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ISSUE BRIEF

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Surplus and Risk-Based Capital for Health Insurance Companies

As insurance premiums continue to rise locally and nationwide and lawmakers become increasingly concerned with the affordability of health insurance, some have questioned whether not-for-profit health insurance companies, such as BlueCross and BlueShield of Vermont, are accumulating surplus funds that are unnecessary or excessive.[1] This issue brief will discuss the idea of surplus, the regulatory tool of risk-based capital, how other states have tried to regulate health insurer surpluses, and additional considerations.

Reserves vs. Surplus

Although they are often used interchangeably, a health insurance company's *reserves* are not the same as its *surplus*. The term "reserves" is often used loosely to describe excess or extra funds; however, in insurance reporting, reserves generally refer to the actuarially estimated amount that should be held to cover various liabilities:

- Known or reported claims or losses not yet paid
- Unknown or unreported incurred losses or claims expected to emerge after the financial year-end
- The company's administrative cost to pay the above amount

In short, insurance (or actuarial) reserves are moneys retained to pay future claims. Surplus (or surplus capital), in accounting terms, refers to the net worth of a company (assets less liabilities). For instance, at the end of calendar year 2016, BlueCross and BlueShield of Vermont (BCBSVT) had a surplus of $135 million. At its most basic level, surplus represents a backstop of capital to ensure that unforeseen contingencies do not render a plan unable to meet its obligations to its policyholders.[2] The questions that are often asked are what amounts of surplus are adequate and reasonable before it can be considered excessive and how can that be measured?

Surplus can be measured in several ways, including months of premium equivalency[3], surplus as a percentage of revenues (SAPOR), or risk-based capital (RBC) ratio to name just a few. The Department of Financial Regulation (DFR), which regulates insurance companies in Vermont, uses a number of tools to assess the adequacy of an insurer's surplus, including periodic financial examinations, review of corporate governance, and analyses of such areas as claims

[1] This issue brief was initially written in response to a request from Senator Tim Ashe.

[2] It is important to reiterate that reserves and surplus are different and for the purposes of this document we will use the general accounting definitions, focusing primarily on surplus.

[3] Note: As of Dec. 31, 2016, BCBSVT had a surplus of $135 million, which is enough to cover 3 to 4 months of claims or $640 per member.

reserve development, risk mitigation strategies, and risk-based capital.[4] This paper will focus primarily on risk-based capital which is arguably the most common industry standard used by regulators nationwide in evaluating an insurance company's solvency.

Risk-Based Capital

Risk-Based Capital (RBC) is a method, used by both banking and insurance industries, for measuring the minimum amount of capital appropriate for an insurance company to support its overall business operations in consideration of its size, structure, and risk profile. It was created by the National Association of Insurance Commissioners (NAIC) in the early 1990s (after the banking crisis of the late 80s and early 90s) as a set of model statutes to provide a capital adequacy standard that is related to risk, raises a safety net for insurers, is uniform among the states, and provides regulatory authority for timely action. RBC limits the amount of risk a company can take and requires companies with higher risk to hold higher amounts of capital in order to provide a cushion against insolvency. It is perhaps the most universally recognized tool existing to evaluate an insurer's financial health. However, RBC is not designed to be a stand-alone tool in determining an insurance company's solvency, but rather is meant to be a tool that gives regulators legal authority to take preventive and corrective measures.[5]

Risk-based capital is usually expressed as a ratio – the total capital of the company divided by the company's risk-based capital (also called the authorized control level risk-based capital or ACL RBC) as determined by a formula. This formula is somewhat complex, particularly for determining ACL RBC (the denominator), looking at credit, investment, underwriting, and other operating risks faced by the insurer.

$$\text{RBC Ratio} = \frac{\text{Adjusted Capital and Surplus}}{\text{Authorized Control Level RBC}}$$

The NAIC system details specific actions to be taken by the company or the state insurance regulator if this RBC ratio declines or hits certain levels. Most states, including Vermont, have adopted statutes, regulations, or bulletins that follow or are similar to the NAIC RBC model for minimum surplus.[6] The levels are:

- *No action* - Over 200%
- *Company Action Level* - 150% to 200%
  - Insurer must submit a written detailed business plan that details the causes and actions that have led to the capital impairment as well as a financial plan describing what actions it will take to increase surplus and improve capital strength.
- *Regulatory Action* - 100% to 150%
  - The regulator has the authority to examine the company and issue corrective orders to address financial problems.
- *Authorized Control Level* - 70% to 100%

[4] Solvency opinion dated July 8, 2016, issued by the Commissioner of the DFR to the Chair of the Green Mountain Care Board relating to the 2017 Exchange rate filing for BlueCross BlueShield of Vermont.
[5] National Association of Insurance Commissioners (NAIC), Risk Based Capital (updated 6/13/16).
[6] ConsumerUnion, How Much Is Too Much: Have Nonprofit BlueCross and BlueShield Plans Amassed Excessive Amounts of Surplus, July 2010

    - The regulator is authorized, but not required, to place the insurance company under regulatory supervision.
- *Mandatory control level* - Less than 70%
    - The regulator is required to take control of the company.

By the NAIC standards, 200% of RBC is commonly known as the minimum level of surplus that a health insurance company must hold before any potential regulatory action is taken.[7] However, it is important to note that an RBC ratio of 200% is not generally seen as a minimum "acceptable" ratio but rather a regulatory trigger for action. In Vermont, a company action level event can be triggered at 300%.[8] It may be difficult for insurance companies to maintain RBC levels at or close to the minimum levels because it can change dramatically due to unexpected circumstances and be difficult to elevate once a company is on a downward trajectory. It is unlikely any health insurance company would have a target RBC ratio any less than at least double the amount that could trigger any regulatory actions. Both BCBSVT and MVP have target ranges of between 500% and 700% and officials from the Department of Financial Regulation (DFR) have testified before the Green Mountain Care Board that an RBC ratio of between 500% and 700% is reasonable. [9,10]

The BlueCross BlueShield Association has its own standard, requiring BCBS affiliates to hold at least 375% of RBC to avoid triggering monitoring by the Association. According to BCBSVT, BCBS plans have higher standards because as non-profits they lack access to capital markets, have limited borrowing capacity, and no parent company that can infuse capital, as well as protecting the BCBS brand.[11] If RBC falls below 200%, the Association may revoke the company's right use the BlueCross BlueShield trademarks. Even by these standards, we estimate that BlueCross BlueShield Vermont (BCBSVT) would be required to have approximately $70 million in surplus capital in order to avoid any State regulatory action (at 200% RBC) and over $85 million just to meet the BCBS Association standard (at 375% RBC).

RBC ratios are neither published nor made public. Under State law neither the company nor DFR is allowed to disclose actual RBC ratios.[12] However, they can be calculated using publicly provided financial reports. Using data provided in its annual statement reported to the DFR, we estimate BCBSVT's RBC (as of Dec. 31, 2016) to be approximately 591%. The following is JFO's estimated historical comparison of BCBSVT and MVP Health Plan (which is the HMO arm of MVP containing the majority of its members across multiple states).[13] Keep in mind it has been argued that the RBC of any insurer is unique to that insurer making it difficult to compare

[7] Note: a company with a 200% RBC ratio has capital equal to twice its risk-based capital.
[8] 8 VSA § 8303.
[9] Based on correspondences with representatives from both BCBSVT and MVP, July 2017.
[10] Oral testimony by the Department of Financial Regulation to the Green Mountain Care Board on July 20, 2017 regarding BCBSVT's Vermont Health Connect rate filings.
[11] Correspondences with BCBSVT, September 6, 2017.
[12] 8 VSA § 8308(a) and (e).
[13] According to annual statements, MVP Health Plan is the HMO part of the business and MVP Health Insurance Company is the PPO part of the business. Both are separate companies with the same parent company of MVP HealthCare. MVP Health Plan had 365,240 lives at the end of 2016. MVP Health Insurance had 4,540 lives at the end of 2016.

companies, since no two insurers have exactly the same mix of assets and risk. [14] As such, comparing the RBC ratio of BCBSVT to MVP Health Plan (or any other out-of-state insurance company) may not necessarily provide a true apples-to-apples comparison.

Estimated Vermont Health Insurer RBC Ratio Comparison - 2012 to 2016

	2012	2013	2014	2015	2016
BCBSVT	587%	575%	666%	663%	591%
MVP Health Plan	629%	840%	695%	764%	485%

In its solvency opinion filed with the Green Mountain Care Board (GMCB) as part of the BCBSVT Vermont Health Connect (VHC) rate filing for 2018, DFR flagged two solvency events concerning BCBSVT. One dealt with adverse utilization in which BCBSVT experienced higher utilization in FY 2016 than expected, which resulted in higher claims than originally estimated. The second dealt with "premium inadequacy" in which BCBSVT sustained a decrease in its surplus and RBC ratio "due to significant underwriting losses during its previous year ending December 31, 2016."[15] This may explain why BCBSVT experienced an 11% drop in its RBC ratio between 2015 and 2016.

RBC Ratios in Other States

According to an NAIC document which reviewed data for 925 health insurance companies, more than one-half of the companies had RBC ratios above 500% in 2016. Roughly 30% had RBC ratios greater than 1,000%, almost 60% had RBC ratios between 300% and 1,000%, and approximately 12% had RBC ratios below 300%.[16] It is assumed (although we cannot confirm), that most of these companies are likely for-profit entities.

Health Insurance Company RBC Comparison, *NAIC 2016*

RBC Ratio	No. of Companies	Percent of Total
Greater than 1,000%	295	33%
Between 500% and 1,000%	238	27%
Between 300% and 500%	283	32%
Between 200% and 300%	80	9%
Less than 200%	29	3%

Source: NAIC Data

Regulatory tools, such as RBC were created to measure and regulate the minimum amounts of surplus companies should maintain to ensure solvency and not to necessarily measure or regulate how much surplus is too much or excessive. Many insurers have argued that other than using RBC as a minimum solvency standard, it is not an appropriate tool to use when determining an appropriate surplus operating range because it does not consider many of an insurer's unique facts and circumstances nor does the formula take into account an insurer's

[14] ConsumerUnion, How Much Is Too Much: Have Nonprofit BlueCross and BlueShield Plans Amassed Excessive Amounts of Surplus, July 2010

[15] Department of Financial Regulations, amended solvency opinion for BlueCross BlueShield of Vermont – July 18, 2017.

[16] NAIC Financial Data Repository, Aggregated Health Risk-Based Capital Data – 2016 data as of 6/28/17

future needs and business decisions.[17] Similarly consumer groups have argued that the system does not create a widely accepted standard addressing when surpluses become excessive or inefficient.[18] And regulators, including the DFR, use it in conjunction with other solvency tools, indicators, and analyses and not in isolation to meet its regulatory obligations. Nonetheless it is a tool that is universally accepted, relatively consistent, and tangible. As such, a handful of states have taken measures to put some limits on surplus using RBC ratios as a measurement standard.

Pennsylvania institutes a surplus standard specific to the state's four BlueCross BlueShield (BCBS) plans. Two of the BCBS plans, which are large and well diversified, must remain within an RBC ratio range of 550% to 750%. The other two, which are smaller, less diversified and susceptible to higher volatility, must stay within a range of 750% to 950%.[19] If a plan exceeds these ranges it is considered "inefficient" and potentially excessive requiring the company to submit a plan on how it will drop back into or below the sufficient surplus operating range in a reasonable time period.

Similarly, Michigan has capped BCBS of Michigan's surplus at an RBC ratio of 1000%. If the cap is reached, the plan must file a plan with the insurance commissioner on how it will adjust its surplus to a lower level below the cap.

The District of Columbia has a law that requires the Districts Department of Insurance, Securities, and Banking (DISB) to review the surplus of CareFirst BlueCross BlueShield[20], which operates in Maryland, Northern Virginia, and District of Columbia (DC), every three years. If the surplus is found to be excessive, the company must submit a plan that dedicates the excess surplus attributable to its DC members to community health reinvestment in a fair and equitable manner. In 2014, DISB found the company's 2011 surplus attributable to its DC customers to be excessive and ordered the company to issue $51.3 million in rebates to its subscribers and $4.9 million in community health reinvestment.[21]

Additional Considerations

While such numeric caps on surplus are intended to provide consumer protections from excessive premiums and regulatory certainties, lawmakers should be mindful of the potential for adverse consequences as well, such as market instability if it results in artificially low premiums (from inadequate surplus levels). In addition, short-term savings could be followed later by pricing spikes. Also, having less surplus capital may result in lower credit ratings forcing the plan to pay higher interest rates if/when it needs to borrow money. Finally, some have

[17] Pennsylvania Insurance Department, Determination and order regarding Pennsylvania's four BCBS plans (2005).
[18] ConsumerUnion, How Much Is Too Much: Have Nonprofit BlueCross and BlueShield Plans Amassed Excessive Amounts of Surplus, July 2010
[19] The difference between the two ranges is due to considerations of size of the company and the levels of portfolio diversification, as well as distinctions in underwriting risk volatility and risk leverage. The two larger companies had over 3 million members and over $7 billion in written premium each at the time. The two smaller companies each had less than a million members.
[20] Also known as govern Group Hospitalization and Medical Services, Inc. (GHMSI).
[21] District of Columbia Department of Insurance, Securities, and Banking, DISB Orders CareFirst to Issue Rebates with Excess Surplus, August 31, 2016.

raised concerns about insurers exiting the market in such an environment, an issue that is likely less of a concern in Vermont.[22]

Lawmakers should also be mindful of the current uncertainty created by the federal environment concerning the future of the Affordable Care Act, cost-sharing and premium subsidies, and Medicaid cuts. Depending on its timing, such federal actions could create significant volatility in the insurance market, highlighting the kind of circumstances in which health insurance companies would need to tap into its surplus.

[22] Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's BlueCross and BlueShield Plans (2005). Prepared for the Pennsylvania General Assembly Legislative Budget and Finance Committee by Lewin Group.