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NAIC Health Update

by Rowen B. Bell

Editor's Note: This article focuses on items of interest to health actuaries from the recent NAIC meeting in Philadelphia (June 2002).

Health Insurance & Managed Care Committee

Experience Rating for Individual Medical

The Academy's Task Force on Health Insurance Rate Filing is in the middle of a multi-year project to make recommendations to the NAIC on how to reform the rating guidelines applicable to individual medical insurance in order to temper the "closed block" problem. The task force's initial report, which is expected to be provided to the Accident & Health Working Group within the next year, will present actuarial modeling on several alternatives for the NAIC's consideration.

One of the alternatives that the task force was starting to investigate was the notion of experience rating (also called "re-underwriting"), in which an insured's renewal premium would be adjusted upwards or downwards (e.g., "good health discounts") based on the individual's actual or perceived health status. The NAIC's 1996 Individual Health Insurance Portability Model Act forbids this rating practice. However, as that model was not widely enacted by the states, experience rating is currently used to varying degrees by certain carriers, although as of late the practice has garnered considerable negative press (most notably in the *Wall Street Journal*).

In recognition that experience rating for individual medical insurance is controversial from a public policy standpoint, the task force asked the NAIC to provide guidance as to whether or not this alternative should be modeled for inclusion in its report. The response from the NAIC's B Committee, the ultimate parent of the Accident & Health Working Group, was that it did not want experience rating included in the report, due to the committee's stated belief that basing renewal rates on an individual's own experience is "contrary to the public interest and should be prohibited."

The task force engaged in considerable internal debate over how it should react to the NAIC's pronouncement. One faction argued that since the task force was formed for the express purpose of providing technical support to the NAIC, it would be a waste of the task force's time to spend further resources on studying an option that the NAIC has indicated it will not entertain. Another faction argued that by not modeling the experience rating alternative, the task force would in effect be taking a partisan position on experience rating for individual health, and that consequently it was appropriate for the profession to continue modeling this option but exclude the results thereof from the report made to the NAIC. In the end, the former faction carried the day, and as a result the task force's flirtation with experience rating has ended.

Accident and Health Worki ng Group

Premium Deficiency Reserves

As mentioned previously, the working group is currently investigating areas of inconsistency between post-codification statutory accounting, existing model laws and regulations, and current actuarial practice with regard to actuarial reserves for health insurance.

One of the areas currently under discussion is the definition of premium deficiency reserves found in SSAP 54. In order to set the stage for future recommendations, the working group is in the process of articulating the regulatory objectives behind the premium deficiency reserve concept.

Health Actuarial Certification Changes

As mentioned previously, the working group is going to take a look at revising the type of actuarial certification requirement applicable to companies filing the health annual statement. In the meantime, however, the working group has made a number of minor refinements to the existing certification instructions.

First, the working group corrected an oversight regarding the scope paragraph. The annual

statement line for "aggregate claim reserves"—reserves as opposed to liabilities in the sense of SSAP 54, i.e., the unaccrued portion—had inadvertently been left out of the list of items required to be in the scope of the opinion.

Second, the working group voted to adopt a change to the required opinion language relating to the recent adoption of revisions to ASOP 5; references found in the existing language regarding the preparation of U&I Exhibit Part 2B no longer made sense in light of the new version of the standard of practice.

Third, the working group voted to strengthen as follows the wording to be used by third parties in the data quality attestation statement accompanying the opinion:

> "I, [name], [title] of [organization], hereby affirm that the listings, and summaries, and analyses relating to of data prepared for and submitted to [actuary] in support of [his/her] actuarial opinion for [entity] as of [valuation date] were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete and are the same as, or derived from, the records and other data which form the basis of the annual statement for the year ended [valuation date]."

Reserves for Long-Term Care Insurance

Reversing course from its previous meeting, the working group agreed to form a subgroup, headed by Larry Gorski from Illinois, to study existing reserve standards for long-term-care insurance.

Long-Term Care Guidance Manual

The working group adopted the Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation. This manual provides helpful guidance for actuaries involved in submitting LTC rate filings in those states that have adopted the 2000 NAIC model. The Life & Health Actuarial Task Force is expected to adopt the manual at the September NAIC meeting.

Statutory Accounting Principles Working Group

Cost Containment Expenses

As expected, SSAP 85 on cost containment expenses was approved in June (see the previous article in this series for further discussion). The

new guidance does not take effect until December 31, 2003. However, once it does take effect, any item falling under the cost containment expense definition will need to be included in the unpaid claims adjustment expense liability (as opposed to in the unpaid claims liability or in the liability for general unpaid expenses).

Annual Statement Instructions Working Group

Allocation of Premiums by State

A proposal was made to alter the way in which group insurance premiums are allocated by state in Schedule T of the annual statement.

Currently, there is no absolute guidance on this subject. However, most carriers appear to rely on a "500-life rule" to simplify the allocation process. There appear to be several different variants of the "500-life rule" in current use, including the following:

- Allocate all premiums by state according to the state of residence of the insureds, except that if the carrier has fewer than 500 insured members living in a particular state, allocate those insureds' premiums to the carrier's state of domicile.
- If a group has less than 500 lives, allocate all of its premiums to the state where the group is sitused. Otherwise, allocate the group's

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premiums according to the state of residence of the insureds.

- If a group has less than 500 lives, allocate all of its premiums to the state where the group is sitused. Otherwise, allocate the group's premiums according to the state of residence of the insureds, except that if less than 5 percent of the group's members live in a particular state, allocate those insureds' premiums to the state where the group is sitused.
- If a group has less than 500 lives, allocate all of its premiums to the state where the group is sitused. Otherwise, allocate the group's premiums according to the state of residence of the insureds, except that if fewer than 500 of the group's members live in a particular state, allocate those insureds' premiums to the state where the group is sitused.

Under the new proposal, all group insurance premiums would instead be allocated according to the "state in which the certificates are held," i.e. the state of residence of the insureds, regardless of the size of the group.

The regulatory intent behind this proposal appears to be two-fold: a desire by smaller states to increase premium tax revenues (since premium tax calculations are often based on Schedule T premium allocations); and a desire by states to obtain a better reckoning on how many of its residents are covered under group insurance contracts (particularly medical insurance) issued in other states.

Although this proposal was not moved forward to the agenda for the Blanks Task Force's annual meeting in October, it seems very likely that the issue will rise again in 2003.

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Health Risk-Based Capital Working Group

Treatment of Prescription Drug Benefits

In the health RBC formula, insurance products are classified into several different categories for purposes of determining the capital requirement. The most common of these categories is called "Comprehensive Medical & Hospital" and is meant to include any product that smells like a major medical product. There are separate categories for products having different risk characteristics, such as Dental and Medicare Supplement, as well as a catch-all "Other Health" category for products not otherwise classified, such as standalone vision coverage.

The intent of the formula has been that prescription drug benefits provided within the context of a major medical coverage should be included in the Comprehensive Medical & Hospital category, as opposed to prescription drug benefits provided on a truly standalone basis, which should be included in the Other Health category (where the RBC treatment is less favorable in most circumstances). However, due to an ambiguity in the instructional language, some carriers have instead been allocating all of their prescription drug benefits to the Other Health category for HRBC purposes.

In response to this situation, the Health RBC Working Group recently made a change to the instructional language for 2002 to clarify that prescription drug benefits are only to be included in Other Health if they are provided on a standalone basis (i.e., if the drug product is one that could be purchased independently of the medical/hospital coverage).

Health Entities Working Group

Health Financial Analysis Handbook

This working group, which was formed to provide a focal point for examination oversight activities relating to health insurers and HMOs, has recently launched a project to write a handbook for regulators to use in performing financial analysis of such companies. Chapters of the handbook are being written serially and exposed for comment during the second half of 2002. The first chapters released for comment cover actuarial reserves. For more information, see *www.naic.org/1finance/health_financial_analysis_hb/index.htm.*