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Session 132PD
Health Valuation Issues: Traditional Products

Track: Health

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Summary: Facilitators lead a discussion of recent experiences and current issues regarding the valuation of medical and dental insurance and managed care products. Possible topics of discussion include interplay between Actuarial Standards of Practice (ASOPs) and codification requirements; revision of relevant Actuarial Standards of Practice; deficiency reserves: insured versus self-insured; statutory versus GAAP; and compliance with actuarial opinion requirements. At the conclusion of this session, attendees learn more about the hot topics regarding the valuation of traditional health products.

MR. NORMAN J. ZWITTER: My name is Norm Zwitter. I'm the valuation actuary at Blue Cross of Tennessee, and I'm going to be the moderator for this session today. I'm kind of excited about this. We have, I think, a very good panel and some interesting topics for you today.

Donna's going to speak first and Donna's background is on the Academy's involvement in some of the topics we're going to be discussing. She'll be followed by Leslie Jones, who is the actuary for the South Carolina Department of Insurance, and she will cover some valuation being addressed by the NAIC, and then finally we have John Lloyd from Ernst & Young, who will present the auditing point of view on some topics.

Donna is currently with her own firm called NovaRest. Prior to that she was with

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

various accounting firms. She's had a lot of involvement in the industry, but also she's been heavily involved in the Academy on various committees that have developed a lot of the regulations regarding things that we're having to address as valuation actuaries. She is also the vice president for financial reporting for the Academy, so she has a very broad perspective on a lot of issues that have been facing us on the valuation side. In particular she's now chairing the committee that's looking at setting up liquidity standards for health companies. She also chaired the committee that developed the NAIC Health Guidance Manual.

MS. DONNA C. NOVAK: Good morning. The topic that I'm going to cover this morning is the deficiency reserve section of the Health Reserve Guidance Manual (HRGM). That's really what had become quite a hot topic after we did the manual, and I think Leslie's going to talk about some specific issues that the regulators are looking at and answer any questions on these from a regulatory perspective. I'm going to talk a little bit about the liquidity tests that the Academy is developing for the NAIC, and as part of that, because liquidity gets into cash flow testing, I'll just talk very briefly about health actuaries working for HMOs where the cash flow testing guidance is, or actually in this case is not, right now.

The HRGM has been adopted. It's not really an official manual; it's a guidance manual, so it does not have the power of law in any state, but it will be referenced in the accounting practices and procedure manuals, which in many states really do have the power of law, because they are referred to as the standards that companies have to follow when filing their statutory blank. So with this reference they have a lot more weight than they did even six months ago or so. The Academy developed the first draft of the guidance manual because the NAIC, as well as the Academy, really felt that more guidance was needed. When we were considering whether to develop a standard of practice, put in one of the reserve models, or do some practice notes, many of those alternatives had a long time frame associated with them. A standard of practice takes a very long time—years to develop in some cases.

A practice note just documents current practice, and one of the problems was that current practice needed to change, especially because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and some of the implications of HIPAA. So it was decided that the best alternative was a guidance manual from the NAIC, even though it might not have as much weight as those other alternatives.

I'm going to go through the issues in deficiency reserves, explain them, and maybe give a couple of ideas about what should be done about gray areas, but one thing I'll caution about is that every state has slightly different interpretations. Even within the same state, I've seen different interpretations in different situations. So I'll go through these just as areas to be careful of, but I'm not going to give you any answers.

What is a block of business for a premium deficiency reserve? Codification has a

definition based on the way that policies are priced and marketed, and it's still a very, very vague definition of what you would have to do on a deficiency reserve on a block. It gives a lot of leeway. Some of the questions that come up are, "If I have a block of business that I have to provide statutorily, such as a Blue's plan that is a carrier of last resort, and that block of business is by definition going to lose money, can I combine that with a block of business that subsidizes it? Can I combine blocks of business that subsidize each other? Can I combine life with health if one subsidizes the other in some cases?

There's a little bit more guidance in the health guidance manual. It would say that health should be separated from life; small group should probably be separated because it has different rules on ratings than large group in most states, and individual should be separated from small group. So some of what we would think of as the normal blocks of business where you manage profit would be your blocks of business. Anything finer than that is possible. What I tell clients is that once you determine what your block of business is, you can't change it every year. Regulators get very suspicious when every time you look at your deficiency reserves, you're blocking things differently, so the consistency is probably the most important thing.

I just got a question the other day: "If you've got a large block of business that renews in July and is losing money the first six months of the year, do you have to set up a deficiency reserve for that period of time?" Codification actually says to the end of the contract period, and the end of the contract period would be that July date, but I think most regulators and most actuaries are saying as long as you don't have a deficiency over the calendar year, you don't have to set up that deficiency during the year. But one of the things that actuaries are cautioned about is not to assume that because you're going to have a rate increase that you're going to be able to increase rates enough so that you're not going to have a deficiency in the second half of the year and so you're going to make up for the deficiency in the first half of the year. If you're looking at a large rate increase, you're also probably looking at some of your healthier individuals or groups leaving the block. Many regulators have seen blocks of business for which companies don't have deficiency reserves because the premiums are going to go up next year. Then for three or four years in a row the business still stays deficient because of the typical death spiral.

How much conservatism do you need to include in your calculation of reserves at the end of the period? Right now there's really no guidance being given, but it's just an issue you should consider. When we started the reserve manual, everybody said we really didn't need any guidance and what we had was really perfectly clear. So we'd have a meeting and we'd go around the room and say, "Well, what does this mean to you?" and if there were five people, there were six opinions on what was perfectly clear! One of the things that I think is perfectly clear is the relationship between the gross premium valuation and a deficiency reserve. Leslie may talk about this a little bit more because she has a group that's looking at that with some

help from the Academy. We're starting to really sort out what the distinction is between what we've always thought of as the gross premium valuation and the process of determining whether or not there's a need for a deficiency reserve.

When the NAIC passed risk-based capital for health entities a number of years ago, part of the industry actually came forward and said, "Well that's fine, you've got a capital requirement, but we know that some of our competitors, although they've got enough capital, don't have enough cash, because their capital is tied up in buildings or health care delivery assets." That was a good point. We had a group at the Academy look at liquidity issues from a life, a property and casualty (P & C), and a health perspective to see if we wanted to coordinate reviewing liquidity requirements altogether. The group decided that on P&C liquidity isn't a problem, that on the life side it wasn't a problem right now—they're working on their C4 risk of the risk-based capital—but that on the health side it was a problem. So we started looking at liquidity on the health side, and the Academy produced a proposal to the NAIC for a paradigm for a liquidity requirement. The group at the NAIC that was responsible for liquidity requirements decided that its first priority was going to be to set some ratios that would indicate a problem very early on, and get some reporting around ratios that it was going to develop. So the group put the liquidity requirements on the back burner while it developed the ratios. Meanwhile, liquidity became a big problem on the life side. The group went forward and had some proposals on liquidity, and now that the health entities working group has completed its ratio and its ratio reporting, it has asked the Academy to resurrect the project on liquidity.

The paradigm that was originally recommended and that is currently under development is really a three-tier test. There would be one test for liquidity that originally was a current type ratio and now is potentially a number of ratios. If you passed a certain benchmark on these ratios, you wouldn't have to go any further, and the regulator would consider you not to have a liquidity problem or potential liquidity problem.

If you didn't pass that first safe harbor, then you could go back and possibly do some off balance sheet adjustments, especially if they had been preapproved by your regulator, because you knew you were in a situation where the off balance sheet adjustments may be needed. The off balance sheet adjustments are things such as letters of credit or parental guarantees that you could draw on if you really had a liquidity problem.

If you couldn't pass either of those safe harbors, then you would have to do cash flow testing against predefined stress tests, unlike the life side where cash flow involves a lot of interest rate and asset liability matching. For the health side, we've oriented it more around stress tests: what happens if you lose your largest group or 10 percent of your business? What if the trend is 10 percent more than you anticipated it to be? Then you would have to do the cash flow testing.

I'm going to go very quickly through a number of ratios. One thing I'll say before I go through them is that you would never do all of these ratios, and right now we're testing to see which ones are most predictive. Sometimes they're very similar ratios, though maybe one's more predictive than the other. You would never use both of them, so it would probably be a subset of maybe three or four.

1.The investment income to cash and invested assets ratio looks at changes in investment income, because that shouldn't vary a lot for most health companies.

2. The combined ratio is a loss ratio with administrative expenses added to it, so it is premium compared to claims and administrative expenses.

3. Profit to revenue, which includes investment income and interest expense.

4. Liquid assets at market to short-term liabilities, which is a little bit like a quicker current ratio, except you look at assets at their market value, not necessarily what they're being carried at on the balance sheet. So you look at what you really thought you could sell the asset at compared to short-term liabilities, taking into consideration whether or not, if for some reason you have a lot of securities or bonds or something, you could sell a large volume for the liquid value. Again, this is not a huge issue with most health insurers, but the larger ones would have to go through some thought process when actually valuing those assets at market value.

5. Change in capital and surplus as a percentage determines if your capital and surplus is fluctuated by X percent, and all of the calibration, of course, will come out in the testing.

6. The liquid assets at market value, less current liabilities, to months of net loss ratio determines how much you can keep losing if you are losing money before you're going to have a liquidity problem.

7. Premium receivable to premium revenue shows if you're starting to have your customers pay you slower and slower.

8. Number of days of unpaid claims shows if you are starting to have backlogs build up. Sometimes when companies start having liquidity problems, they stop paying their claims quickly.

9. Change in claims payable per member per month might be an indication of trends not being estimated properly because it's a larger change than what may have been anticipated.

10. Large decreases in membership may indicate that you're losing a lot of your better groups, or if your membership is increasing very quickly, you may be growing too fast.

All of those are potentials. We may find that some of them have no predictive power whatsoever. So the next step is to test the ratios. We have identified, or the regulators have identified, some companies that have run into liquidity problems, so we can test if these ratios could have predicted a problem or not and at what level or calibration they'd have predicted a problem. We have a data request into the NAIC right now. I don't expect to get data before the next quarterly meeting, or maybe by the end of the year, and then I would anticipate two or three months of testing the data before we could come back with the report to the NAIC with a recommendation of which ratios to use.

Also I mentioned the stress test. There were, I believe, five stress tests that were originally defined. We still think those five are pretty good. I don't think we've added any more. Actually, we may have added one more, and right now the team that's working on this is going through each one of the stress tests to define a little bit more thoroughly what exactly would have to be done. A couple of the companies that are represented on the committee are taking it back to their actuarial staff and saying, "Could you do this if I gave this to you as a project, and what questions would you have?" so we think we've got something that's well enough defined that the industry and the regulators could react to it.

The NAIC process on this is hard to predict, but I would anticipate that maybe by the first quarter or the middle of next year, the Academy will have all of its work done and the recommendations into the NAIC. It could be a year or 18 months after that before anything is actually out as a requirement. However, this isn't a bad thing to follow. Because of the time frame with risk-based capital, a lot of actuaries ignored it, and then once it was passed they ignored it because it hadn't passed in the state, and then all of a sudden it passed in the state and there was a big panic. Another thing that happens is that as these develop, regulators know about them and start using them, so it's not a bad idea to see how you would fall on some of these ratios as they firm up a little bit more and as they get calibrated.

Let's talk about cash flow testing. The standard valuation law that I've always gone to actually only applies to life companies and fraternal companies. It does not apply to HMOs or HMDIs. The NAIC is going to all Section 8 opinions as part of the standard valuation law, so life companies will have to do Section 8 opinions for all of their cash flow testing. They won't have a Section 7, but because health companies do not fall in the standard valuation law right now, that won't apply to them.

This standard valuation law states that the commissioner will promulgate minimum health reserve regulation. It's just wonderful that all regulations for most states are on Web sites.
The health reserve model regulation does not have any asset adequacy requirements, as you probably know, so we don't come to a situation right now where we have to do any cash flow testing. The standard valuation law, though,

states that the actuarial opinion is based on the AFB standards. The old Actuarial Standard of Practice (ASOP) 14, which is still out there, describes the conditions under which you do cash flow testing for life and health companies, but it has been revoked. What are the others?

MR. ZWITTER: Seven and 22.

MS. NOVAK: Seven and 22, and I don't have those titles memorized, but they are going to be used in place of 14. ASOP 18 talks about long-term care, and long-term care and disability insurance (DI) are probably the two areas that many health actuaries consider for cash flow testing.

MR. ZWITTER: Next I'd like to introduce Leslie Jones. Leslie is the chief life and health actuary for the state of South Carolina. Prior to that she worked at different commercial companies up in New England and several consulting firms. She also taught business and statistics courses for a while as a professor at the College of Charleston business school. In her role as the actuary for the state of South Carolina, Leslie's been involved in a lot of the committees and is currently involved in various issues that Donna's already alluded to, but the committee that she's working on now is looking at some cash flow testing issues for the NAIC and is going to clearly resolve all those issues for actuaries. So I turn the podium over to Leslie.

MS. LESLIE M. JONES: Thanks, Norman. I thought I'd start first by identifying the sources of guidance and statutory requirements for statutory health valuations and then explain the relevance of these sources from a regulatory perspective. Finally, I'll talk about the activities of this NAIC working group that Norm and Donna have alluded to.

With respect to sources of guidance, basically you see this guidance coming from a variety of places. The NAIC promulgates model laws that the states can adopt. Health practice notes, of course, don't have the same force as the ASOPs do within our professional standards, but they're out there and are very helpful. The financial accounting standards board promulgates standards that sometimes get adopted into our requirements and then, most importantly, is state law.

With respect to the NAIC, it's interesting for me to hear Donna talk about these requirements from a regulatory perspective. I see where the confusion comes from, because even with what Donna says, I would take things with a little different plan. The standard valuation law is a law that sets forth minimum valuation requirements for life insurers, but it also gives the authority for the commissioner to promulgate regulations for health insurance and sets forth requirements for actuarial memorandum regulations for life and health insurers. So if you are an indemnity company rather than an HMO or an HMDI, the standard valuation law applies to you in the sense that it gives the director the authority to promulgate rules that apply to health insurers. We just revised the Actuarial Opinion and

Memorandum Regulation (AOMR) to take out the Section 7. It essentially requires an asset adequacy opinion, and I say that versus cash flow testing because when people hear that Section Seven's been eliminated, they think they have to do this unnecessary cash flow testing. Clearly from what Donna talked about with respect to liquidity, it's not unnecessary, but it's not the elaborate cash flow testing that everybody thinks about. It's asset adequacy analysis and matching your liabilities and your assets and making sure that under a stress scenario you've got enough cash to pay your claims. So at any rate, the AOMR applies to health insurers and indemnity carriers who are writing health products, and the Health Insurance Reserves Model Regulation (HIRMR) that Donna pointed out is referred to in many state laws. I think it's only been adopted by 16 states, but South Carolina happens to be one of the states that has adopted the HIRMR. So it is an obscure reference and very difficult to find, but the HIRMR sets forth minimum reserve standards for major med, indemnity products, and all of your standard supplemental products, long-term care, DI, that sort of thing.

Again, the standard valuation law, AOMR, and the HIRMR applies to life insurers and health insurers. Then you've got this whole area of HMOs and HMDIs. Well the HMOs are covered by the HMO model act, which essentially says you have to set up a claim reserve and an unearned premium reserve, and some states didn't even adopt that provision. For example, South Carolina didn't adopt that provision into our state law. That's guidance that applies to HMOs and then, of course, all of that has somewhat been replaced by the all-encompassing accounting practices and procedures manual, which is now what we generally refer to as codification. So there's just a variety of guidance out there.

I have to say the Blue Cross plan in South Carolina is a P&C company, so who knows what rules apply to the Blue Cross plan?. You've got standard valuation laws, AOMR, the HMO model act, and then you've got codification, which applies general standards to everybody.

I'm not going to spend a lot of time talking about the HRGM because Donna talked about that, but I think that it is one of the most helpful things that the NAIC has produced in a long time. Although we label it the NAIC's HRGM, in fact the Academy developed the manual. The regulators got their fingers on it and tweaked a few things, but it was basically the work of the Academy that has now been adopted by the NAIC.

However, the model laws that are developed by the NAIC have no effect truly until they become adopted in state law. The regulators may look to them for guidance, but in court they have no effect until they're adopted into state law. Many states adopt the NAIC models, but there may be state variations, and those state variations are the law, and that's what you've got to follow.

Now, from a national company's perspective, it's a mess to have a model law that states can adopt or not adopt and can modify if they want to. One thing that's

helpful, at least from a valuation perspective, is that most states don't know a lot about valuation issues, so they assume that the NAIC and the Academy know what they're doing and don't tweak with things too much on the valuation side. Every now and then, though, you'll have a state with the rogue actuary who says, "But I really wanted this and I didn't get it at the NAIC level, so we'll put it in."

Accreditation has come around, and I think that's helped a lot, because I think there were states that didn't have any valuation standards, so then the company actuaries might follow lesser standards that other states might think were appropriate. So, many years ago, the NAIC undertook an accreditation project to make sure that states at least had minimum financial solvency standards for the company. States are responsible for their domestic companies, basically for insuring their financial solvency. Now, if I have a huge company that's not domiciled in my state but writing a lot of premium, how do I get comfortable as a regulator that that company is being monitored properly without going in and monitoring that company myself? Well, accreditation to some extent gives me that comfort, because accreditation sets forth laws that states have to adopt to be accredited and standards that they have to implement with respect to financial analysis and financial examinations.

Every five years a team comes in and makes sure that South Carolina is taking care of its domestic companies in accordance with these accreditation standards, and that really has helped a lot. Say, for example, a state was not accredited. Then South Carolina would be responsible for going to that company in that other state and insuring the financial solvency of that company. Well, we don't want to do that. We want to be able to rely on that domestic regulator to take care of that company. So it's very important to every state that they maintain their accreditations. States have gone to great lengths to convince their legislators to adopt model laws without any changes so that they are substantially similar to the NAIC models. So that's gone a long way toward standardizing at least the basic financial requirements that are out there.

One problem with accreditation at least that I've seen in the past from the health perspective is that the HIRMR was not in the accreditation standard. Now for South Carolina that's not a problem. We have the HIRMR on the books, but I can't be sure that the other states in the country don't have that on the books. The HMO model act, at least the reserve portion of that, was not an accreditation standard, so for health entities, I think it still was not very standardized, and not only did we have different sets of rules applying to different types of entities, but also those standards that were out there weren't required to be uniformly adopted because they weren't a part of the accreditation.

Well, codification came along, and I think it more than anything is going to do the job of making regulators develop a common set of rules for health entities and give you all good guidance with respect to what you should be doing. The nice thing about codification is that it is a comprehensive basis of accounting that sets forth

general requirements for just about everything you can think of via the Statements of Standard Accounting Practice (SSAPs). SSAP 54 and 55 are particularly important for health reserving. Codification generally became effective 1/1/01, and it is now being seasoned to become an accreditation standard, so within a couple of years all the states will have to have codification on the books, and that brings me to the point about effect on state law.

Most states take the position that they must actively adopt codification or that's an illegal delegation of their state's authority. They can't have the NAIC setting their reserve standards for them, so they have to take an affirmative step to adopt codification. Where state law is silent on any issue, codification is the law. States can choose to deviate from codification, but then the companies who use the different standards dictated by state law must disclose that on their financial statements.

Actuarial standards of practice are important from a statutory perspective, in that any of you who signed an opinion know that you've got to say that you prepared the opinion in accordance with relevant actuarial standards of practice. Therefore, they are incorporated into state law, because you've got to attest when you sign your actuarial opinion that you have prepared your statements in accordance with state law. ASOP 7 and 22 have been revised in accordance with the changes to the AOMR and ASOP 14 has gone away. Note that, even within our actuarial professional literature, HMOs have a different set of rules than health insurers, as seen in ASOP 28, statements of actuarial opinions for HMOs and HMDIs.

So where does that leave us? The NAIC has a working group called the A & H working group that reports to the life and health actuarial task force, and that working group looked at this portfolio of guidance and different standards and decided it needed to look at the fact that the standard valuation law and the HIRMR don't apply to HMOs and HMDIs. Why should HMOs and HMDIs have a different set of rules than health insurers? At one point in time, maybe the business was so different that a different set of standards was appropriate, and I think HMOs developed in a whole different regulatory context than the traditional health insurer, so the rules were separate, but they have evolved over time to a point at which the products that are offered are virtually identical. So why shouldn't that standard valuation law and the HIRMR apply to HMOs and HMDIs? We decided to pursue this issue, so we formed an HMO/HMDI subteam, which I'm chairing, and we said, "OK, well, let's just apply them." Well that was met with severe resistance from the industry, because it is very different. The biggest difference that we identified has to do with the actuarial opinion and/or certification, depending on which one you're doing. If you're a health insurer, you're doing asset adequacy analysis. You're doing a stated filing opinion, or were at least, rather than a stated domicile opinion. If you're an HMO or an HMDI…I remember one actuary that wore both hats. He did the opinion for his health insurance business and also for his HMO business, and he said, "Well, on the one hand, I do this elaborate analysis, cash flow testing, etc., but on the other hand I just do a red face test for my HMO business. That's a

problem, that he has to do different work for essentially the same business. I mean if you look at a principal-based system for developing reserves, that's a problem. But at any rate, we realized that we needed to step back as a team and look at what we really want to do. We decided that if somebody is issuing essentially the same product, then the reserves and the requirement for the reserves should be the same. We thought that was a principle that we could all live with. We all agreed that if people were issuing the same product, then the reserving method, requirements, etc., should be the same.

So the subteam went back to our A & H working group and said, "We really think that we should be about achieving consistency in reserving standards and reserving requirements among all health entities. We think that that's a principle we can all live with and a goal that we can achieve. It may take time, but we can achieve it, and we think the best way to get there is via codification because it's an accreditation standard. All the states are going to adopt it, and it sets forth general standards for reserving for health entities and HMOs." Well, the A & H working group told us to go ahead.

So we told the Academy that we wanted a consistent basis of reserving for HMOs. The Academy said, "The first thing we need to do is identify inconsistencies that exist today between codification, the standards of practice, and the standard valuation law. We'll look at that and we'll report back to you." In January they wrote us a little paper and identified three key areas of inconsistencies. One was the premium deficiency reserve versus the gross premium valuation. Another was items to be included or excluded from unpaid claim liabilities, and then they noted a variety of problems with the HIRMR, which is an appendix 810 of the codification requirements.

So the Academy pointed out a lot of problems, but they didn't tell us how to fix them. They said they wouldn't tell us how to fix them until we answered some basic questions for them and told them what we thought about the work that they've done to date. A lot of times the NAIC will send the Academy off on these projects and then we come back and they say , "That wasn't what we wanted." So this time they said, "You give us some guidance based on the work we've done to date, and then we will continue our work."

Well, one of the things we identified immediately was that the NAIC was revising the HMO model act, and there is a section within the HMO model act that talks about liabilities for HMOs, so we asked for guidance on what we should recommend, and we actually decided to refer to codification in that model since we want codification to be the basis.

We noted that the differing actuarial certifications and opinion requirements for health entities versus HMOs and HMDIs were missing from the list. So we asked the Academy if they would add that, as controversial as that may be. But you have to remember you're doing liquidity ratios and talking about cash flow testing. I

think this wouldn't be an issue if there were asset adequacy in the appropriate form for whatever entity or liability you're dealing with.

The Academy said, "One huge issue that we've identified in the codification standards and the rest of the requirements that are out there is the premium deficiency reserve versus the gross premium valuation. We think a premium deficiency reserve and the gross premium valuation are the same thing, and we need you to tell us how and why they're different, and what your regulatory goals are."

So the subteam went to work on that, and I've kind of given you the guidance. There is guidance even within codification that's confusing. It says that the gross premium valuation is the overall test for the adequacy of a company's health block of business. Well, that comes from the HRGM that says you just project your premiums, your claims, and your expenses, and then you're allowed deficiencies to offset. If your gross premium valuation is larger than the other reserves you set up, then you set up an additional reserve.

Donna said we think it's obvious, but for those of us who grew up with the HIRMR, that's what a gross premium valuation was. The A & H working group was not involved with premium deficiency reserves, and on the other side, the accountants were developing codification, and they were saying that GAAP requires a premium deficiency reserve, and sometimes GAAP reserves will be higher than stat reserves, and that's not acceptable. So if there's ever a deficiency in your premium, you have to set up a reserve over a remaining contract period, and you can't offset that with other deficiencies. So that's where the premium deficiency reserve came from. It was a GAAP requirement that got incorporated into codification.

We regulators looked at this and said, "Well, we think the goals are solvency and appropriate reporting. We also think that there's this issue of HMOs coming in and undercutting the market and then not being able to pull up because they've gotten themselves in trouble, so we need this deficiency reserve. So we think the goal is sufficient premiums." Actually, I think that's an inappropriate way to say it. I don't think there's any intent to regulate premiums via the premium deficiency reserve, but if you're going to undercut the market, then you better have reserves to make up for it, right? So those were the goals, and then the team decided that the gross premium valuation and the premium deficiency reserve were two separate requirements, one being long-term and the other being short-term.

So we took that to the A & H working group, and of course, the industry had some concerns. One concern is that at least one segment of the industry really believes that a gross premium valuation is a method for calculating the premium deficiency reserve, and if you set your contract duration appropriately, they yield the same result.

So that's something that this team is looking at. We talked to our parent, and our

parent told us to figure it out and tell them what we want to do. So this team is working on this issue. At this point in time, we can figure out what it should be and then make all of the appropriate adjustments, the codification into the reserve model regulations so that it works appropriately from an actuarial perspective. We are at that point right now in the decision-making phase, so if anybody has input, we would be very interested in hearing that input. We know where it came from, and we know what we think it is, so now we need to figure out what it should be and what we need to do to fix it.

There's a variety of guidance out there. State law, of course, is of primary importance, and codification provides a comprehensive basis that will prevail in the absence of state law and if the state has adopted it. ASOPs must be adhered to from both a professional and a regulatory perspective, and we are attempting to establish consistency in reserving for all health entities.

MR. ZWITTER: Our final speaker is John Lloyd. John's an actuary with Ernst & Young out of Atlanta, and before that he worked with Anthem. He is the health practice leader for financial reporting at Ernst & Young, and I think his role is basically to figure out how to interpret all this and make sure all his audited companies are doing what they're supposed to do so they can sign off on it. He's going to explain what he's seen and what he's been finding out in the audit process of a company.

MR. JOHN C. LLOYD: Having worked with accountants, one of the things we're struggling with, frankly, is how you reconcile some of the things that have come out lately and still maintain certain actuarial standards in the process. If you look at the way most actuaries set reserves, which is the primary thing that we're struggling with right now, most actuaries do some kind of a completion development method or some systematic process, we hope, and come up with certain scenarios. Typically the process has been to pick a point estimate out of some kind of a range based on some scenario we believe is predictive and then at that point we add the dreaded word "margin." The dreaded word margin is usually added as a dreaded flat percentage. Sometimes it's scale based on the perceived variability, and we come up with some rationale. Typically we prefer to use sheep's knuckles and chicken feet and maintain the CFO to some degree of clouded, vague impression of how we did this! Luckily some folks actually add loss adjustment expense, the percentage of the unfunded current liability (UCL). That's the way most people have always done it; it's been done that way by my forefathers. It's perfectly good as a process.

Accountants actually have a point, loath though we are to acknowledge it, and that is that reserves on a theoretical basis are established to make some adequate provision for adverse deviation. Some accountants have told us that large plans with good underwriting results and stable operations usually seem to hold a provision for adverse deviation. Small plans with underwriting problems and operational issues typically don't. This seems to be contrary to what one would

hope provision for adverse deviation would call for. It also makes it difficult not to view what we do as somehow being too subjective and a distortion to reported earnings.

We've also discovered lately, much to the surprise of everybody but the *New York Times*, that accountants actually help people avoid paying taxes. This makes the IRS nervous. They look at this and say well, we're supposed to put up a fair and reasonable estimate, and they tie it to the statutory reporting. The challenge it poses, though, is they look at the actual runout and believe we're adding some arbitrary stuff on top of this. The way we get around this is to have some documentation for provision for adverse deviation and to avoid arbitrary approaches. That's the general counsel. It will not necessarily prevent you from having problems, but it certainly helps.

The statutory guidance that we're operating under has been the document released by the emerging issues working group—the SSAP 55—about unpaid claims. That's one of the primary regulations for statutory reporting guidance that you get. The actuarial guidelines, the opinion and memorandum regulation, ASOP #5, #22, #7, #28, all those are also in play at the same time, as is for some under GAAP in which FASB 60 rules. One of the problems that we have is while we've noted that for life companies you can have statutory reserves, GAAP reserves, tax reserves, and New York reserves, there seems to be an opinion that for health companies, there needs to be one set of reserves. They can live with the ambiguity of four or five sets of reserves on life companies, but not for us, which makes life much more interesting.

When SSAP #55 came out, it was pretty clear that you needed to put down claims, other losses, and loss adjustment expense. This was a new territory for some companies that had never put up loss adjustment expense. They also said that we needed to cover payable contracts if probable to require funding and make sure that we accrued all of our withhold and medical incentives. The interpretation that came out of this was a bit of a problem for those of us that interact with accountants, however, because it states that it should be management's best estimate that if no single best estimate were to be booked, you use the midpoint of a range. This is proof that accountants, while they won't acknowledge it, are huge believers in the central limit theorem that everything does generate toward a mean, and the distribution is usually normal. Trying to explain to them that that's not the case is somewhat problematic. And unfortunately for us, unlike some of the SSAPs, we didn't get a good cross-reference to ASOP or guidelines directly in there. However, there was interpretation that followed up which we carry around in our wallets and try to insert in front of accountants on a regular basis. One of them is that there should be conservatism. The whole idea is that there should be a margin of protection for policyholders, and the concept of conservatism should be followed.

The emerging issues working group also rendered an interpretation because it

dawned on them that some people were beginning to say that SSAP 55 met no margin, which is I think what SSAP 55 sort of meant, was no margin. However, they did come back and render an interpretation that says that you should include some conservatism, but you don't have to.

A more liberal interpretation of that is sometimes followed, and, in defense of it, what it's really trying to say is it's hard to say how much margin you should have, because the amount of margin you have is a function of how conservative your estimate was in the first place. Therefore, since actuaries are loath to tell you how conservative they were in the first place, mandating a margin on top of it is somewhat problematic. So all they're trying to ram home here is that they think there should be some conservatism.

If you look at the standards of practice and convention, for that matter, whether you're a health entity doing good and sufficient, a life entity doing adequate, a P&C doing reasonable, or a GAAP doing moderately adverse conditions, all those sound to me like they mean some degree of conservatism. The conventional wisdom, back to the sheep's knuckle theory, is that while there's a broad range of practice, typically actuaries hold 5 to 10 percent.

We did a Webcast earlier this year, and about 100 companies participated. As you can see in Table 1, most of them said they were targeting some degree of conservatism that ran in the 3.5 to 12.5 percent range, with 3.5 to 7.5 being the most common, but a few folks were more than 12.5 percent. Luckily for us, almost of them said they were also holding some loss adjustment expense, as shown in Table 2, so the target there seems to be proportional to about what we think it costs to pay claims, which is 2.5 to 4.5 percent.

Table 1

SOA Survey – Provision for Adverse Deviation

- Target Provision for Adverse Deviation
- Responses from SOA On-Line Webcast

None	7
< 3.5%	5
3.5 – 7.5	46
7.5 – 12.5	34
12.5+	8

Table 2

SOA Survey – Loss Adjustment Expense

- Loss Adjustment Expense (LAE or CAE)
- Responses from SOA On-Line Webcast

None	7
< 1.5%	4
1.5 – 2.5	25
2.5 – 4.5	42
4.5+	22

Because we are having this ongoing debate with accountancy, we went back and

looked at a number of annual statement filings and tried to figure out what the one-year runout test looked like for these companies. Being actuaries, we'll acknowledge that the one-year runout test doesn't work well if you have interest on disability or if you have a lag that's more than a year, but for most health entities it's a pretty good test of how much redundancy is in their reserves. Only 26 companies on this particular blank were commercial companies, whatever that means, so that's not a really great sample, but you can see in Chart 1 that a lot of them are holding between 0 and 5 percent. We found 36 Blue Cross companies, and the one-year redundancy is a little healthier than that, probably 10 to 15 being the most common amount in Chart 2, and there's some noise in this. The Blues went through a change in the way they could account for ASO/ASC business, and somehow I think there's a mismatch between what they booked last year and what they posted for run-out this year, so we'll ignore the ones out there at 60 and 70.

Then on the HMOs in Chart 3, unfortunately a few of our HMO friends were slightly less than adequate, but you can still see that a large number of them have anywhere from 0 to 5 percent, and quite a few have actually 10, 15, or 20 percent, and that's about 212 companies, so that's a fairly good test. I was sitting in my office trying to figure out what the bark looked like on all these trees, and I wasn't real happy with some of the numbers, and my colleague Darrel Knapp came in and showed me the forest immediately by saying, "Well it's not 0." So therefore, I think there is evidence that companies are managing to what they say they're doing, which is having some degree of conservatism in the reserves they book.

One of the things we've done is question how good the conventional wisdom, the 5 to 10 percent rule is, and we've started the comparison process because we run a lot of reserves for a lot of companies to get a range of comparable estimates. One problem we have is that the traditional development method is not a stochastic method. By its very nature, it doesn't develop confidence intervals, and when you try to do something with it, you can end up getting a huge range of possible outcomes, which is about as good as having no range.

We have looked for some variability in the underlying factors that drive it; in particular, the variability of a model-weighted blend of per month per member (PMPM) and lag factors, and the historical variability of recast incurred but not reported claims (IBNRs). In general we looked at a couple of dozen companies, and what you tend to see is if you put a 90 percent confidence interval around the PMPM lag factors and how they varied over time, you get about 5 to 10 percent. We find that it builds from there with some operational issues. If you have backlogs or if you changed systems, you need to have something in there to do it. What we're really looking for is to convince our accountants that we don't make this stuff up and that there is a rational basis for why we add provisions for adverse deviation.

We see several factors that impact UCL estimates. One is that there are random

variations in utilization and cost. This is not a straight line thing, that we do see pure random variation. We also see pure random variation in the speed of processing and the speed of payment. You have to start doing more subjective add-ons when you get to things like changes in anticipated provider reimbursement of benefit plans or in morbidity shifts if you added a large block of business or changed enrollment dramatically or had some kind of other change in your business environment. More importantly, if you've got systems changes that can create processing backlogs, the most common drop off we see in estimation accuracy is if you've got an undisclosed backlog.

We're trying to reach some kind of reconciliation that we believe is a rational approach to getting here, and that is that management's best estimate, whatever that means, can be considered to be a term of art, meaning it's an amount that management believes to be appropriate to record based on its anticipation of what might happen—not necessarily absolutely what's going to happen, but some provision for conservatism in case bad things do happen.

The best estimate should, therefore, include some assessment of factors likely to impact the claims liability. There should be an appropriate provision for adverse deviation, and that can be assessed against some historical measures of payment patterns and trends, and a reserve adequacy has to be considered in the entire context of the balance sheet. One of the things we talked about earlier is that you see very conservative reserves and very conservative risk-based capital (RBC), and suddenly redundancy starts to become a little less important if you're strong in other places in the balance sheet. To the contrary, unfortunately with some of our friends, we see no RBC and no conservatism, so then that's the point at which we have embarrassing problems.

What we're hoping is that a documented logical approach is going to be better support. However, we recognize that we still have some problem in that a lot of regulators, particularly SEC accounting people, look at it and say, "You've never had enough variable to get close to what you're booking, so how are you going to rationalize it?" It should be sufficient to maintain actuarial standards, but actuarial standards call for an actuarial process, something that is a little more refined than a flat add-on percentage. So I'm hoping that we're moving toward a debate with the regulators that says if it is somehow rational and consistently logical, then it ought to be supportable.

MR. ZWITTER: Okay, thank you very much for all the comments from our panel. We have some time left for questions.

MR. FRANK ARMINE: I have two questions, probably for Donna. It looks like the liquidity work is looking at a snapshot, like RBC is the snapshot, whereas it strikes me that maybe liquidity investigation should look at trends: Is this company becoming more liquid, less liquid? Am I misinterpreting what I've seen so far, or is the committee thinking in that way?

MS. NOVAK: It's not quite a snapshot. If you read the document, it goes into a lot more detail of where we're looking at change versus a snapshot. We're talking about looking quarterly instead of annually, and that's for the safe harbor. So the safe harbor will be looking at some changes, but it will be looking retrospectively. The stress test is prospective. The stress test is saying to look over the next year and model out what's going to happen to your liquidity. Do you ever hit a point where you've got zero cash? Do you ever hit a point where you've had to sell some things off or you've had to take on some liabilities and your RBC has come down further than what it indicates at the end of the year?

MR. ARMINE: Thank you. I guess anybody could answer my second question. Regarding the new AOMR that's been accepted, and let's say promulgated, by the NAIC, what states have implemented it to be effective at the end of 2002?

MS. JONES: I can't tell you exactly which states have implemented it. I know a couple have, and some are in the process. I will say that at this recent Philadelphia NAIC meeting, they voted to expose the changes as an accreditation standard. That means there will be a two-year exposure period and then two years for states to adopt it, so ready or not, it's coming. If it becomes an accreditation standard, which the vote to expose it pretty much ensures, within four years all the states will be required to have it on the books.

MR. RODNEY BRUNK: I have a question for Mr. Lloyd. I was wondering what you see in terms of seasonality in reserves. Are they allowed to go over a calendar year-end? Can you hold a seasonality reserve at year-end?

MR. LLOYD: Yes. In fact, I've worked with some firms that have seasonality reserves that are sort of a perversion of a gross premium reserve, and I think it is a reaction to the fact that if you're an SEC company, even though you tell the analysts that you're going to have a bad first quarter and you're going to have a good second quarter, they don't wait for the second quarter. I think it is a practical reality that there are firms that are smoothing across quarters based on seasonality. I'm not real sure exactly what the regulatory justification for that is, but I think we are seeing it in a lot of firms as a practical reaction to the problem.

MR. BRUNK: Including holding something over year-end?

MR. LLOYD: I think you almost have to hold something over year-end, especially if you have the problem that the first quarter is the bad quarter. Yes, so there's a pile-up of the provision for adverse deviation, and it's almost akin to a premium deficiency reserve in that in some sense of the term, I think that's how we're rationalizing it.

MR. BRUNK: OK. From the regulatory standpoint, the more, the better probably.

MS. JONES: Yes, more is more.

MR. BRUNK: I have another question. In terms of grouping on the deficiency reserves, could someone give me an industry standard, if one exists, for handling group conversion reserves, whether they can be included with an overall block or whether they should be handled separately?

MS. NOVAK: There's no industry standard on deficiency reserves, but I think what a lot of companies are doing is combining those the way they do when they look at a profit prospective. They combine the conversion with the block that it came from and so I think that for deficiency reserve purposes, they're looking at it in total.

MR. WILLIAM WELLER: I thought it would be useful to give everyone an update on the actuarial standards board meeting that occurred last week. There were two things that I think are important to health actuaries. The first is that there will be, in the very near future on the Web site, a new ASOP exposure draft for the non-claim liabilities, and this is particularly of interest to health actuaries, because it gets into provider-related liabilities and what the actuary is to do there. So I would encourage everyone to look for it, read it, and get your comments in, because I think the standards board is particularly looking for comments in that area. There is not a wealth of guidance around in terms of what actuaries should do when you're analyzing the risk transfers that your client has made to others and you're worried about the financial wherewithal of that other entity.

The other thing that I thought was particularly interesting was that the Actuarial Standards Board (ASB) had to wrestle with a request to take another look at the scope of ASOP 7. This came from P&C actuaries who said, "Hey, we don't do cash flow testing, and you shouldn't ask us to analyze assets in all of our rate-making and our estimating of liabilities?" One of my concerns at that meeting was that if we made some changes for P&C actuaries, we were suddenly raising the bar for health actuaries. I feel relatively comfortable that the resolution is fine.

It's pretty clear that you do cash flow analysis and cash flows can be assets, policies or obligations (liabilities) and you can decide which of those cash flows are material. So if you have a fairly straightforward asset block for your HMO or an HMDI plan, then I think you can just look at your obligations and you don't need to look at the cash flows. If you're doing rating, you can just look at the policies and assume you're not looking at getting a 15 percent return on real estate as the justification for making these premiums profitable. On the other hand, you do have to look at the assets to see if they are unique and, therefore, would affect it. I think that's a reasonable solution that would be acceptable, hopefully, to regulators as we go forward in this. The last item that I would like the group to consider is Standard of Practice 84 or 85, which deals with what I consider actuarial contraliabilities. They're pharmacy rebate assets with regard to amounts due under provider arrangements, where the expectation is that the providers will end up owing the insurance entity some money at the end. I think that when we focus on

the liability side, as we tend to do in the health area and in the actuarial opinion, we need to realize that these are calculated much the same way as liabilities are—they just happen to be on the asset side.

MS. NOVAK: I've got a question for John along those lines, because I've worked for two of the big five firms. One of the things I noticed was that once you get away from IBNR, the accountants think that they can and will calculate some of these things. So do you see that there may be an issue as to if the actuary will be responsible for them versus the accountant?

MR. LLOYD: Yes. One of the issues that I think we're faced with is whether actuaries are going to stay in accounting firms, because whether you believe it or not, we like to do things besides audit, and so doing the outside work sometimes becomes a consulting conflict if we're going down the Enron track. One of the concerns I have is that once it's a cash-out-the-door proposition to get somebody to do it, the accountants, if they can find a spreadsheet, will use a spreadsheet, and that's why we don't leave any evidence of having ever been there when we leave! (laughter) The bottom line is that there is a tendency for the accountants to think that they can analyze a lot of this based on historical ratios, while actuaries use a certain amount of judgment when we look at these things. I think there is an issue coming forward, and we have to push our way into things like that sometimes.

MS. NOVAK: Because I no longer work for a big firm, I can maybe be a little firmer about that. I think it's a huge issue that when they would bring me in from another profit center and even "funny money" internally, they didn't want to use me unless they had to have an actuary's signature. If they thought that they could do a projection, they always thought that they could do it as well or better than an actuary.

MR. LLOYD: The reason I kind of gave the pep talk about being a little more analytical and a little less vague is we do actually bring value to these situations as a profession. We tell management things in the process of setting those numbers that they won't hear if they only go back and look at ratios and some of those tests that accountants typically perform in an audit process. Actually, there's an informational content besides just passing the bar, and I think that's what actuaries bring to bear that I hope we step up to.

MR. TIMOTHY ROSS: First of all, there was a question a few minutes ago about the seasonality issue, and I think this probably hasn't been recognized or dealt with in any systematic fashion. If you think about it, with HMOs, generally you have a level premium, whether they have a right to rerate or not. Customarily they operate on one year with an effective one-year rate guarantee. If trend is continuous or if trend has various jump starts through the years through provider contracting and so on, essentially you have a level premium and you have an uprising claim pattern. So if you look at your typical December 31 claim reserve, a portion of the premium has been taken in that is on a level basis for a non-level

claim value. Very often there's a high percentage of business written on January 1, and reserves are often done on December 31, so it can dilute that effect somewhat, but I think it's something that people need to think about. The other comment I have is that you had a slide up on the HMO reserves, and there was a comment in the Academy letter or regulation that the guidance should be enough to allow for something bad to happen, but not so much as to avoid all possible bad scenarios. I wasn't clear if that was to say that good and sufficient didn't have to have 100 percent probability, but you could add that much if you wanted to. My point, though, is that the techniques that I've seen people use don't really allow for assessing a probability of how good a particular level of reserve is, and I think there's a need for that sort of approach.

MR. LLOYD: Regarding the seasonal reserves, I used to manage all the senior products for a pretty large company, and I could almost set my clock by the first quarter. Some time in there I would get a phone call wanting to know why I was losing money on my med sup policies, at which point I would say I knew I was going to lose money on my med sup policies in the first quarter—just wait until the second quarter and it will all go away. It was still a painful experience, and you don't get that option in today's environment, in which people look at your earnings more than once a year. A lot of the focus is on statutory, in particular on the once–a-year reporting cycle. We do have an issue that people who publish earnings on a quarterly basis are going to get beat up on a quarterly basis.

FROM THE FLOOR: If one of my clients says they want to do the RBC calculations this year, I say great, but one of the things that is in the model valuation law is model language for an opinion, and that was developed some years back. Is there any consideration to revise that language to include more explicitly things like premium deficiency? That would certainly clarify that we think the actuaries should be opining on these items explicitly.

MS. NOVAK: We're hoping that when the Academy takes that up, it will look at what items should be in the opinion. Also there's this issue of the health insurers signing a Section 8 opinion that says "moderately adverse," while the other health entities are saying "good and sufficient," so there is a discrepancy even within the standards of practice with respect to what should you be saying. I think that the regulators will come down on the side of "moderately adverse," and then hopefully we can address what items should be in the opinion.

Chart 1

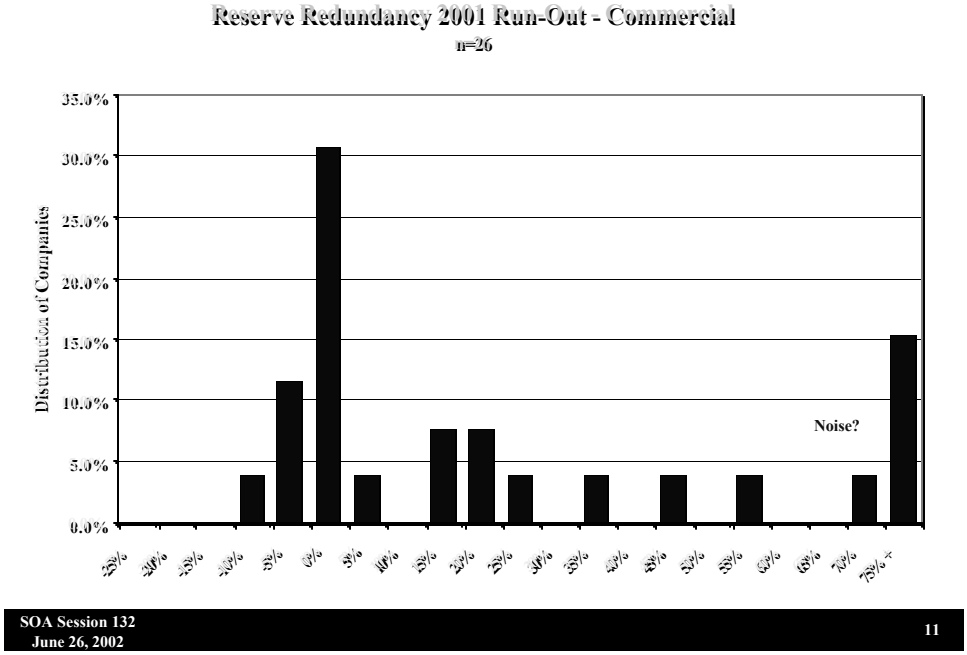


Chart 2

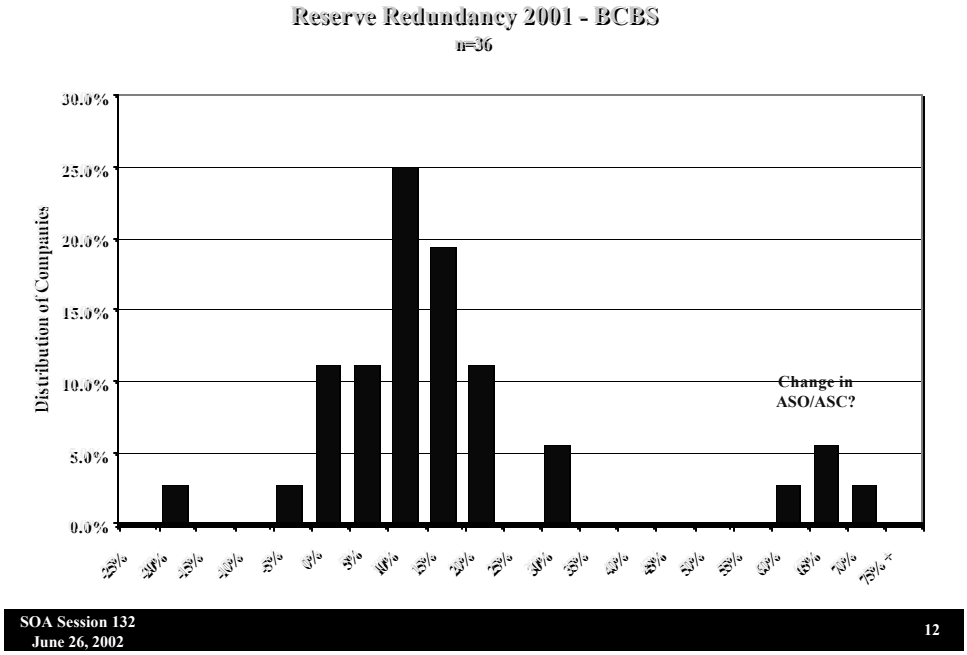
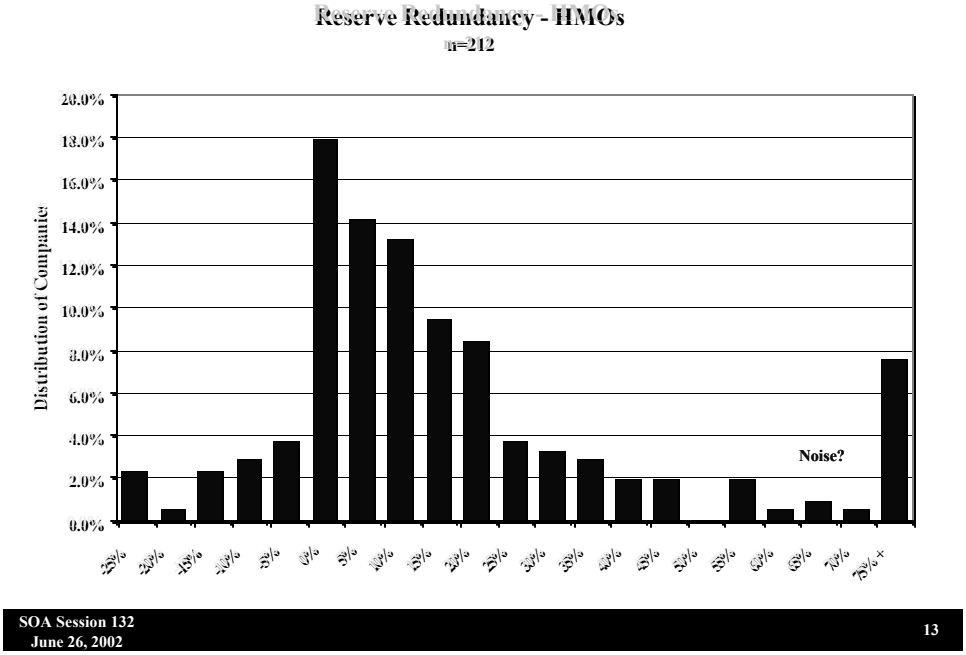


Chart 3


Reserve Redundancy - HMOs
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18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Noise?
-25%
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