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Session 102PD
Health Valuation Issues: Traditional Products

Track: Health

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Summary: Panelists lead participants in a discussion of recent experiences and current issues regarding the valuation of medical and dental insurance and managed care products..

MR. Kenny Kan: Welcome to the panel discussion "Health Valuation Issues: Traditional Products." My name is Kenny Kan. I am a staff vice president and a valuation actuary at WellPoint Health Networks. In addition to valuation, I'm also involved in corporate forecasting and Wall Street briefing analysis activities. Jin-Dih Shih is a vice president and a valuation actuary at WellPoint. He has worked almost 20 years at WellPoint. Marty Staehlin is a director and consulting actuary at PricewaterhouseCoopers. He has been with PwC for 15 years. He consults to health-plan providers, government entities and plan sponsors.

Do note that statements represented by the panelists today are their own opinions and do not necessarily reflect the views of their respective employers or the Society of Actuaries.

In today's session, I will discuss the interplay between codification and Actuarial Standard of Practice 22, which addresses asset adequacy analysis for statements of actuarial opinion. Jin-Dih Shih will speak about technical valuation issues and elaborate on the importance of communication. Marty will do a sequel to communication and finish with revisions to actuarial standards of practice (ASOPs), premium deficiency reserve, and compliance with actuarial opinion requirements.

Codification is a comprehensive basis of accounting that sets forth financial reporting requirements via Statements of Standard Accounting Practices (SSAP). This basis is intended to enable insurers to present their information in a manner

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

that is more useful and meaningful to regulators and CPAs. All states have opted to adopt codification effective January 1, 2001. When codification first came out, a key requirement of codification that impacts health valuation actuaries is SSAP 55, which states that management shall record its best estimate of the unpaid claims liability. Where no best estimate exists, then the midpoint of the range is to be used. When it first came out, codification was initially interpreted as not allowing any provision for adverse deviations. Naturally this caused a lot of confusion for many actuaries. You see, we health valuation actuaries have been trained and grilled under a microscope to practice ASOP 22, and I quote: "When forming an opinion, the actuary should consider whether the reserve and other liabilities being tested are adequate under moderately adverse conditions." I'll let you in on a secret. When codification first came out, my hair actually turned gray. I'm actually really bald because of all this confusion concerning codification. To address the confusion and concern of many health actuaries, the Emerging Issues Working Group of the NAIC issued interpretation 01-28, which states, "the concept of conservatism is inherent to the estimation of reserves and as such should not be specifically prohibited in the consideration of management's best estimate." In short, codification allows but doesn't require provision for moderately adverse conditions.

Let's do some introspective analysis into how the codification's best estimate concept first came about. This is my understanding of the sequence of events. The codification's best estimate concept was first advocated by property-and-casualty (P&C) industry regulators. The P&C industry has periodically experienced over-capacity, cutthroat pricing and aggressive reserving. NAIC regulators, concerned about the solvency of the entities advocated best estimate reserving to justify increasing the level of reserves. At the time when the concept first came out, there was then, and there still exists now, a lack of clarity about unpaid claim liabilities for health insurers. So regulators superimposed the concept on health insurers. Naturally this caused some problems at the onset.

In terms of a managed care organization's reserving practices, unpaid claim liabilities are typically expressed as a best estimate plus the dreaded word "margin," which may be implicit or explicit, and it's typically expressed as a flat percentage of the best estimate. In a 2002 SOA health reserving Webcast, an informal survey of the participants on percentage of margin used on medical reserves revealed that 46 percent of the participants used a margin between 3.5 percent and 7.5 percent, 34 percent of the participants used a margin between 7.5 percent and 12.5 percent, and the remaining 20 percent used a margin either less than 3.5 percent or greater than 12.5 percent. Note that the margins I just quoted are typically in addition to the loss adjustment expense reserves, which averaged about 2.5 percent to 4.5 percent in the same poll.

Differences between P&C and managed care organization (MCO) reserving practices can also be inferred from the language in the actuarial opinions. For P&C reserves, reserves have to make a "reasonable" provision. For MCO reserves, they

have to make "good and sufficient" provisions. In life and health actuarial opinion language, reserves have to make "adequate" provisions. As such, in an ideal world, it is my conclusion and my interpretation that MCO reserves should be sufficient under moderately adverse conditions.

Now, let's come down from the 50,000 feet level where we just talked about codification and ASOP 22 and get down to the nitty-gritty of technical valuation issues. Before we do that, I'd like you to ponder the next two questions. How many of you think that valuation is a science? How many of you think that valuation is an art? I am not surprised by the overwhelming show of hands for the notion that valuation is an art.

With that, I now turn control of the podium to Jin-Dih Shih, who will talk about technical valuation issues.

MR. JIN-DIH SHIH: When dealing with valuation issues, there are many judgment calls. One has to understand what's going on. Seasonality for health insurance is different than life insurance. On seasonality, I will approach seasonality from aspects such as number of working days, benefit changes and other factors such as customer segments. With life insurance, maybe every 10 years you update the mortality table, and the life expectancy changes every year or two. You don't have to do a lot of changes in the interim. With health insurance, we're experiencing double-digit trends. The environment is dynamic and moving along very rapidly. We frequently get surprises, even from the first quarter to the second quarter, and then maybe in the third quarter something else happens. That's part of the problem. What's going on? What activities caused the changes? Seasonality is one of the major issues we have to be very careful of. By looking at the calendar, we can gauge seasonality for hospitalizations, for visits to the doctor's office, etc. Doctors' offices are not open on weekends and holidays, and even sometimes Wednesday afternoons they're not open. So the number of working days is very important in order to know what's going on. Here's a simple example. February with 28 days is exactly four weeks. If they take their weekends and the presidential holiday off, you have 19 working days. For the rest of the year, you can have as many as 23 working days in a month. However, for hospitalization, scheduled operations may sometimes not take place or they may be delayed. So you have anywhere between 19 to 23 working days in a month, which translates to a 20 percent variance on the days of admission or service. The first way of viewing seasonality is to look at the number of working days in the month.

Let's talk about Mondays and Fridays. Those are weekdays, right? Right, but have you ever tried to get a Monday appointment with a doctor's office? Most likely you're not going to get one on Monday. Maybe you'll get one on Thursday or Tuesday, but not Wednesday, because most Wednesday afternoons the doctor is not in the office. So, if you get more Mondays versus Fridays of the month, this could affect your reserves. When we're looking at a potential, say, $1 billion reserves, you need just a swing of one-tenth of 1 percent to be significant. There's

plenty of money involved. Because of the holidays, which I mentioned before, you have fewer working days, so that too will have an impact on the seasonality.

Next are plan designs. Nowadays, with all of the buy-down activities, we have many high-deductible plans. Higher deductibles, which kick in at the first of the year, may be up to $2,500 now, primarily to cover hospitalization. Generally you're not going to see much of the physician's bill. Most physicians now work for a couple of thousand dollars, right? You don't see a lot of free ticket items. Even for a surgery, it may be $5,000 or $8,000. So if you have a $2,500 deductible you can have much less of an incurred claim impact in the beginning of the year, versus the end of the year. People getting close to their $2,000 or $2,500 deductible are going to make sure that on the first of the new year that they are not going to make themselves pay for the new deductible again. Typically members want to get their services performed by November and December each calendar year. Actually in California, some doctors are complaining that they can't take their holiday vacations in December, because everybody is coming out to see them. Why? It's because of the deductible. We have seen as much as a 15 to 25 percent swing between December and January with high-deductible activities, which is very significant because we're paying almost $1 billion of claims. When you have a 10 percent swing for certain specific products, the deductible becomes a major issue, versus a co-pay plan, which you can spread out through the year. In a co-pay plan, if a member has to see a doctor, it's going to cost the member $15 co-pay, so January or December doesn't matter; whenever they need to go, they go.

In comparing HMOs and PPOs, many PPOs are deductible products, whereas HMOs are co-pay plans. Nowadays, with the trend of pharmacy costs, a lot of health plans have started introducing some deductibles. When you're imposing a $150 deductible up front for pharmacy, this causes yet another form of seasonality. January's seasonality for pharmacy has been as low as 50 percent, compared to the average month. Seasonality in the summer months has to do with customers' preferences. In the summer when educational institutions normally close, students and teachers take advantage of scheduling non-emergency procedures with their medical care providers. This too will cause a fluctuation. This is apparent again with occupations that are seasonal. Members are going to opt to have an out-patient procedure during their "down" time instead of during their busy part of the year. These examples clearly show that as an actuary, you need to be careful in analyzing population and the true utilization for your reserves.

Another item is large claim adjustments. Remember, earlier I mentioned that we have some months like January and December, where you can have a 10, 20 or 35 percent swing from month to month. In the later months, of course adjusted for seasonality, the impact may only be 4, 5 or 6 percent between months. If you have a block of business, say $5 million, you may have a $500,000 claim, which is not unusual any more. I remember many, many winters ago when I first started as an actuary, you looked at $10,000 and thought, "Wow, it's huge." Today, $10,000 is insignificant. Now you're worried about $50,000 and above. Here's a

block of $5 million, and $500,000 is a 10 percent swing. If you don't adjust for large claims, your seasonality may get messed up. You need to get feedback and information to better control and understand what is going on.

The next issue is looking at enrollment changes, in particular add/deletes of large cases. Recently, Blue Cross of California underwrote the University of California system case. This case has a lot of young people with different utilization behavior. You have to consider the demographic change, the population involved and their impact on utilization. Remember, when you do this, the rate is based on history, projected for the future, not for the present. For reserving, we don't worry about the future. Valuation is as of the end of last month. When you're looking at it, you've got to know what's going on, where your population is changing and what the exposure is. There are all the premium increases and more people shifting down, to lower cost and higher deductible, from PPO to HMO. When they're changing, the population mix looks different now. Your plan is different. Is there more deductible? Less deductible? Whatever is coming through and because of all the changes, your claims completion pattern may also be different. You need to understand. You need to talk to the pricing actuary. You need to talk to the underwriters. You need to talk to everyone involved to find out what's going on.

Prior to the double-digit trend era, people wanted choices in medical options. If you want choice, you pay for it. If you want a Cadillac, you pay for it. So the benefit is changing, the cost is changing, but there are a lot of buy downs. When you have a benefit buy down, the impact is very different. For example, consider this scenario with senior management. "Many people switched from a $500 deductible to a $1,500 deductible, so why are you still charging the same reserve for this plan?" My response was, "Who are the ones who bought down? Not the people in the hospitals. Only the people who don't think they're going to need to see a doctor next year are going to want to buy down. The ones who know they are going to need to have service, like a diabetic, are not going to buy down. So your claims are not going to change right away, at least for three months or so during the selection period." Don't get misled. Yes, the benefit went down, the premium is down, but the claim is not going to go down right away. It's going to take anywhere from three to six or seven months before the selection starts wearing off and the claims start to balance out. Hold your ground.

The next topic is new benefit designs. We have come up with innovative new products to give members more choice. On these new products, we may not have much of a history. When you get a new product, you may not have much information, and of course, typically you start with best estimates. Talk to the pricing actuary and find out what he or she thinks the initial cost estimate is. Reserve on that basis, normally for a few months only. As soon as you have more paid claims develop, you need to update the reserve. Assume for a large block of business, your estimated cost is going to be $500,000 a month. The first month's paid claim is $100,000, and then a couple of months later, first incurral month's paid is now up to $700,000. Of course $500,000 is not going to be enough, so

you need to update the reserve. On the other hand, if it levels out to only $200,000 to $300,000 paid, you're not going to drop the $500,000 reserve right away. Hold on a little bit just in case the favorable paid claim pattern is a blip. I always assume the worst. Be careful and know what's going on. As soon as you have enough experience coming, you need to start updating your completion factor projections. You can't just say that this is good, the plan is set, and you're going to have a 75 percent loss ratio that you can use for the first year. You may just get a big surprise.

Constantly analyze the elements and assumptions used in financial projections for new products. Claim cost trend and leverage impact: higher deductible, higher leverage, right? Be careful. Watch the product you're looking at and what segment you're dealing with. Catastrophic claim adjustments are more controversial because the pricing actuary, product manager and the business unit general manager may confront you saying, "Wait a minute, we plan for this and we plan for that, but what do you mean that we did not plan for catastrophic claims?" The CEO asked me once, "Why do two actuaries always have different opinions?" I said, "You're lucky. If you've got three actuaries, you may have five answers, because everybody has a different approach." The valuation actuary and pricing actuary are competitive, right? There's a difference in how you approach valuation versus pricing. We have different elements we have to consider, adequacy and consistency.

The next issue is a little bit of a science but more of an art. You've got to know the claim inventory. The inventory is good; the inventory is bad. Be careful. A lot of people get carried away. Look at short-term trends versus long-term trends—is this a blip? This month the claims processor took personal leave, so I lost 20 percent of productivity, so my inventory is up. It's one month—don't get nervous and don't overreact. Remember, you don't really use the completion factor in the most current month because you would typically use per member per month (PMPM) projections. For inventory, if it's a short-term blip, it's generally going to be the current month, current two or three months, because that's when most of the information comes in and the claims are filed. Hopefully people are not going to wait five or six months to file claims. So for the current period, you're now using projected PMPM based on prior history. The prior history is already 80 to 90 percent complete, so the blip impact to your reserving assumption is minimal if it's a one-month blip. If they have a three-month performance issue, then you may have to be careful because you may start dipping into your completion assumption period. Frequently your general manager may say, "My inventory just decreased 25 percent. How come you're not giving a discount on my PMPM?" I say, "Wait a minute, your operation has nothing to do with people getting sick or not, right? You are improving inventory, which means your claim cost is lower; give me a break. Go ahead, put in all these target results, that's fine, but I cannot deal."

So be careful to see if it is actually a long-term versus a short-term issue. Long-term claims issues we're seeing include technology changes (big front end),

improved auto adjudication, etc. We have seen changes in technological improvement in the last two years, notably in making the claim adjudication process faster. I talked a little bit about system migration. When that's coming through, you can see some change in the trend, in the history. Update your history.

Things happen when the short-term claims processing approach changes from FIFO. Normally you want to see the claim operation from the view of the claim department. There's no preferential treatment, based on your historical data, based on the date when you received the claim. However, to sometimes meet certain operational metrics, the FIFO approach may be changed to easy out first (EOF). For example, say your inventory count went up 25 percent. There is a mandate that you have to cut inventory count down by the end of this month. You want the inventory count down? That's no problem. A $50,000 claim will take me an hour each. I'm not going to touch it until I get my count down by clearing numerous $50 claims. My experience tells me not to talk to the claim vice presidents; they have no idea, like me. Talk to the line people, supervisors, walk around once a month, make some friends, and take them out to lunch. Understand what's really going on. You need a good friend down there. Walk around the claims operation and you will understand what's going on. Remember you are like an artist. How can you paint a complete picture if you don't study your subject?

Let's talk about error rates and duplicates. Again, don't overreact, because when you take a pure inflated claim count number, you may be overestimating due to error rates and duplicates. At the end of the month, if the provider doesn't get paid, you get a second bill, plus the provider sends out letters to the insured. Suddenly you have three claims sitting there instead of one. Be careful. The numbers don't lie, but there are a lot of tricks in the numbers.

In many of the plans, our companies are paying claims once a week or every other week. The recording of claims processed and issuance of claim checks to the general ledgers are performed as two separate entries and may be based on two different calendars. For example, if it is a weekly payment cycle you typically get four weekly payments in a month. How do you adjust reserves if it is a five-week payment month? Earlier I mentioned the long-term trend of the electronic data interchange (EDI), auto–adjudications, etc. When you get the changes implemented right, you see the trends changing. About a quarter ago, when we were going to announce our earnings for the quarter, the response from Wall Street was, "Oh, you are reducing your reserves and you have a faster turnaround. I like it, but I don't like it because of the impact to your cash flow." It's a two-sided story; with faster reporting, we know what's going on earlier. If we can react a month ahead of everybody else, we have an advantage and happier customers. With the doctors, you pay them fast, they don't have to hassle you and they like you. On the cash flow issue, you're not going to earn much interest anyway in today's environment, so you might as well pay faster and make them happy.

On systems migration and conversions, you need to know how the data is coming

through. Use a real case and do the testing. Don't just rely on somebody to do your work. This way, when you get a system changeover, you don't get killed, at least for three to six months. With a new system, people can learn how to use it and how to process with it, but there's a learning curve. You need to give them slack. You may have some inventory problems or some backlog. Don't think that with the new system, you will get better payments or lower payment and then lower costs. No, no, no. There are things we may not even realize. Be careful what's coming through; know what's happening out there. Be aware of the coding modification, the new system and new or larger capacity. Now you have line item adjudication. Your accounts and everything else are different now. You have to understand what your new system is capable of and what is going on there. You need to understand it. You need to communicate. You need to talk to your associates.

On provider liabilities such as incentive bonus accrued and withholding, you need to periodically get claims experience updated because in an incentive bonus arrangement, if providers meet certain targets, they have earned the incentive bonuses. If you don't meet a target, you don't get it. You need to update, preferably once a quarter. So update your claims experience. This is usually where we have a separate unit or a contracting unit where we deal with them. We ask them, "Are you updating monthly? Do we take action on a quarterly basis?"

Let's talk about provider settlement and disputes. Sometimes after providers receive their settlement checks, they come back and say, "Wait a minute. I expected double because of good performance against the metrics." Sometimes there are providers saying, "You took advantage of me last year because I didn't have actuaries. Now I have actuaries working for me. Write me a check for $500,000 before I will negotiate or accept the new contract." You need to know these issues as they come up. You need to get information and updates on whatever is going on.

As far as contracting changes, many providers don't like capitation anymore because they are taking risks. If you insure, you take risks. Some providers have also threatened to move away from fixed fee schedules or per diem rates to discounted fee-for-service arrangements. Now we have less control because things are changing. One of the worst culprits is the hospital stop loss. After exceeding the hospital stop-loss threshold, the arrangement changes from a fixed per diem per day to a discount off billed changes. This has a material impact on reserves.

The world is changing. Actuaries need to communicate. Internally, these are our customers, and we have to discuss and deal with them daily. Know the business unit actuary because he or she makes a lot of assumptions and has a good understanding of what is going on as far as cost trends and pricing. It's hard for the general managers because they're the ones the actuaries do need out there to sell and service the business instead of focusing on reserves. You need to understand what they are thinking, what they are anticipating and what they are doing. Today,

the financial staff is asking a lot of questions. They need answers. They may have a target; they may have some ideas. You need to have communications with the finance people so when they make a target or an assumption, they know where you stand. They are concerned about running behind plan. Where are your assumptions, where are we at and where are we going? It's very critical that they all understand why we make certain decisions; otherwise we'll be in the ivory tower and detached from reality.

Then there are the issues. You need to communicate with internal business partners and ensure reserving adequacy via margins. For the reserving actuary, adequacy is critical. A 50th percentile reserve is no good because it means half of the time you don't have enough money to pay the rent. We need to reserve for moderately adverse conditions instead of just a 50/50 reserve. Take your best shot at a best estimate reserve before making any adjustments for moderately adverse conditions.

Find out what's going on in claims inventory and backlog status. You need to communicate and know what's going on there not only from a claims supervisor, but also communicate with senior management to verify what you're doing so that everybody is comfortable. You may have the best ideas, but if you're not communicating, and nobody knows what you're thinking, it means nothing. I'm always arguing with actuarial mathematicians. They are geniuses. Normally they're 30 to 50 years ahead of us. The problem with a lot of mathematicians is that they don't know how to communicate, so they're stuck in the library. Actuaries need to have that ability to communicate and experiment, make some type of science out of the art and communicate it so people understand it. That's our job. You've got to be able to take your stand, understand what you're doing and communicate it to others on their level of understanding.

Let's look at prior period incurred adjustments (PPIA). One time, a senior manager came to me and said, "In January, I had a $2 million PPIA, in February I had a $2 million PPIA, and so on. By the end of the year, I had a $24 million bottom line without having to do anything. The corporate actuary is my friend now, and he just made $24 million for me." No. The same $2 million is rolled over every month. Conceptually senior management needs to understand what actuaries are communicating. In looking at claim cost of current projections, remember that on buy-downs, claims are going to continue until six months later when the selection periods run out. Then you may see a cost advantage and the claim cost coming down, but definitely for the first three months you're not going to get any significant impact.

On partnering with auditors, some people don't take them seriously. I do. They're doing their job, they're helping us with a second pair of eyes, looking and reviewing things I'm missing. They may see something else. Work with them in understanding, communicating, explaining to them how and what you're doing. The regulators want to make sure, if anything happens, you have money left to pay the

claims. The worst case for them is, "I'm sorry. I'm out of business. There's no money left. I don't know what to do." They don't like that scenario. You have to explain to them where you are because their major concern is the customers in their state. The three important things to regulators are reconciliation, consistency and documentation. The auditors and the regulators like to see consistency. Don't be conservative one year and aggressive the next year. Stay consistent so they understand what you're doing and understand your philosophy.

On reconciliation, your paid claims are matched with general ledger and your reserve is developed based on the same block of business; you're not missing anything. Many systems people, when they gather their reports, say, "Wait a minute, this adds up to $X." I say, "What did you not collect? Give me a garbage can. Before you dump the paid claims reconciliation report, I want to see it, regardless of whether it's changed or not." You always have control. List everything so you can reconcile. You know what's in, what's out, what's your selection and what's your choice, because otherwise you may miss a significant piece without even realizing it. If there's new coding, a new line of product, or a new line of business, you may think you have it, you didn't pick it up and it's in the garbage can. Make sure it's $25 and that it doesn't say $250,000. Be careful you know what's going on. Document your assumptions, so you can communicate better.

WellPoint is a public company, and investors like to know what is going on at all times. Suddenly, in the last couple of years, something called "days in claims" metric has emerged. This is something actuaries prefer not to mess with. Unfortunately, there's another reality; we need to help investors understand what this means. For the most part, communication has gotten better over the last couple of years. People understand what we are doing operationally. However, many people still do not understand the days in claim metric. The metric has a denominator and numerator, thus taking us back into a mathematician forum. Just remember to understand it and communicate it. I now turn control of the discussion to Marty.

MR. MARTIN STAEHLIN: At the beginning Kenny said I was going to talk about a whole lot of things, but I want to try and stress communication. I want to talk a little about communication generally. Then I want to talk about the four principal audiences that I deal with. I'm going to talk from the perspective of an actuary working for an accounting firm, talking to other actuaries and regulators and different audiences, and then I want to talk about the reasons why we have so many communications. There are interrelated parties, and so there are going to be a lot of interrelated communications that you have to pay attention to. Saying "communication" so many times, I'm going to talk a lot about ASOP 41, and I'm going to give you some references.

In ASOP 41 there is a definition of actuarial communication as written, electronic or oral communication by an actuary with respect to actuarial services. For your first thinking point from my talk, I'm not sure there is anything that is purely oral

communication, because I have ASOP 41 here. In section 3.3.1, it says, "The actuary's oral communications shall not conflict with anything he's ever written." So if you want to have a stand-alone oral communication, I think you'd better make sure you make some notes. When it's talking about written, and electronic, it can be an e-mail, a memo or a note. But if it starts oral, it probably needs to be written, because in the last point about general requirements, it says "the actuarial communication should, as appropriate, identify the principal for whom the findings are made, should make clear the scope, including any limitations." Now, what I'm talking to you about right now, and I'm going to tell you the scope and I'm going to say your name—we don't write all that down. We don't stop with each audience and say, "What I talk to you about right now only can be used for this conversation, and it doesn't have any bearing on any other conversations I'm going to have." So it is a broader audience. It's a body of communication and a body of documentation. I know it's two long words, but every time we talk about communication, it's followed by documentation. It's a pair that goes together.

Now "actuarial services are services provided by one acting as an actuary." So if you have been acting as an actuary and providing a service, you're providing an actuarial service, which you need to communicate appropriately, and you need to document it.

In ASOP 41 there are a number of types of communications. The first one, as I talked about, is an oral communication. As I just talked about, I don't think there's any stand-alone oral communication, so in section 3.3.1, after you make an oral communication, you're going to make a note, a write-up, and a memo to file or e-mail. It talks about communication of significant actuarial findings, and it doesn't define "significant," so you do need to communicate any significant actuarial findings and you have to have some kind of an agreement over what is "significant." Now, remember, in a minute I'm going to talk about a bunch of different audiences, and what is significant to one audience might not be significant or might seem very significant to a second audience. You have to make sure that you understand these reserving, financial estimate practices and whom it's going to affect. It's a broader audience.

There's another term; they seem to move down (at least the first four terms) in levels of seriousness, because you go from an oral communication to needing to make sure if it's significant. Then you might do an actuarial report. Those of you who have done actuarial reports know that they are usually not stand-alone, so an actuarial report is not a single communication. You have a whole work paper file. As a matter of fact, if you work for a regulatory body or for clients, you might say in your report, "Here's a one-page thing that says what I did, and I have a whole bunch of paper back at my office that you should certainly feel free to take a look at." That's a nice thing to say, but make sure you have the detailed work paper support. The work paper support might be at your client's site, so you're going to give them a copy of everything you do—maybe. As an auditor, I have reporting requirements, so I have to have documentation as an auditor. I have to have

documentation as an actuary so I can explain to the client the opinions or the ideas that I have.

As far as a prescribed statement of actuarial opinion, there are some very strict guidelines about what you're supposed to follow when you do that, and you need work paper support for that also because the report might not be stand-alone. As a matter of fact, prescribed statements of actuarial opinions are usually one-page documents that say you did everything you were supposed to do, everything looks okay or not and there's a lot of work paper support that supports that opinion.

Analysis of medical claims payable is a new area. The point here is that there is no framework or dialogue about medical claims payable that WellPoint deals with every quarter or periodically. At least every year, but every six months and maybe more often than that, talking about what it means, and there is no body of knowledge. If you've looked at some of the disclosures, there's some general consistency, but people use different benchmarks and different words to describe what it means. If you're communicating in a new area, you need to understand what you're saying. We're all bright as actuaries and we've done this for a number of years, but it's not just an actuarial communication, it's a communication to broader audiences.

I talked about documentation. You need to be able to support exactly the opinions that you reached, and back in ASOP 41, "deviation from standard." There are two comments in here. There is a broad disclaimer at the end that says if you don't follow everything that's in here, you need to say why you've deviated from the "standard for communication." There's also a paragraph in here about "actuarial findings that an actuary considers to be significant should be in written or electronic form and when appropriate incorporated into an actuarial report unless you and your client agree." Say I'm having a one-on-one conversation with you, and we reach something. Okay, it's not significant. I thought it was significant a couple of minutes ago, but you've convinced me it's not significant. However, there are broader audiences, so you have to consider the broader audiences. Don't read this that it's a one-on-one communication, and if we agree it's not significant, then we don't have to write it down. You need to define "significant." You need to define when you need to document what you've done—always, I would say—and then when it needs to be communicated and to which audience. There's a code of professional conduct that covers the work that we do, and then there are communications to specific audiences, which it goes into at length in ASOP 41. What I'm trying to advocate is that there are broader audiences that you have to be aware of.

There are at least four audiences that I deal with. The principal audience is the client, and here I'm talking about the CFO or the management of the client. The next audience I'm going to talk about is the internal actuaries at the client, to the extent that they exist. This is the client, the company; sometimes you talk about it that way, but there are usually one or two people that you're talking to. They have to understand a range methodology. Why am I using the term "range methodology"?

There is a range of reasonable results that anybody would get when they do reserves. We may be asked to do a “best estimate.” Every time we’ve used "best," we put quotes around it, so it really is our best estimate, and often we’re asked by people to make a best point estimate knowing that there is no best point estimate.

So you have to make sure that your client understands what range methodology means, and so there is a range of reasonable results. There is credibility that comes into this. I’m again now talking from the accounting profession. I am an actuary in an accounting firm. There is an actuarial range, and there is an accounting range. I have to get them at least somewhat similar so that it will help communication and help in talking about it. We have to discuss the financial implications of that range, and what I mean there is that your place in the range is very important from an accounting perspective. So when Larry, CFO, comes to me and says, "You know, I have always been in the high end of the range and I’ve been thinking that just under the midpoint is a better place to be." That might be a better place to be, but you need a lot of communication and a lot of documentation because it’s a red flag to the accounting profession that you have changed your place in the range. Now, obviously it needs to be a significant change (undefined), but you need to understand what that is; you need to understand your audience, because you don’t usually talk to one company. Often there are families of companies, and you need to talk about the financial implications of one’s place in the range.

In measurement of restated reserves, there has to be a discussion of what reserve restatement means. I don’t mean the discussion is, "Let’s beat ourselves up, because on average we got it right but sometimes we’re high and sometimes we’re low." As Jin-Dih was talking about, people want to know what your run rate is. Sure, they want to know what your reserves are, and they want to know about your current quarterly earnings, but in the long term they want to know what your run rate is. When you restate your reserves, you get a change in your run rate. We know that as actuaries we have to create the history of what’s going on at the company so we can understand what the history meant and what we should be doing next quarter, but we also have to report and explain. So you need a mechanism for restating reserves and talking about it.

Regarding quantification of all reserve items, it used to be you could say your loss adjustment expense (LAE) is somewhere in your margin, but now most audiences want it specifically identified. You have to make sure your client understands that regulators and accountants want to see a number called "LAE," and, by the way, that you’ve covered all reserve items that you should. You have to understand GAAP to Statutory translations. For some people they’re different, and you have to be able to explain why it is, because the audience that I said I was talking to, the CFO, has to talk to a lot of people about GAAP and Statutory.

There should be auditor confidence in rationale for actuarial decisions. As we get in the room with the management of the client, the client’s actuaries might be there. I’m there as the auditor actuary, and the audit partner is there, and there’s no safe

harbor anymore in saying, “We’ve got health-care actuaries, and they’re really bright." "That’s great and congratulations, but we need to see something written, not only that your actuary says is the reason why you did what you did." The audit partner has to be able to read what you did and say, "Okay, there’s documentation and there’s work paper support, and so we sign off and it’s appropriate." So that prior environment, given all that’s going on in the accounting arena, has to change a little. Here’s your early warning signal. I would encourage you to read Actuarial Standard 28 and Actuarial Standard 21. There are a lot of comments in there about these discussions.

The second audience is other internal actuaries. This is a shorter list. Hopefully you can speak actuarial to one another and you have the reasons for the range selected. You can defend them. As Jin-Dih said, it’s not really a hostile environment. We are coming together so it doesn’t create confusion. Often when actuaries don’t agree, it makes everybody nervous and it’s confusing. We want to come and have agreement because most people don’t understand what we do and the depth of some of the adjustments that Jin-Dih alluded to. So you want to come together in understanding.

Volatility is a complicated subject. Volatility to me means that there’s theoretical volatility, there’s practical volatility, or there’s operational constraint volatility. For example, your claims people, we don’t know what they were doing, but they had way too many parties and employees of the week, and so they didn’t pay any claims last month. There is systems volatility, and we do it to ourselves sometimes, but we do systems changes, we have systems problems and we can’t understand them. All those create volatility and might be a reason why you need a different reserve. Historic development again goes back to medical claims payable. We’re going to discuss it in detail as actuaries and then explain to people what it means in general terms. I think I remember WellPoint once said in their discussions that they have 150 reserving cells. The point is, you can’t talk about 150 cells. You have to get up a couple of feet from five feet off the ground and explain what’s going on. So you have to come to an agreement about what that is.

We had hoped to have a regulator here, but the person was too busy, so I’m now going to speak as a regulator. Often we are hired by states to go in and review health plans. In looking at favorable development and its impact, often the regulators just want to make sure you have enough, so that conversation takes about five seconds. When it’s an unfavorable development and what’s going on, those conversations take longer. On prior period development, sometimes they’re up and sometimes they’re down. If you’re always under reserved, that’s just really bad. Let me just suggest that you shouldn’t do that.

For those of you that are not health-care actuaries, Schedule H is like a look back and a restatement similar to the medical claims roll forward. You’re trying to understand what the run out has been. Anyway, so as an auditor now, I often have to say that you filled out Schedule H right, so it’s something you need to focus on.

Now you have medical claims payable roll forward. It ought to somehow relate to that, and it ought to be tied in and reconciled, like Jin-Dih said. That's sometimes a problem area that we need to get under, because it bothers the regulators a lot if something doesn't balance. As an actuary, on average it looks good to me, but if it doesn't balance, then it's a problem.

The only thing I want to say about premium deficiency reserves is that sometimes you can get a double whammy. People don't really understand this issue. Regulators don't understand premium deficiency reserves very well, and they rely on their consulting actuaries to tell them what it means and that the plan is doing things correctly. However, if they are under reserved and they need higher IBNR claim reserves, they probably need a higher premium deficiency reserve also. So you have some double-whammy problems that regulators are concerned about.

Regarding loss adjustment expense (LAE) reserve, regulators like that. If you're not used to putting it on your balance sheet, I'd encourage you to put it as a liability—and an asset if you want to, but you'd better have LAE liability on your balance sheet.

Let's talk about other actuaries as consultants. Sometimes when we get in these discussions, we have actuaries from the plan, actuaries from the regulator, consulting actuaries, health actuaries at the plan and we have myself as an actuary on behalf of the state. It gets a little confusing. As Jin-Dih said, three people can have five opinions. If you have four groups of actuaries, you get a lot of opinions. You want to have that discussion ahead of time.

Of course, I don't want to leave out Wall Street, because I know there's at least one person here from Wall Street. From my perspective as an actuary at an auditing firm, right now all I'm talking about is medical claims payable roll forward. As Jin-Dih said, there are a lot of discussions that individual plans have with Wall Street, and right now there is variability in the discussion of this item, and so that's going to require additional communication. That's what I'm talking about. There's also an analysis of trend. This is a time when people are trying to look at and understand how they can interpret trends from the data that I've shown them.

Chart 1 shows a PMPM line. This is a real-life example, and the circles mean this is November-December year one, November-December year two, and November-December year three. When I have to set reserves here at December 31, I don't know much about these two points. But if you believe the seasonality and believe everything that's going on at your company, you're going to set a reserve with those two PMPM estimates. Now, people who don't understand what you do are going to look at this neat regression line that says you have a 12 percent trend, or 1 percent a month. I can even multiply that. Now, if I put a 12 percent trend on that number, the October peak that we all love, rather than these two numbers, I'm going to get quite a different answer of that reserve, and as I do my restatements, that doesn't come down to November-December, and we're going

to have a whole lot of communication in the first quarter rather than a group hug. You have to be prepared for the items that you know are going to be difficult to communicate, again, across all the broad audiences that we talked about.

There's a great publication by the Academy called *Winning in the Public Eye.* Like we're doing here, sometimes you have to talk to a public audience. You have to be prepared that your message has substance and that you're ready for delivery. You have to dress for success, and make sure you remember to get dressed when you show up for your talk. If you have to talk to the public, it's a good publication for you to read.

I'm going to close with the interrelated actuarial standards of practice. If you want to check to make sure I got most of them, there is also a publication called "Applicability Guidelines for Actuarial Standards of Practice," by the Council of Professionalism, American Academy of Actuaries, dated August 1999. From my perspective, it's very interesting that they listed these as the actuarial standards of practice you should know if you do reserves: 3, 5, 6, 7, 11, 12, 14, 16, 18, 19, 21, 22, 23, 28 and ACG4. Since 25 is not on there, I added number 25. You need to understand how credible the estimates are and what they mean, because it's going to increase the amount of communication and documentation that you need to do.

MR. JOHN FINLEY: This is not a question, just an observation concerning the inventory. I had a recent example where both the count and the dollars of inventory came down, and there was a great deal of pressure to do something about it. But when I looked at an aging report and got the total bill for count and compared that, I found that there was roughly $20,000 of bills per count in the 90-day-plus that just suddenly appeared, so it's a good thing to keep in mind. If you can get your hands on an aging report, also keep that in mind.

MR. STAEHLIN: Thank you, John. I think that's part of what Jin-Dih was saying about this easy-out-first approach, that sometimes we get the easy ones paid but the old ones are a mess.

MR. KAN: Before the second question, I just want to comment for those who use claims inventory as a guideline for your reserves. One thing you may want to take note of is how inventory has changed over time in terms of consistency. What units get counted? If you think about it, inventory counts can be either envelopes that are open, keyed claims only, or it could be keyed and unkeyed claims. I think you need to understand what claim unit counts are being used to count inventory. Has the basis been consistent over time?

MR. STEPHEN ARNOLD: My question is on the seasonality. If we have extreme seasonality patterns, like in the prescription drugs where the first month might be 50 percent of the prevailing year, should that just be reflected and reported through into earnings? Should something be done from a reserving perspective to reflect

the fact that you've got an unequal incident of claims relative to your premium? How should that be addressed?

MR. SHIH: That's a very good question. Basically, I think I'd emphasized a little that we are doing the valuation, so you have different angles to look at it, because you are exactly right. Frequency is still there and expense is still there. The difference is we're not paying. Reserving-wise, you need to recognize it, but pricing-wise, you need to factor in the impact of the deductible on incurred claim costs. That's why in our company we have two different actuarial functions. In valuation, we're looking at where the real numbers are coming through. Where do we need to reserve? What is liability as of today? Pricing-wise, there's a different actuary who projects into the future. The cost is still there. The trend assumption is still there. Then you'll bring in the overall total trend, apply your deductible factor and the use of leveraging, and get the pricing out there.

MR. STAEHLIN: I'm going to answer it from the perspective of, "Is it significant to your financial statement?" If you have only one line of coverage, and you want to use a very interesting argument to prove this seasonality one way or another, you have to do exactly that. You have to communicate it and you have to document it. I perhaps won't go this far, but you have to almost give me an actuarial proof so that I can agree with you actuarially, and then together we're going to have to explain it to the audit partner. If you have one line of coverage that looks like this, you have more work to do. If these are 10 lines of coverage in your company, then there's probably more room for having not as firm of proof of this, but this is the indication. You documented exactly what you were doing. I might not agree with your assessment of seasonality, but show some latitude in that. You know the business, you work with it every day, and I'm not trying to make your life difficult, but if your whole company looks like this, it's a harder discussion that we're going to have.

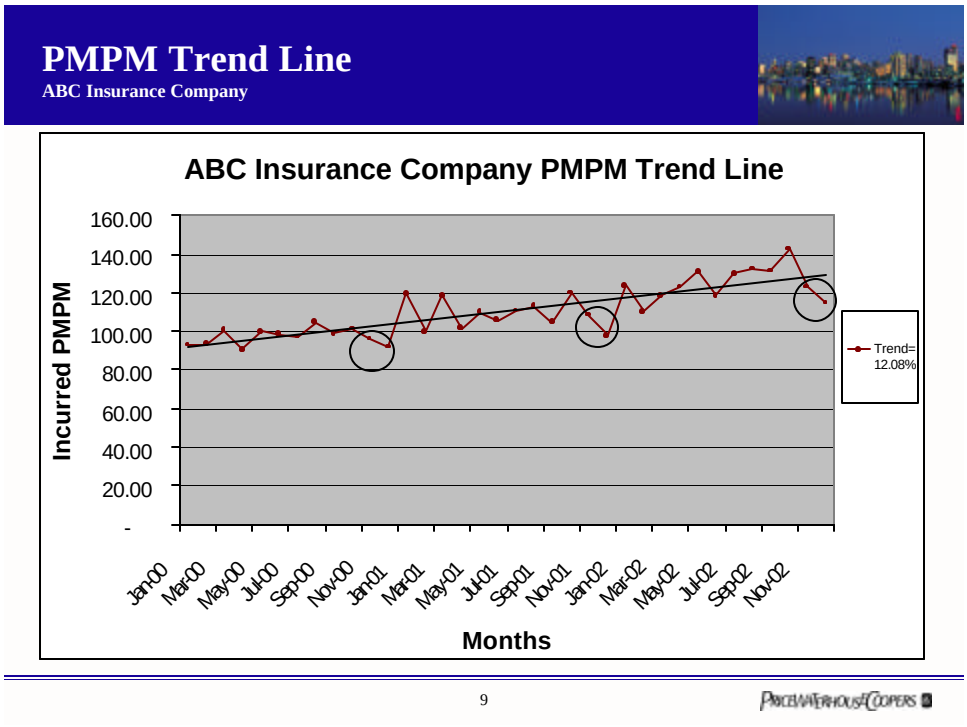
MR. BILL LANE: This is also more of a comment. I signed the annual statement for Mutual of Omaha for almost a decade, and at one point in time I went through a study where I took, first of all, the difference between the restated reserve and the formula reserve at that point in time and compared it with the claim inventory at the same time. Statistically speaking, there actually was a very small negative correlation. There was no correlation between claim inventory and what the actual reserves were going to do relative to what your formula said.

MR. KAN: That's exactly what I was saying. It depends on if it's short term or long term, if there's trend or no trend. Don't overreact because the inventory went up 10 percent or whatever for just one month.

FROM THE FLOOR: There have been a lot of comments about claim inventory, and what I've found is that generally there's a method to the madness of the claims department. They have a wealth of reports down there that they use to manage the day-in and day-out operation of their departments. When I was

responsible for the reserving, a couple of times a month I made a point to go down to the claims department to sit down with those folks, look at their management reports and talk with them about what was going on. Then when you see, say, a 7,500 blip in claim counts at the end of the month, they can explain it. They say that there's a blip in hospital inventory, hospital XYZ had a billing problem, and guess what, three weeks of claims showed up yesterday. You understand better, and it's a much better understanding than using 12 Excel worksheets.

Chart 1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ABC Insurance Company PMPM Trend Line
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