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NAIC Health Update

by Rowen B. Bell

This is the first of what is intended to be a regular series of articles providing an update, aimed specifically at health actuaries, on items of interest at the quarterly meetings of the National Association of Insurance Commissioners (NAIC).

With the September 11-inspired cancellation of the Fall NAIC National Meeting (which was to have been held in Boston in mid-September), this is an inauspicious time at which to begin such a series of articles. However, many of the actuarial and financial NAIC working groups managed to meet during October, either in person or via conference calls, and much of the work that was to have been accomplished in Boston has in fact since been achieved.

As this is an initial article, I thought that in addition to reporting on topical issues, I would take some time to introduce some of the various NAIC groups whose work may on occasion be of interest to health actuaries. I will also add the global caveat that any opinions expressed herein are strictly my own and should not be construed as reflecting the position of my employer.

Accident & Health Working Group

The Accident & Health Working Group (A&HWG) is composed entirely of actuarial regulators, and as such it is the NAIC group that traditionally has been of greatest interest to health actuaries. You may have noticed that recent issues of the Health Section News have contained reproductions of the official minutes of A&HWG meetings. A&HWG is a subgroup of the Life & Health Actuarial Task Force (LHATF), which tends to focus on life issues and farms out health-only issues to A&HWG. Ted Schlude regularly writes a column for the SOA's *Financial Reporter* newsletter on LHATF's activities.

I want to focus on two ongoing A&HWG initiatives of particular interest.

Leslie Jones, an actuarial regulator from South Carolina, has been leading a review of the reserve standards that currently apply to HMOs and HMDIs (e.g., most Blue Cross / Blue Shield organizations). Her group's initial conclusion is that an appropriate policy objective is for all writers of health insurance products to be subject to the same reserve standards—meaning both minimum reserve requirements as well as which types of reserves need to be established—and moreover, the best means of assuring consistency in this regard is the new "codification" of statutory accounting principles, as opposed to new or revised model laws or regulations. As such, her group will shortly begin reviewing the codification SSAPs (Statements of Statutory Accounting Principles) to see if there are any adjustments that need to be made in keeping with this objective.

Still to be resolved is the question of differences in actuarial certification standards between different forms of companies writing health insurance. Life companies (those filing the "blue" statement blank) are subject to the asset adequacy analysis requirements of the Actuarial Opinion and Memorandum Regulation (AOMR), with its "adequate in light of the assets held" opinion language. Health companies (those filing the new "orange" statement blank, i.e. HMOs and HMDIs) are subject to a different certification standard that does not contain an asset adequacy analysis component but uses the phrase "good and sufficient" in the opinion language. P&C companies (those filing the "yellow" statement blank) that write health insurance, of which there are several (most prominently Anthem), are subject to a third standard.

Another A&HWG initiative involves revisiting the current rate filing paradigm for individual health insurance. One of the objectives of the initiative is to see if a solution can be found to the public policy quagmire caused by the "closed block problem". This refers to the situation where an individual medical policy form is closed to new entrants and future increases are based on the experience of this closed cohort, which over time tends to deteriorate at an increasing rate owing to the effects of what has been labeled "cumulative antiselection". As a result, the people remaining under the policy form (who typically are no longer insurable, else they would apply for a new policy at lesser rates) are faced with a Hobson's choice: lapse and join the ranks of the uninsured, or bear the burden of large rate increases year after year. This problem has led some to suggest that our current individual health insurance marketplace is intrinsically unhealthy.

The A&HWG has outsourced the study of this complicated issue to an Academy task force, chaired by Bill Bluhm and including representatives from the industry, regulatory, and public policy communities. The task force has been active for well over a year at this writing but is not expected to conclude its work until late 2002.

Statutory Accounting Principles Working Group

The multi-year "codification" project culminated in the issuance of a new Accounting Practices & Procedures Manual that became effective in January

2001. This new statutory accounting manual is organized as a series of Statements of Statutory Accounting Principles (SSAP), in much the same way as GAAP accounting centers around a sequence of Statements of Financial Accounting Standards (FAS). The regulators on the Statutory Accounting Principles Working Group (SAPWG) were responsible for the codification project, and their work continues today with respect to both the issuance of new SSAPs and the modification of existing SSAPs.

A significant portion of SAPWG's attention in 2001 was devoted to SSAP 84, a new statement on admissibility of health care receivables that takes effect 12/31/2001. These assets were not addressed during the original codification project, which means that they would have automatically become nonadmitted on the year-end 2001 statutory balance sheet had SSAP 84 not been approved. I want to focus here on some aspects of SSAP 84 that may influence health actuaries' reserving practices.

First, SSAP 84 affirms that rebates owed to insurers by pharmaceutical benefit managers are to be booked as a separate asset, and that when the rebates are received they are to be booked as a reduction to claims expense rather than as a revenue item. This has several implications on reserving:

- If you have been explicitly reducing your unpaid claims liability by the amount of pharmacy rebates yet to be received (rather than booking the rebates as a separate asset), then you will need to change your practice.
- If you have not been explicitly booking pharmacy rebates as either an asset or a contra-liability, but instead have been implicitly taking their existence into account in setting the unpaid claims liability, then you will need to change your practice.
- Reserve adequacy studies will need to be adjusted to reflect the fact that the paid claims runout contains "negative claims" (i.e., the rebate payments received) that weren't part of what was accounted for in the unpaid claims liability.

Second, the portion of SSAP 84 dealing with admissibility of loans or advances to providers uses provider-specific claim liabilities as a cap on the amount of the asset that may be admitted. In most cases, the admissibility cap is the liability for reported claims relating to the given provider. However, in certain cases involving hospitals, the admissibility cap on the loan or advance is the total unpaid claim liability (i.e., inclusive of IBNR) relating to that hospital. Thus, finance staff may need the valuation actuary to prepare ICOS and/or IBNR estimates on a provider-by-provider basis in order to establish that the amount advanced to each such provider is below the SSAP 84 admissibility limit.

Emerging Accounting Issues Working Group

Whereas SAPWG promulgates new or revised statutory accounting guidance, the regulators on the Emerging Accounting Issues Working Group (EAIWG) issue authoritative interpretations on the meaning of existing statutory guidance. Obviously there are indelible connections between these two topics, and indeed the two working groups share many regulators in common and rely on the same NAIC staff. The topics addressed by EAIWG can come from many sources—insurers, trade associations, audit firms, and professional bodies such as the Academy.

One recent EAIWG interpretation involves a portion of codification that has been somewhat controversial among health actuaries, namely the language in SSAP 55 stating that "management shall record its best estimate of its liabilities for unpaid claims". EAIWG was asked to clarify this language as it pertains specifically to health insurance and the concept of a margin for adverse deviation. Its conclusion was to assert that SSAP 55 neither prohibits nor mandates conservatism in health claim liabilities. This answer may not assuage the concerns of some health actuaries that, insofar as this issue is concerned, statutory accounting is not entirely in synch with the Actuarial Standards of Practice.

Risk-Based Capital Task Force

The Risk-Based Capital (RBC) Task Force is charged with maintaining the NAIC's RBC formulas, of which there are three, corresponding to the three primary statement blanks—Life, P&C, and Health. The task force has a separate working group for each formula, although there is some overlap in membership between the three working groups. While each working group makes decisions with respect to its own formula, those decisions are subject to approval by the task force, so as to assure consistency between the formulas where appropriate. The RBC Task Force relies heavily on the Academy to provide technical recommendations in response to requests for assistance.

Earlier in the year, the Life RBC Working Group approved an extensive series of changes recommended by the Academy, many of which fell under the label of "tax consistency" changes. The Life RBC formula now has a dual structure: each risk component uses a "pre-tax" risk factor to calculate a capital requirement that is ultimately reduced by a "tax adjustment" in order to arrive at a "post-tax" RBC number. While this new structure will take effect for Life RBC in 2001, it was not replicated by either of the other two formulas. As a result, the differences between the Life and Health RBC formulas are somewhat greater in 2001 than in previous years.

The Health RBC Working Group had asked the Academy to make recommendations for 2002 with regard to these same tax consistency issues. In an October report that was approved by the working group, the Academy concluded that there was no urgent need to adapt the pre-tax / post-tax dual structure for use in Health RBC. Moreover, the Academy recommended that, with respect to asset and credit risks, there should be agreement wherever possible between the Health and P&C RBC formulas. In particular, the Academy recommended that Health formula should only move to the dual structure if and when the P&C formula does so; as of this writing, the P&C RBC Working Group does not

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appear to be seriously contemplating such a move.

For further details on Academy RBC proposals, see *http://www.actuary.org/naic.htm*, which contains an archive of all recent Academy reports to NAIC groups on RBC and many other issues.

Blanks Task Force

The regulators on the Blanks Task Force approve changes to the annual and quarterly statement reporting forms and instructions. In their annual meeting each October, they consider changes not for the next year but for the subsequent year, i.e. the October 2001 meeting dealt with changes to the 2003 blanks. Proposals for blanks changes are typically referred to the Blanks Task Force from other NAIC groups, such as those discussed above.

A major initiative that was just passed by this task force in October is what I will call the "Health blank migration" proposal. This idea originally came from the RBC Task Force, who observed that there are many companies that anyone would think of as being "health insurers" but that, for historical reasons, file the Life blank or the P&C blank. Since risk-based capital is tied to the statement blank, such companies are subject to Life RBC or P&C RBC rather than to Health RBC. The RBC Task Force felt that it would make more sense for all "health insurers" to be regulated by the Health RBC formula, and it concluded that the most practical way to accomplish this would be to get all health insurers filing the Health statement blank.

What the migration proposal does is create a framework by which certain Life and P&C filers will move over to the Health blank, assuming no objection from their domiciliary regulator. To be eligible for migration, health insurance products must represent (on a net-of-reinsurance basis) at least 95% of a company's premiums, and at least 95% of its reserves, for two consecutive years. Companies that are 100% health under this measurement are always eligible to migrate; companies that are between 95% and 100% health are only eligible if they pass some geographic concentration tests. It is very important to note that, in this context, "health insurance" excludes long-term care and disability coverages.

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From Art to Science - Using Clinical Insight Modeling to Strengthen Actuarial Prediction

by Harry Poteat

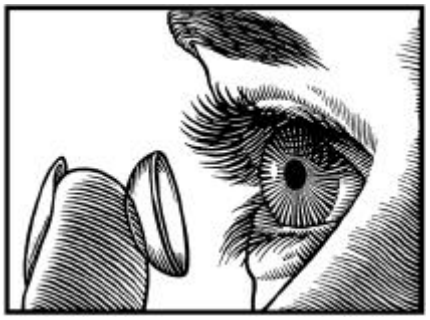
(Summary of Dr. Poteat's talk at the Society of Actuaries Annual Meeting, October 21-24, 2001, Section # 58 – "Applying Clinical Insight to Price Catastrophic Risk.")

During my talk I explained the concept of clinical insight modeling. He discussed two different models: the Markov State Transition (MST) and the Rational Artificial Intelligence (RAI) model. The MST model is designed to function in data-poor environments utilizing a benchmark database developed through a process of triangulation. The RAI model is designed for use in data-rich environments where data mining and analysis can identify whether the data forms patterns that facilitate the prediction of future costs of individual patients (claimants).

Clinical insight modeling consists of three fundamental elements: 1) the incorporation of reproducible, objective processes into predictive models; 2) the use of all available predictive data, particularly epidemiology; and 3) validation of the models. In catastrophic risk prediction, standard statistical models often do not apply. Technology moves forward so rapidly that what made patients expensive five years ago may not make them expensive today, and even if the types of expense remain similar, the case rates and severity for cases in these areas is constantly in flux.

Leverage Technology

One way to achieve repeatable, definable and objective processes—a core element of clinical insight modeling, is



by developing predictive modeling software technologies. Medical Scientists Inc., a Boston-based healthcare software and services firm, has developed a portfolio of predictive modeling technologies to address both data-poor and data-rich environments. MediSave ™ is a disease-specific decision-support software suite that predicts