



Draft date: 02/12/24

Virtual Meeting

**HEALTH RISK-BASED CAPITAL (E) WORKING GROUP**

Thursday, February 22, 2024

11:00 a.m. – 12:00 p.m. ET / 10:00 – 11:00 a.m. CT / 9:00 – 10:00 a.m. MT / 8:00 – 9:00 a.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 November 8, 2023 Minutes—*Steve Drutz (WA)* Attachment One
- 2) Consider Exposure of Proposal 2024-09-CA (UW Risk Factors – Investment Income Adjustment)—*Steve Drutz (WA)* Attachment Two
- 3) Discuss Comments Received on the American Academy of Actuaries (Academy) Health Care Receivables Presentation—*Steve Drutz (WA) and Kevin Russell & David Quinn (Academy)* Attachment Three
  - UnitedHealth Group Comment Letter—*Jim Braue (UnitedHealth Group)* Attachment Four
- 4) Discuss Pandemic Risk—*Steve Drutz (WA)*
- 5) Consider Adoption of Working Agenda—*Steve Drutz (WA)* Attachment Five
- 6) Hear an Update on the H2-Underwriting Review from the Academy—*Steve Guzski (Academy)*
- 7) Discuss Any Other Matters Brought Before the Working Group—*Steve Drutz (WA)*
- 8) Adjournment

Draft: 12/4/23

Health Risk-Based Capital (E) Working Group  
Virtual Meeting  
November 8, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Nov. 8, 2023. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair, and Aaron Hodges (TX); Sarah Mu (CT); Tish Becker (KS); Danielle Smith (MO); Margaret Garrison (NE); and Tom Dudek (NY). Also participating was: Tom Botsko (OH).

1. Adopted its July 25 Minutes

Drutz said the Working Group met July 25. During this meeting, the Working Group took the following action: 1) adopted its May 17 and April 17 minutes; 2) adopted its 2023 health risk-based capital (RBC) newsletter; 3) adopted its 2022 health RBC statistics; 4) exposed proposal 2023-11-H for a 30-day public comment period that ended Aug. 24; 5) referred a health test proposal to the Blanks (E) Working Group; 6) heard an update from the American Academy of Actuaries (Academy) on its health care receivables project; 7) heard an update from the Academy on the H2-Underwriting Risk Review; 8) adopted its updated working agenda; 9) received an update on the Excessive Growth Charge Ad Hoc Group; and 10) discussed pandemic risk.

Drutz said the Working Group met Oct. 2 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to meet with the Academy to address questions on data reported by specific companies related to the H2-Underwriting Risk Review.

Smith made a motion, seconded by Dudek, to adopt the Working Group's July 25 (Attachment **xx**) minutes. The motion passed unanimously.

2. Adopted Proposal 2023-11-H

Drutz said proposal 2023-11-H (XR014 Fee-For-Service and Other Risk Revenue-Medicare and Medicaid) 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). The proposal was exposed for a 30-day comment period, during which time no comments were received.

Dudek made a motion, seconded by Garrison, to adopt proposal 2023-11-H. The motion passed unanimously.

3. Exposed the Academy's Health Care Receivables Presentation

David Quinn (Academy) presented the "Health Care Receivables (HCR) Current and Proposed H3 Factors" (Attachment **xx**) to the Working Group. He said that the health care receivables are part of the H3 credit risk component, and this presentation will go over what the Academy has seen in recent years of reporting, what may happen if the factors were changed, and the effect it may have. He said there are various categories of health care receivables. For purposes of this presentation, the Academy grouped them into two main categories: Pharmaceutical Rebates (pharmacy) and Non-Pharmaceutical Rebates (non-pharmacy) which includes claim overpayment receivables, loans and advances to providers, capitation arrangement receivables, risk-sharing receivables, and other health care receivables. He said slide six represents the percentage that these health care receivable dollars make up, based primarily on Exhibit 3 and Exhibit 3a of the annual statement. He said in 2021,

certain blue blank companies began reporting these health care receivables. The X-axis represents time, and the Y-axis represents the percent of health care receivables dollars, with pharmaceutical rebates making up the majority of health care receivable dollars and the remaining making up all others. Slide seven looks at how well companies are collecting health care receivables. The collection ratio is a combination of surplus held plus what can be collected in the current year, then dividing that over the admitted health care receivable assets. He said the idea is that if a company is doing a good job of collecting what they believe they are owed, they would get to 100% or more because of the surplus. Using that collection ratio and data from 2018-2022, slide eight shows a count of companies that had these types of receivables and the percentage of those companies that had a collection ratio of 100% or more. He said the percentage of companies that are collecting should be high. He said it was fairly consistent across the years, including during the pandemic.

Quinn said slide nine is the antithesis of the additional research that the Academy performed, which looked at the breakout by company size, small being less than \$1 million in health care receivables, large being greater than or equal to \$10 million, and medium being in that \$1-\$10 million range. He said that, on average, the larger companies tend to do a better job collecting. Quinn said this led to the question of what would happen if the H3 factor was applied as a tier factor, similar to the H2 factor. He said currently, there is only one factor, and the Academy asked what would happen if two factors were applied with a threshold for the tier cut off in the middle. Slide 10 shows the proposed tiered factors, with the tier-one factors noticeably higher than the current factor. After the tier one cut-off, the factor is lower on average than the current factor. Quinn said the idea is that it would help target surplus holdings to smaller companies that seem to have collected less on average than larger companies and larger companies will benefit from their size and scale, thus having a lower factor on average since historical reporting indicates better collection based on the collection ratios.

Quinn said slide 11 reflects where the Academy has run these factors through by year, and the table shows the effect of the tiered factors. He said the middle column shows the percentage of companies that meet the collection ratio under the current factor, and the last column shows the percentage of companies that would meet the collection ratio using the tiered factors with the percentage point changes in the parentheses. He said that over the years, there has been a uniform increase, with a little bit more on the pharmacy than non-pharmacy in the bottom table. Quinn said slide 12 shows the same type of analysis but by company size instead of year. There is a noticeable increase in the collection of pharmacy rebates for small and medium companies. The results for the non-pharmacy rebates are mixed but still target improvement toward that medium size. He said part of the reason we see less of an improvement in the small size is reporting. Quinn said that, overall, changing to a two-tier structure shows that an increase to the factor for surplus held would result in a better coefficient. The idea is that if a tiered approach is used with two factors, those smaller companies that have collected less on average can be targeted.

Quinn said the Academy's initial proposal thus far comes from Monte Carlo simulations, with set parameters to reach somewhere in the 90%–100% collection ratio for companies. The Academy randomly selected different combinations from a range of factors and cut-offs, tested if goal was met, if so accept, if not reject that proposal. The result is a statistic, called sample space, that shows there are many combinations of factors and cut-offs that meet these criteria. He said that the Academy picked one of those and moved forward with it, but there is flexibility to adjust the factors in the cut-off. It is still getting to the same desired result if smaller companies can be helped to meet higher collection ratios. He said slide 15 shows an example of that simulation output. The black dots are accepted solutions, and those marked in purple are the proposed pharmacy factors in the tier where they fit in the sample space. Quinn said that if one moves around between factors and tiers within where there are black dots, those solutions meet the goal of bolstering the collection ratio. Slide 15 is for pharmacy rebates, and slide 16 is the same chart type but for the non-pharmacy rebates. These slides represent and document where the proposed factors are one of many acceptable proposals. He said the Academy did not see as large of an improvement on small, non-pharmacy rebate health care receivable collection, which was partly due to reporting.

This is an area where, on the non-pharmacy side, one will see health care receivables set up the prior year but then not collected. The expectation is that something is to be collected, but instead, zero is reported. This deflates the ratio of how well one thinks companies are collecting and appears like the company did not collect. However, it is possible they collected it through some other means. For example, if it is a provider overpayment, instead of having an explicit check back to collect on those overpayments, there could have been an agreement to reduce future payments until the difference is made up, but that agreement did not get reported. This makes it harder to know the true effect of holding more surplus for small companies on the non-pharmacy side, depending on the quality of the reporting.

Quinn said, as mentioned before, there are many combinations of the health care receivable size and therefore there will be different impacts depending on the company size, which will be discussed next. Essentially, small companies will be holding more surplus, which has its own financial and economic consequences. Larger companies, on average, will hold less. One can take advantage of those smaller proposed factors beyond the threshold. Holding less surplus on average will also have financial and economic consequences.

Quinn said slides 18 and 19 show some of the average effects on the 2022 data. The first column shows that if the proposed two factors were used, companies would see an increase in H3. For pharmacy rebates, 89% of companies would see an increase in their surplus holding, or 11% would see a decrease on average. For those that had an increase, the company would hold 240% more on average. For those larger companies with a decrease, on average, it would be a 19% decrease. The last two columns show the maximum and minimum a company would be affected by. Quinn said those same statistics are repeated for non-pharmacy on the bottom line, with a large number of companies that would hold more and few companies that would hold less. He said slide 19 shows what that would mean in total reported dollars. For the pharmacy rebate side, the increase one would see is \$197 million more. On the decreased side, one would see a \$245 million loss. Thus, the total is a net negative of \$48 million due to the significant number of smaller companies that would hold more, offset by a few large companies holding a little bit less. However, they are large, so a relatively small amount offsets the small companies' increase. Slide 20 shows the same thing as slide 19 but for non-pharmacy receivables with similar results. Again targeting smaller companies to bolster their collection ratio and then the scale of larger companies, can hold a little bit less surplus on average because they've been doing well collecting relative to small companies.

Quinn summarized that small companies do not collect as well on health care receivables as large companies, as a result, the Academy looked at what would happen if the charge was moved to a two-factor tiered approach. He said, on average, a two-factor tiered approach does help small- to medium-sized companies collect better and larger companies as a benefit of their size and relatively better collection rates can hold less surplus.

Jim Braue (UnitedHealth Group) asked if the collection ratio was calculated at the company action level because the Academy is just applying the unmodified factors to the prior years' receivables. Quinn said the factors are applied to the prior years' admitted health care receivable assets, which is the surplus component at the period T - 1, and then there are collections that are coming from Exhibit 3A and then normalizing that over the admitted healthcare receivable assets from the prior period. He said if this comes out to one or higher, it is counted as collecting. Braue asked if the surplus component is just the straight factor from RBC or if it was divided by two to adjust it to the authorized control level. Quinn said it has not gone through the rest of the larger formula, so it has not gone through the covariance. Braue said the surplus component then is effectively at the company action level, so all other things being equal, the Academy is saying the company action level amount is being used to determine whether they are covering the asset from the prior year. Braue asked if the collection ratio was calculated separately for the non-pharmacy portion for each of the five-line items or if those were added together before for the collection ratio. Quinn said he would have to go back and look because the Academy looked at things in different ways.

Braue said when the current factors were developed, the Academy thought that because non-pharmacy receivable amounts were so much smaller, there would not be much credibility to looking at them separately, and they were all pretty much lumped together in the analysis. He said the corollary to that is for the proposed factors with the \$10 million threshold. He asked whether that threshold would be applied to the five categories added together or be applied to them category by category. Quinn said the factors in the threshold were designed to be applied category by category and said that one looks at the results when they are summed together on the back end but apply it line by line. Braue asked if the Academy looked at how this might change if everything had been added together. Quinn said that for simplicity and presenting here, the Academy aggregated them, but he was fairly certain the Academy looked at and applied the factors line by line and then aggregated on the back end. Then the Academy designed the proposed factors to be the same way, targeting them as a bundle. He said the desired result is in aggregate for all non-pharmacy lines, but the math in between is line by line. Braue said that, presumably, one might get a different answer regarding what the factors should be if they were added together because there could be shortfalls in one of those subcategories offsetting excesses in another. Quinn said it would change it. Braue said he may still be concerned about that same credibility issue that the Academy raised regarding whether it makes sense to try to analyze them separately.

Braue said that some of the footnotes on these slides say that the data come from the orange blank filings, but it looked like, at least for some of them, that blue blank data is being included for years 2021 and 2022. He asked whether that was correct. Quinn said that it does include the blue blank data starting with 2021. Braue asked if the Academy looked to see if the results were materially different for blue blank versus orange blank companies. Quinn said that they did not. Braue said when looking at it year over year, it does not look like there was a big change when the blue blank was added. He said he would only be concerned that the same H3 factor is not in the life formula for the blue-blank companies. Thus, the Academy would potentially be applying something based on blue blank data to a subset of companies to which that does not apply. Braue said that, again, if the blue blank experience pretty much looks the same anyway, that would not matter, but he would just be concerned about making sure that is the case. Quinn said this is a nuance that he does not know enough about to comment on. Crystal Brown (NAIC) said there is not a charge for health care receivables in the life blank. Braue said his concern would be that the experience for a blue-blank company could be different from an orange-blank company. He said he would be concerned that if it is, that experience it might not apply to the subset of companies to which this formula is actually going to apply.

Braue said that with proposed factors and splitting the results by size, it still shows much lower success percentages for the smallest amounts, some of which may be due to some reporting issues. He asked if the Academy looked at possibly going to a three-tier factor to try and apply something even higher to the smallest amounts and then a mid-range factor to the next level of amounts and then the small factor to the very highest ones. Quinn said this is a good observation, and early on, the Academy did look at three factors (meaning two cut offs and three factors), and it came down a handful of companies where it saw there was a health care receivable established the prior year but looking at the next year's 3A, nothing has been collected. So, no matter what factor has been applied for the prior year to create a larger holding of surplus, it is not going to be enough to ever put those zero reporting companies over. Quinn said it is a variable to consider that is deflating the collection ratio stats looked at earlier. He said a good example of that is on slide 12. Even with the proposed factors, 85% is in the top right, the Academy was trying to target 90 over the years of data considered here. There are more than 400 small companies and over the four years, about 18 of them have this zero reported situation. Those then get into the denominator and lower the small company collection ratio. He said if they are excluded and then those who set up a receivable and a receivable is collected, they are at the 90 that gets diluted as these cases where the reporting does not seem to match what one would have expected given the prior year's established receivable.

Braue asked for a distribution of what the shortfalls look like when the collection ratio is under 100%. Some companies will always have a large percentage shortfall because they essentially collected zero. He asked if most

of them were fairly small once these proposed factors have been applied or if there is a pretty wide range other than those outliers. Quinn said the work group had some exploratory data analysis that looked at that distribution. Fortunately, most of them are close. He said that it is desirable if one is at one or higher when thinking of that collection ratio formula. He said the Academy saw that if a company missed, it was still fairly high at 0.9 or so, but there were definitely outliers.

Drutz said the non-pharmacy rebates on slide 12 were still shy of the 90% marker. He asked if that was based on some sort of conservatism in the opposite direction, whereby there is concern that there is not as much data available and that the data may have reporting issues. So, the charge was not increased as much as the data might suggest. He asked if that was correct. Quinn said there are a number of companies that have established a receivable, but zero dollars was collected on that receivable. No matter what kind of surplus is put on that, they will not move over. In those cases of 81%, 83%, and 86%, some companies in that denominator did not report what was suspected to be collected. This happens more frequently in the non-pharmacy rebate lines than on the pharmacy rebate side. On the pharmacy rebate side, it all felt clean and consistent. Quinn said it was more common to see these cases on the non-pharmacy rebate side, especially since there are more, smaller lines in cases where companies were not collecting where the Academy thought they went. That will deflate those numbers on the bottom right, even though the Academy is trying to target 90% or higher for those collecting.

The Working Group agreed to expose the presentation for a 61-day public comment period ending Jan. 8, 2024.

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

Steve Guzski (Academy) summarized the letter on the H2 Underwriting Risk factors as being worked on by the track 2 work group (Attachment xx). He said the work group has increased its volunteer participation over the last few months, which has aided in developing more of the analysis of the factors. The group is meeting weekly to analyze the historical data that the NAIC has provided from the annual health filing. He said the work group is working through its analysis of the H2 Underwriting Risk factors by specifically reviewing the various splits in the lines of business, and then assigning volunteers that have a deeper knowledge of specific lines of business and analyzing data and loss ratios, to develop a draft analysis and findings by the end of the calendar year.

#### 5. Discussed Pandemic Risk

Richard summarized his report on “Pandemic Risk and Insurer Solvency – A Review of Personal Consumption Expenditures (PCE) on Healthcare Before, During, and After the COVID-19 Pandemic” (Attachment xx). He said he has reviewed many different reports and analyses to help understand how things went during the COVID-19 pandemic and how they might go during the next pandemic. He said the Kaiser Family Foundation (KFF) reported on aggregate health services expenditures, meaning what people spent on health care, from January 2017 through June 2021. He said that prior to the pandemic, the thought was that health care costs would go up during a pandemic. However, the report indicates that in March 2020, there was actually a steep decline. Because hospitals canceled or deferred elective services, there were stay-at-home orders and other things of that nature. Then, in June 2021, there was a recovery, but it was not a complete recovery. He said at this point, it was not clear if there would be a gradual return to normal or if there would be a spike in spending due to services being performed that had been deferred during the pandemic. Richard said he could replicate the report and run it monthly to use it to monitor the recovery progress. This analysis is included on page 3 of the report. The graph on page 3 shows the gradual return to normal through August 2023 at a national level, with projected spending right about where it would have been expected before the pandemic. He said page 4 reflects this breakout by state based on the annual data released by the U.S. Bureau of Economic Analysis (BEA) a few weeks ago. Richard said he was then able to replicate this to show how much of a collapse there was in spending during the pandemic by state, which

is the orange lines in the table. The long-term trend is in blue, and then the increase over and above that long-term trend is in red. Richard said this indicates several things: 1) every state was affected by the pandemic, but each state was affected differently; 2) spending decreased in different ways; 3) it increased differently; and 4) different states had different policies and timing in those policies.

Richard said page 5 shows another way of looking at the data with just some box spots. From 2015 through 2019, the trend in the per capita spending was fairly tightly clustered together. Then, in 2020, during the crisis, there were significant negative trends. Still, these were also relatively widely dispersed. Then in the recovery period in 2021, there was a significant increase in trend, but these were again widely dispersed. He said from a solvency perspective, the crisis period itself is still important. He said it is unknown how things will happen next time, but the recovery and its timing also present interesting issues for state insurance regulators because if the insurance company assumes a two- or three-year return to normal when there is actually a one-year return to normal, that could have adverse impacts on the adequacy of their pricing.

Richard said pages 7–19 are additional reports that show the per capita spending amounts, as well as the trends from 2015 through 2022 for each region. There are additional tables for quality assurance purposes that also help to provide an idea of what happened in each state with respect to the levels and the trend. Drutz said that the report discusses scrutinizing health insurance pricing assumptions and forecasting more rigorously during and after the pandemic. He asked if this would be done by those reviewing rates. Richard agreed that it would be part of the rate review and the examinations. He said RBC is one tool to manage pandemic risk, but another tool might be our financial analysis teams so that when we are going through a pandemic, they can reach out to the insurance companies and ask for additional information about the pricing assumptions and their forecasts. He said then, from the actuarial side, when the statements of actuarial opinion are reviewed, it is important to make sure that for the adverse scenarios, a quick return to normal and the higher trends associated with that are considered.

Drutz asked Richard to discuss the suggested sensitivity testing of the experience fluctuation risk component. Richard said that from the pandemic in 2020, spending decreased significantly. He said low claims translate to a low capital requirement for the insurance companies. He said regarding RBC levels for each company, the report shows that from 2015 through 2019, there were fairly steady increases, and then in 2020, a small increase followed by a significant jump in 2021 because it was sensitive to the decrease in claims in 2020. He suggested looking at those companies 2019 loss ratio levels and ask would the capital still be sufficient.

Drutz said the Working Group will continue to look at and evaluate pandemic risk, if there is an effect on the health RBC formula, and the experience fluctuation risk component of RBC.

## 6. Discussed the Risk Evaluation Ad Hoc Group

Botsko said the Risk Evaluation Ad Hoc Group was under the Capital Adequacy (E) Task Force and established three additional ad hoc subgroups. He said the first is the RBC Purposes and Guidelines Ad Hoc Subgroup, led by Rachel Hemphill (TX). This group is evaluating the preamble, going through the ultimate purpose of RBC, and trying to clarify that through the guidelines and the purposes. The second ad hoc subgroup is the Asset Concentration Ad Hoc Subgroup, led by Kevin Clark (IA) and Ed Toy (Risk & Regulatory Consulting—RRC). This group is primarily focused on assets, but outside of the realm of collateralized loan obligations (CLOS), it is looking at other types of assets and other types of investments and trying to determine what needs time, money, and investment from the RBC working groups, as well as the Capital Adequacy (E) Task Force. The group is in the early stages of developing a flow chart for looking at new types of investments, how to categorize them, and whether the risk warrants further investigation. The third ad hoc subgroup is the Geographic Concentration Ad Hoc Subgroup, primarily a property and casualty (P/C) group led by Wanchin Chou (CT). This group is looking at companies that only write in

one or two states and only write one or two lines of business, as they can have a concentration risk as well. He said the topic of long-term care (LTC) has also come up for this group. Botsko said the Risk Evaluation Ad Hoc also discusses risks that have not been in the RBC formula and risks that have not been reviewed since the early '90s when these RBC formulas were implemented. Botsko said if anyone has any comments, they can bring them to himself or NAIC staff.

Drutz said that as the H2 Underwriting Risk process goes forward, the Working Group should consider whether a single line of business writer is a concern. He said the Geographic Concentration Ad Hoc Subgroup did ask if there are any areas of concentration to consider for health business. Drutz said he was not aware of any but asked Working Group members to reach out if they have any concerns.

#### 7. Discussed Questions on the 2022 Health RBC Statistics

Drutz said the Working Group discussed the 2022 health RBC statistics during its July 25 meeting, and several questions were raised, including: 1) whether there was a significant reason for the companies to trigger an action level, given the number of companies in an action level increased from 12 to 28 in 2022; and 2) if any new companies trigger an action level. He said the statistics report is run in aggregate on a specific date. Therefore, the company-level detail for the companies in an action level as of the date the statistics were run is not available. When NAIC staff reran the data for the company-level detail, there were some differences in number counts that could be a result of amendments filed. He said NAIC staff were able to evaluate and identify key information that will be helpful in understanding the reasons for the action levels. However, this is confidential information that cannot be discussed in detail during this meeting. Drutz suggested a regulator-to-regulator meeting be held if the Working Group wanted to go through the results.

Drutz said from his analysis, he has looked at the number of companies that triggered an action in 2021 versus 2022. He said 23 companies were identified to be in an action level in 2022. He said that seven of those companies were either in their first or second year of operations and did not trigger the prior year. He said that the companies in an action level were primarily writing comprehensive business or Medicare business. Drutz recommended that going forward, the company-level detail also be run while the aggregate statistics reports are run so that the results can be evaluated better on a going-forward basis. Hearing no objections, he asked NAIC staff to include this request going forward.

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

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|---|--|---|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force           | <input 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>2-12-24</u></p> <p><b>CONTACT PERSON:</b> <u>Crystal Brown</u></p> <p><b>TELEPHONE:</b> <u>816-783-8146</u></p> <p><b>EMAIL ADDRESS:</b> <u>cbrown@naic.org</u></p> <p><b>ON BEHALF OF:</b> <u>Health Risk-Based Capital (E) Working Group</u></p> <p><b>NAME:</b> <u>Steve Drutz</u></p> <p><b>TITLE:</b> <u>Chief Financial Analyst/Chair</u></p> <p><b>AFFILIATION:</b> <u>WA Office of Insurance Commissioner</u></p> <p><b>ADDRESS:</b> <u>5000 Capitol Blvd SE</u> <u>Tumwater, WA 98501</u></p>	<p style="text-align: center;"><b>FOR NAIC USE ONLY</b></p> <p>Agenda Item # <u>2024-09-CA</u> Year <u>2024</u></p> <hr/> <p style="text-align: center;"><b>DISPOSITION</b></p> <p><b>ADOPTED:</b></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><b>EXPOSED:</b></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><b>REJECTED:</b></p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p><b>OTHER:</b></p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

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

Annual update of the underwriting factors for Comprehensive Medical, Medicare Supplement and Dental & Vision for investment income adjustment.

Update the underwriting factors for Comprehensive Medical, Medicare Supplement and Dental & Vision on pages XR013, LR019, LR020, PR019 and PR020 for the investment income adjustment.

**Additional Staff Comments:**

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

**Revised 2-2023**

<https://www.treasury.gov/resource-center/data-chart-center/interest-rates/Pages/TextView.aspx?data=yield>

Date	1 Mo	2 Mo	3 Mo	4 Mo	6 Mo	1 Yr	2 Yr	3 Yr	5 Yr	7 Yr	10 Yr	20 Yr	30 Yr
01/02/2024	5.55	5.54	5.46	5.41	5.24	4.80	4.33	4.09	3.93	3.95	3.95	4.25	4.08
01/03/2024	5.54	5.54	5.48	5.41	5.25	4.81	4.33	4.07	3.90	3.92	3.91	4.21	4.05
01/04/2024	5.56	5.48	5.48	5.41	5.25	4.85	4.38	4.14	3.97	3.99	3.99	4.30	4.13
01/05/2024	5.54	5.48	5.47	5.41	5.24	4.84	4.40	4.17	4.02	4.04	4.05	4.37	4.21
01/08/2024	5.54	5.48	5.49	5.39	5.24	4.82	4.36	4.11	3.97	3.99	4.01	4.33	4.17
01/09/2024	5.53	5.46	5.47	5.38	5.24	4.82	4.36	4.09	3.97	4.00	4.02	4.33	4.18
01/10/2024	5.53	5.46	5.46	5.39	5.23	4.82	4.37	4.10	3.99	4.01	4.04	4.35	4.20
01/11/2024	5.54	5.47	5.46	5.38	5.22	4.75	4.26	4.02	3.90	3.95	3.98	4.32	4.18
01/12/2024	5.55	5.47	5.45	5.37	5.16	4.65	4.14	3.92	3.84	3.91	3.96	4.32	4.20
01/16/2024	5.54	5.47	5.45	5.37	5.18	4.70	4.22	4.02	3.95	4.01	4.07	4.43	4.30
01/17/2024	5.54	5.47	5.47	5.40	5.20	4.80	4.34	4.12	4.02	4.07	4.10	4.42	4.31
01/18/2024	5.53	5.48	5.45	5.39	5.20	4.80	4.34	4.13	4.04	4.10	4.14	4.48	4.37
01/19/2024	5.54	5.47	5.45	5.39	5.21	4.84	4.39	4.18	4.08	4.12	4.15	4.47	4.36
01/22/2024	5.53	5.47	5.46	5.39	5.22	4.83	4.37	4.14	4.03	4.07	4.11	4.44	4.32
01/23/2024	5.53	5.46	5.45	5.38	5.21	4.81	4.31	4.16	4.06	4.11	4.14	4.48	4.38
01/24/2024	5.52	5.44	5.44	5.40	5.22	4.83	4.34	4.19	4.06	4.14	4.18	4.52	4.41
01/25/2024	5.54	5.48	5.44	5.39	5.19	4.76	4.28	4.12	4.01	4.07	4.14	4.49	4.38
01/26/2024	5.54	5.45	5.44	5.39	5.19	4.78	4.34	4.15	4.04	4.10	4.15	4.49	4.38
01/29/2024	5.53	5.46	5.42	5.37	5.19	4.76	4.29	4.10	3.97	4.02	4.08	4.42	4.31
01/30/2024	5.53	5.47	5.42	5.38	5.19	4.80	4.36	4.14	4.00	4.03	4.06	4.40	4.28
01/31/2024	5.53	5.46	5.42	5.40	5.18	4.73	4.27	4.05	3.91	3.95	3.99	4.34	4.22



February 2, 2023

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

Re: Request for Additional Analysis to Incorporate Investment Income into the Underwriting Risk Component of the Health Risk-Based Capital (HRBC) Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries<sup>1</sup> Health Solvency Subcommittee (the subcommittee), I am pleased to provide this response letter to the NAIC's Health Risk-Based Capital (E) Working Group request to provide additional investment return scenarios within the subcommittee's summary of the Investment Income Adjusted Health H2 Experience Fluctuation Risk Factors. These factors are included within the table below.

**Investment Income Adjusted Tiered Risk-Based Capital (RBC) Factors**

Assumed Investment Return	Comprehensive Medical (CM)	Medicare Supplement	Dental/Vision
High Tier (i.e., less than \$3Million (M) or less than \$25M)			
0.0%	15.00%	10.50%	12.00%
3.5%	14.53%	10.01%	11.63%
4.0%	14.47%	9.94%	11.58%
4.5%	14.40%	9.87%	11.53%
5.0%	14.34%	9.80%	11.48%
5.5%	14.27%	9.73%	11.43%
6.0%	14.21%	9.67%	11.38%
Low Tier			
0.0%	9.00%	6.70%	7.60%
3.5%	8.56%	6.23%	7.25%
4.0%	8.50%	6.16%	7.20%
4.5%	8.44%	6.09%	7.16%
5.0%	8.38%	6.03%	7.11%
5.5%	8.32%	5.96%	7.06%
6.0%	8.25%	5.90%	7.01%

<sup>1</sup> 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.

Please note that the subcommittee updated the claims completion pattern assumptions slightly in this analysis. The impact of this change on the RBC factors is approximately 0.01%. Otherwise, the methodology is unchanged.

\*\*\*\*\*

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](mailto:williams@actuary.org).

Sincerely,

Derek Skoog, MAAA, FSA  
Chairperson, Health Solvency Subcommittee  
American Academy of Actuaries

Cc: Crystal Brown, Senior Health RBC Analyst & Education Coordinator, Financial Regulatory Affairs, NAIC

**Health Instructions****Page XR013, Line 13**

← Detail Eliminated to Conserve Space →

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 5.05%.

	\$0 – \$3 Million	\$3 – \$25 Million	Over \$25 Million
Comprehensive (Hospital & Medical) Individual & Group	0.14 <del>2734</del>	0.14 <del>2734</del>	0.083 <del>28</del>
Medicare Supplement	0.09 <del>7380</del>	0.05 <del>96603</del>	0.05 <del>96603</del>
Dental & Vision	0.114 <del>38</del>	0.07 <del>0611</del>	0.07 <del>0611</del>
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

The investment income yield was incorporated into the Comprehensive (Hospital & Medical) individual & group, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will identify the yield of the 6-month Treasury bond ([U.S. Department of the Treasury](http://www.treasury.gov)) on each Monday through the month of January and determine if further modifications to the 5.50% adjustment is needed. Any adjustments will be rounded up to the nearest 0.5%.

**P/C Instructions****Page PR020, Line 10**

← Detail Eliminated to Conserve Space →

Line (10) Underwriting Risk Factor  
A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue.

	\$0 - \$3 Million	\$3-\$25 Million	Over \$25 Million
Comprehensive Medical	0.14 <del>2734</del>	0.14 <del>2734</del>	0.083 <del>28</del>
Medicare Supplement	0.09 <del>7380</del>	0.05 <del>96603</del>	0.05 <del>96603</del>
Dental & Vision	0.114 <del>38</del>	0.07 <del>0611</del>	0.07 <del>0611</del>
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151

**Life Instructions**

**LR020, Line 10**



Detail Eliminated to Conserve Space



Line (10) Underwriting Risk Factor

A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income.

	\$0 - \$3 Million	\$3 - \$25 Million	Over \$25 Million
Comprehensive Medical	0.14 <del>2734</del>	0.14 <del>2734</del>	0.083 <del>28</del>
Medicare Supplement	0.09 <del>7380</del>	0.05 <del>96603</del>	0.05 <del>96603</del>
Dental	0.114 <del>38</del>	0.07 <del>0611</del>	0.07 <del>0611</del>
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151

**UNDERWRITING RISK**

**Experience Fluctuation Risk**

	Line of Business	(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							
(2) †	Title XVIII-Medicare		XXX	XXX	XXX	XXX	XXX	
(3) †	Title XIX-Medicaid		XXX	XXX	XXX	XXX	XXX	
(4) †	Other Health Risk Revenue		XXX				XXX	
(5)	Medicaid Pass-Through Payments Reported as Premiums		XXX	XXX	XXX	XXX	XXX	
(6)	Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)							
(7) †	Net Incurred Claims						XXX	
(8)	Medicaid Pass-Through Payments Reported as Claims		XXX	XXX	XXX	XXX	XXX	
(9)	Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)						XXX	
(10) †	Fee-For-Service Offset		XXX				XXX	
(11)	Underwriting Risk Incurred Claims = Lines (9) - (10)						XXX	
(12)	Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/(6)						1.000	XXX
(13)	Underwriting Risk Factor*					0.130	0.130	XXX
(14)	Base Underwriting Risk RBC = Lines (6) x (12) x (13)							
(15)	Managed Care Discount Factor						XXX	XXX
(16)	RBC After Managed Care Discount = Lines (14) x (15)						XXX	
(17) †	Maximum Per-Individual Risk After Reinsurance						XXX	XXX
(18)	Alternate Risk Charge **						XXX	XXX
(19)	Alternate Risk Adjustment						XXX	XXX
(20)	Net Alternate Risk Charge***						XXX	
(21)	Net Underwriting Risk RBC (MAX{Line (16), Line (20)}) for Columns (1) through (5), Column (6), Line (14)							

TIERED RBC FACTORS*						
	Comprehensive (Hospital & Medical) - Individual & Group	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non- Health
\$0 - \$3 Million	0.142734	0.09738	0.11438	0.251	0.130	0.130
\$3 - \$25 Million	0.142734	0.0596603	0.070644	0.251	0.130	0.130
Over \$25 Million	0.08328	0.0596603	0.070644	0.151	0.130	0.130

ALTERNATE RISK CHARGE**						
** The Line (18) Alternate Risk Charge is calculated as follows:						
LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	N/A

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR014.

\* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.

\*\*\* Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.

**UNDERWRITING RISK - PREMIUM RISK FOR COMPREHENSIVE MEDICAL, MEDICARE SUPPLEMENT AND**

(Experience Fluctuation Risk in Life RBC Formula)

	(1)	(2)	(3)	(4)	(5)
	<u>Comprehensive</u>	<u>Medicare</u>		<u>Stand-Alone</u>	
	<u>Medical</u>	<u>Supplement</u>	<u>Dental &amp; Vision</u>	<u>Medicare Part D</u>	<u>TOTAL</u>
				<u>Coverage</u>	
(1.1) Premium – Individual	0	0	0	0	0
(1.2) Premium – Group	0	0	0	0	0
(1.3) Premium – Total = Line (1.1) + Line (1.2)	0	0	0	0	0
(2) Title XVIII-Medicare†	0	XXX	XXX	XXX	0
(3) Title XIX-Medicaid†	0	XXX	XXX	XXX	0
(4) Other Health Risk Revenue†	0	XXX	0	0	0
(5) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)	0	0	0	0	0
(6) Net Incurred Claims	0	0	0	0	0
(7) Fee-for-Service Offset†	0	XXX	0	0	0
(8) Underwriting Risk Incurred Claims = Line (6) – Line (7)	0	0	0	0	0
(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)	0.0000	0.0000	0.0000	0.000	XXX
(10.1) Underwriting Risk Factor for Initial Amounts Of Premium‡	0.142734	0.09738	0.11438	0.251	XXX
(10.2) Underwriting Risk Factor for Excess of Initial Amount‡	0.08328	0.0596603	0.070644	0.151	XXX
(10.3) Composite Underwriting Risk Factor	0.0000	0.0000	0.0000	0.000	XXX
(11) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)	0	0	0	0	0
(12) Managed Care Discount Factor = PR021 Line (12)	0.0000	0.0000	0.0000	0.000	XXX
(13) Base RBC After Managed Care Discount = Line (11) x Line (12)	0	0	0	0	0
(14) RBC Adjustment For Individual = [ {Line(1.1) x 1.2 + Line (1.2)} / Line (1.3) ] x Line (13)§	0	0	0	0	0
(15) Maximum Per-Individual Risk After Reinsurance†	0	0	0	0	XXX
(16) Alternate Risk Charge*	0	0	0	0	0
(17) Net Alternate Risk Charge‡	0	0	0	0	0
(18) Net Underwriting Risk RBC (Maximum of Line (14) or Line (17) )	0	0	0	0	0

† Source is company records unless already included in premiums.

‡ For Comprehensive Medical the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision the Initial Premium Amount is \$3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller.

§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).

\* The Line (16) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000	\$50,000	\$50,000	\$150,000	Maximum
	or	or	or	or	of
	2 x Maximum Individual Risk	2 x Maximum Individual Risk	2 x Maximum Individual Risk	6 x Maximum Individual Risk	Columns (1), (2) (3) and (4)

‡ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.

Denotes items that must be manually entered on the filing software.



**UNDERWRITING RISK**

**Experience Fluctuation Risk**

		(1)	(2)	(3)	(4)	(5)
	Line of Business	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Total
(1.1)	Premium – Individual					
(1.2)	Premium – Group					
(1.3)	Premium – Total = Line (1.1) + Line (1.2)					
(2)	Title XVIII-Medicare†		XXX			
(3)	Title XIX-Medicaid†		XXX			
(4)	Other Health Risk Revenue†		XXX			
(5)	Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)					
(6)	Net Incurred Claims					
(7)	Fee-for-Service Offset†		XXX			
(8)	Underwriting Risk Incurred Claims = Line (6) – Line (7)					
(9)	Underwriting Risk Claims Ratio = Line (8) / Line (5)					XXX
(10.1)	Underwriting Risk Factor for Initial Amounts Of Premium‡	0.142734	0.09738	0.11438	0.251	XXX
(10.2)	Underwriting Risk Factor for Excess of Initial Amount‡	0.08328	0.0596693	0.070614	0.151	XXX
(10.3)	Composite Underwriting Risk Factor					XXX
(11)	Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)					
(12)	Managed Care Discount Factor = LR022 Line (17)					XXX
(13)	Base RBC After Managed Care Discount = Line (11) x Line (12)					
(14)	RBC Adjustment For Individual = [ {Line(1.1) x 1.2 + Line (1.2)} / Line (1.3) ] x Line (13)§					
(15)	Maximum Per-Individual Risk After Reinsurance†					XXX
(16)	Alternate Risk Charge*					
(17)	Net Alternate Risk Charge£					
(18)	Net Underwriting Risk RBC (Maximum of Line (14) or Line (17) )					

† Source is company records unless already included in premiums.

‡ For Comprehensive Medical, the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision, the Initial Premium Amount is \$3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D, the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller.

§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).

\* The Line (16) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000	\$50,000	\$50,000	\$150,000	Maximum
	or	or	or	or	of
	2 x Maximum Individual Risk	2 x Maximum Individual Risk	2 x Maximum Individual Risk	6 x Maximum Individual Risk	Columns (1), (2), (3) and (4)


£ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.

Denotes items that must be manually entered on the 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


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## 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

$$\text{\$Authorized Control Level} = 1.03 \times \frac{H_0 + \sqrt{(H_1^2 + H_2^2 + H_3^2 + H_4^2)}}{2}$$

Credit Risk



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## Applying HCR Factors

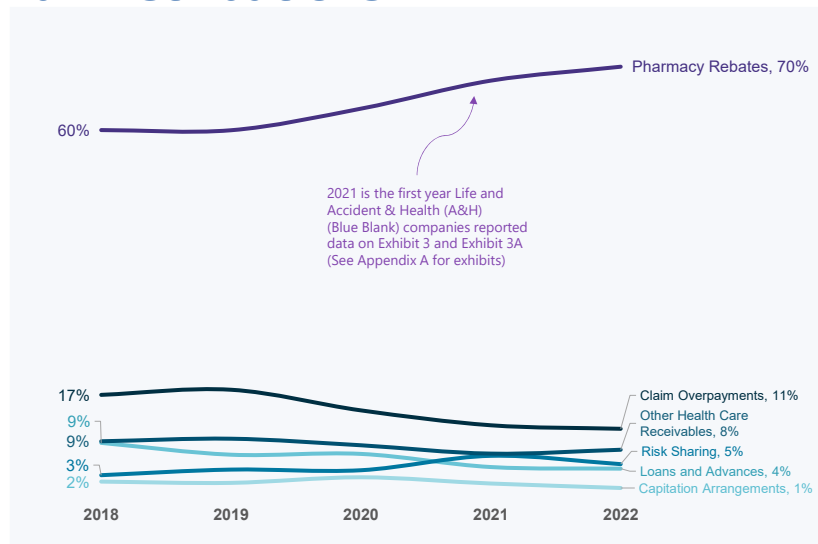
- HCR Factors
  - Vary by Pharmaceutical Rebates or Non-Pharmaceutical Rebates

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

} Non-Pharmaceutical Rebates Receivables

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## HCR Dollar Distributions



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

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## 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

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## 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

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## 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



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## 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 ≥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



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## 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

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## 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

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## First Proposed Tier Factors

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

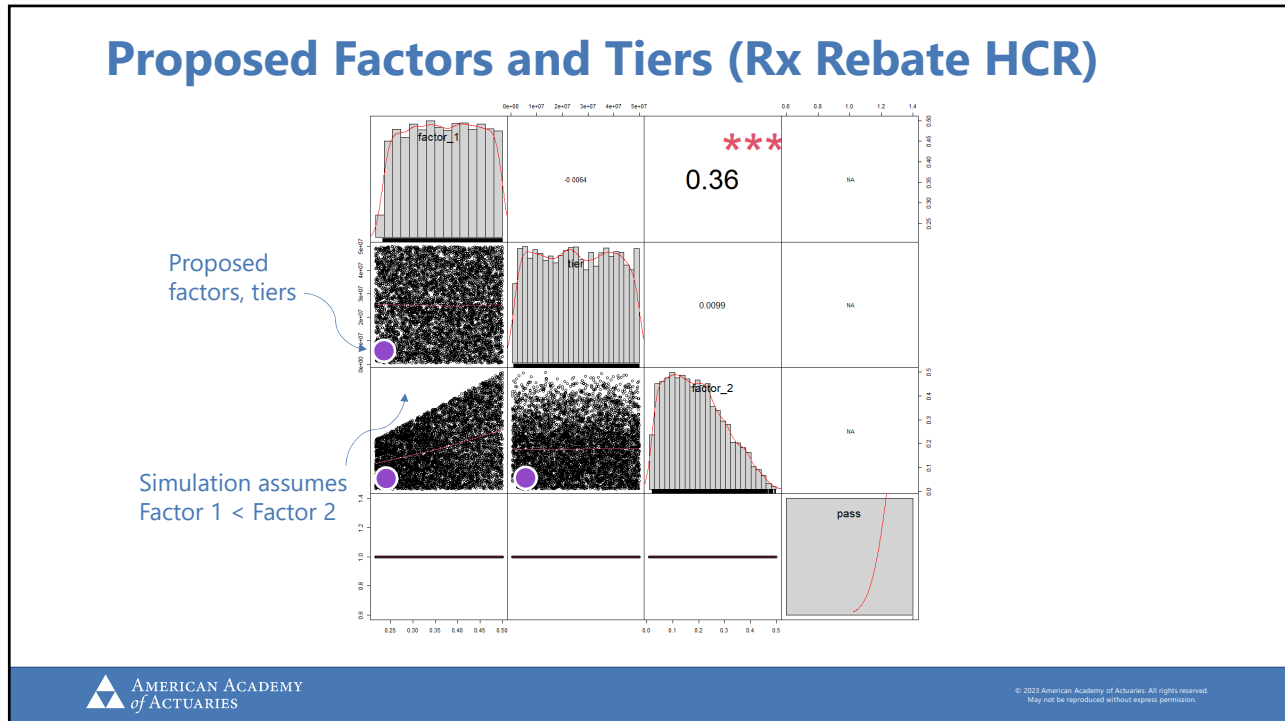
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## First Proposed Tier Factors

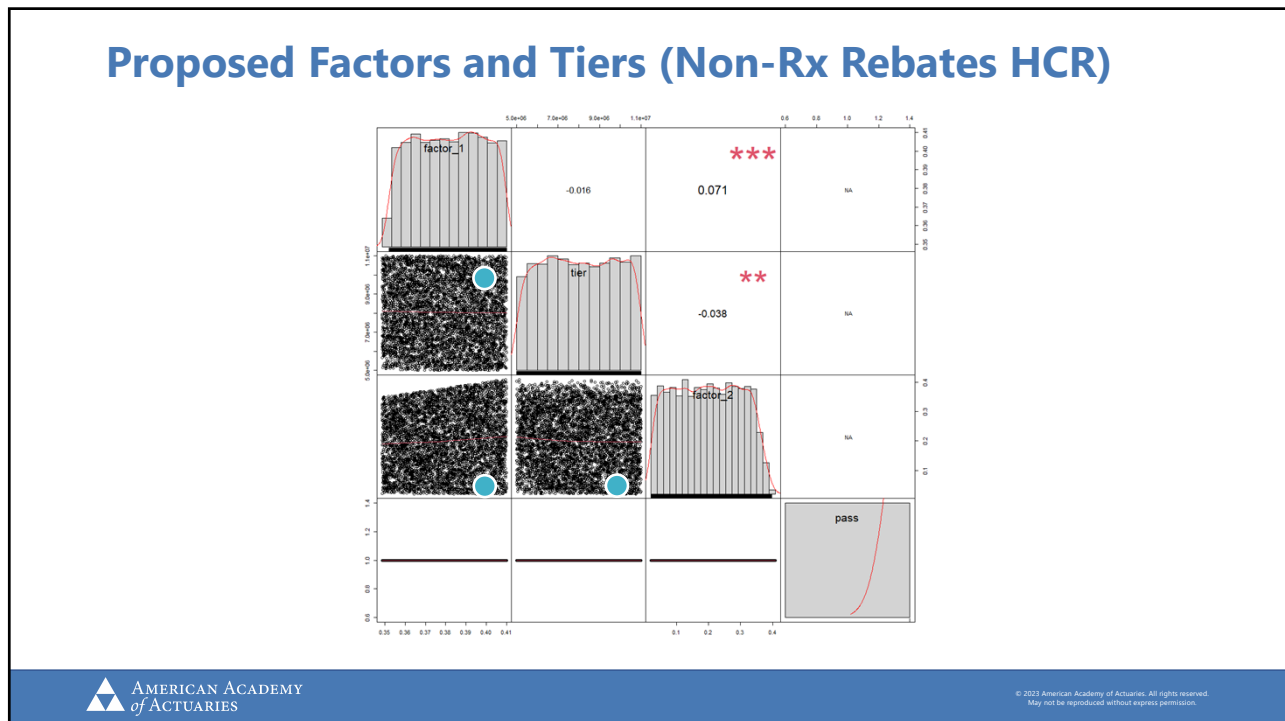
- Goal of percent of companies meeting Collection Ratios  $\geq 100\%$ 
  - 90%–100% for Rx HCR
  - 90%–100% for Non-Rx HCR
    - For 10 or more of the 15 size and line combinations (3x sizes by 5x Non-Rx HCR types)
    - Acknowledge variance in reporting accuracy (more on this later)
- Many combinations 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

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## 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

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## 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

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## Surplus Component Change in H3

- Rx Rebate HCR (2022)

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

## Surplus Component Change in H3

- Non-Rx Rebate HCR (2022)

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

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## Questions?

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## Thank You

For more information, please contact

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# UNITEDHEALTH GROUP

Corporate Finance – Actuarial Services Division  
185 Asylum Street, CityPlace I • Hartford, CT 06103

November 29, 2023

Mr. Steven Drutz, Chair  
Health Risk-Based Capital (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Via electronic mail to Crystal Brown.

Re: November 8, 2023, Academy presentation on Health Care Receivables.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group with regard to the November 8, 2023, presentation by the American Academy of Actuaries on “Health Care Receivables (HCR): Current and Proposed H3 Factors,” as exposed for comment by your Working Group, also on November 8. We appreciate having had the opportunity to ask questions regarding the presentation during the Working Group’s November 8, 2023, conference call, and we thank the Academy’s representative for his thoughtful responses.

As a follow-up to that conversation, there are four areas of concern that we would like to address in this letter, as indicated by the headings below.

Degree of aggregation of non-pharmacy HCRs.

There are six categories of HCRs reported in the Annual Statement. The Academy’s presentation indicated that a single category, pharmacy rebate receivables, accounts for some 60-70% of the total amount of HCRs. The other five categories (which we will refer to collectively as “non-pharmacy HCRs”) ranged from about 1% of the total to about 11% of the total.

The current H3 factors for HCRs were originally proposed in the Academy’s April 15, 2016, letter regarding a “Recommendation on Credit Risk Factors for Health Care Receivables.” The analysis that supported the April 15, 2016, recommendation grouped the non-pharmacy HCRs together, in order to achieve a sufficient volume of data. At the time, we expressed some concern about this grouping, as it seemed that different categories of HCRs were likely to have differing collection experience; in particular, one might suppose that an entity would have better experience for HCRs where the entity had an opportunity to consider a provider’s credit quality before creating the receivable (e.g., loans and advances) versus those where there was no such

opportunity (e.g., claim overpayments). However, we recognized that as a practical matter, it might be necessary to combine categories of HCRs in order to obtain a credible volume of data.

In the analysis presented on November 8, 2023, a single set of tiered factors was proposed for all of the non-pharmacy HCRs, and the factors were chosen to achieve a certain percentage of collection ratios greater than 100%. However, the collection ratios were calculated separately for each non-pharmacy category, and the breakpoints between the tiered factors are intended to be applied separately to each non-pharmacy category. It seems to us that this approach is internally inconsistent. The reason for calculating separate collection ratios and applying separate breakpoints would be to capture differing experience among the non-pharmacy categories. However, by applying the same factors and breakpoints to each category, the formula clearly would not be accomplishing that differentiation.

This approach to aggregation also does not reflect how the relative size of an entity's receivables might impact its collection activity. For example, suppose an entity has \$10 million of claim overpayment receivables, relating primarily to three hospitals; and \$100,000 dollars of risk-sharing receivables, relating to two medical groups. It seems reasonable that the entity might focus more of its collection efforts on the \$10 million of claim overpayments than on the \$100,000 of risk-sharing receivables; and as a result, while it might achieve a 90% collection rate for the claim overpayments, its collection rate for risk-sharing might be only 40%. The Academy's current approach would treat those as two separate data points of 40% and 90% (averaging to 65%), while from the entity's standpoint, its collection facility is achieving an 89.5% collection rate. It would therefore seem more appropriate to aggregate the non-pharmacy HCRs for each entity for the purposes of calculating the collection ratios. Then, the factors and breakpoint should be determined in such a way so that, applied to the non-pharmacy HCRs in aggregate for each entity, they would achieve the desired success rate among collection ratios (as calculated on an aggregate basis).

#### Inclusion of Blue Blank data.

Most of the data used in the Academy's analysis came from entities that file their financial statements using the Health Annual Statement format (the "Orange Blank"). However, beginning with 2021, data were also available from entities that file using the Life, Accident & Health Annual Statement format (the "Blue Blank").

We do have some concerns about the inclusion of the Blue Blank data. If a Blue Blank filer is primarily a writer of medical insurance, then it seems reasonable to suppose that its collection experience will be comparable to that of an Orange Blank filer. However, if a Blue Blank filer's business is primarily life insurance and/or annuities, and medical insurance represents only a small portion of its business, it is possible that the collection of health care receivables will not receive the same level of attention and dedication of resources, resulting in poorer collection experience.

If the new H3 factors were going to be applied to Orange Blank and Blue Blank entities alike, it would be appropriate to base the factors on the combined experience of both types of filers. However, as discussed on the November 8, 2023, conference call, these H3 factors will not become part of the Life Risk-Based Capital formula that is applicable to Blue Blank filers. It therefore seems inappropriate to use the Blue Blank experience in the analysis if that produces a

materially different result from the Orange Blank experience, which is directly relevant to the affected entities.

On the November 8, 2023, conference call, the Academy's representative indicated that the Academy had not analyzed the differences, if any, between Orange Blank collection experience and Blue Blank collection experience. We believe that before factors based on the combined experience are adopted, such an analysis should be performed, to ensure that the Blue Blank experience is not materially distorting the results.

Entities with zero collections.

For the smallest size category of receivables (less than \$1 million in size) in both the pharmacy and non-pharmacy categories, the proposed factors would achieve a lower level of success (percentage of collection ratios equal to 100% or greater) than for the two larger size categories. This could potentially be mitigated by adding a third tier of higher factors for the very smallest receivables; however, the Academy considered and rejected that approach. The Academy noted that there are a significant number of small receivables associated with collections of zero dollars, which would have required a very much higher factor for that size of receivable; and applying such a high factor to all of the smallest receivables did not seem justified, because of the possibility that many of the zero-dollar collections were the result of reporting issues, not genuinely bad collection experience.

There are three reasons why the collections associated with a particular receivable might be zero:

- (a) The entity genuinely collected no part of the receivable, and does not expect to collect any part in the future;
- (b) the entity did collect part or all of the receivable, but the collection data could not easily be extracted from its data systems, so that the collections could not be reported; or,
- (c) the entity did collect part or all of the receivable, and the failure to report any collections was simply an error of omission.

If the reason for reporting zero dollars of collections is (b) or (c), then those data points should be excluded from the analysis. At this point, the reason for any given entity cannot be determined with certainty, so it is not possible to tell the degree of distortion caused by including the inappropriate data points (if any). However, it would be useful to see an analysis that omits all of the zero-dollar collections. The final H3 factors could be set between the two extremes (using all zero-dollar collections and no zero-dollar collections) using judgment; or, perhaps, by contacting a sample of the zero-dollar reporters, the NAIC might be able to get some idea as to the proportion resulting from reason (a) above versus reasons (b) and (c).



### Weighting of data points.

As noted in each of the first two sections above, an entity's collection efforts might quite reasonably depend on the relative importance of the receivable. Giving equal weight to each data point tends to obscure this fact. The Academy's current analysis, as we understand it, would give the same weight to the collection experience for a \$100 receivable as to the experience for a \$100 million receivable. Nor is absolute size the only relevant criterion; Entity A may have a receivable only half as large as Entity B's, but if Entity B is twenty times the size of Entity A, then the receivable is much more significant to Entity A.

In our May 20, 2016, comments on the Academy's April 15, 2016, letter cited above, we suggested the following with regard to weighting.

Accordingly, it is necessary to consider the relative importance of these receivables to each company that holds them. It seems reasonable to suppose — subject, of course, to confirmation from the data at hand — that the more important a receivable is to a company, the more effort will be expended on properly estimating the receivable (where estimation is necessary) and the more effort will be expended on actually collecting the receivable. The appropriate weighting to reflect that consideration would not be the absolute size of the receivable, since a company could have a receivable twice as large as another's but be less affected by it because that company is twenty times the size of the other. A more appropriate weighting would be the size of the receivable as a percentage of the company's capital and surplus. That weighting would more directly reflect how important the collection of the receivable is to the company's solvency.

We recommend that the Academy's analysis be redone using this method of weighting, for both the pharmacy rebate receivables and the non-pharmacy HCRs. While this approach might understate the H3 factor for the least material receivables, by definition those receivables will be less relevant to solvency, and such understatement would not put solvency at risk.

### Conclusion.

In summary, we recommend the following:

1. All the non-pharmacy HCR receivables should be aggregated for purposes of calculating collection ratios, determining the H3 factors, and determining and applying the factor breakpoints.
2. Blue Blank data should be excluded from the analysis. At the very least, a separate analysis of Blue Blank versus Orange Blank data should be performed, to determine whether the Blue Blank data are materially biasing the result.
3. An analysis should be performed excluding entities that report zero collections for non-pharmacy HCRs.

4. The data points in the various analyses should be weighted to reflect the relevant importance of each data point to entity solvency.

We would be happy to discuss these comments with you and the Working Group.



James R. Braue  
Senior Director, Actuarial Services  
UnitedHealth Group

cc: Crystal Brown, NAIC  
Tracy Arney, UnitedHealth Group

Priority 1 – High Priority  
 Priority 2 – Medium Priority  
 Priority 3 – Low Priority

**CAPITAL ADEQUACY (E) TASK FORCE  
 WORKING AGENDA ITEMS FOR CALENDAR YEAR 2024**

2024 #	Owner	2024 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
<b>Ongoing Items – Health RBC</b>							
X1	Health RBC WG	Yearly	Yearly	Evaluate the yield of the 6-month U.S. Treasury Bond as of Jan. 1 each year to determine if further modification to the Comprehensive Medical, Medicare Supplement and Dental and Vision underwriting risk factors is required. Any adjustments will be rounded up to the nearest 0.5%.	HRBCWG	Adopted 2022-16-CA (YE-2023) <u>Exposed 2024-09-CA (YE-2024)</u>	11/4/2021
X2	Health RBC WG	3	Ongoing	Continue to monitor the Federal Health Care Law or any other development of federal level programs and actions (e.g., state reinsurance programs, association health plans, mandated benefits, and cross-border) for future changes that may have an impact on the Health RBC Formula.	4/13/2010 CATF Call	Adopted 2014-01H Adopted 2014-02H Adopted 2014-05H Adopted 2014-06H Adopted 2014-24H Adopted 2014-25H Adopted 2016-01-H Adopted 2017-09-CA Adopted 2017-10-H The Working Group will continually evaluate any changes to the health formula because of ongoing federal discussions and legislation.  Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.	1/11/2018
<b>Carryover Items Currently being Addressed – Health RBC</b>							
X3	Health RBC WG	2	Year-End 202 <del>5</del> <sup>4</sup> RBC or Later	Consider changes for stop-loss insurance or reinsurance.	AAA Report at Dec. 2006 Meeting	(Based on Academy report expected to be received at YE-2016) 2016-17-CA Adopted proposal 2023-01-CA	
X4	Health RBC WG	2	Year-end 202 <del>4</del> <sup>5</sup> RBC or later	Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula.  <u>Work with the American Academy of Actuaries (Academy) to inquire through the NAIC on the reporting of the health care receivables to better understand why these</u>	HRBC WG	Adopted 2016-06-H Rejected 2019-04-H Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal	

				<del>receivables are being reported as such. With the intention to produce recommendations to improve instruction clarity or provide additional guidance.</del>		(Year-End 2021) referred to the Blanks (E) Working Group	
X5	Health RBC WG	1	Year-end 2024 <del>5</del> RBC or later	<p>Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the health RBC formula including the Managed Care Credit review (Item 18 above)</p> <p>Review the Managed Care Credit calculation in the health RBC formula - specifically Category 2a and 2b.</p> <p>Review Managed Care Credit across formulas.</p> <p>As part of the H2 - Underwriting Risk review, determine if other lines of business should include investment income and how investment income would be incorporated into the existing lines if there are changes to the structure.</p>	HRBCWG	Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 & 1 to 2a and 2b.	4/23/2021  12/3/2018
X6	Health RBC WG	1	Year-end 2024 <del>5</del> or later	Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.	HRBCWG	Review if changes are required to the Health RBC Formula	4/7/2019
<del>X7</del>	<del>Health RBC WG</del>	<del>2</del>	<del>Year End 2024 or later</del>	<del>Consider the impact of COVID-19 and pandemic risk in the health RBC formula.</del>	<del>HRBCWG</del>	<del>-</del>	<del>7/30/2020</del>
X8	Health RBC WG	3	Year-End 2025 or later	Discuss and determine the re-evaluation of the bond factors for the 20 designations.	Referral from Investment RBC July/2020	Working Group will use two- and five-year time horizon factors in 2020 impact analysis. Proposal 2021-09-H - Adopted 5/25/21 by the WG	9/11/2020
<b>New Items – Health RBC</b>							