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Professional Standards Affecting Health Actuaries

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Summary: While you've been busy worrying about the financial implications of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs), the Actuarial Standards Board (ASB) Health Committee has been grappling with a definition for actuarial soundness and what an actuary should do if, in his or her opinion, a plan is not actuarially sound—among other things. Learn more about standards of practice under development by the Academy Health Committee. Topics to be discussed in this session will include standards for the actuarial certification of small employer health benefit plans and documentation and disclosure in health benefit plan ratemaking.

Mr. Harry L. Sutton, Jr.: We will discuss some developing health care standards and bring you up to date on where the ASB is. We have only one of the two latest draft standards, but we can talk about all of them. I will be a member of the ASB for two more months. So my last word is to explain what we've been trying to do for the last couple of years and bring you up to date on what's immediately forthcoming.

Because of the crunch of what we've been doing, I don't think we've done much thinking about what we're going to do next year. I'll explain what happened at the last board meeting. Have any of you been in past discussions of health standards—mostly about small group reforms certification? I'll bring you up to date on that. At the last ASB meeting, which took place a week before this meeting, we

adopted a standard of Actuarial Certification of Small Employer Health Benefit Plans.

The second standard that the ASB approved as an exposure draft is Documentation and Disclosure in Health Benefit Plan Ratemaking. It's not a health ratemaking standard. The term "rate" means an estimate of the pure cost, but it's the documentation that the actuary should maintain. It does not relate to pricing. The ASB is very concerned about any standard that apparently would force people to price something the same way. We've started following the models developed by the Casualty Society that don't relate to pricing, but they define ratemaking, administrative costs, and investment or cost of capital.

All these items are considered in ratemaking, but there's a final decision to be made by management as to what the prices are going to be, and we don't relate to that. In other words, we're talking about the underlying claim cost and how you should document how you got that. Remember, for those of you who haven't been involved in this very much, documenting relates to keeping a record for your boss when you're doing a job—coming up with a rate for a particular product or changing a rate. The amount of documentation you need to do depends on the complexity and materiality of what you're doing. If you're just adding one more $5 co-payment to a rate, you need to document what you did, but you don't need to do a whole study. I'll talk about that a little later.

One of the things that we like to impress on everyone when we're talking about standards is that standards don't apply exclusively to state filings. They apply to your internal documents. When you have an assistant who is developing a rate, he or she should be following these standards and documenting all the assumptions that he or she gives you. Everyone is intended to use these—even for internal documents. One of the things in the documentation is that another actuary should be able to review the records and decide whether what you did was reasonable. In other words, if you're no longer there, somebody picking up the pieces the next year needs to know exactly what went on when the rates were developed to understand how they were developed. The new actuary can adjust for new conditions and revise the rates. Again, he or she should document that.

This is an ASB perspective, but some people feel that it doesn't apply to them. If your boss tells you to do this and get this table of data from inside your company, that's fine, but you should document everything as outlined in our standards. You should follow the same rules. You can always use judgment and you can make an exception. But you should make notes, in the event you considered something inconsequential, that will explain why you didn't go into complex details. There's no way that the ASB intends to take away the use of judgment in whatever aspect of

actuarial work we're talking about. But you should document—that is, leave a trail—so that you know that this was the assumption you made and explains why you did this instead of doing something different.

I think probably the hardest thing about standards is to get everyone to realize that no matter who they are or at what level of work they are at, the standard applies to them, and they should consider it when they do their internal work as well. It's most important if you're regulated to have everything in file if the state regulators ask you.

Another relevant item is a first draft that we did about a year ago that indicates for health actuaries what standards apply to certain areas of practice. There are nearly 30 standards now. You will find that the majority of them will still apply to health care, even though some of them sound unrelated. Many standards are common to almost everything: data quality, other sources of information, and so on.

This is an open discussion session. I plan to talk about two standards that we have just completed. The first is, "Actuarial Certification of Small Employer Health Benefit Plan Rates," and it is ready for final release. The second is, "Documentation and Disclosure in Health Benefit Plan Ratemaking," which will be released as an exposure draft.

We voted to approve the new standard on use of credibility methodology in developing rates. The standard could apply to the valuation of reserves as well; it relates to casualty, accident and health, and group term life. I'm not going to discuss that standard, but it will be in the mail in a month or two.

The Standards Board has been very busy in 1996. Are there any general questions about the function of the ASB, of the standards, and the Actuarial Board for Counseling and Discipline? Frank Irish, a member of the ASB, is here. He can help me, if necessary.

First, are there questions about the use of standards or about standards in general? This is probably the most productive year we've had in a long time concerning health standards. We have three important standards relative to health care that are coming out.

There has already been much discussion of the actuarial certification of small group rates. Even though we've worked hard to finish it up, the complexity of the small group business and rating has resulted in a lot of differing opinions, and even one of the regulatory actuaries on our committee voted against it. I will explain why he did, but we approved it anyway.

I would like to mention the major things in the standard that caused concern. First, states require many things in filing small group rates under reform laws. Those include market conduct, renewal practices, how notices are worded—things that are nonactuarial in nature. Our standard relates only to the certification that rates meet the standards required by the state. Some actuaries may feel they know enough about marketing, and what your marketing department does out in the field, to certify that those practices are in accordance with the statute or regulations. Others may not feel that comfortable—those actuaries should certify only to the development of the rates. Some regulators suggest the actuary should certify everything.

A second item is the time period for which the actuary has to file certifications. We tried to make it clear there are several forms of certification required. Normally, when you file a set of rates to be effective January 1, you have to certify that, to the best of your knowledge, the rates conform with the state law. Some of the laws are vague. Many state laws do not define when and exactly what you're supposed to certify to. Normally, at year-end, when you are doing your annual statement, the actuary who certifies for small group should certify that to the best of his or her knowledge, he or she complied with the state laws during the prior calendar year.

There has been some question as to what we're certifying. The standard states that if it's not clear about when you certify, we assume you're certifying to the annual statement period. The ASB interpretation is that when you certify compliance, you are certifying that all the rates filed for the past year met the state requirements. A number of states require a Certification of Actuarial Soundness. The dissenting regulator said, "When you certify the actuarial soundness retroactively, it means that you made a profit on your business." Well, we know there are many companies who don't make any profit and can certainly be in a loss position for a year. The ASB maintains that as long as your assumptions were reasonable in the beginning, those rates, in fact, qualify during the year and certification has nothing to do with whether you made money or not. That was a regulator's bone of contention. If every carrier in the small group business in each state had to certify that rates made money the last year, they're in trouble.

Another question is, what do you do if you've just made a rate filing, and then discover a problem that relates to that filing. You're probably going to have to refile your current rates to be sure that they conform because you know they won't conform. This question of knowledge of noncompliance—when you get it and what you have to do—has been an issue. If, during the year, you learn something, you don't have to do anything until the next certification. If you are doing a certification, you should make a note that if there's something in what you've done that doesn't quite meet the requirements of the state that you're going to correct it

or you have corrected it. We don't require that after you've done the certification—as long as it was legitimate—that you have to go back to the regulators for a new rate filing or annual statement certification; rather, you will cover them during the next certification. A major issue is when you have to tell the state that something is wrong, or that you're out of compliance.

It's worth considering carefully the question of actuarial soundness. At various times, the NAIC models have required that you certify the rates are actuarially sound. A number of us, including one former board member, feel that small group is social regulation, and, by definition, the rates can't be actuarially sound if they've told you to do something stupid. You can't guess the pattern of enrollment and validity of actuarial soundness. The standard has indicated the actuary can and should use a qualified or limited opinion. The limited opinion means the actuary is not certifying that market conduct is correct, if he doesn't know what the market conduct is. Somebody else in the company—a marketing or executive officer—would have to certify that.

The qualified opinion means that you have major doubts that the rates are actuarially sound. We don't have a definition in actuarial literature other than sound actuarial practices or usual actuarial practices. Because we did not have a good definition of what actuarially sound means, we drafted one.

We didn't get as many objections to it as we thought. Actuarially means that premium revenue less claims, expenses, and cost of capital are expected to produce, or at least break even over a one-year period. In other words, you're not intentionally going into business knowing that you're going to lose money.

The main argument in this is the fact that you may be investing in a new line of business, and you plan to amortize the start-up costs of this business until volume supports the overhead. There's no reason you can't do that. The standard requires you to explain and document what you're doing. The ASB did not want to get into the complexity, but you certainly have a right to say you're going to plan to lose money.

This is a relatively narrow definition. The standard really doesn't relate to whether what you're doing could bankrupt the company as a whole. We are only talking about a line of business. You could be a large company with a small line of business and lose a great deal of money, and it doesn't affect your overall corporate financial results to any serious extent.

From the Floor: Does it address redundant premiums or inadequate premiums only?

Mr. Sutton: There's no limit on how much you can charge, assuming you can sell it. ASB doesn't care what the profit margins are, although some states require rates not to be excessive. We're more worried about your going broke than making an excessive profit. The market will take away the excessive profit part of it; the market may cause you to lose money, also. If the state has a loss-ratio requirement, there is an additional limitation. You still have to say that your best estimate is that you're going to have an X% loss ratio. The standard does not address every particular state law. We use as our base the NAIC models and the states that are similar to that, because with so many variations by state, we couldn't possibly cover them all.

From the Floor: Actuarially sound equals financially sound—that's what the definition sounds like. Our company had comments on the definition of actuarially sound. I can demonstrate a case that was actuarially sound and shows a negative profit margin, although all of my assumptions were actuarially sound. Say profit margin was minus 9% of premium. I guess it is actuarially sound. Financially sound? Hardly. But I realize the difficulty in trying to define that term.

Mr. Sutton: There are at least two aspects of actuarial soundness. The methodology used to come up with the net rates must do a good job projecting what was likely to happen to the population mix. Then, are the rates set so that you can make money at it. The regulator wants to know that you think your company won't go insolvent with these rates. Remember, they're more concerned with insolvency. As long as you meet the rating requirements, they don't care how you came up with them.

I do think the standard expects you to consider the factors that could affect the rates, such as guaranteed issue, age banding or community list bill rates, no adjustment for sex, and so on, wherever the state requirements are heading to full community rates. Then, you must estimate what kind of age/sex spread you're going to get. It's very difficult.

In any event, you'd better document internally exactly what kind of assumptions you're making, and then measure what's happening so you adjust if projections are off the mark.

When New York State went to community rating for small group, some of the carriers claimed they had a 5–6 year increase in the average age of the employees enrolled. Now, the state's been trying to refute that, so I don't know the result. Maybe all the young people went into the HMOs that had low rates, and all the old people stayed with the indemnity, but there are also other major questions. With guaranteed issue, how many unhealthy individuals are you going to get compared

to the average? It's really almost impossible to guess. It requires a much better database than you might have had before because you must try to figure out what's happening soon.

From the Floor: I haven't heard a regulator yet who was concerned about inadequate rates. The only time regulators worry is at statement time.

Mr. Sutton: I agree. That's the social do-good aspect of both the state legislatures and some of the commissioners. In fact, you wonder if they're worrying about the solvency of the companies when they pressure them to get the rates down. In Minnesota, they required under their small group reform that you have a 75% loss ratio, and then the next year a 76% loss ratio, and then a 77% loss ratio up to 80% in five years. And there's no way you could guess within 5% what the loss ratio, was going to be in the first place. But you still have to certify it. I question where the actuaries who are commissioners are (my own personal opinion—not an ASB opinion) when the legislature passes these laws and requires doing things with the rates that may cause carriers to lose great deal of money. But I still don't think the states like it when it happens. They don't recognize that they're the ones who caused it to happen by the way they have been regulating and pushing people to come up with unsound rates.

From the Floor: Harry, would you like to hear the other side of that story? I haven't met a regulator who was concerned about inadequate rates. I've listened very attentively to the snide comment from the front of the room and the laughter throughout the room about that—poking fun at regulators—some of which is warranted. Think about what we've done, from a consumer's viewpoint. Think about the people over the last 25 years who've become unhealthy over time, and because of our rating practices, we have isolated them ratewise. We have put them in a position where they can no longer afford to buy health insurance. We've done that with our rating practices that we snicker about.

As a result, we've got federal legislation now. The primary purpose for that was affordability. The concept of going from group coverage to individual coverage—why do we have to have that? The primary reason we have to have that is because with our rating practices we isolate people who become unhealthy over time, and we put them in a situation where they can't afford insurance. The whole concept of insurance is to form a pool. Everybody's going to pay a little bit more to include those who need coverage—but that's not what's happened with our rating practices.

I'm not trying to justify what regulators, commissioners, or actuaries do. But I'm trying to get you to see the other side of this. We do really dumb things as

regulators. I will admit that. Actuarially, they don't make much sense. I think our primary purpose is to try to get you to understand that with your rating practices you isolate the sick and the well, which closes blocks of business, and which leads to assessment spirals. Folks, that doesn't work. We have to find a way to quit doing that.

Dumb laws and rules are really aimed at that. I'd love to have a lengthy discussion with any of you about how we could change rating practices, not because the state regulators require it, but because it's the right thing to do. And the people who buy coverage, either group or individual, are allowed to maintain that coverage until they're eligible for Medicare, because our rating practices are appropriate. If we could do that, voluntarily, then I would contend that this adverse regulation would go away.

Mr. Sutton: That's a very meaningful point of view and I agree it's a problem.

From the Floor: In talking to many regulators over the phone, I think the biggest concern the regulators have in many cases is the letters they're going to get from people who have large rate increases. I think the only way of getting around the assessment spirals and the other issues is to have some sort of a back-end risk adjustment mechanism. It's a very cumbersome thing to do, but I think it's the only way that works for all companies and is fair.

One of the things I often see in regulation—especially very small group and individual—is parts of the law force the prudent to subsidize the imprudent, things like very strict limits on the period in which preexisting conditions may be imposed. That's really for people who can't get insurance when they need a big operation. We've actually had people call us and say, "I need a heart transplant. I can wait six months. Sign me up." I think we ought to eliminate provisions in the law that prevent insurance companies from doing some sort of medical underwriting when people initially get into the pool. This forces the prudent to subsidize the imprudent.

Mr. Sutton: Right. I really appreciate Tom's remarks. We argue a lot, but he does have a good social point of view. Social equity is not a subject of the Standards Board which is trying to keep companies solvent in accordance with the rules, and they are getting more and more complicated.

As Tom pointed out, but didn't go into, the Kennedy-Kassebaum bill mandated guaranteed issue for groups of 2–50 nationwide. Some states don't have guaranteed issue, and every state must have their legislature on tap. If states are experimenting with individual insurance reforms, sometimes they roll it in with the small group,

and sometimes they don't. My own personal opinion, which has nothing to do with the Standards Board, is that until we mandate universal coverage and force employers to cover everybody, and for every employee to have insurance, we can't get at self-employed individuals who don't insure. The problem is health insurance is voluntary, and any time the premiums get too high, some people are going to drop health insurance, because they think they can spend less out of their own pocket than the premium. No one can force the good risk to come into a pool to subsidize the bad ones because everything's voluntary.

I understand Tom's point. I think, probably, before 1980 when inflation wasn't so bad, we had more pools and it was better. It was in the 1980s when the health care inflation rates went up to 20% or 25% a year that people started dropping out and the terminations caused the down cycle for major blocks of business. I don't know how we get to universal coverage or mandated coverage for employers. I think that would solve a big part of the problem because then you'd force a much more average pool instead of having a high-cost pool.

We're trying to solve a problem that's very difficult to solve. And I'm not sure that the insurance industry and a voluntary system can solve all those problems in a very satisfactory way. The standard discusses how you have to conform with what your state requires you to do. I would certainly advise you to work with your states and other carriers and whatever consortiums are there to work on these state health insurance purchasing cooperatives (HIPCs) and other approaches to pools that might work. It's hard to say whether they'll work or not; there are many of them to watch.

To summarize, those were mostly the bones of contention in the standard. We have limited and qualified opinions. Unsound rates could relate to both the projected financial outcome and the uncertainty with which you can predict the kind of people you're going to enroll when the state law is changing the rating systems.

From the Floor: Do regulators think you have to get a qualified opinion?

Mr. Sutton: So far, according to the chairperson of our ASB Health Committee, a consultant, many carriers have filed qualified or limited opinions. As far as I'm aware, none has been challenged by a state commissioner. Frequently, they just approve the filing and don't ever say anything. But, in fact, the later NAIC models removed the reference to actuarial soundness. The commissioners don't want to be accused of putting insurance companies under, so they want the actuarial soundness certified by somebody.

From the Floor: I'm a little confused by this discussion. I would appreciate it if you would just clarify something. In your opinion, does actuarial soundness require an expected profit or no loss?

Mr. Sutton: We've put a very simple definition in there. We're not saying you can't file with a loss, but if it doesn't meet the definition of actuarial soundness that we have, you have to file a modified opinion saying that it doesn't meet it for a particular reason and then state the result.

From the Floor: Harry, there are some states that have an adequacy requirement; that is, rates are reasonable with respect to benefits–nonexcessive, adequate, and nondiscriminatory.

Mr. Sutton: Yes. The standard wording for most health-rate filings.

From the Floor: And the adequacy requirement is basically the one you read on financial soundness.

Mr. Sutton: Yes. I'll read the definition.

> Small employer health benefit plan premiums are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing, and administrative expenses, and the cost of capital.

It means that you would project to breakeven in a state including the cost of capital, which could include a profit margin for the period for which you're filing your rates. It's not long term. It just relates to the period for which you are certifying the rates.

As an aside, it's interesting when I have looked at certain data. For example, in risk-based capital studies of the Academy, we have received data from insurance companies, for example, that sell Medigap coverage. They average a 120% loss ratio every year for 10 years. Probably their salespersons want to sell it.

I have a question for Tom. How does an actuary file the rates as adequate if there is always a 120% loss ratio? Is that considered socially acceptable when it doesn't affect the profit margin of the company as a whole? For many companies it's a small line of business. I wouldn't consider the rates are adequate if you know it's going to have a 120% loss ratio.

From the Floor: If I get that kind of filing and that kind of admission from a company, then I'm going to have a lengthy discussion with them. But then, where I come from, which may be different from a lot of regulators, I try to judge the competency of the company. Do they know what they're doing? And do they have some sense of fairness across their entire range of policyholders? If they do, then the dialogue the company and I need to have is limited.

Mr. Sutton: I think it's fair that you ought to say that you know what you're doing and you're planning to lose this much money on this business. I don't know if you consider that predatory marketing or not.

From the Floor: Each individual situation is going to call for that kind of interaction. As I indicated a while ago, I think one of the difficult areas, and the result of much of the federal and state legislation we're seeing right now, is for guaranteed issue. I'm not a fan of guaranteed issue. If you talk to actuaries who are regulators, I don't know many of them who are fans of guaranteed issue. The Life and Health Actuarial Task Force has gone on record on several occasions indicating to the NAIC that guaranteed issue in an individual voluntary market doesn't work.

Let's make sure that the rates are adequate, not only initially, but that as best we can foresee, given that we're not going to be able to predict everything that's going to happen, we expect a reasonable frame of renewal premiums so that people will be able to maintain that coverage no matter what health condition they are in. If we can do that, we eliminate many of the problems that we're bringing upon ourselves because of closing blocks of business which lead to assessment spirals. That gives the ammunition to the social wonks. They can point to that and say, "Well, here are all these people who don't have coverage. We have to fix it."

Mr. Sutton: I think I can predict in the next two years, because of Kennedy-Kassebaum and other factors, the states are going to be toying around with changes in the individual health insurance market, and more of them are going to come up with some form of guaranteed issue. Five or six states already have it. The problem with guaranteed issue on individual coverage is it's a small line of business. There aren't many carriers that even write it. Many of them are specialty carriers, and the question is, what business do they have to pool it with?

If you look at Clinton's reform bill, one of the things he did was take all the individuals in Medicare and pool them in the Health Plan Purchasing Cooperatives with all employer groups up to 5,000 employees. In other words, that's the only way they could come out with a pool large enough so the rates wouldn't be so high for some individuals that they couldn't afford to buy. But he also mandated that everybody have coverage. Because he needs what he still calls free riders in the

pool. It's hard to get a young male to pay $100 a month premium if he voluntarily can stay out. If he can get back in without any preexisting condition limitation, then you're going to have a difficult situation. I don't know how we're going to solve it.

The Standards Board has a general committee that will look at such items as materiality, actuarial soundness, and others.

From the Floor: I just want to point out, as you already have, that the definition of actuarial soundness is probably the most important thing in the standard. You've heard a couple of opinions as to what the regulatory intent was—you were required to file a statement as to whether the rates were or were not actuarially sound. I think one of the major concerns of the ASB was that we not let this term fade into insignificance or become meaningless.

We did not want this to be a routine matter where you just check off and say the rates were actuarially sound. That's not professional, which is the big point. It's not professional. The difficulty, as Harry says, is we really don't have a good definition of actuarial soundness. We put many good health actuaries to work on it, and they came up with the working definition. From now on, when an actuary asserts to the state the rates are or are not actuarially sound, the state can rely on the fact that this is according to an agreed-upon standard or a professional standard. Professionalism is very important for all of us. The actuary certifies that good actuarial work was done and that with the expected rates at the time they were set up, the expected experience would produce a breakeven situation. When an actuary says something, it's meaningful. I think that's important.

Mr. Sutton: I think it's important to realize that when the standard is there and you determine your rates don't necessarily meet the definition of actuarially sound, you can always modify your certification and explain why. If you use a different definition of actuarial soundness, that's a modification of the standard and you should so state. I agree.

From the Floor: It's more than just stating. I think that if you use your own definition of actuarial soundness, you've got to say, "I did not follow the actuarial soundness definition."

Mr. Sutton: That's what I meant.

From the Floor: I was going to point out, as a general rule, when you do something that's a little different, you should state your procedures. Think about it—if you're in doubt about following the standard, just state what you did. As a general rule, I think that's a good practice to follow.

Mr. Sutton: Yes. The standards allow for judgment. If you want to take an approach different from the standard, you are making a deviation, and you should explain why you made a deviation. You support the deviation. The standard is not a cookbook and cannot consider every situation.

From the Floor: Is there mention of amortization of start-up costs?

Mr. Sutton: There's nothing in the standard about it.

From the Floor: Could you define costs?

Mr. Sutton: The standard says marketing and administrative expenses are supposed to be covered by the rates.

From the Floor: I would assume that means the actual costs.

Mr. Sutton: Right. The standard does not address the question of whether you use an amortization schedule for certain costs and actual costs for other things.

From the Floor: The referral to cost of capital would seem to imply you need to determine the amount of capital required as a product of your rating.

Mr. Sutton: Yes. There is a broader reference in our exposure draft of Documentation and Disclosure in Health Benefit Plan Ratemaking and considerable discussion in the latest exposure draft concerning cost of capital in property and casualty insurance ratemaking. The cost of capital definition has been adapted from the casualty standards. I'll just read you the definition. "Cost of capital: The rate of return that capital could earn in an alternative investment of equivalent risk. The source of capital may be internal or external." In other words, the theory is that a company wouldn't go into business unless it could have a return commensurate with the risk. It's like buying junk bonds with a high coupon rate versus buying government bonds with a low coupon rate. It may also be based on risk-based capital requirements. In other words, how much risk-based capital do you need for this line of business? All those things enter into the cost of capital. The profit margin may include both the cost of capital and a risk margin, if you've got a highly volatile business.

Without hope of a reasonable rate of return, a lot of carriers have gotten out of the small group business in some states or even totally; others are out of the health insurance business completely. I have a personal concern as to what happens if most of the carriers get out of the market. Will we wind up with a very few carriers or HMOs as the only survivors? I think some states could make it so difficult, even

unintentionally, that a majority of the carriers could get out of the market. Tom, can you see the number of carriers in some of these markets shrinking to a point where access to insurance will be limited?

From the Floor: I guess it's my sense that reform will continue as we're seeing in small group, and now we're seeing federal reform in individual as well as individual reforms throughout the states. At the NAIC level, there were a couple of individual models passed within the last two years. The rating systems proposed require much work. I would challenge people in this room to work through associations or come to me directly. I would very much like to get some workable rating reform in individual and small group insurance because I think we can head off some of this legislation that's coming down. But we need to do it now. If we wait two years, it's going to be too late. Because then the social wonks—and I don't say that to be negative about them because they're doing what they should do given what we've done. In a very real sense, the ball can be in our court if we want it. If we don't change, then it's my sense that you are absolutely right. Within a couple of years, the social mechanism will get us to the point where there's no way that we can make money; therefore, there's no reason for the individual and small group carriers to even be in the market. So, we'll end up with the major Blues organizations which are consolidating, the HMOs, and maybe even the direct provider groups controlling the market.

Mr. Sutton: The latest exposure draft that you will be receiving in the mail is Documentation and Disclosure in Health Benefit Plan Ratemaking. This standard, I have to emphasize, relates to documentation. It is not a detailed ratemaking standard, but it does discuss elements you have to consider in developing rates. Again, rates are the projected costs, not prices. It's very much modeled after some of the casualty standards.

In discussing documentation, the standard is relatively educational in enumerating the types of assumptions you should document. Essentially, the standard tries to remind people of a number of the things that we think are important in the ratemaking process, and they need to consider them. We eliminated much of the excess language. Our new standard formats are not as educational as standards have been historically; for example, continuing care retirement communities. The standard itself is much shorter, with background and history in the appendices.

I'll enumerate to you a few examples of documentation issues related to risk. In these there's something that most experienced actuaries would consider, but remember these are for everybody, including junior actuaries or actuarial students who are working on projects, as well as external audiences:

- The effects of reinsurance including assessments for pooling arrangements
- Operational changes such as changes in underwriting practices, renegotiating provider contracts, and lowering costs or marketing systems
- External influences such as we've been talking about: judicial environment or guaranty funds
- The risk classification system to be used
- Rating method and factors
- Experience rating, and the effect of that on your basic rating system

Other broad areas discussed include data sources and experience, credibility, trending procedures, claim definition, and analysis of expenses.

Some of these areas may warrant specific standards. The actuary's decision on these important variables needs to be documented. Various factors interact in ratemaking. The actuary should have them documented and available, internally and externally, as appropriate.

The standard does not require the actuary to file all the assumptions if there is no requirement, but they should be available on request. Documentation is also to provide continuity and consistent evaluation. An actuary may come in and change the methods that he or she used, but he or she should know what methods somebody else has been using prior to that. The standard does not tell you exactly how to do ratemaking, but says you should document each decision you made and how that factor affects your rates.

The enumeration is not all-encompassing, because it's impossible to predict every circumstance. But ratemaking is much more complicated than it used to be, particularly in the areas that are heavily regulated. The standard applies to HMOs, PPOs, Physician Hospital Organizations (PHOs), whatever. The ratemaking systems for those are much more complex than rating major medical 20 years ago. I think ratemaking uses more of the basic utilization cost patterns now. The ASB is asking for your comments on the draft. The ASB is concerned about whether there is too much or too little to document; there is no intent to limit ratemaking methods. And remember, the standard is a protection for the actuary.

Do any of you think we should have a ratemaking standard? I don't think the Standards Board is inclined to move, but I don't know to what extent you feel a need for a ratemaking standard. The ASB has found it very complex to try to come up with a ratemaking standard on health care, and the Health Committee had been working at it for eight or ten years. We came down to this one on documentation.

From the Floor: This seems to be a checklist of things that you should look at similar to the reserving standard that you made regarding HMOs and other managed care organizations. It's really a checklist of all the things you should consider.

Mr. Sutton: Yes. I must say that the ASB is not trying to take anyone's freedom away to come up with methods to do things or use his or her judgment. We're trying to list variables we think are likely to be used, and we want the autonomy to document them so there is a trail of assumptions.

From the Floor: I think what might be more helpful is for the Academy to come up with a standard for rate filings. Right now, keeping track of what the states require in terms of the rate filing is a big chore. Having a standard as to what kind of information would be required—I think it would be helpful for both the regulators and the regulated.

Mr. Sutton: In discussions with the NAIC and commissioners, there are complaints about the way rates are filed. For some coverages, you don't even have to file rates in some states. Often rates are filed with no details of assumptions that were used to come up with the rates. Sometimes the commissioner asks for the assumptions, and other times he or she doesn't. There are rate filings that look absolutely unbelievable to a commissioner. I think it would be helpful if everybody had exactly the same filing requirements. But I don't know how we do that. Tom, how do we address trying to simplify the dealing with 50 jurisdictions that have different requirements for everything?

From the Floor: I was a regulatory actuary in Florida for four years before I moved to North Dakota last year. In Florida we developed a new rating regulation. Any of you who file in Florida are familiar with this. We had a list of about 28 items that needed to be in the actuarial memorandum. And this comes primarily from ASP No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" Then I moved up to North Dakota and was amazed and delighted to see, unsolicited, the number of actual memorandums I got that followed that same format. So what I did, without authority, was just start sending out that same list. And the rationale was exactly the rationale that you're talking about now.

If we all know that we have this standardized format, then I know that you're going to have to go through all these 28 items when you go through the rating process. I was a company actuary for 20 years, and most of that time was in health insurance. So I know that you're going to have to go through those. There have been three companies to object in the last year to using that format. And those three, I know, were trying to hide something from me. Do you think we don't know when you're

trying to hide something? We get the sense that you think we fell off the turnip wagon and maybe some of us did. I don't know.

But almost everyone has readily adopted this format, whether they were happy to do it or not. I certainly wouldn't have any objection, and could use what influence I have to put together a group that would make this part of an overall rating approach that I'm encouraging people to do. I think this may be helpful to everyone because this can be the documentation device, an interaction device.

Let's make the format—standardize the format—as a part of this revolution that we're going to undertake.

Mr. Sutton: We have a few companies that are still in favor of national regulation versus state regulation, but this has not gotten very far yet. You should be getting in the mail shortly the Documentation and Disclosure of Health Benefit Plan Ratemaking as soon as it's retyped.

Mr. Robert B. Likins: You asked about whether companies would be interested in some kind of ratemaking standard practice. I've been listening to Tom Foley's comments about pushing people into closed blocks of business, and they potentially get into ratings spirals and that kind of thing. Has the Actuarial Standards Board thought about preparing a standard related to how you could treat these blocks of business? Some states might not employ actuaries familiar with reasonable techniques, and may do something completely social so far in one direction that it would not be very healthy for the company to develop that kind of business. In other states, actuaries might be more reasonable. Has the Actuarial Standards Board considered that?

Mr. Sutton: Not that I'm aware of. *ASP No. 19*, "Actuarial Appraisals," is related to purchasing blocks of business and acquiring—putting a valuation on a block of business—but not in the way you're talking about exactly.

Mr. Likins: It seems like it could potentially cover many policyholders and many companies with insolvency concerns also.

From the Floor: It sounds like it's something more appropriate for an Academy committee than the Actuarial Standards Board.

Mr. Sutton: If laws or regulations require a specific approach, the ASB could develop a standard to relate to it. But, the ASB doesn't have the capability of finding a solution to a structural problem. I think Frank is right. Some standards certainly result from strong demand from the NAIC to get something done. Other

recommendations come internally from Academy members or ASB specialty committees.