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minimum loss ratio, or other, pricing requirements. The additional compliance support and the potential systems enhancements needed to support state variations in product design may have cost implications the actuary should consider in establishing pricing expense factors for the CI policy. However, it is unlikely that any of these issues would be serious enough to prevent the CI insurance line from going forward to market from purely a product administration perspective.

Why Now?

Why should insurers enter the CI marketplace now? What is the future growth potential of the CI market, and would insurers be at a disadvantage if they waited to enter it? First, let's consider the future of the stand-alone CI product market. Undoubtedly the stand-alone CI insurance market will grow—the only question is how large. While managed care health insurance products have recently received bad press, it is still safe to assume that HMOs, PPOs and other primary health insurance coverages that limit access to certain medical providers or treatment options are here to stay. In this case, CI's flexible lump sum benefit offers Americans a way to circumvent access constraints at a time when access is crucial—when a critical illness has occurred. Already the CI product has enjoyed some limited success in the work-site sales distribution channel, perhaps because workers at small employers are likely to have, and recognize the gaps in, their primary managed care health insurance.

The work-site distribution channel is well positioned for growth in the 21st century as the trend of U.S. employment at small companies with less than 100 employees, the prime work-site distribution channel segment, continues. The CI product can be efficiently and effectively sold through this channel and since many insurers are seeking to diversify their distribution systems, selling a product like CI that lends itself to alternative distribution may be a good fit. On the flip side, CI insurance may be a good option for employers to consider making available to their employees and dependents on an employee-pay-all basis since it will not add to their benefit costs and may result in increased employee productivity and lower absenteeism when critical illnesses strike workers or their families.

The barriers to enter the CI marketplace are not large. CI is not a labor-intensive product to administer so very large in-force volumes are probably not needed to drive an efficient operation. Insurers can enter the CI market without offering major medical since simply having access to major medical experience data does not necessarily provide an insurer an advantage in pricing CI. Even if some carriers can use their major medical experience in their CI pricing, carriers without such access are not out-of-luck. They can obtain whatever pricing and product design guidance they need from consulting firms and re-insurers. Reinsurance can also be purchased to help the direct writer manage the CI risk to an acceptable level. Thus, developing a stand-alone CI product should enable an insurer to diversify and expand its health product portfolio without subjecting the insurer to unacceptable business risks.

Entering the CI market earlier rather than later, and developing a reputation for being a market leader and innovator in CI, may give an insurer an edge over its competitors, particularly in the group distribution channel, where reputation in the market is sometimes the most important criterion used in the vendor selection process. Reputation and name recognition are also important sales factors in the career agent and broker distribution channels.

It may even be easier to conclude that developing and marketing a CI rider to life insurance, annuity or other health insurance products makes sense. Already, these riders are becoming more and more prevalent, particularly in the life insurance market. Insurers are using them to distinguish their products from those of their competitors, which may enable them to maintain or increase their market share in their other core lines of business, whatever they may be. Not having a CI rider available may shortly become a detriment to the underlying product's sales prospects. CI riders are less risky from a claims perspective, since the underlying product's underwriting process can be used to underwrite the CI rider, and reinsurance may also be used to manage the claim risk. Both rider design and positioning is simpler, since it is not necessary to utilize product design limitations to control claims risk, and the supplemental nature of the CI benefit lends itself well to sale as a rider to a primary insurance product. So, with this in mind, it is easy to see why so many insurers are boarding the critical illness express. The train is about to pull out—don't be left at the station!

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NAIC Health Update

by Rowen B. Bell

Author's Note: This article focuses on items of interest to health actuaries from the recent NAIC meetings in Chicago (December 2001) and Reno (March 2002).

Accident & Health Working Group

Consistency in Health Reserving

One of the current charges of the Accident & Health Working Group is to investigate ways of achieving greater consistency in reserving requirements and standards among all types of entities authorized to write health insurance (e.g., HMOs, Blue Cross/Blue Shield plans, life/A&H insurers, etc.). As an initial step, in early 2002 the working group commissioned a report from the Academy's Health Practice Financial Reporting Committee (HPFRC) to identify areas of inconsistency between post-codification statutory accounting, existing model laws and regulations and current actuarial practice.

In its report, the HPFRC focused on three areas: definitional issues involving premium deficiency reserve and gross premium valuation requirements; accounting requirements that require certain items to be included in, or excluded from, the unpaid claim liability; and differences between the Health Insurance Reserves Model Regulation (which applies only to life/A&H insurers) and the corresponding accounting guidance on minimum reserve standards (which applies to all entities). The working group will use the Academy report as a guide in assessing areas for proposed change to the Accounting Practices & Procedures Manual, the Health Reserves Guidance Manual and/or appropriate model laws or regulations.

Actuarial Certification Standards for Health Entities

As part of the same project, the Accident & Health Working Group will consider whether the current actuarial opinion instructions for health blank filers (e.g., HMOs, most Blue Cross/Blue Shield plans) should be revised.

To this end, the working group has asked the HPFRC to prepare a report comparing and contrasting the health actuarial opinion requirements with the requirements of the Actuarial Opinion and Memorandum Model Regulation, which pertains to companies filing the life/A&H blank. (Recall that last year, the Life & Health Actuarial Task Force approved revisions to this model regulation which eliminated the "Section 7" exemption and thereby subjected all life/A&H companies, regardless of size, to an opinion requirement based on asset adequacy analysis.)

At the same time, it is worth keeping an eye on developments at the Casualty Actuarial Task Force, who is working on revisions to the actuarial opinion instructions for P&C blank filers. They anticipate completing their work by June 2002, for implementation in 2004, and it is quite possible that their efforts will attract the attention of the Accident & Health Working Group as they contemplate changes to the health opinion.

Two aspects of the proposed P&C revisions are of particular note. First, the current draft would require the opining actuary to disclose his/her best estimate for the reserve and his/her full range of reasonable reserve estimates, in addition to opining on the booked reserve ("management's best estimate").

Second, the opining actuary would need to explicitly indicate that his/her opinion falls into one of five categories: reserves are reasonable; reserves are redundant/excessive; reserves are deficient/inadequate; qualified opinion; no opinion.

Reserves for Group Disability Insurance

The Health Insurance Reserves Model Regulation allows a group LTD insurer to use its own experience (if credible) in setting the claim reserve for claims of duration less than two years, and has a similar provision for claims of duration between two and five years. Some confusion has recently arisen within the regulatory community as to whether company experience is allowed for all future claim payments or only for those claim payments lying within the credible period. The perceived problem with the former interpretation is that it can lead to "cliffs" in the reserve for a given claim; the progression (for example) from the 24th month to the 25th month could result in a dramatic change in the reserve as the calculation shifts from full reliance on company experience to full reliance on a prescribed morbidity table. The latter interpretation would create a smoother gradation into the tabular reserve.

The working group has agreed to study this issue further and ascertain the nature of current company practice, with assistance from the relevant trade associations (HIAA and ACLI).

Reserves for Long-Term Care Insurance

The working group received a letter from a prominent actuary arguing that existing reserve standards for long-term care insurance are overly conservative and represent a barrier to entry, unnecessarily dampening the growth of the LTC market. The working group decided against reopening the topic of minimum reserve standards for LTC insurance.