's antitrust policy is available online at <https://www.actuary.org/content/academy-antitrust-policy>.
- Academy members and other individuals who serve as members or interested parties of any of its boards, councils, committees, etc., are required to annually acknowledge the Academy's Conflict of Interest Policy, available online at <https://www.actuary.org/content/conflict-interest-policy-1>.

Setting the Context

- Authorized Control Level
 - National Association of Insurance Commissioners (NAIC) Risk-Based Capital Formula
- Health Care Receivables (HCR)
 - Part of the H3 Credit Risk
 - Factors applied to all HCR assets are a part of the H3 result

$$\text{\$Authorized Control Level} = 1.03 \times \frac{H0 + \sqrt{(H1^2 + H2^2 + \text{H3}^2 + H4^2)}}{2}$$

Credit Risk


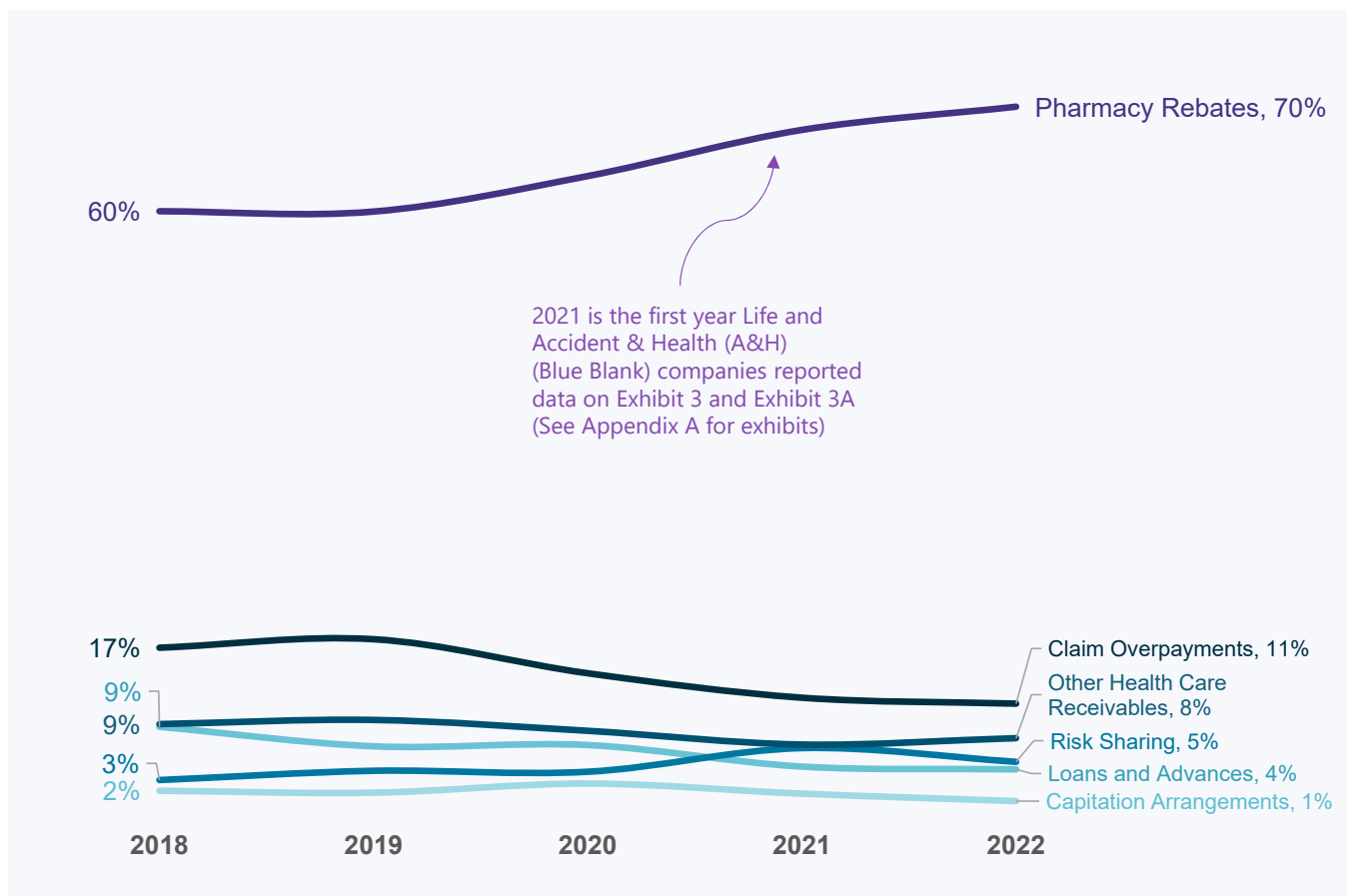
Applying HCR Factors

- HCR Factors
 - Vary by Pharmaceutical Rebates or Non-Pharmaceutical Rebates

HCR Type	Factor (Current)
Pharmaceutical (Rx) Rebate Receivables	0.05
Claim Overpayment Receivables	0.19
Loans and Advances to Providers	0.19
Capitation Arrangement Receivables	0.19
Risk Sharing Receivables	0.19
Other Health Care Receivables	0.19

Non-Pharmaceutical Rebates Receivables

HCR Dollar Distributions



Source: NAIC Annual Health Filings (Orange Blank) 2018–2022, for companies with established receivables

Collecting HCRs

$$\text{Collection Ratio} = \frac{\text{Surplus Component}_{t-1} + \text{Collections}_t}{\text{Admitted HCR Assets}_{t-1}}$$

- *Surplus Component*, prior year: Factors multiplied by admitted assets
- *Collections*, current year: Exhibit 3A Column 5 "Health Care Receivables in Prior Years (Columns 1 + 3)"
- *Admitted HCR Assets*, prior year: Exhibit 3 Column 7 "Admitted"
- *Collection Ratio*: Goal is for a company to collect $\geq 100\%$
- See Appendix A for exhibit layouts and column names

Collecting HCRs (Year)

- Data: NAIC Annual Health Filings (Orange Blank) 2018–2022, for companies with established receivables
- 2021 is the first year Life and A&H (Blue Blank) companies reported on the Health Care Receivables Supplement (Exhibits 3 and 3A)
- 2018 is prior year input for 2019 results, so the table begins with 2019

Year (Rx Rebates HCR)	Company Count	Collection Ratio \geq 100%
2019	519	87%
2020	559	83%
2021	621	86%
2022	674	83%
Year (Non-Rx Rebates HCR)	Company Count	Collection Ratio \geq 100%
2019	366	85%
2020	402	79%
2021	411	81%
2022	457	79%

Source: NAIC Annual Health Filings (Orange Blank) 2018–2022, for companies with established receivables

Collecting HCRs (Size)

- Each company has an HCR size by year for this analysis
- HCR size “Small” if total HCR <\$1 million, “Large” if ≥\$10 million, “Medium” otherwise
- HCR <\$0 were then excluded (rare) and =\$0 excluded (common)

Size (Rx Rebates HCR)	Company Count Four-year Avg.	Collection Ratio ≥100%
Small	112	79%
Medium	216	84%
Large	259	89%

Size (Non-Rx Rebates HCR)	Company Count Four-year Avg.	Collection Ratio ≥100%
Small	58	80%
Medium	137	79%
Large	206	84%

Source: NAIC Annual Health Filings (Orange Blank) 2018–2022, for companies with established receivables

Tiering HCR Factors

- Propose tiered HCR factors
 - Smaller HCR-sized companies hold more surplus component
 - Give larger HCR-sized companies credit for observed stability (higher counts of Collection Ratios $\geq 100\%$)

HCR Type	Current Factor	Tier 1 Factor	Tier Cutoff	Tier 2 Factor
Rx Rebate Receivables	0.05	0.20	\$5 Million	0.03
Claim Overpayment Receivables	0.19	0.40	\$10 Million	0.05
Loans and Advances to Providers	0.19	0.40	\$10 Million	0.05
Capitation Arrangement Receivables	0.19	0.40	\$10 Million	0.05
Risk Sharing Receivables	0.19	0.40	\$10 Million	0.05
Other Health Care Receivables	0.19	0.40	\$10 Million	0.05

Collecting HCRs (Year Revisited)

- Improved Collection Ratio (CR) by year

Year (Rx Rebates HCR)	CR \geq 100% (Current Factors)	CR \geq 100% (Proposed Factors)
2019	87%	91% (+4%)
2020	83%	87% (+4%)
2021	86%	89% (+3%)
2022	83%	88% (+5%)

Year (Non-Rx Rebates HCR)	CR \geq 100% (Current Factors)	CR \geq 100% (Proposed Factors)
2019	85%	87% (+2%)
2020	79%	81% (+2%)
2021	81%	84% (+3%)
2022	79%	82% (+3%)

Source: NAIC Annual Health Filings (Orange Blank) 2018–2022, for companies with established receivables

Collecting HCRs (Size Revisited)

- Improved collection by HCR size

Size (Rx Rebates HCR)	CR \geq 100% (Current Factors)	CR \geq 100% (Proposed Factors)
Small	79%	85% (+6%)
Medium	84%	90% (+6%)
Large	89%	90% (+1%)

Size (Non-Rx Rebates HCR)	CR \geq 100% (Current Factors)	CR \geq 100% (Proposed Factors)
Small	80%	81% (+1%)
Medium	79%	83% (+4%)
Large	84%	86% (+2%)

Source: NAIC Annual Health Filings (Orange Blank) 2018–2022, for companies with established receivables

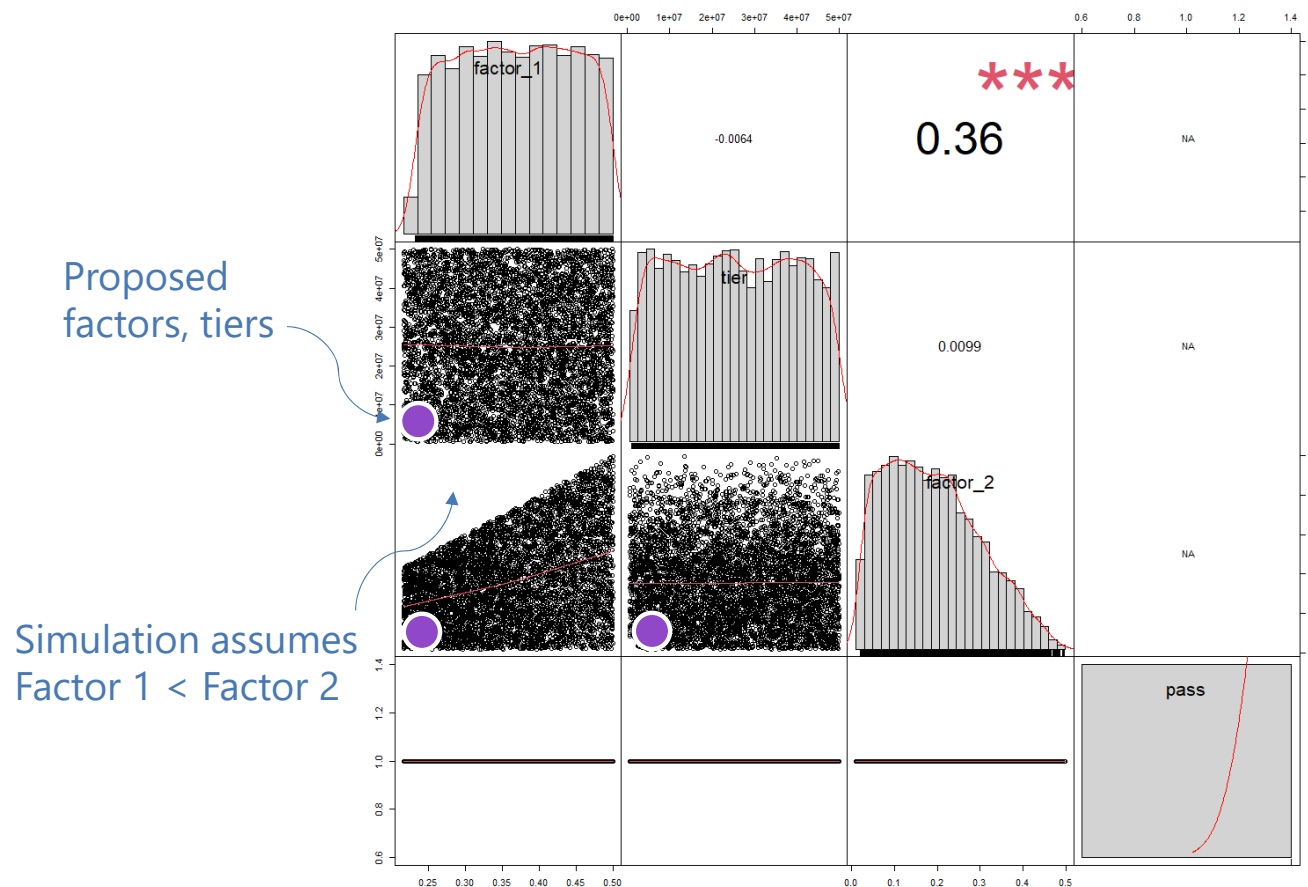
First Proposed Tier Factors

- Which combinations of factors and tier cutoffs work?
- Monte Carlo simulation

First Proposed Tier Factors

- Goal of percent of companies meeting Collection Ratios $\geq 100\%$
 - 90%–100% for Rx HCR
 - 90%–100% for Non-Rx HCR
 - For 10 or more of the 15 size and line combinations (3x sizes by 5x Non-Rx HCR types)
 - Acknowledge variance in reporting accuracy (more on this later)
- Many combinations of factors and tier cutoffs work
 - There's flexibility in the final factors and tier cutoff
 - Each black dot on the next charts is a possible solution

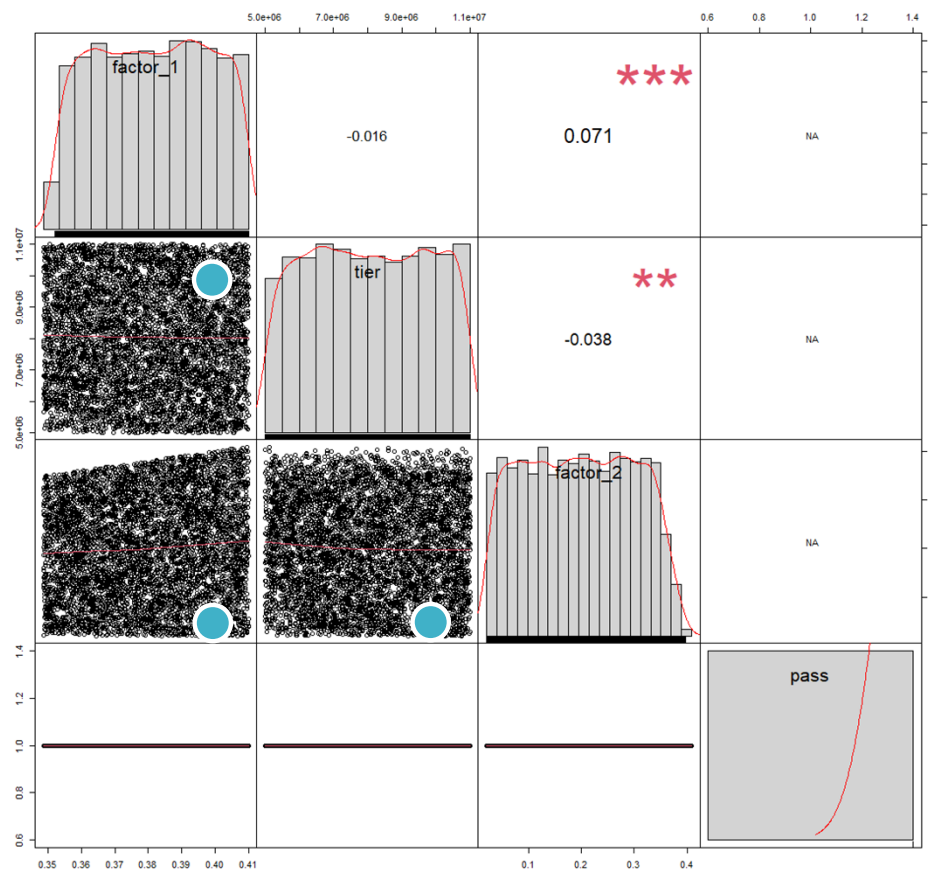
Proposed Factors and Tiers (Rx Rebate HCR)



Proposed factors, tiers

Simulation assumes Factor 1 < Factor 2

Proposed Factors and Tiers (Non-Rx Rebates HCR)



Limitations and Considerations

- Recommendation subject to approval and comment
- Reporting Accuracy
 - Parity between prior year Exhibit 3 and current year Exhibit 3A
 - A company may establish a prior HCR but collect on it in a way not reported in Exhibit 3A
- HCR Size
 - Many combinations of tiers and tier cutoffs
 - Smaller tier threshold, higher factor
 - Proposed factors will have variable impacts on companies

Surplus Component Change in H3 (Proposal)

- 2022 Data

HCR Type	Co. with an Increased H3 Surplus (+)	Co. with a Decreased H3 Surplus (-)	Avg. Relative Change in H3 Surplus (+)	Avg. Relative Change in H3 Surplus (-)	Largest Magnitude Relative Change (+)	Largest Magnitude Relative Change (-)
Rx Rebate HCR	89%	11%	+240%	-19%	+300%	-39%
Non-Rx Rebates HCR	91%	9%	+105%	-14%	+111%	-69%

Source: NAIC Annual Health Filings (Orange Blank) 2018–2022, for companies with established receivables

Surplus Component Change in H3

- Rx Rebate HCR (2022)

Rx Rebate HCR (Millions)	H3 Surplus <i>Before Proposal</i>	H3 Surplus <i>After Proposal</i>	Difference
If an Increase (+)	\$188	\$385	+\$197
If a Decrease (-)	\$780	\$535	-\$245
Total	\$968	\$920	-\$48

Surplus Component Change in H3

- Non-Rx Rebate HCR (2022)

Non-Rx Rebate HCR (Millions)	H3 Surplus <i>Before Proposal</i>	H3 Surplus <i>After Proposal</i>	Difference
If an Increase (+)	\$326	\$551	+\$225
If a Decrease (-)	\$630	\$329	-\$301
Total	\$956	\$880	-\$76

Appendix A: Exhibit 3, Exhibit 3A Examples

EXHIBIT 3 – HEALTH CARE RECEIVABLES

ANNUAL STATEMENT FOR THE YEAR 2013

1 Name of Debtor	2 1 – 30 Days	3 31 – 60 Days	4 61 – 90 Days	5 Over 90 Days	6 Non-admitted	7 Admitted
Pharmaceutical rebate receivables						
Claim overpayment receivables						
Loans and advances to providers						
Capitation arrangement receivables						
Risk sharing receivables						
Other receivables						
Gross health care receivables					R6	R7

EXHIBIT 3A – ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5 Health Care Receivables in Prior Years (Columns 1 + 3)	6 Estimated Health Care Receivables Accrued as of December 31 of Prior Year
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year		
1. Pharmaceutical rebate receivables						
2. Claim overpayment receivables						
3. Loans and advances to providers						
4. Capitation arrangement receivables						
5. Risk sharing receivables						
6. Other health care receivables						
7. Totals (Lines 1 through 6)						A6 = Prior Yr(R6+R7)

Questions?

Thank You

For more information, please contact

Matthew J. Williams, JD, MA

Senior Policy Analyst, Health

American Academy of Actuaries

williams@actuary.org



October 31, 2023

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula

Dear Chair Drutz:

On behalf of the Health Underwriting Risk Factors Analysis Work Group of the Health Solvency Subcommittee of the American Academy of Actuaries (the work group),¹ I appreciate the opportunity to provide these updates to the National Association of Insurance Commissioners (NAIC) Health Risk-Based Capital (E) Working Group in response to the request to comprehensively review the H2—Underwriting Risk Component and the Managed Care Credit Calculation in the Health Risk-Based Capital (HRBC) formula.

A subset of members within the work group now meets on a weekly basis to work on the tiered RBC Factor development (Track 2); volunteer participation has increased since the summer. Progress has been made getting new volunteers up to speed on the work track, providing access to collected data, and reviewing historical work products and reports from the Health Solvency Subcommittee.

Members of the work group have been assigned lines of business and are exploring the partitioned data and developing high-level statistics. The next steps of the work group include:

- Finalize data exploration and analysis and share additional questions with NAIC staff, as necessary;
- Share data findings and statistics with fellow work group members for review and discussion of methodology and results;
- Determine additional data and resources, if necessary, for completing the analysis;
- Share data and risk analysis insights and determine a consistent methodology across the applicable lines of business (e.g., consistent method of determining outlier data points);
- Generate premium tiers based on risk analysis and premium growth across lines of business;
- Develop premium risk factors for each applicable premium tier and line of business; and
- Document analysis and draft findings for review.

The goal of the work group continues to be to develop the draft analysis and findings by the end of this calendar year.

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson, Health Solvency Subcommittee
Health Underwriting Risk Factors Analysis Work Group
American Academy of Actuaries

Cc: Crystal Brown, Senior Health RBC Specialist & Education Lead, Financial Regulatory Affairs, NAIC

NAIC Health Risk Based Capital (E) Working Group
Working Paper: Pandemic Risk and Insurer Solvency

A Review of Personal Consumption Expenditures (PCE) on Healthcare
Before, During, and After the COVID-19 Pandemic

Matthew Richard, ASA, MAAA, CEBS, ARe
Texas Department of Insurance
November 8, 2023



PO Box 12030 | Austin, TX 78711 | 800-578-4677 | tdi.texas.gov

Executive Summary

As the Health Risk-Based Capital (E) Working Group has been discussing Pandemic Risk, we noted an innovative analysis from August 2021, published by the Kaiser Family Foundation. This analysis used Personal Consumption Expenditures (PCE) data to explore the decline and recovery in aggregate healthcare spending in the United States due to the COVID-19 pandemic. In October 2023, actuaries at the Texas Department of Insurance updated this analysis with the latest data from the Bureau of Economic Analysis (BEA). We then performed additional analysis by state and by BEA region.

Our key finding is that although per capita healthcare expenditures fell dramatically during the pandemic and rose even more dramatically immediately afterwards, the magnitude of these changes varied significantly by state. During the crisis in 2020, spending fell by an average of 5.0% from 2019 levels, from a 0.2% decrease in Louisiana, to a 9.3% decrease in Alaska. Then during the recovery in 2021, per capita spending increased by an average of 11.5% from 2020 levels, ranging from a 7.6% increase in Maine, up to a 16.9% increase in North Carolina.

In 2022, we see a stabilization, and a return of both trends and levels to pre-pandemic projections.

The implication for solvency regulation is that although the crisis period is important, the recovery period also presents risks to insurer solvency. Trends are very high as expenditure levels return to historic norms, but they are also volatile, with widely dispersed trends across the states.

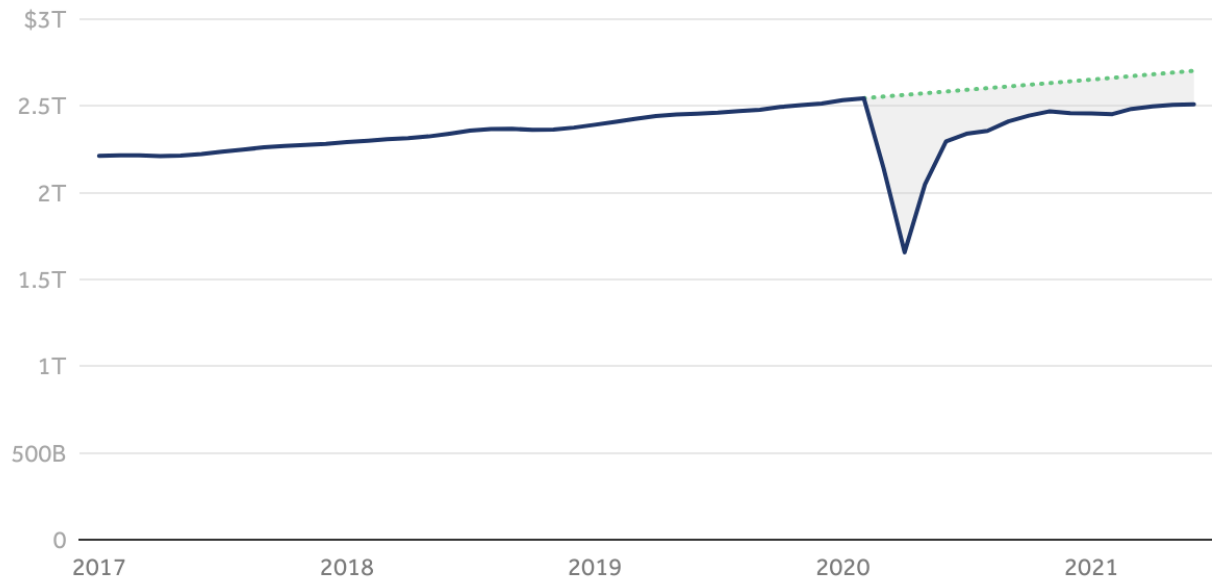
Introduction

On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. Businesses, schools, and workplaces were shut down nationwide, and stay-at-home orders were declared to limit the spread of this illness. Non-essential healthcare treatments were delayed or canceled to focus medical resources on managing COVID-19.

In August 2021, the Kaiser Family Foundation (KFF) published their analysis of aggregate Personal Consumption Expenditures (PCE) on healthcare. This analysis showed a decrease in spending during the pandemic, and no significant rebound in health care utilization. Through June 2021, expenditure levels remained below long-term trends:

Health services expenditures (seasonally adjusted annual rates), Jan. 2017-June 2021

Select: **Health services** **Hospital**



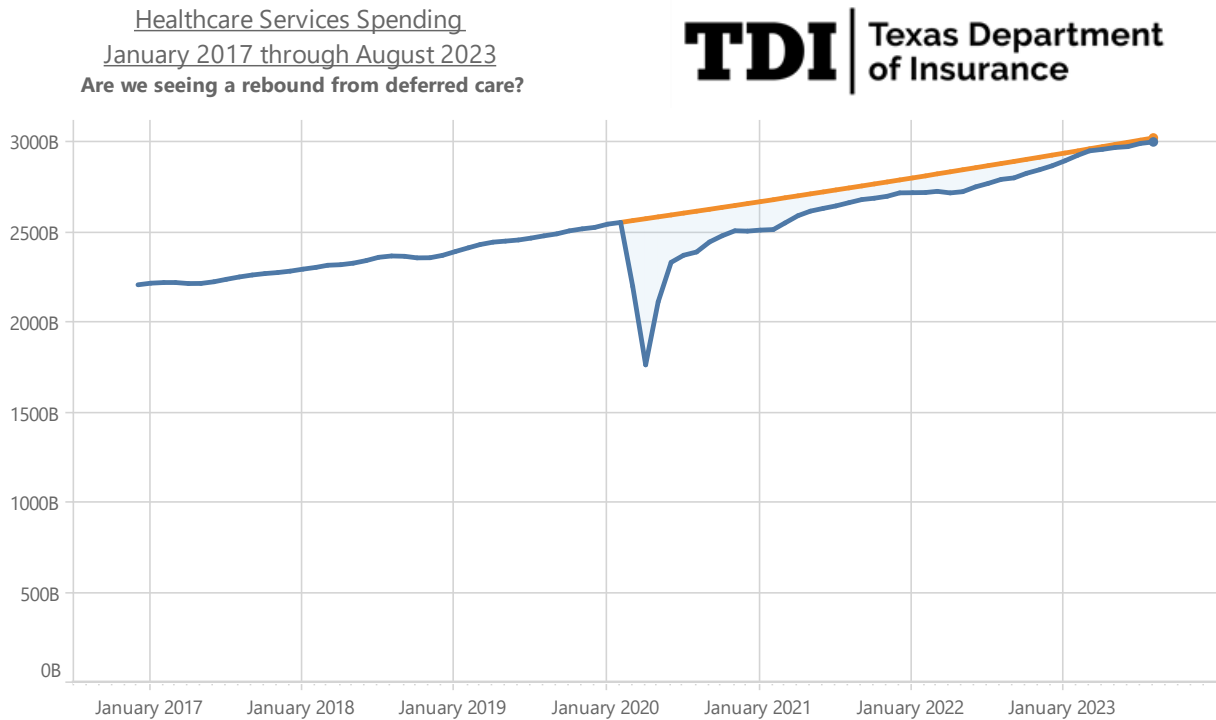
Note: Projected health services expenditures are based on January 2017-January 2020 monthly average growth rate applied to February 2020-June 2021.

Source: KFF analysis of BEA data

Peterson-KFF
Health System Tracker

The source data is produced by the Bureau of Economic Analysis (BEA) to support the official estimates of GDP. Per the BEA's documentation, "PCE also includes expenditures financed by third-payers on behalf of households, such as employer-paid health insurance and medical care financed through government programs."

In October 2023, the Texas Department of Insurance refreshed this analysis with monthly data through August 2023. We see that aggregate healthcare spending remained below long-term projections for three years, with the gap finally closing in the middle of 2023:

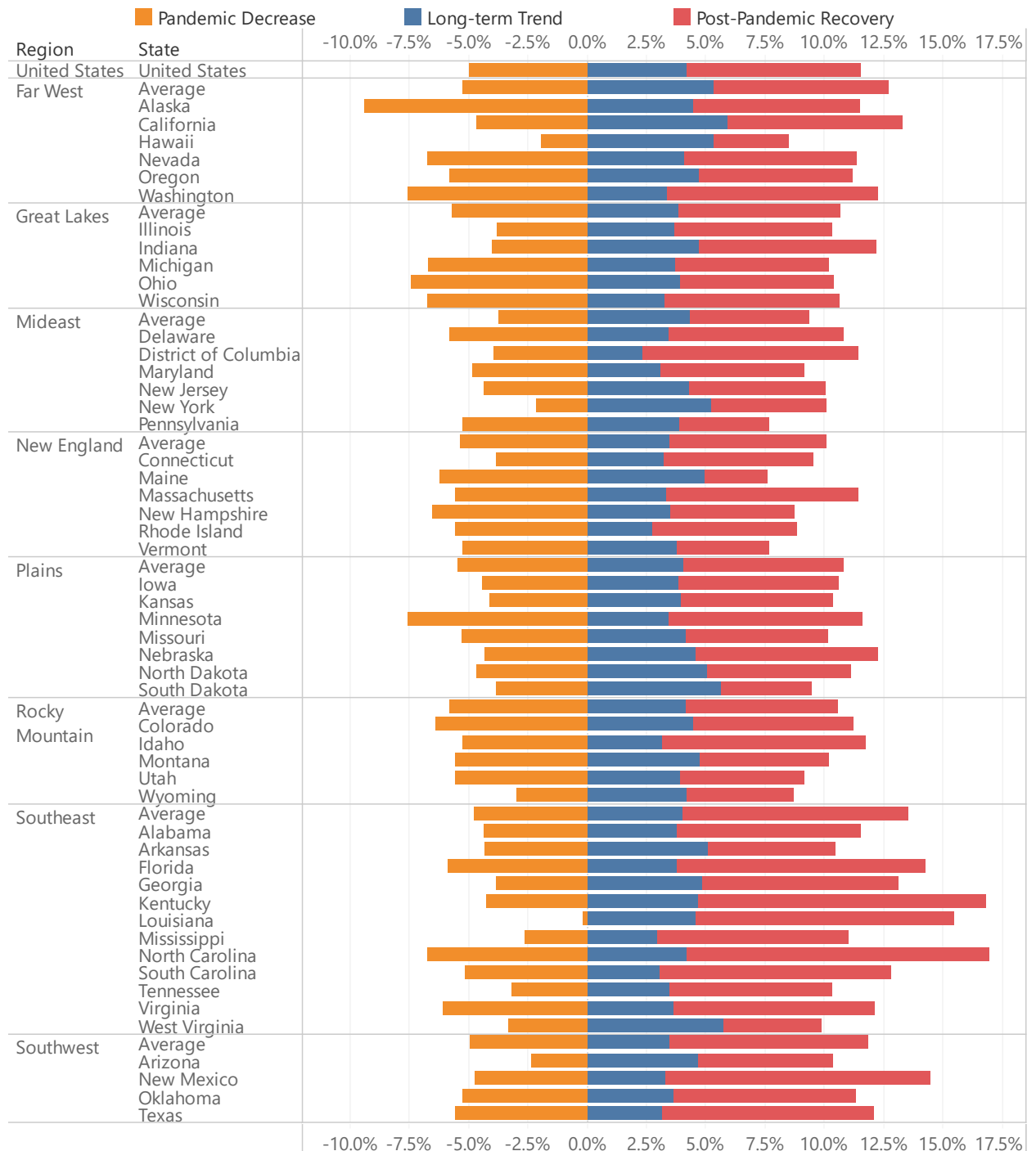


Documentation

Data from Bureau of Economic Analysis, Table 2.3.5U:
Personal Consumption Expenditures by Major Type of Product and by Major Function
Modeled on 2021 analysis from Kaiser Family Foundation:
<https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/>

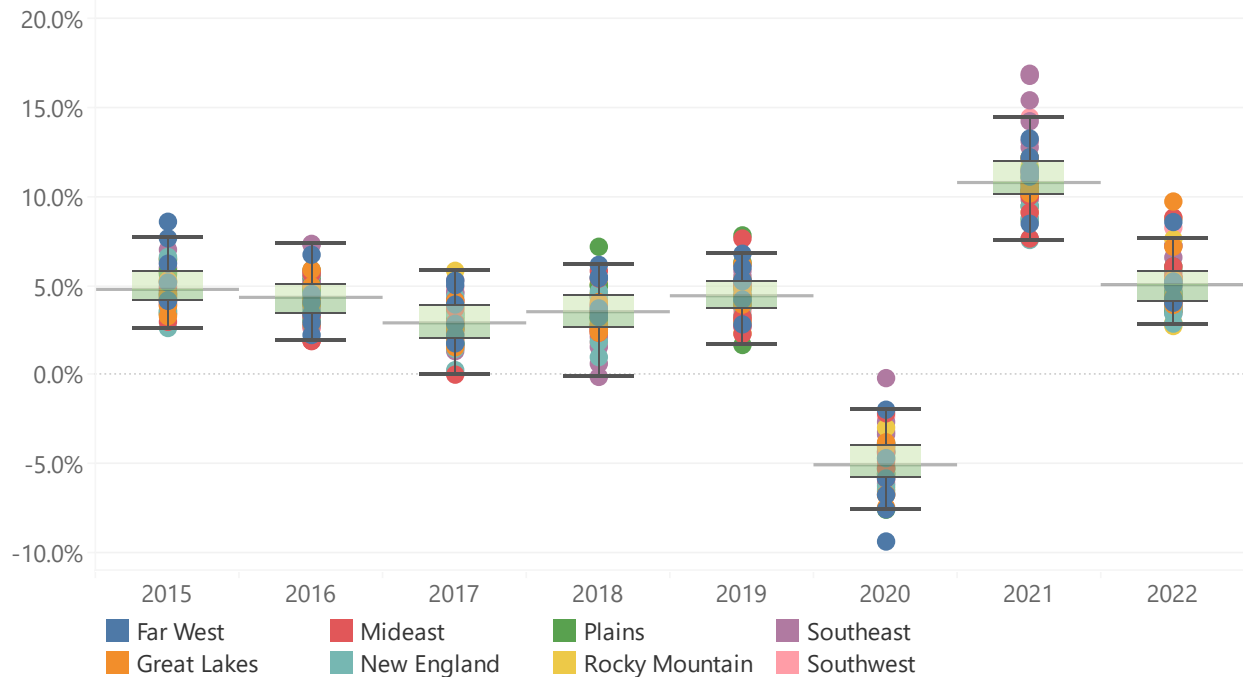
Our next step was to review healthcare expenditures data on a per capita basis, and by state. We compared historical trends from 2014-2019 to the crisis period in 2020, and then the recovery period in 2021. We see a reduction in expenditures during the crisis, followed by very high trends during the recovery. For example, the year-over-year trend in the United States was minus 5.0% in 2020. The long-term trend was 4.2%, and the 2021 trend was 11.5% (7.3% higher than the long-term trend).

Dispersion of Trends in Healthcare Spending
Before, During, and After COVID-19 Pandemic



In both 2020 and 2021, healthcare expenditures trends were widely dispersed. By 2022, trends had largely returned to historic levels.

Dispersion of Trends in Healthcare Spending
 Before, During, and After COVID-19 Pandemic



Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product

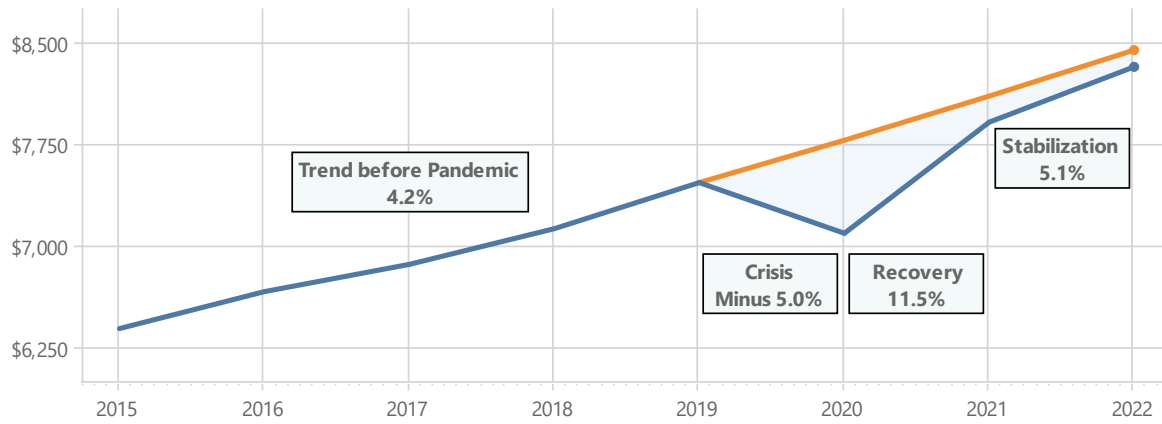
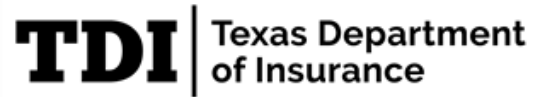
We can conclude with the following recommendations:

1. Regulators should scrutinize health insurers' pricing assumptions and forecasts more rigorously during and after a pandemic.
2. The Experience Fluctuation Risk component of RBC could be sensitivity-tested by recalculating it with the prior year's Underwriting Risk Claims Ratio.
3. The review of Statements of Actuarial opinion should ensure that the moderately adverse scenario used to develop the Premium Deficiency Reserve consider very high trends in a post-pandemic recovery period.

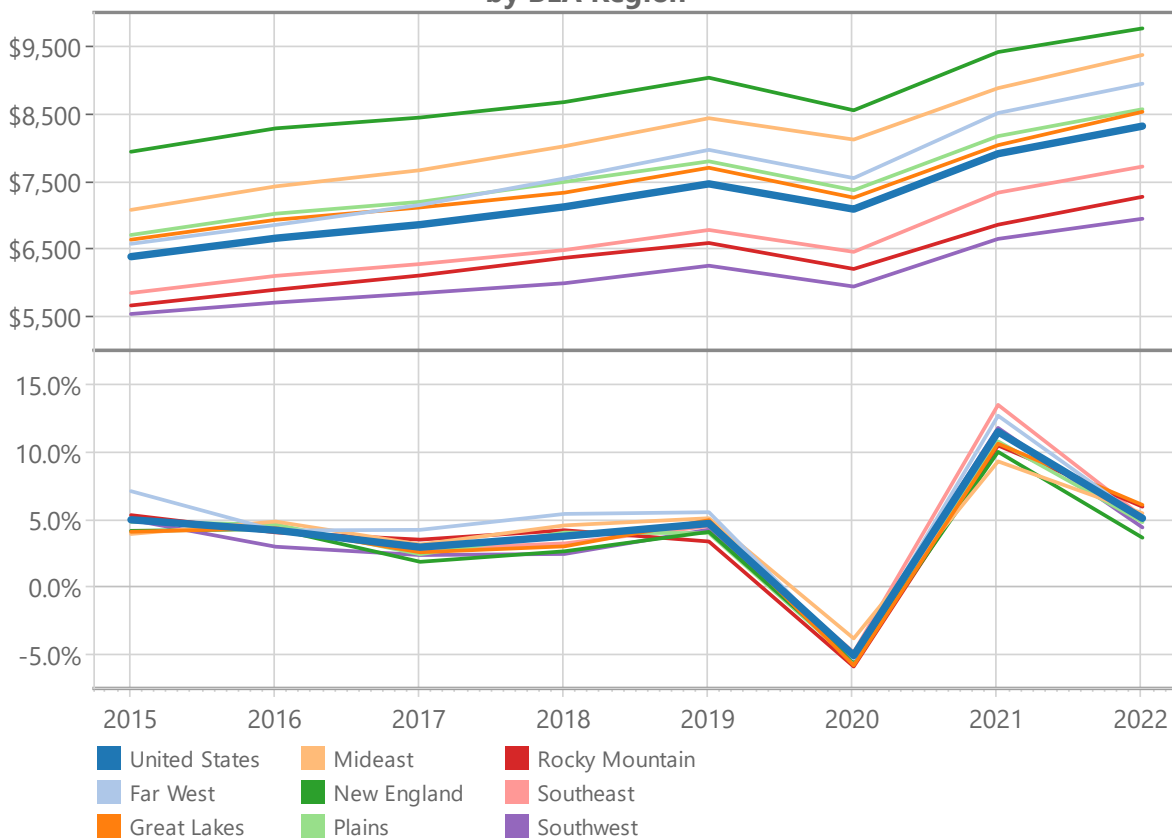
Appendix A

Summaries of Health Expenditure Trends by BEA Region

Per Capita Healthcare Services Spending
 2015 through 2022
 United States



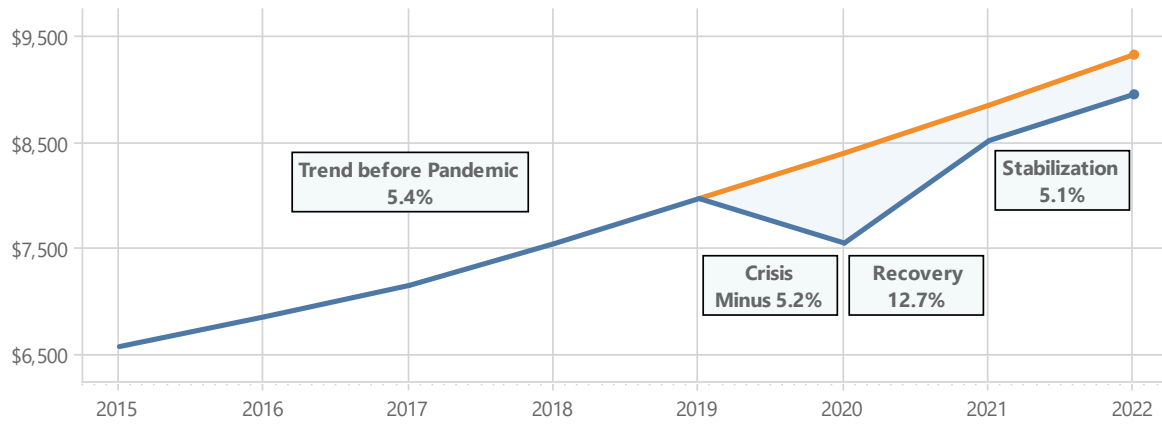
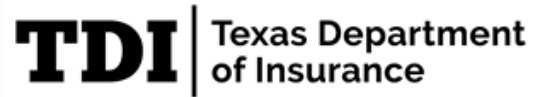
Spending and Trends
 by BEA Region



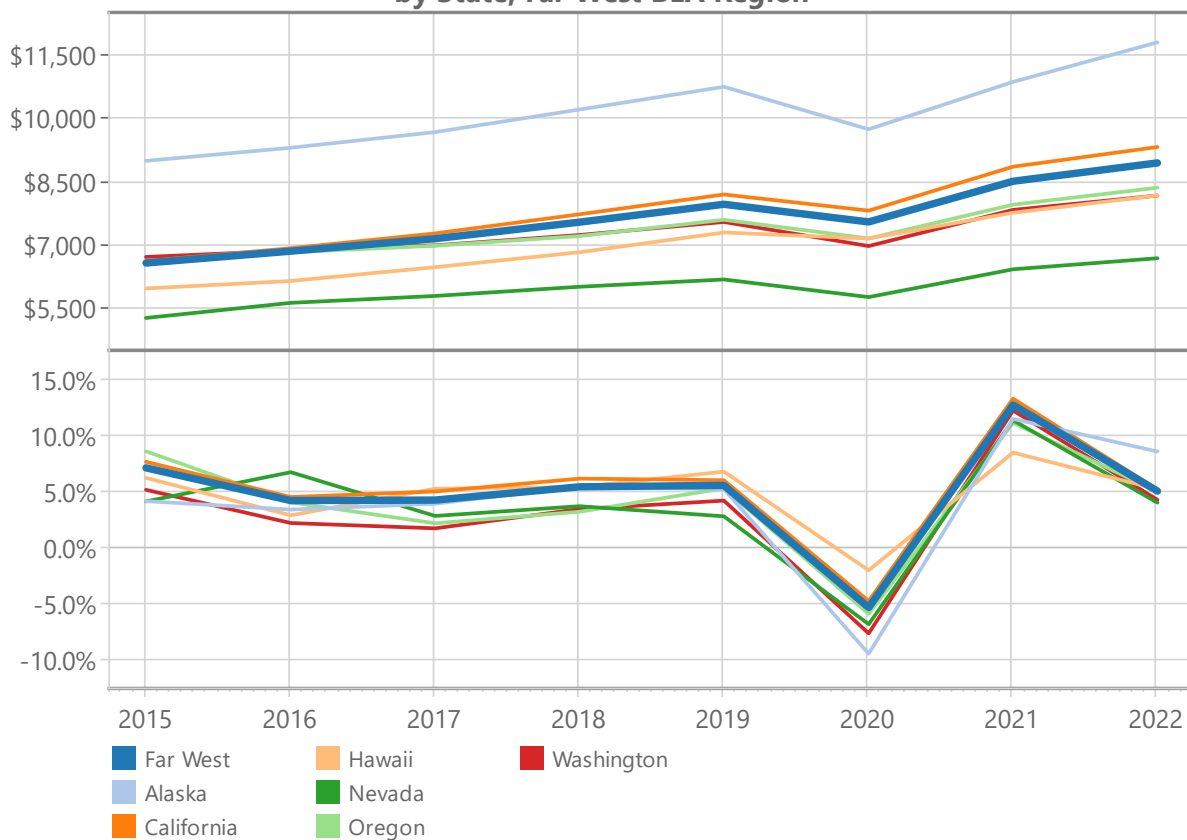
Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product

Per Capita Healthcare Services Spending
 2015 through 2022
 BEA Region: Far West



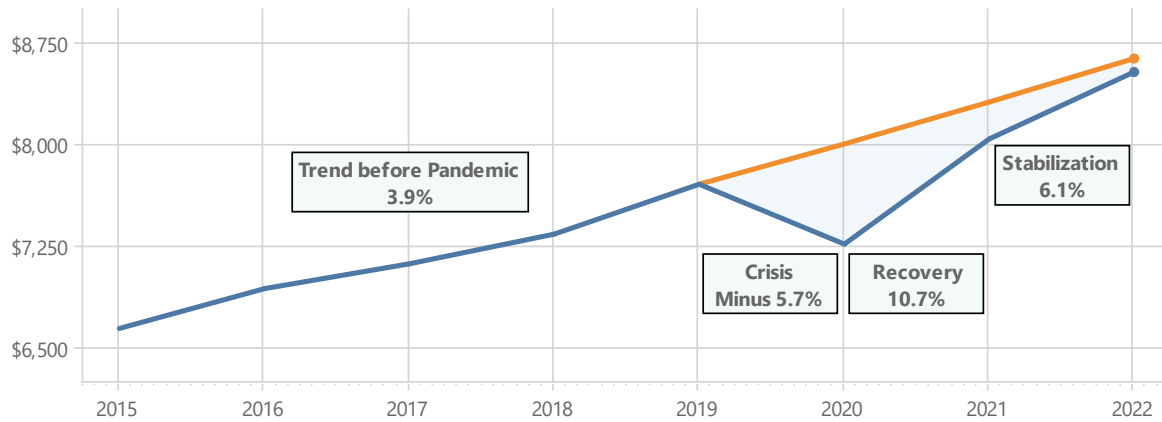
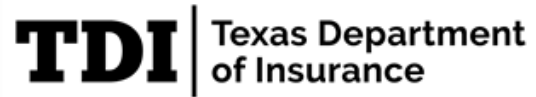
Spending and Trends
 by State, Far West BEA Region



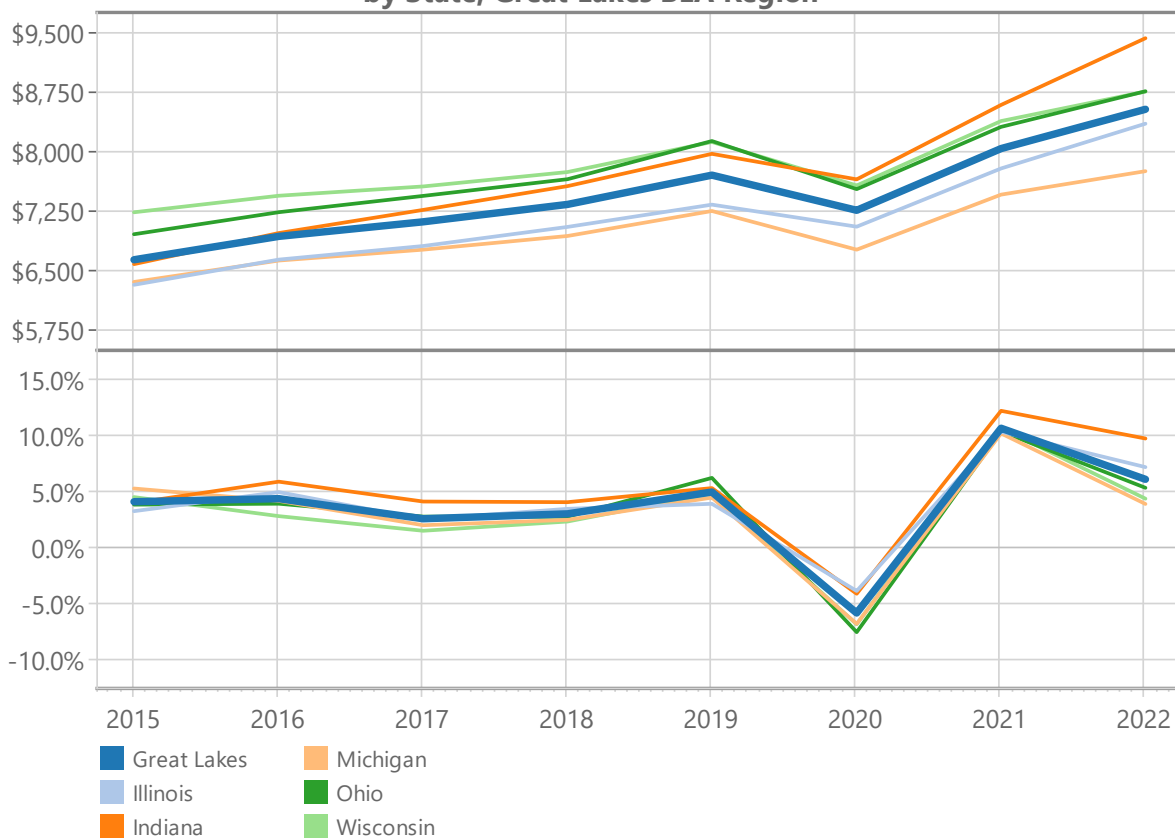
Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product
 Far West includes Alaska, California, Hawaii, Nevada, Oregon, and Washington.

Per Capita Healthcare Services Spending
 2015 through 2022
 BEA Region: Great Lakes



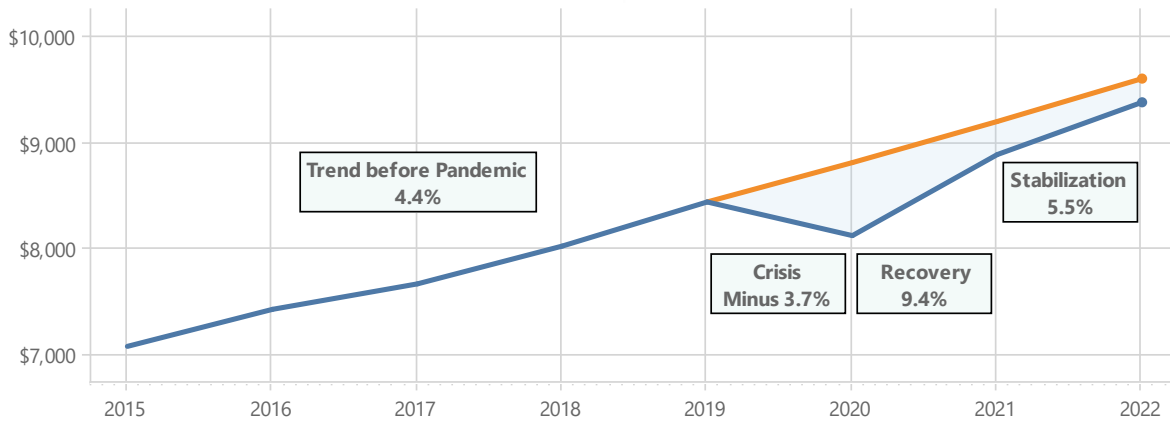
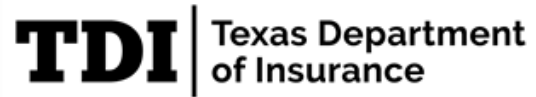
Spending and Trends
 by State, Great Lakes BEA Region



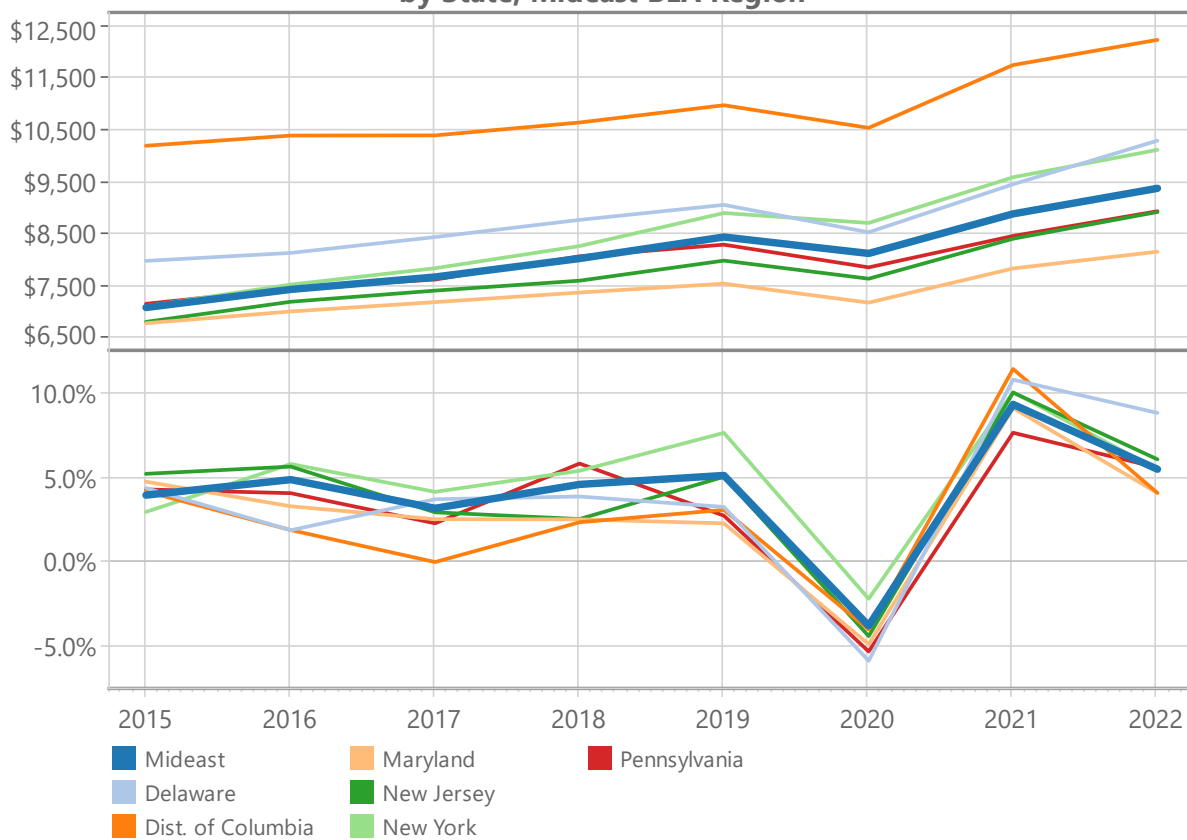
Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product
 Great Lakes includes Illinois, Indiana, Michigan, Ohio, and Wisconsin.

Per Capita Healthcare Services Spending
 2015 through 2022
 BEA Region: Mideast

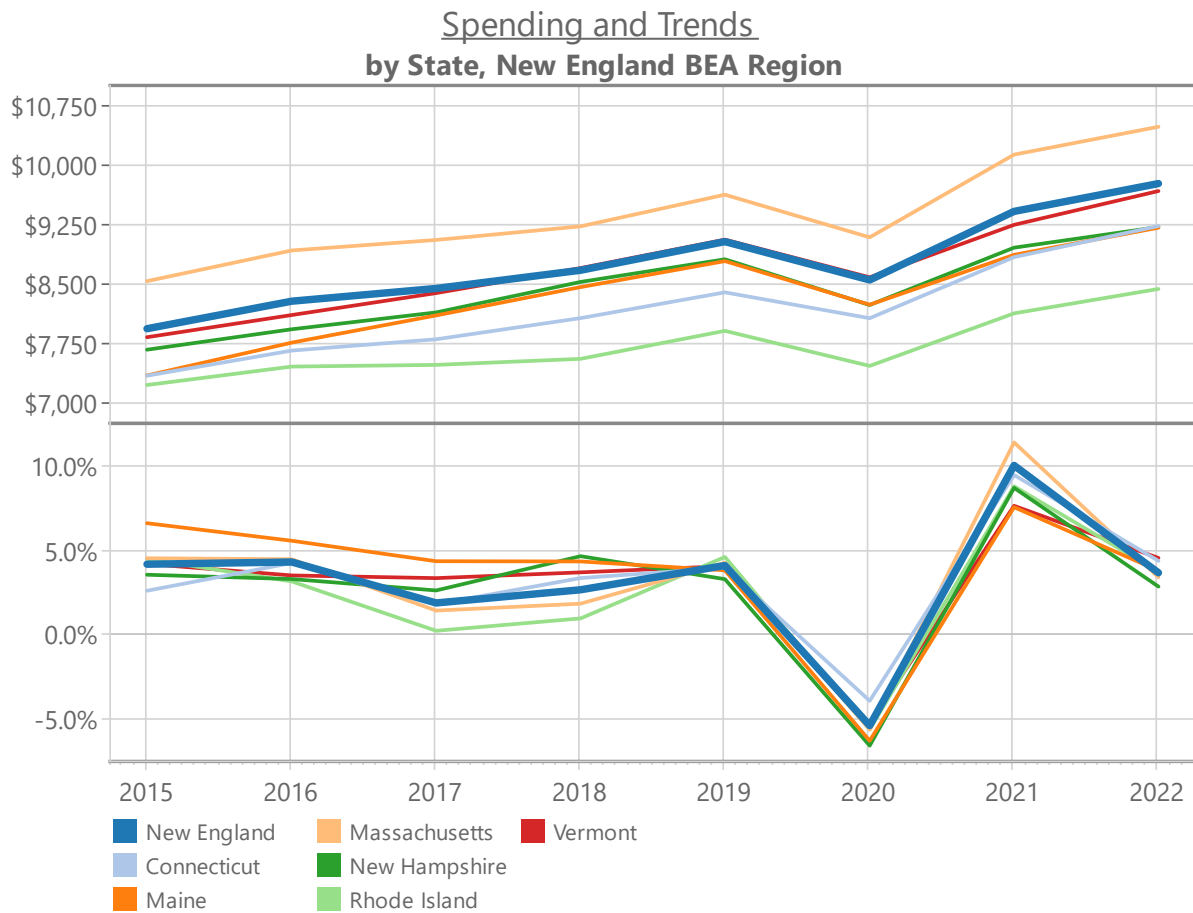
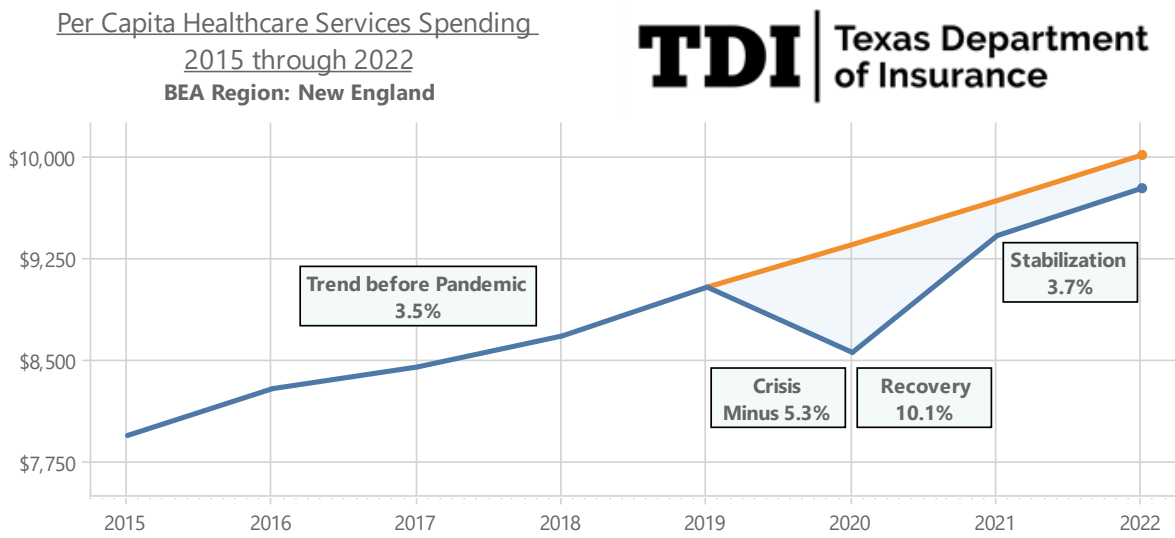


Spending and Trends
 by State, Mideast BEA Region



Documentation

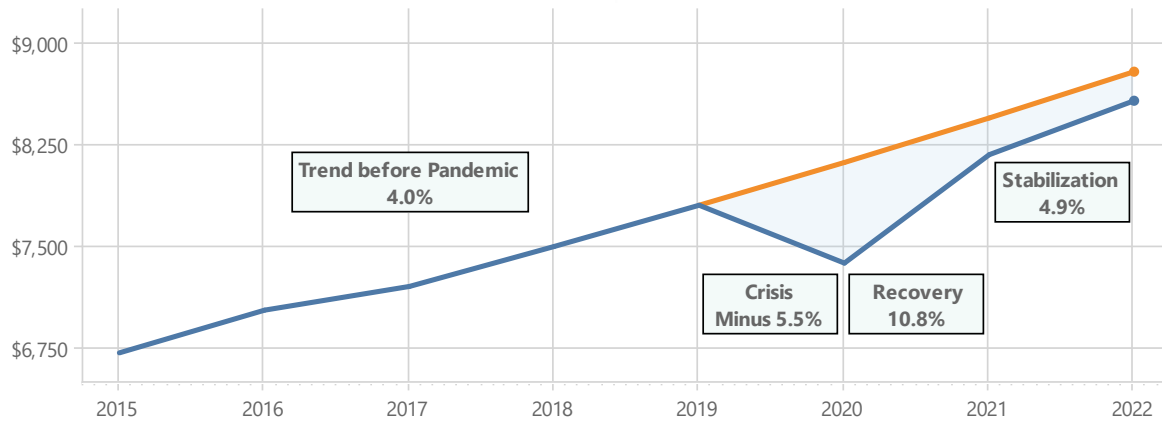
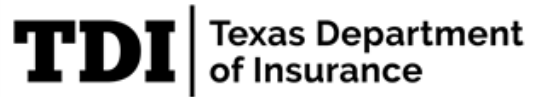
Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product
 Mideast includes Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania.



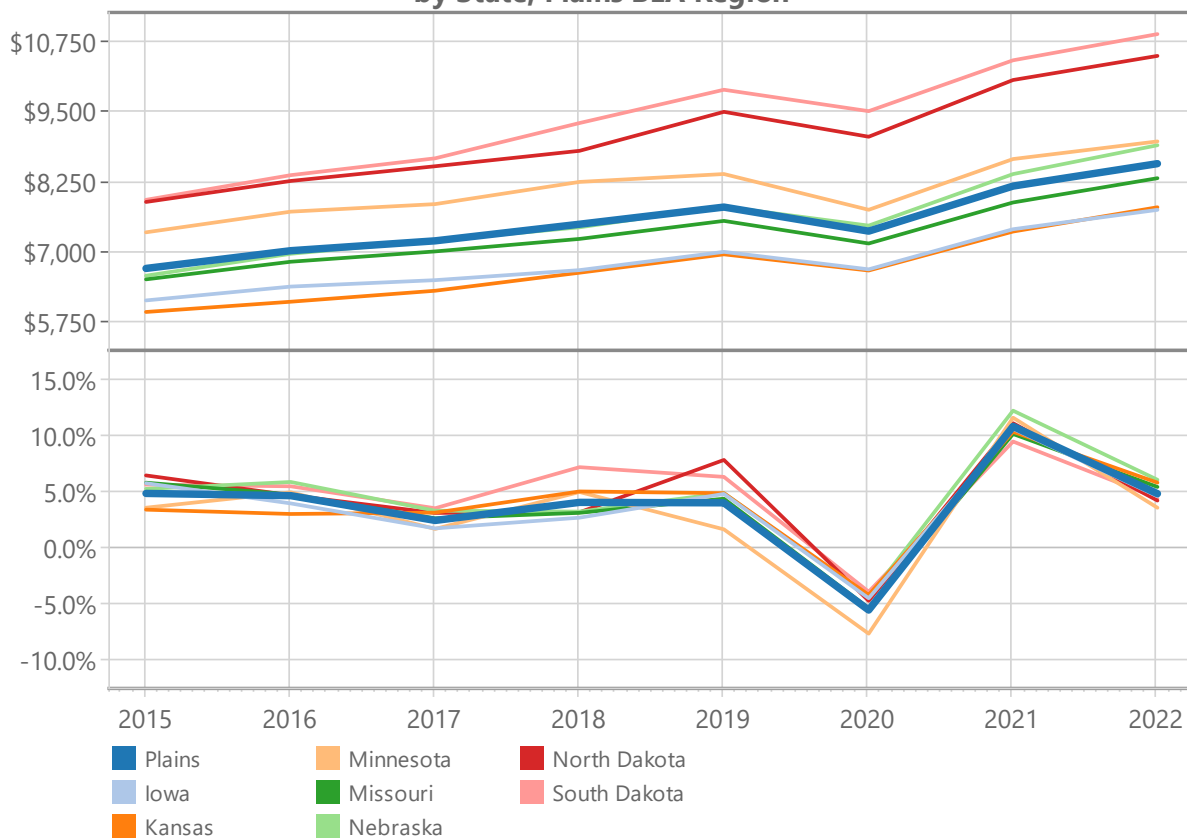
Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product
 New England includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

Per Capita Healthcare Services Spending
 2015 through 2022
 BEA Region: Plains



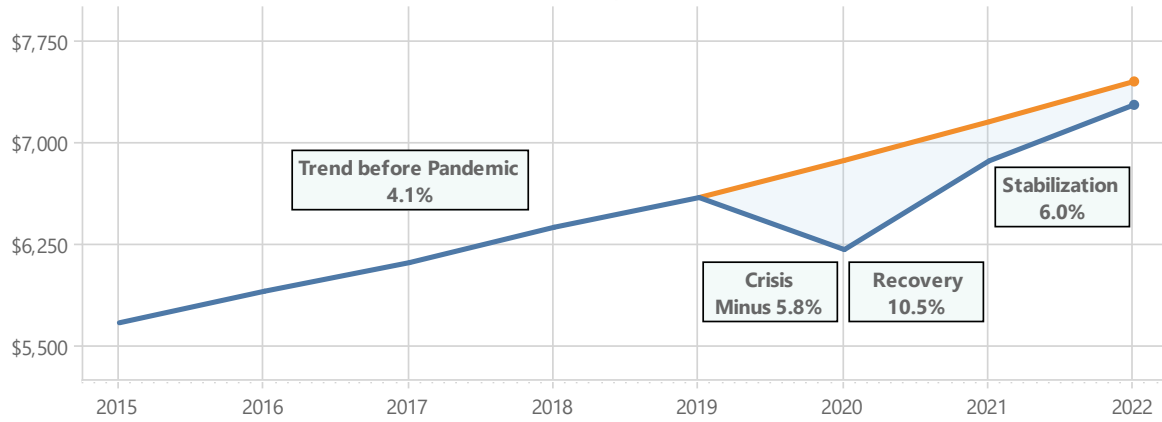
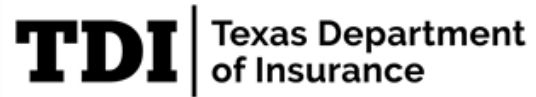
Spending and Trends
 by State, Plains BEA Region



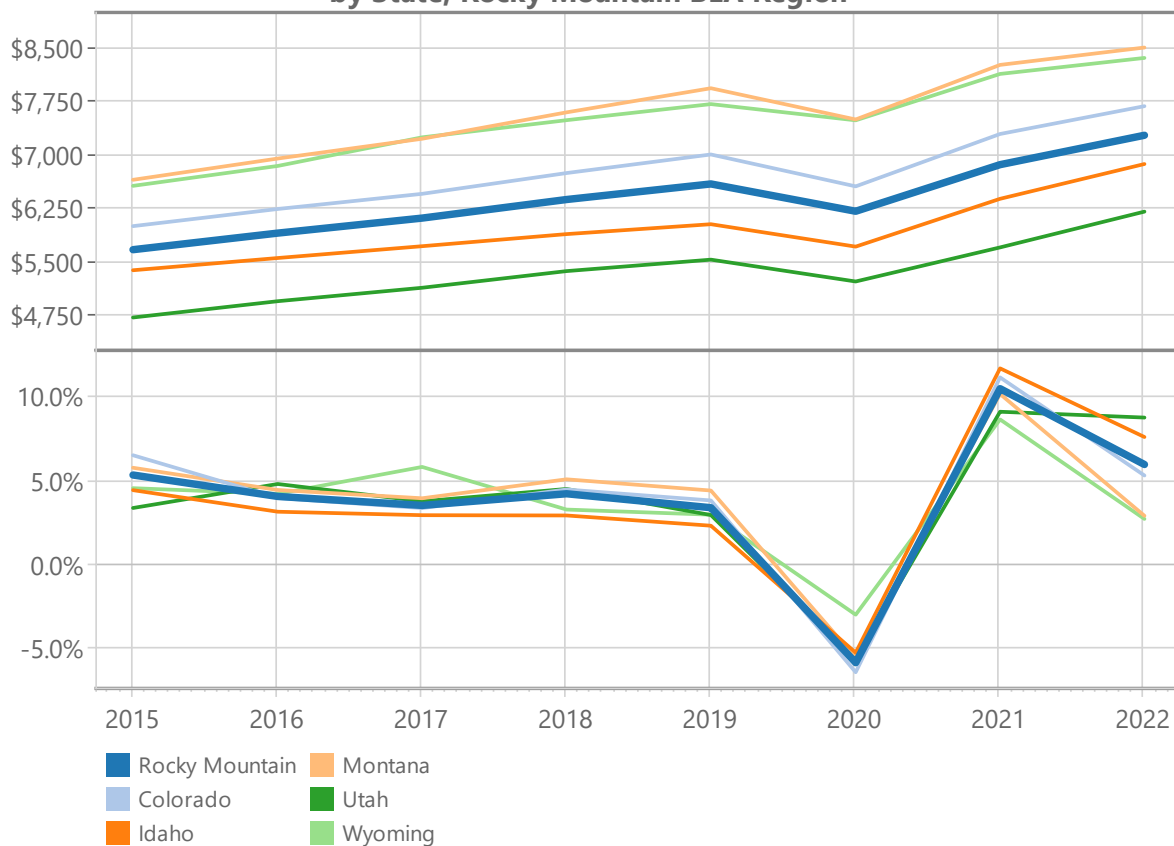
Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product
 Plains includes Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota.

Per Capita Healthcare Services Spending
 2015 through 2022
 BEA Region: Rocky Mountain



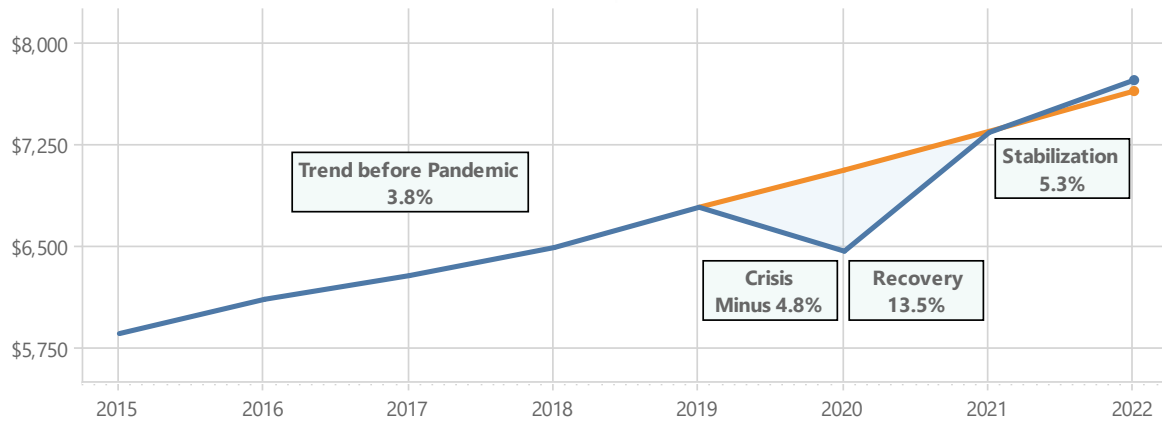
Spending and Trends
 by State, Rocky Mountain BEA Region



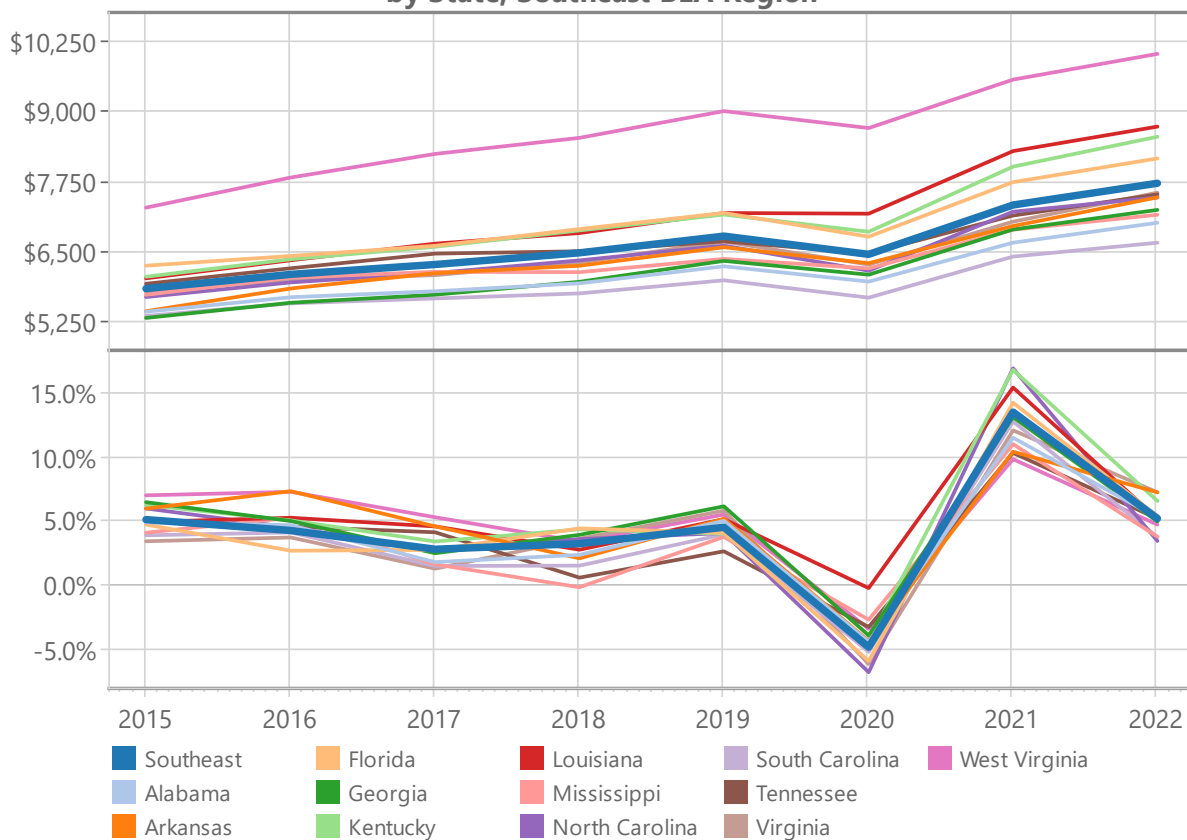
Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product
 Rocky Mountain includes Colorado, Idaho, Montana, Utah, and Wyoming.

Per Capita Healthcare Services Spending
 2015 through 2022
 BEA Region: Southeast



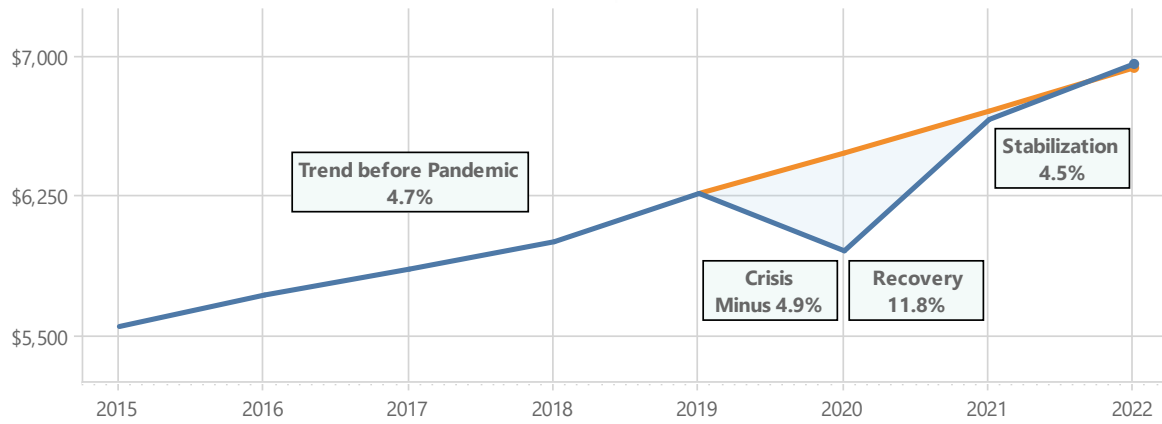
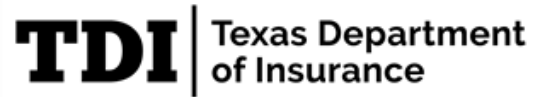
Spending and Trends
 by State, Southeast BEA Region



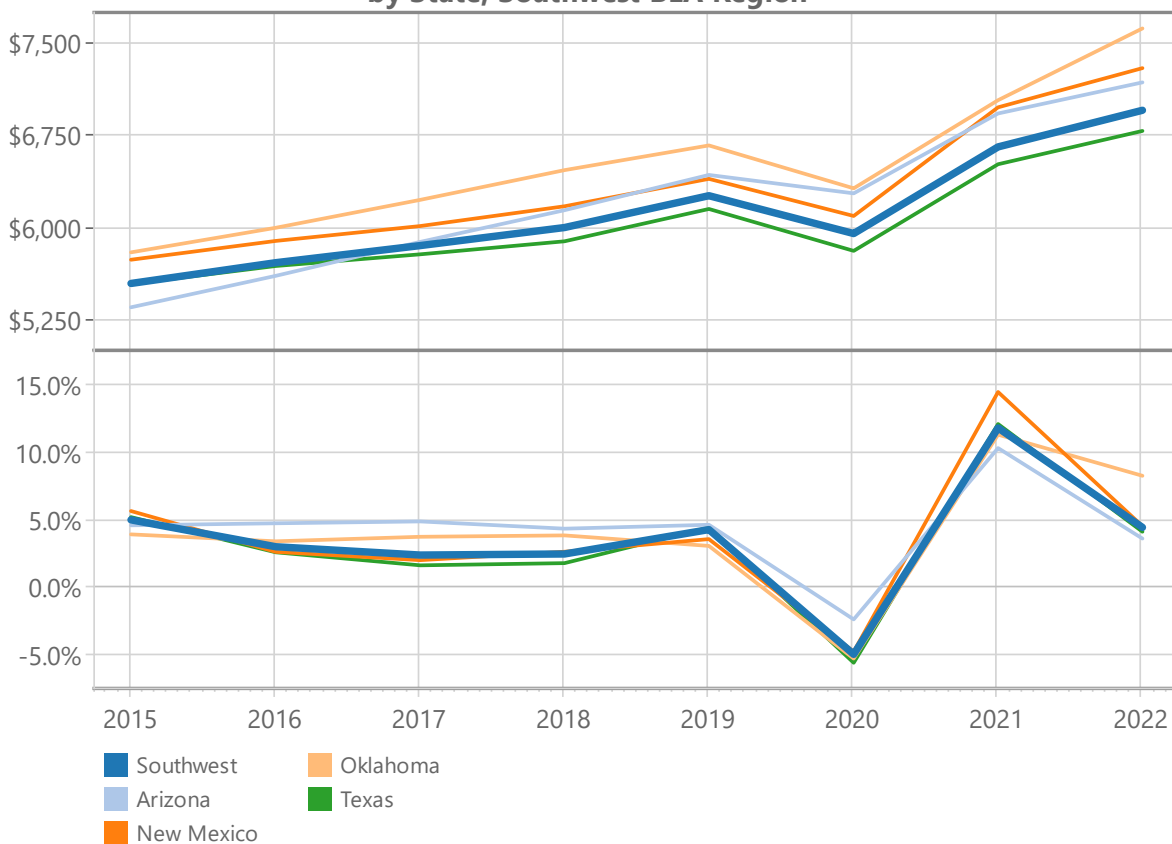
Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product
 Southeast includes Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Per Capita Healthcare Services Spending
 2015 through 2022
 BEA Region: Southwest



Spending and Trends
 by State, Southwest BEA Region



Documentation

Data from Bureau of Economic Analysis, Table SAPCE2:
 Per Capita Personal Consumption Expenditures by Major Type of Product
 Southwest includes Arizona, New Mexico, Oklahoma, and Texas.

Appendix B

Per Capita Expenditures on Healthcare Services, Levels and Annual Trends

PER CAPITA EXPENDITURES ON HEALTHCARE SERVICES, LEVELS AND ANNUAL TRENDS
NATIONAL AVERAGE AND BUREAU OF ECONOMIC ANALYSIS REGIONS

Region	Group	Per Capita PCE, Healthcare Services									Annual Trend							
		2014	2015	2016	2017	2018	2019	2020	2021	2022	2015	2016	2017	2018	2019	2020	2021	2022
United States	United States	6,093	6,400	6,673	6,874	7,137	7,477	7,103	7,923	8,331	5.0%	4.3%	3.0%	3.8%	4.8%	-5.0%	11.5%	5.1%
Far West	Far West	6,150	6,590	6,870	7,165	7,557	7,980	7,562	8,525	8,959	7.2%	4.2%	4.3%	5.5%	5.6%	-5.2%	12.7%	5.1%
Great Lakes	Great Lakes	6,386	6,651	6,945	7,128	7,347	7,715	7,273	8,049	8,543	4.1%	4.4%	2.6%	3.1%	5.0%	-5.7%	10.7%	6.1%
Mideast	Mideast	6,820	7,092	7,440	7,679	8,034	8,448	8,132	8,893	9,384	4.0%	4.9%	3.2%	4.6%	5.2%	-3.7%	9.4%	5.5%
New England	New England	7,630	7,952	8,298	8,458	8,687	9,047	8,565	9,427	9,777	4.2%	4.4%	1.9%	2.7%	4.1%	-5.3%	10.1%	3.7%
Plains	Plains	6,408	6,721	7,036	7,211	7,506	7,810	7,383	8,183	8,581	4.9%	4.7%	2.5%	4.1%	4.1%	-5.5%	10.8%	4.9%
Rocky Mountain	Rocky Mountain	5,388	5,678	5,911	6,122	6,383	6,602	6,218	6,873	7,286	5.4%	4.1%	3.6%	4.3%	3.4%	-5.8%	10.5%	6.0%
Southeast	Southeast	5,575	5,863	6,116	6,291	6,498	6,795	6,471	7,347	7,733	5.2%	4.3%	2.9%	3.3%	4.6%	-4.8%	13.5%	5.3%
Southwest	Southwest	5,286	5,552	5,721	5,860	6,007	6,266	5,958	6,663	6,961	5.0%	3.0%	2.4%	2.5%	4.3%	-4.9%	11.8%	4.5%

PER CAPITA EXPENDITURES ON HEALTHCARE SERVICES, LEVELS AND ANNUAL TRENDS

FAR WEST, GREAT LAKES, MIDEAST, AND NEW ENGLAND

Region	Group	2014	2015	2016	2017	2018	2019	2020	2021	2022	2015	2016	2017	2018	2019	2020	2021	2022
Far West	Far West	6,150	6,590	6,870	7,165	7,557	7,980	7,562	8,525	8,959	7.2%	4.2%	4.3%	5.5%	5.6%	-5.2%	12.7%	5.1%
Alaska	Far West	8,644	9,007	9,318	9,688	10,222	10,761	9,755	10,877	11,813	4.2%	3.5%	4.0%	5.5%	5.3%	-9.3%	11.5%	8.6%
California	Far West	6,163	6,637	6,940	7,291	7,743	8,212	7,829	8,870	9,335	7.7%	4.6%	5.1%	6.2%	6.1%	-4.7%	13.3%	5.2%
Hawaii	Far West	5,635	5,988	6,164	6,491	6,845	7,312	7,170	7,780	8,189	6.3%	2.9%	5.3%	5.5%	6.8%	-1.9%	8.5%	5.3%
Nevada	Far West	5,077	5,289	5,647	5,810	6,028	6,200	5,783	6,441	6,703	4.2%	6.8%	2.9%	3.8%	2.9%	-6.7%	11.4%	4.1%
Oregon	Far West	6,055	6,577	6,846	6,999	7,227	7,613	7,171	7,971	8,372	8.6%	4.1%	2.2%	3.3%	5.3%	-5.8%	11.2%	5.0%
Washington	Far West	6,400	6,733	6,885	7,008	7,253	7,561	6,991	7,847	8,186	5.2%	2.3%	1.8%	3.5%	4.2%	-7.5%	12.2%	4.3%
Great Lakes	Great Lakes	6,386	6,651	6,945	7,128	7,347	7,715	7,273	8,049	8,543	4.1%	4.4%	2.6%	3.1%	5.0%	-5.7%	10.7%	6.1%
Illinois	Great Lakes	6,133	6,336	6,653	6,824	7,064	7,344	7,067	7,799	8,362	3.3%	5.0%	2.6%	3.5%	4.0%	-3.8%	10.4%	7.2%
Indiana	Great Lakes	6,340	6,596	6,987	7,278	7,577	7,983	7,662	8,598	9,437	4.0%	5.9%	4.2%	4.1%	5.4%	-4.0%	12.2%	9.8%
Michigan	Great Lakes	6,050	6,372	6,641	6,778	6,950	7,264	6,778	7,470	7,765	5.3%	4.2%	2.1%	2.5%	4.5%	-6.7%	10.2%	3.9%
Ohio	Great Lakes	6,711	6,972	7,249	7,454	7,664	8,144	7,539	8,322	8,770	3.9%	4.0%	2.8%	2.8%	6.3%	-7.4%	10.4%	5.4%
Wisconsin	Great Lakes	6,932	7,248	7,456	7,573	7,754	8,132	7,585	8,395	8,766	4.6%	2.9%	1.6%	2.4%	4.9%	-6.7%	10.7%	4.4%
Mideast	Mideast	6,820	7,092	7,440	7,679	8,034	8,448	8,132	8,893	9,384	4.0%	4.9%	3.2%	4.6%	5.2%	-3.7%	9.4%	5.5%
Delaware	Mideast	7,652	7,989	8,142	8,447	8,777	9,066	8,539	9,463	10,301	4.4%	1.9%	3.7%	3.9%	3.3%	-5.8%	10.8%	8.9%
District of Columbia	Mideast	9,791	10,203	10,399	10,402	10,650	10,982	10,547	11,755	12,239	4.2%	1.9%	0.0%	2.4%	3.1%	-4.0%	11.5%	4.1%
Maryland	Mideast	6,480	6,790	7,016	7,196	7,380	7,551	7,186	7,843	8,166	4.8%	3.3%	2.6%	2.6%	2.3%	-4.8%	9.1%	4.1%
New Jersey	Mideast	6,476	6,816	7,203	7,417	7,608	7,994	7,646	8,415	8,929	5.3%	5.7%	3.0%	2.6%	5.1%	-4.4%	10.1%	6.1%
New York	Mideast	6,911	7,118	7,533	7,848	8,274	8,909	8,718	9,597	10,124	3.0%	5.8%	4.2%	5.4%	7.7%	-2.1%	10.1%	5.5%
Pennsylvania	Mideast	6,866	7,163	7,457	7,630	8,077	8,301	7,864	8,468	8,944	4.3%	4.1%	2.3%	5.9%	2.8%	-5.3%	7.7%	5.6%
New England	New England	7,630	7,952	8,298	8,458	8,687	9,047	8,565	9,427	9,777	4.2%	4.4%	1.9%	2.7%	4.1%	-5.3%	10.1%	3.7%
Connecticut	New England	7,171	7,361	7,677	7,819	8,085	8,409	8,084	8,852	9,243	2.6%	4.3%	1.8%	3.4%	4.0%	-3.9%	9.5%	4.4%
Maine	New England	6,905	7,364	7,777	8,119	8,475	8,802	8,254	8,881	9,222	6.6%	5.6%	4.4%	4.4%	3.9%	-6.2%	7.6%	3.8%
Massachusetts	New England	8,176	8,550	8,936	9,068	9,239	9,637	9,101	10,141	10,491	4.6%	4.5%	1.5%	1.9%	4.3%	-5.6%	11.4%	3.5%
New Hampshire	New England	7,421	7,688	7,945	8,157	8,540	8,825	8,250	8,971	9,231	3.6%	3.3%	2.7%	4.7%	3.3%	-6.5%	8.7%	2.9%
Rhode Island	New England	6,930	7,244	7,476	7,497	7,573	7,925	7,484	8,145	8,452	4.5%	3.2%	0.3%	1.0%	4.6%	-5.6%	8.8%	3.8%
Vermont	New England	7,526	7,845	8,124	8,400	8,714	9,072	8,598	9,258	9,683	4.2%	3.6%	3.4%	3.7%	4.1%	-5.2%	7.7%	4.6%

PER CAPITA EXPENDITURES ON HEALTHCARE SERVICES, LEVELS AND ANNUAL TRENDS

PLAINS, ROCKY MOUNTAIN, SOUTHEAST, AND SOUTHWEST

Region	Group	Per Capita PCE, Healthcare Services										Annual Trend						
		2014	2015	2016	2017	2018	2019	2020	2021	2022	2015	2016	2017	2018	2019	2020	2021	2022
Plains	Plains	6,408	6,721	7,036	7,211	7,506	7,810	7,383	8,183	8,581	4.9%	4.7%	2.5%	4.1%	4.1%	-5.5%	10.8%	4.9%
Iowa	Plains	5,816	6,153	6,399	6,513	6,691	7,015	6,705	7,417	7,761	5.8%	4.0%	1.8%	2.7%	4.8%	-4.4%	10.6%	4.6%
Kansas	Plains	5,750	5,948	6,130	6,325	6,645	6,971	6,684	7,376	7,807	3.4%	3.1%	3.2%	5.1%	4.9%	-4.1%	10.4%	5.8%
Minnesota	Plains	7,105	7,362	7,729	7,863	8,257	8,397	7,762	8,663	8,976	3.6%	5.0%	1.7%	5.0%	1.7%	-7.6%	11.6%	3.6%
Missouri	Plains	6,167	6,527	6,840	7,023	7,245	7,565	7,164	7,892	8,323	5.8%	4.8%	2.7%	3.2%	4.4%	-5.3%	10.2%	5.5%
Nebraska	Plains	6,261	6,592	6,981	7,215	7,451	7,817	7,481	8,396	8,908	5.3%	5.9%	3.4%	3.3%	4.9%	-4.3%	12.2%	6.1%
North Dakota	Plains	7,420	7,901	8,274	8,535	8,809	9,501	9,059	10,066	10,494	6.5%	4.7%	3.2%	3.2%	7.9%	-4.7%	11.1%	4.3%
South Dakota	Plains	7,513	7,939	8,377	8,676	9,302	9,893	9,513	10,416	10,881	5.7%	5.5%	3.6%	7.2%	6.4%	-3.8%	9.5%	4.5%
Rocky Mountain	Rocky Mountain	5,388	5,678	5,911	6,122	6,383	6,602	6,218	6,873	7,286	5.4%	4.1%	3.6%	4.3%	3.4%	-5.8%	10.5%	6.0%
Colorado	Rocky Mountain	5,639	6,009	6,250	6,463	6,755	7,016	6,568	7,304	7,695	6.6%	4.0%	3.4%	4.5%	3.9%	-6.4%	11.2%	5.4%
Idaho	Rocky Mountain	5,158	5,389	5,561	5,727	5,897	6,036	5,721	6,393	6,882	4.5%	3.2%	3.0%	3.0%	2.4%	-5.2%	11.7%	7.6%
Montana	Rocky Mountain	6,294	6,660	6,959	7,237	7,608	7,947	7,508	8,275	8,519	5.8%	4.5%	4.0%	5.1%	4.5%	-5.5%	10.2%	2.9%
Utah	Rocky Mountain	4,569	4,725	4,954	5,143	5,377	5,538	5,231	5,710	6,213	3.4%	4.8%	3.8%	4.5%	3.0%	-5.5%	9.2%	8.8%
Wyoming	Rocky Mountain	6,286	6,575	6,855	7,257	7,498	7,724	7,496	8,148	8,373	4.6%	4.3%	5.9%	3.3%	3.0%	-3.0%	8.7%	2.8%
Southeast	Southeast	5,575	5,863	6,116	6,291	6,498	6,795	6,471	7,347	7,733	5.2%	4.3%	2.9%	3.3%	4.6%	-4.8%	13.5%	5.3%
Alabama	Southeast	5,195	5,452	5,710	5,816	5,957	6,259	5,987	6,678	7,032	4.9%	4.7%	1.9%	2.4%	5.1%	-4.3%	11.5%	5.3%
Arkansas	Southeast	5,152	5,462	5,865	6,137	6,269	6,597	6,314	6,974	7,482	6.0%	7.4%	4.6%	2.2%	5.2%	-4.3%	10.5%	7.3%
Florida	Southeast	5,984	6,270	6,442	6,623	6,920	7,206	6,785	7,753	8,174	4.8%	2.7%	2.8%	4.5%	4.1%	-5.8%	14.3%	5.4%
Georgia	Southeast	5,015	5,342	5,612	5,755	5,984	6,355	6,110	6,913	7,260	6.5%	5.1%	2.5%	4.0%	6.2%	-3.9%	13.1%	5.0%
Kentucky	Southeast	5,714	6,074	6,384	6,605	6,896	7,177	6,872	8,028	8,559	6.3%	5.1%	3.5%	4.4%	4.1%	-4.2%	16.8%	6.6%
Louisiana	Southeast	5,758	6,045	6,366	6,661	6,849	7,205	7,193	8,304	8,739	5.0%	5.3%	4.6%	2.8%	5.2%	-0.2%	15.4%	5.2%
Mississippi	Southeast	5,524	5,753	6,059	6,161	6,155	6,390	6,222	6,909	7,174	4.1%	5.3%	1.7%	-0.1%	3.8%	-2.6%	11.0%	3.8%
North Carolina	Southeast	5,388	5,713	5,973	6,140	6,364	6,626	6,181	7,228	7,481	6.0%	4.6%	2.8%	3.6%	4.1%	-6.7%	16.9%	3.5%
South Carolina	Southeast	5,173	5,377	5,601	5,688	5,778	6,010	5,702	6,432	6,677	3.9%	4.2%	1.6%	1.6%	4.0%	-5.1%	12.8%	3.8%
Tennessee	Southeast	5,656	5,949	6,224	6,484	6,526	6,702	6,488	7,160	7,535	5.2%	4.6%	4.2%	0.6%	2.7%	-3.2%	10.4%	5.2%
Virginia	Southeast	5,607	5,802	6,021	6,102	6,326	6,697	6,290	7,052	7,566	3.5%	3.8%	1.3%	3.7%	5.9%	-6.1%	12.1%	7.3%
West Virginia	Southeast	6,819	7,300	7,835	8,254	8,539	9,014	8,713	9,573	10,030	7.1%	7.3%	5.3%	3.5%	5.6%	-3.3%	9.9%	4.8%
Southwest	Southwest	5,286	5,552	5,721	5,860	6,007	6,266	5,958	6,663	6,961	5.0%	3.0%	2.4%	2.5%	4.3%	-4.9%	11.8%	4.5%
Arizona	Southwest	5,121	5,358	5,614	5,890	6,148	6,435	6,285	6,935	7,188	4.6%	4.8%	4.9%	4.4%	4.7%	-2.3%	10.3%	3.6%
New Mexico	Southwest	5,436	5,745	5,898	6,019	6,180	6,403	6,101	6,985	7,304	5.7%	2.7%	2.1%	2.7%	3.6%	-4.7%	14.5%	4.6%
Oklahoma	Southwest	5,584	5,805	6,005	6,232	6,474	6,675	6,326	7,043	7,627	4.0%	3.4%	3.8%	3.9%	3.1%	-5.2%	11.3%	8.3%
Texas	Southwest	5,272	5,548	5,694	5,789	5,895	6,158	5,817	6,522	6,793	5.2%	2.6%	1.7%	1.8%	4.5%	-5.5%	12.1%	4.2%