RECORD, Volume 30, No. 1*

Spring Meeting, Anaheim, CA
May 19–21, 2004

Session 85TS
Valuation Issues for Statements of Actuarial Opinion

Track: Health

Panelists: ROWEN B. BELL
JOHN F. FRITZ
THOMAS D. SNOOK

Moderator: THOMAS D. SNOOK

Summary: There's more to signing the actuarial opinion on a health insurer's annual statement than simply running a few claim triangles and selecting an incurred-but-not-reported (IBNR) estimate. In this session, experienced valuation actuaries share information on a variety of relevant issues apart from the raw calculation of the unpaid claim liability (UCL). Topics include: selecting and testing levels of margin; premium deficiency reserves, loss adjustment expense reserves and other ancillary liabilities; and interplay between regulatory requirements and actuarial standards of practice.

MR. THOMAS D. SNOOK: I will be your moderator today. As it turns out, I will be one of your speakers too.

We have an esteemed panel here today. Bob Dobson, as you can tell, is not here, and he has a good reason for not being here. He called me on Friday, so I will be doing Bob's presentation for him. The esteemed members of the panel include John Fritz, who is chief actuary at PacifiCare, just down the street. John has been with PacifiCare about three years, and before that he was with Ernst & Young. Also we have Rowen Bell. Rowen is head of the Financial Regulatory Services unit at the Blue Cross/Blue Shield Association in Chicago, and he's responsible for the Association's monitoring and advocacy activities on financial and actuarial regulation initiatives at the NAIC and other bodies. Rowen is also active in various American Academy of Actuaries activities and is currently vice chair of the Academy's Health Practice Financial Reporting Committee.

MR. ROWEN B. BELL: Before we get started here, I'd like to get a sense of the room on a few questions. The first question I'd like to ask is: How many people in the room are responsible for signing the actuarial opinion for one or more companies? It looks like probably half the room. That's great. It looks like we have a good, experienced crew of people here. For those who didn't raise their hands, how many are also involved in valuation activities that support the statement but do not actually sign it? That's probably another quarter of the room.

What I'm here to do in this presentation is provide a little bit of the lay of the land and talk about the regulatory framework with respect to the statements of actuarial opinion. Then I'll turn it over to my fellow panelists. As Tom indicated, I'm a trade association chap. I follow NAIC developments, mostly on what I characterize as the theoretical level. I'm not actually there signing actuarial opinions; I'm just watching the decisions that get made on the regulation that affects the opinion.

Earlier today at a session I heard that, in dealing with actuarial valuation issues, thinking about the regulatory framework issues is something like the third step. You start doing the work first, and eventually there's a point at which you step back and say, "Okay, are there things from accounting guidance or from the actuarial standards of practice that are relevant to what I'm doing?" This is after you've already started to do the work. Obviously I think that's the right approach. I would not want to argue that everything should be driven by regulatory considerations. However, it's clearly important for everyone to be aware of the regulatory considerations and to try to stay up-to-date on that. That's the perspective that I'm here to try to provide.

First, I'll mention the main categories of regulatory and/or professional guidance that are out there that would impact the statement of actuarial opinion. The NAIC obviously does have quite a bit of impact on this, since we're talking about a statement that is an NAIC requirement. But there are several different dimensions of NAIC guidance that are relevant, starting with the accounting guidance itself.

The NAIC maintains the *Accounting Practices and Procedures Manual*. In the last several years, since codification, this has become a much more important, regularly updated and refined document than it has been in the past. Every year a new printed version of the *Accounting Practices and Procedures Manual* comes out. The current version for 2004 has a bright fire-engine red cover. It came out a few weeks ago.

It is important to realize that there are continual updates being made to the *Accounting Practices and Procedures Manual* throughout the year. The NAIC meets every quarter. They have a working group that deals with developing new Statements of Statutory Accounting Principles (SSAPs). They have another working group that deals with interpreting the existing SSAPs, and it issues documents called interpretations (INTs). Both the SSAPs and the INTs are found in the *Accounting Practices and Procedures Manual*. Again, throughout the year, there

could be new SSAPs developed, minor amendments to existing SSAPs or new interpretations developed. In many cases, new accounting pronouncements throughout the year become immediately effective or become effective for year-end.

What does this mean to this audience? When it comes to January 2005 and you're working on the 2004 statement, it would be incorrect to assume that the red book that came out in March 2004 represents the last word on statutory accounting. There's the potential that things have happened during the year that affect you as valuation actuaries. It's important for there to be some sort of channel of communication, whereby you, as a valuation actuary, have a means of becoming informed about things that have happened during the year that would affect you. If you're a company actuary, your accounting firm or your trade association is probably providing information of this nature, at least to your finance staffs, and it's important that you tap into that to the extent that it may be relevant to you.

The annual statement instructions are also important from a regulatory framework standpoint. This is especially true for health actuaries, where the actuarial opinion instructions are part of the annual statement instructions, as opposed to life actuaries, where there's a separate NAIC model regulation—the Actuarial Opinion Memorandum Regulation (AOMR). The annual statement instructions are less likely to change on a year-to-year basis, but again it's going to be important to be aware, when it gets to year-end, whether there have been any changes in the instructions for the actuarial opinion from the previous year.

A much older form of NAIC guidance that is relevant, particularly in the context of contract reserves, is the Health Insurance Reserves Model Regulation. This is a model that has been around for many years. Probably all of us had to read parts of that model at some point during our actuarial exams. It was on the curriculum, at least when I was taking some of the exams, to understand some of the methodologies with respect to contract reserves. Today the NAIC's Accident and Health Working Group still updates that model regulation. At the same time, it is also part of the accounting manual. Appendix A-010 takes the relevant portions of the Health Insurance Reserves Model Regulation and effectively appends it to the NAIC accounting guidance. We'll talk a little later about some of the difficulties that this interaction creates.

Finally, there's the *Health Reserves Guidance Manual*, which was published about three years ago by the NAIC, as a result of a significant amount of work done by the actuarial community through the Academy. In more recent years, the accounting manual was actually amended in order to make explicit reference to the *Health Reserves Guidance Manual* within the accounting guidance. If you now look, for example, at SSAP 54—the piece of accounting guidance that pertains to contract reserves—you'll see a reference in there that the *Health Reserves Guidance Manual* is an additional source of guidance relating to those reserves.

When you have several different pieces of guidance that were developed by different people at different times, there are bound to be some ambiguities as to how these pieces of guidance interact with one another. Trying to sort out those ambiguities and resolve them is an active area right now. The question of ambiguities is augmented, to some extent, by the fact that as actuaries, we are also bound by the actuarial standards of practice (ASOPs). ASOP 5, with which I'm sure you are all familiar, deals with claim liabilities. Hopefully you'll be getting familiar in the months ahead with the brand new ASOP 42. I received my copy in the mail just before I came to this conference, so I'm sure that if you haven't received your copy in the mail from the Academy already, it will be waiting for you when you get back to the office. Of course, you can also simply download it from the Internet. ASOP 42 deals with health liabilities other than the unfunded current liabilities (UCLs), for the first time providing an ASOP relating to things such as premium deficiency reserves (PDRs), claim adjustment expense (CAE) liabilities, etc.

Finally, there's also going to be the relevant ASOP for whichever actuarial opinion you happen to be signing. If you are signing the health blank actuarial opinion, that is ASOP 28. For that small number of companies that are health carriers but are still filing the P&C blank, it would be ASOP 36. For those of you that are life companies and therefore subject to the AOMR, there are other ASOPs (I think ASOP 7, primarily) that would relate to that.

If you were signing the health statement actuarial opinion, the scope paragraph should include at least the following line items from the health blank liability page: the liability for unpaid claims, liabilities for provider pool or bonus payments and the liability for CAEs. The line item for policy reserves is also included, and in addition to including your normal contract reserves, that line item, which feeds to Part 2D of the health blank underwriting investment exhibit, also includes your unearned premium liability and PDRs. It's important to note that you are, within your scope paragraph, implicitly opining on PDRs. The liability for experience-rated refunds is also thrown in there, as are any other actuarial liabilities that have been put as a write-in item.

The geography of the health statement is driving the scope paragraph. For that reason, it's very important to understand the geography. Again, going back to the point I made earlier, it's not like the geography should be the driving consideration. You're doing your valuation work, and only then do you need to be cognizant of these geographic types of issues.

By geography, I mean what is and what isn't in the line items that you're opining on. You may be doing your calculation of the UCL, and you provide that number to your finance department. That goes into the blank; but there may also be other items that are going into that same line-item in the blank. When it comes back to you as the person signing the statement, you need to recognize the extent to which

the number that you gave finance may or may not be the same number as what actually goes into the blank.

Now I'll talk about the impact of the NAIC's accounting guidance itself on the geography of financial reporting. For example, there has been specific accounting guidance that indicates that when you are setting up the liability for unpaid claims, you get to net salvage and subrogation and coordination of benefits (COB) against that claim liability. There's language in SSAP 55, the accounting guidance that governs UCLs, specifically addressing salvage and subrogation. Later there was an INT that the NAIC issued that extended that guidance to COB situations. Again, you can't just look at what's in SSAPs 54 and 55; you also need to be aware of the interpretations of those statements and how that also becomes definitive statutory accounting guidance.

Unfortunately, you can't look at only SSAPs 54 and 55, because there's guidance in other SSAPs that is relevant. Health-related assessments include risk pool assessments. If it's an assessment to the company related in some way to health insurance, SSAP 35 indicates that the liability for those assessments (if you've been assessed, but you haven't paid it yet) goes into the UCL. Now from your standpoint, that's not an item that you're taking into account when you do your development method and triangles to come up with your UCL. Yet at the end of the day, this item is also going into that same line item as the result of your work. When you're signing the opinion, you need to be cognizant of that.

More recently, there has been accounting guidance that talks about items that you can no longer net against the UCL. Instead you have to, according to the NAIC, set up separate assets. SSAP 84 on health-care receivables talks about the need to do this in several instances, including pharmaceutical rebate receivables and claim overpayment receivables. Both of these, I think, are important because you have to think about the data that you've used to develop your claims triangle and to develop your liability. If that data had pharmacy rebate payments in it, or if that data had claims in it that you had previously overpaid but then you got that money back, you may need to think about whether you need to take that data out in order to come up with your liability. The NAIC instruction is that the pharmaceutical rebate receivable can't be netted against the UCL; it has to be set up gross. Similarly, the receivable for claims that you've overpaid and that you expect to get back from the hospital can't just be explicitly netted against the UCL; it has to be set up separately as an asset. There are certain rules indicating when you can and can't admit that asset. You need to be aware that the accounting guidance is written the way it is, because that may drive the way in which you need to do your valuation work.

Even more recently than SSAP 84, we've had SSAP 85 on cost containment expenses. This has implications both with respect to the UCL and to the liability for unpaid CAEs.

The notion of SSAP 85 is to find a consistent home across all entities for many of the items that health insurers spend money on that are neither purely administrative costs nor purely contractual benefits. These include anything having to do with disease management, large case management, utilization review, pharmacy benefit manager (PBM) access fees, other network access fees, etc. Insurers spend money on these things because they believe that, by doing so, they're lowering the ultimate cost of incurred claims. However, they are not a pure administrative expense, nor are they a contractual benefit. Historical practice has varied significantly among carriers as to whether these items were reported in claims or in administrative expenses.

One of the principal concepts of NAIC accounting is consistency, and regulators felt that these financial statements were inconsistent between entities. In order to remedy that, they developed a new accounting standard that said, "There is a middle ground called cost containment expenses." While cost containment expenses are defined as being part of CAE rather than part of incurred claims, they will be presented separately. You can now look at a company's statement starting in 2004 and see incurred claims separate from cost containment expenses and separate from the other administrative expenses. That gives everyone comparable information and a consistent place to report these items.

This accounting standard was passed in 2002 with an effective date of year-end 2003. However, the aspects of the accounting standards that relate to how things are reported in the blank became effective for the first time here in the first quarter of 2004. Hopefully, those of you who were signing health blanks at year-end 2003 were aware of this issue. It does mean that certain items that may have been thrown into the UCL in the past can no longer be put there. For example, if your plan had always considered your case management fees to be part of incurred claims, any due and unpaid case management fees at the end of the year would have been lumped into the UCL. Historically that may have been the case, but it should not have been the case at year-end 2003. Those due and unpaid case management fees should have been flowing into the liability for unpaid CAEs, because they are now considered under SSAP 85 to be part of cost containment expenses, which is a subset of CAE. For that reason, the liability for unpaid CAEs starting at year-end 2003 may have had a lot of items in there that weren't there before.

For example, let's say you are developing your own network rather than renting someone else's so that you have your own provider contracting staff. The salaries of the provider contracting people are considered to be a cost containment expense activity under SSAP 85. The liability for the week-and-a-half of salary that those people had earned at the end of the year, but wasn't paid to them yet, would be considered an unpaid cost containment expense. Therefore, it would be considered an unpaid CAE, and, therefore, would probably get rolled up into the line item that, as the valuation actuary, you have to opine on. That means there are now potentially some non-actuarial items being lumped in with your actuarial estimate

of the unpaid CAE. As I've said, there's a need to understand the geography so you can understand the connection between the work that you do and what actually ends up in the statement—what you are actually signing to in the end.

I want to spend a minute talking about margin and claim liabilities. The language in SSAP 55 states that "management shall record its best estimate of the UCL." It's important to note that SSAP 55 is an accounting standard that applies to both health and P&C alike. There seems to be a difference of opinion and/or practice between the two industries with respect to not only historical practice, but also with respect to what this phrase "best estimate" really means.

From the standpoint of health actuaries, ASOP 28 and the actuarial opinion statement indicate that you're signing in the opinion paragraph that you've booked a "good and sufficient provision." I think most people would believe that "good and sufficient provision" would mean that whatever the 50th percentile of your estimate was, if you could quantify it in that fashion, the number that you would need to book would probably have to be in excess of that in order for it to be a "good and sufficient provision." The P&C standard, by contrast, speaks of a "reasonable provision."

It was not too surprising that one of the first things after codification that people were asked to interpret was this phrase, "management's best estimate." I think it was in 2001 that the Life Financial Reporting Committee of the Academy asked the NAIC to explain what it meant by "management's best estimate." In INT 01-28, the NAIC came out with what I have called a "Solomonesque" promulgation, saying that "conservatism is neither mandated nor prohibited." Basically, they punted.

Around that time, as the NAIC was debating INT 01-28, the health side of the Academy formed some comments that it wanted to submit to the NAIC on this issue. Interestingly, those comments were never submitted, due to concerns by the casualty side of the Academy that the views that the health actuaries wanted to articulate were inconsistent with the interests of the casualty actuaries. As a result of that, although those comments were never submitted, it was then decided that the Health Council and Casualty Council would work together in order to develop a white paper about the phrase "management's best estimate" and about historical reserving practices in the casualty industry relative to the health industry. That has been going on for quite some time, and the project is close to reaching fruition. What was thought to have been a final draft started circulating internally to the Academy around March, then many of the health actuaries started looking at it and said, "No, no, this still isn't quite right." There's some talk of redrafting. However, I expect you will see something sometime during the summer from the Academy on this issue. I would encourage everyone to read that white paper once it's released, if for no other reason than to give you some food for thought on these issues.

With respect to CAE liability, it's not clear to me whether there is generally accepted actuarial practice as to how you compute this liability. ASOP 42, as I

mentioned, has just come out. It says relatively little about this liability. There's a section of the ASOP that discusses it, but I would not say that it provides any sort of prescriptive guidance as to what one is to do.

There is a side issue here that I want to mention regarding whether the insurer needs to book a liability for business that a third party is contractually obligated to administer. Most health actuaries probably have operated under the belief that if you have a contract with a third-party administrator (TPA) and you have agreed to compensate them based on the incurral date of the claim rather than the payment date, you would not need to book a liability on the insurer's statement because you've already paid the TPA the money to cover the claims that were incurred prior to the evaluation date. It's therefore their responsibility to pay the run-out, even if you were to terminate your agreement going forward.

An interpretation came out in late 2002 or early 2003 called INT 02-21. Again, it came from the P&C side. They said that on the P&C side, it was always the case in statutory accounting before codification that you had to book a loss adjustment expense (LAE) liability. It doesn't matter that you have a TPA involved; it's still your ultimate responsibility. Even if you've already paid them, you have to book a liability anyway. Since that had been the pre-codification guidance for casualty insurers, they wanted to make sure that was clear post-codification. Then they said, "Well, heck, A&H isn't that different from P&C. We'll do this for A&H too."

A number of people were not all that fond of that viewpoint. The accountants did agree to let the actuaries have some input on the issue, and there was a discussion at the Accident and Health Working Group. The Accident and Health Working Group indicated that, if they were to reissue the *Health Reserves Guidance Manual*, they would include some language that clarifies the situation somewhat. The bottom line is that it's still a very muddy issue. If you have TPA business and you have not been taking that TPA business into account in setting your CAE liability, you may need to revisit that issue.

I'm running a little short on time here, so I don't want to spend as much time on PDRs as I could. Everyone knows that there's a lot of actuarial judgment required in setting the PDR. There's also a lot of confusion and uncertainty as to how to do this and also as to why we're doing this in the first place. A group of health actuaries has been trying to enter into discussions with the NAIC by asking, "What's the purpose of this? Why are there PDRs? How does the PDR requirement relate to the existing requirement in the Health Insurance Reserves Model Regulation that you have to do a gross premium valuation as the ultimate test of reserve adequacy?"

This is one of these issues where, as I was saying, there is confusion over the fact that you had different guidance developed by different people at different times. The gross premium valuation requirement was developed as part of the Health Insurance Reserves Model Regulation many years ago, and it was grafted into SSAP 54 when that was developed. At the same time, the notion of PDRs was introduced

in the P&C side as they were developing SSAP 53, and then got ported into SSAP 54. When you look at SSAP 54, it doesn't seem to be internally consistent, because there are parts of it that seem to conflict with one another. There has been some work going on here, both in the Academy and at the NAIC, to see if anything can be made of this mess.

There are two minor issues I want to mention before I turn it back over to the rest of the panel. Those of you employed by life companies may have noticed that many of the companies that used to file the blue blank are migrating over to the orange blank, the health blank. If you were only writing health business, then it certainly makes some sense to do that. Even so, you are still subject to the AOMR because that is based not on what statement you file, but on your corporate form of organization. If you're organized as a life insurer, you still have to do the AOMR because you're subject to the standard valuation law as a life insurer.

There's a technical issue as well involving the AOMR, which specifically references Exhibit 5 of the life blank in indicating the line items that you have to opine on. If you're not filing a life blank, that doesn't make a lot of sense. They are trying to think about a technical fix for that.

I mentioned earlier that the Health Insurance Reserves Model Regulation has been ported into the accounting guidance into what's called Appendix A-010. What's interesting here is what happens if the NAIC makes a change to the Health Insurance Reserves Model Regulation. Let's say, for example, that they were to adopt a new contract reserve standard for long-term care. That would get into the model regulation, and then on the state level, each state would have to go back and decide whether or not to make that change. However, on the NAIC level, it goes directly into the accounting guidance through A-010. This might mean that the NAIC standard for the contract reserve basis may be more up-to-date than what's actually been adopted in your state. In that case, that would generate a permitted accounting practice. You're following your state's statute, but if the state's statute is more old-fashioned than what the NAIC has adopted, then under SSAP 1 you might need to disclose the difference. Using your state's own standard versus using the more modern NAIC standard, if that has a material difference in the reserves that you booked, may need to be quantified and disclosed as a permitted accounting practice.

Again, these are regulatory framework issues that need to be in the back of your minds.

MR. SNOOK: I'm going to have to work from notes on this. As I said, Bob bowed out at the very last minute. I got these notes just three days ago.

I'm going to talk about the actuarial opinion itself that we sign—what it says, what it means in reality and problems that can arise in practice. Then I will look at some case studies. I'll be concentrating on weaknesses, because they're more interesting

to talk about. In our experience, the stuff we've looked at has really done quite well, but I am going to focus on weaknesses.

If there's anything you want to remember from this presentation, it's these three points. First, read. Read what the statement you're signing actually says, read what the ASOPs say, as Rowen talked about, and read what other guidance available says. It's surprising to me sometimes how people will sign something because that's what their job said they have to do, but they haven't actually read it.

Think about what you're signing. Can you really make those statements? Have you done the work to support the statement? Have you documented the work in your files that supports the statement that you're making? We'll give plenty of examples of this as we go along.

Finally, write. Don't just sign the statement as is, as in the recommended NAIC form, if there are issues that need to be mentioned. Write what you actually think. Also, write down (not necessarily in the opinion statement) what you did to support the statement you've made and put that in your files.

But before we even get that far, before you can sign a statement, you have to be qualified to do so. Sometimes people assume that they're qualified to sign an opinion blank just because they've been doing something for a long time. The Academy qualification standards are quite explicit, and they have three components: basic education, experience and continuing education. You need all three. In fact, given the current exam syllabus, recent FSAs often do not meet the basic education criteria defined in qualification standards. Because of that, the Academy is now offering a course to meet those basic education requirements. As far as continuing education is concerned, coming to a session like this certainly helps. Remember also to document your continuing education. That's part of the requirement. If you have not met any one of the three requirements, you should not sign the opinion statement.

I'll talk a little about the items on which we opine. Rowen covered this, so I'll just go through them quickly here. These include: claims unpaid, IBNR, accrued medical incentive, the CAEs, aggregate policy reserves, claims reserves and experience-rated refunds. One thing that's interesting to talk about, where there is some difference of opinion, is, if you're signing the opinion where your client or your employer doesn't have a liability (one of these items), should you include that in your opinion statement? Bob's opinion, and I certainly agree with him, is that, yes, it should be included in the opinion statement with a zero by it. Of course, that requires investigation to determine that a zero is really the right number and that no liability is needed.

Also, for the consultants in the audience, we have come across (from time to time) clients that will tell us that they don't want us to opine on a certain item. They want us to just look at these things, and they'll leave that other thing to somebody else.

Again, in our opinion, that requires a modification to the wording of the statement. The omission cannot be ignored in the wording of your statement. In the statement, one of the things we say is that all actuarial items that ought to be established have been. If you've been told not to look at something, you can't say that, so you have to modify your wording.

Finally, the other thing we opine on is whether there are any actuarial liabilities included in the write-in line. PDRs, for example, are frequently put there. We'll come back to these in a little bit.

Now let's look at what we actually say. There are three things that we say in the statement. One is that the reserves are calculated in accordance with accepted actuarial standards. The second is that the methods and assumptions have been consistently applied. The third is that the liabilities are fairly stated in accordance with sound actuarial principles. Not only do they have to meet standards, they also have to meet principles. They should be consistently applied and fairly stated. Now it's not clear to me how you can meet one of these and not the other, but what we are saying in the opinion is that the liabilities and reserves we are opining on meet all these standards.

"Consistency" here does not mean year-to-year consistency, because we say that later. It's not obvious what is meant by "consistency" here. Bob and I talked about this, and we interpret it to mean consistent application within the various calculations you do to support the liabilities and reserves within the current year's calculation. What does that mean? If you have one cell on the claim reserve calculation where you're using a six-month average factor, and another where you use a 12-month average factor, does that mean you're being inconsistent and have to change your wording? No, I don't think so. As long as that difference is actuarially justified, if there are sound reasons for using a different methodology, then you're not being inconsistent at all.

The second thing we say is that the assumptions are appropriate, that they are consistent with the contract and that they are appropriate for the purpose of the statement. On this last point, speaking here of a statutory statement, actuaries have traditionally taken that to mean that they ought to be conservative. This is what Rowen talked about at the end of his presentation. You think of a best estimate as a 50/50 number—50 percent chance that it's high or low. For a statutory statement, you go back to an old Jack Bragg paper in the *Transactions*. The claim liability estimate for a statutory statement ought to be more. For example, it ought to have a 75 percent chance of sufficiency—a 75/25 rule. It's interesting how this fits in with what Rowen said earlier. That's the rule of thumb that actuaries have traditionally used over the years.

As far as the part about being consistent with the contract, that means things like having your incurral date assignment consistent with the way liabilities are actually

incurred in the contract and making sure the determination provisions are appropriately reflected in the liability calculation.

The next thing we say is that we meet the requirements of the state. Meeting the requirements of the state can be difficult to prove, at least for group insurance, since there's not much typically said in state law or regulation about group health liabilities. This seems to be more geared to life or individual A&H policies that have active life reserves. Bob notes that the newer version of the AOMR, which I guess has been adopted in just a handful of states, also requires that we attest to meeting the laws of the state in which the statement is being filed, not just the state of domicile. If you have a plan in a lot of states, you have some research to do about the laws in those states.

The next topic is the big one—the "good and sufficient" provision for all unpaid claims and other actuarial liabilities. There's a statement coming up later about including all items, but we're actually saying the same thing here. We say it more than once; we say it twice. As far as "good and sufficient," I think we all understand "sufficient." It means that there's enough there. Traditionally it means that there's enough there with a little bit of margin to make sure that even with reasonably adverse deviation there's still enough there.

What if a company is insisting on booking a number that's a best estimate? What if they insist on booking a 50/50 number? We might say that instead of the reserves being sufficient, they are reasonable. We can change the wording if we're not confident in the sufficiency statement.

What does it mean for reserves to be "good"? Historically, for many actuaries, this has meant that the reserves are not too fat—that there's not too much margin in the reserves. If a liability has 25 percent margin, and we think that's way too much, we may not feel that it is a "good" provision. Just drop that word out of the opinion statement and leave it with "sufficient." There is certainly disagreement on that point, including disagreement between Bob and me. Bob thinks fat reserves are fun and should be let alone. I think there are implications in things like earnings (which ties in with what John is going to say) and possibly rate increase filings. There have been some discussions on surplus appropriateness for Blue Cross organizations where that could also have an impact.

I mentioned consistency from year to year before. Here, changes in completion factors or number of months used in the calculation of claim reserves are okay. If you're going to do something like use a loss ratio approach one year and move to a claim development method the next year, you might want to mention that in the statement. It doesn't mean that there's anything wrong with what you've done, but since you're changing methodologies, you might want to disclose that and say it. Typically, if we see a qualification on this part of the statement, it is for one of two reasons. One is if the actuary was not involved in the prior year's calculation and really has no knowledge of how it was done last year; it's tough to say that you did

it the same way if you don't know how it was done last year. The second is if the actuarial item didn't exist the year before; if it's something new, it doesn't make sense to say this.

The sixth thing we say is that all actuarial items that ought to have been established have, in fact, been established. This is also kind of incorporated in the "good and sufficient" statement I mentioned a minute ago. This one requires some research. It requires that the opining actuary have knowledge or the ability to get knowledge about what's going on in the company. Interviewing management, asking about new lines of business and asking about new reinsurance agreements or new types of contracts are all appropriate things you ought to do to make sure you meet this requirement.

Bob notes, interestingly, that he has even asked about things like unfunded deferred compensation arrangements for officers. Some may say that's going a bit far, but that's how far he takes it. Consultants who are on the outside of a company rather than on the inside of a company may not feel confident that they know everything that is going on. They will change the wording to say something like "according to management," and have in the data reliance letter a statement from management that the actuary has been told everything that's relevant.

Let's move on to some practical applications of how this works. We have two fictional hypothetical companies: Shoestring Health Plan and Deep Pockets Mutual. Neither of these are actual clients, but all the characteristics that we're going to outline for the two companies are things we've actually seen in practice, although not all at any one company.

Shoestring has established its own claim liability, and the liability that it has established is below the mid-point of our claim reserve estimate. It's below our mid-point, but within our range. It has added a margin on top of that of 2 percent. It does not separately establish any unpaid CAE liability; it assumes that that's covered in the margin. In reality there's no margin at all, and the 2 percent doesn't even cover that. To top things off, when it calculates its experience-rated refund liability, it is assuming that it's going to recover all its deficits. It's using that to offset its liabilities. Obviously, it's an optimistic management team. For consultants, this is what we call a lawsuit. First you get the insolvency, and then you get the lawsuit. What can you do in this situation other than run away? We'll talk about that in a minute. There are possibly other things you can do.

Let's set up the other company. Deep Pockets Mutual is booking a UCL liability above the high end of our range, to which it has appended a 20 percent margin. Its LAE reserve is very adequately funded at 10 percent. Deep Pockets Mutual holds a conservative PDR on its individual business because it is assuming no rate increases on its individual business. It is holding an unearned premium reserve of 50 percent of a month's premium on all its business, including on its group business, even though 90 percent or more of groups pay on the first of the month. This may seem

silly, but we've actually seen companies want to hold this type of unearned premium reserve on group business where everybody is paying on the first of the month. Finally, they are also booking a liability for deferred compensation for officers, so they're pretty conservative.

Here are some remedies. These are obviously two very extreme cases, one on either end. But as I said, elements of these extremes come up all the time. What can you do? One thing you can do is issue a qualified opinion. Just say what you think is true in your opinion statement, and let the regulator decide what to do about it.

In the Shoestring case, you could write a paragraph, right before the opinion statement, that lays out the facts we just discussed. Then in the lead to the opinion, you say, "Except for the matters mentioned in the previous paragraph, in my opinion, etc." That would work in probably a less extreme case. For the case of Shoestring, as we laid it out, it wouldn't work because it would be like saying, "Reserves are not adequate, but except for that, the reserves are good and sufficient."

What are your options? You have two options. One is to educate management. Maybe they just don't understand and would be willing to book a reasonable reserve. The second option is that you walk away. You don't sign the opinion sheet. You know I say that and it's easy to say that, but that's not something I take lightly. If you're a consultant and you don't sign an opinion, it means you lose a client. If you're an employee, it means you probably lose your job. That's not a happy circumstance. Qualifications don't work in the case of Shoestring, but in less extreme cases they can.

As I mentioned before, we'll sometimes replace the words "good and sufficient" with "reasonable" if we feel the liability estimates are more like best estimates. However, we would not use "reasonable" if the number book was below the mid-point of our range.

Look at Deep Pockets, which is certainly a better problem to have. There are concerns, as I mentioned earlier, about earnings implications and regulatory concern about hiding some money. We may not be able to say "good and sufficient;" we may just say "sufficient." We're professionals. It's our name going on the bottom of the opinion statement, so it's in our judgment to decide whether we want to say it's "good and sufficient" or not.

There are four other caveats that we at Milliman will use from time to time and that may be of interest to discuss.

One relates to ASOP 16 and specifically the provision in ASOP 16 about capitated entities. ASOP 16 says that the actuary, at a minimum, should disclose how much he or she knows about the financial status of the entities being capitated. The risk

here is, of course, if you capitate a provider group, and if the provider group goes broke, you may be on the hook for paying some claims that you thought you had covered in the capitation. If that seems like a likely scenario, you need to set up the liability for those claims. We will typically add a caveat to our opinion. The problem there is that typically it's difficult for the actuary to know the financial status of the capitated entity. You may know how that group is doing under your contract, but they may have multiple contracts. These things aren't generally publicly traded; their financial statements aren't readily available. It's difficult to know. Typically we'll put it in as a disclosure that we do not know that there are capitated entities and that we do not know their financial status.

We also put a data reliance statement explicitly in the opinion letter that goes beyond the NAIC wording. We go into more depth. We talk about how if the data is wrong then our numbers are wrong. We will say that explicitly. Even in situations where an asset adequacy analysis is not required, we'll put in the caveat that says, "We have not looked at the assets. We have assumed that the assets that back the liabilities are okay." Then we'll put in a variability caveat about how there are a lot of projections and estimates, and actual results will vary from those estimates.

This is the part Bob wanted you all to take home. Read what you are signing. Read all the appropriate standards. Read the other stuff that's important to read. Think. When you sign that statement, you're making a professional commitment. That's your name at the bottom. Think about what you are committing to and whether or not it's actually true. Write appropriate qualifications or caveats, write what you think and document the thinking that supports your conclusions in your file.

MR. JOHN F. FRITZ: I'm going to take a little different direction than our first two speakers. Because I'm part of a for-profit health plan, I thought I would take that perspective and talk more on the GAAP side of things. I'd like to discuss how the actuarial opinion or certifications—the numbers that we opine to—end up being used and how they are being perceived by the investment community.

First of all, I'm going to talk about some of the things we've recently done where we've changed as an industry with respect to disclosures and about the processes that we now use as a result of those disclosure changes. Some of those changes have been self-imposed because of a desire to be better documented and have more information available in case of audits or other reasons why we're being questioned in terms of our estimates.

Some of these changes have resulted because of the confusion that seems to be out in the investment community. When all this first started, some of the health plans actually were giving training sessions in conference calls to investment analysts about IBNRs. I heard some of the questions that were coming up. I kept thinking: What's the big deal? In three months we'll know the answer. It has been interesting, and then the investment analysts use their own benchmarks in terms of analyzing the numbers that we come up with. At the same time, the SEC has sent

out letters to many health plans, including ours, asking for certain modifications in terms of our disclosure and what we present, not only as part of the 10-Qs and 10-Ks, but also in terms of the press releases that we may be putting out.

Then I want to touch on how consistent we are as an industry from one company to the other, in terms of these disclosures. Obviously consistency is important if analysts are going to compare one company to the other.

First of all, I'm going to discuss our own company's reaction to Sarbanes-Oxley. As you know, the Enron situation and WorldCom have kind of spooked everybody—the investment analysts as well as investors—on what a company's financial statement really means. As a result, we have Sarbanes-Oxley and other things like that. We and our auditors got together and started to do some things on our own to strengthen our own internal processes. We have a much more formalized IBNR process; we have an extremely detailed flow chart that follows that entire process that can be followed by someone who may not even know what IBNR is all about. We have a lot of detailed descriptions and other documentation, including a signoff checklist. We have analysts sign their own checklists. It kind of goes up the line until, ultimately, I sign each of the checklists to make sure that everything has been done along the way and we've touched all the bases. Then we have a "what can go wrong" list. In that "what can go wrong" list, we talk about what to do when it does happen, who's responsible for fixing it and so on. A great deal of documentation has resulted on our end.

As far as the analyst confusion, some of this has been touched on already by Rowen. There has been a lot of confusion about the IBNR, as well as a recent S&P criticism of P&C actuaries. It came out in November 2003. Part of the statement was this: "Actuaries are signing off on reserves that turn out to be wildly inaccurate. It's an abysmal track record. Whether by naiveté or knavery, the property and casualty industry's ongoing parade of reserving additions has undermined confidence in the estimates given by insurance actuaries." Those are strong words. That's just part of the environment that we're in. People do not trust the numbers, and they want to find a way to be able to determine what is "good and sufficient." How good is "good"? How high can you go with the reserves? How conservative can you be? Are you playing with those numbers and thus affecting what's shown on the income statement?

Rowen talked about the best estimate and the controversy between the various actuarial practices. The P&C actuaries use the term "reasonable provision," which is really like a 50/50 estimate—50 percent probability of being adequate, no particular margins above that unless maybe part of the discount factor that they use to discount this long-term liability may be at a conservative interest rate. On the other hand, in our opinions we say "make good and sufficient provision." As Rowen said, that usually means some kind of an explicit margin. On the other hand, life actuaries say, "make adequate provision," and then talk about the assets underlying this and all that. We're adding to that confusion by having different

terminology, and it's incumbent on us to explain that and why it is that we deal with it in different ways.

How much conservatism is appropriate? People can be all over the map. Obviously the 20 percent example that Tom had up here is certainly adequate, or should be, if you've done a good job in the actual estimate. But it's probably too large, especially if you're a for-profit entity. It may be misstating, and you may be understating earnings as a result, especially if you change the percentage along the way. That's one of the things that the analysts are trying to make sure doesn't happen with the benchmarks that they use to try to analyze our numbers.

The analysts have come up with one benchmark, and I'm not exactly sure when they started using that: a days claims payable benchmark or metric. I'm going to talk about that in a little bit and show the inconsistency that we put out there, which then causes this benchmark to maybe not mean that much, especially when you compare one company to another.

One of the SEC requirements is new, at least to us. Some companies had been using a three-year roll-forward in their 10-K. We did not. We were asked by the SEC to do something similar to that, so we did. In our case, we decided to use the IBNR as part of the roll-forward. Some companies use medical claims and benefits payable (MCBP). Later I'll list, in our case, what's in MCBP. Other companies may have other lines of business, and there would be other liability items in that same category. In our case, we look at hindsight and we determine how accurate or how good our estimate was in the prior quarter or prior year-end and so on. So we thought that should be part of the roll-forward. Then I'll go through a quickie illustration of how the roll-forward works and how that gives some information to Wall Street.

The SEC also asked (I'm surprised that they had to ask this because I would have assumed that most health plans would do this as a matter of course), if there is a significant revision to a prior period MCBP liability, that you'd disclose why it changed. If it's a material change you should explain those kinds of things routinely. One or two of the health plans have started to give an indication of the sensitivity of some of the key assumptions in coming up with their IBNR estimates. I know WellPoint was one that had been doing that. Basically it involves taking the trend factors that are used to project the most recent months for the IBNR purposes, and it projects the most recent incurred claim numbers. It also considers the completion factors themselves. You can make a statement or show a table that indicates that if you change those assumptions by 1, 2 or 3 percent, what the impact on reserves would be, giving the investment analysts an idea of how sensitive that estimate is, and what that impact could be on the income statement.

Here's the roll-forward. We start with the IBNR at the beginning of the year; we subtract out two components of the incurred claims for the period. The period is a year. So the amount applies to the current year, as well as the amount that may

apply to the prior year. That prior year's number is an indication of how sufficient or how adequate the explicit margin was. If that number is almost right on track with your explicit margin, then that probably indicates that your estimate was a pretty good one last year-end, in terms of having an explicit margin. If it ends up being much greater, then you had a lot of conservatism. If it ends up being negative, that means that the margin that you put up was not adequate. Then subtract health-care claim payments for current year service dates as well as prior year service dates, and the ending number should be the reserve at the end of the year. That's basically the formula. We can compare things from one company to the other, as long as we have consistency.

I want to first of all define what in our case is in the MCBP. Obviously, there is the IBNR. For us that's the largest piece; it's 80 percent or more of the total MCBP liability. There's the provider withhold pool, a provider incentive pool, capitation expense payable, provider insolvency reserves and litigation reserves. Then there's the miscellaneous category of small items. That's what's in our line item.

I want to move to talking about a task force that I'm a part of within the Society of Actuaries. Last year, during the Health Chief Actuaries Forum, we had a similar kind of discussion. In fact, we had an investment analyst at the session who spoke about how the investment analysts look at us. Toward the end of the meeting, we looked at ourselves and said, "Gosh, maybe we ought to get some more guidance out there and educate Wall Street a little bit more than we have. If we don't do it, somebody else is going to it for us and maybe we'll end up with the property and casualty standards, as opposed to the ones we want." That's what this work group or task force is working on, and hopefully we're going to get a white paper out sometime later this year. One of the reasons for me bringing it up is to make you aware of that, and also, to encourage you to participate in the process. When you do receive this white paper in draft form, read it and give us your input, so that we can take all those things into consideration as we finalize it before we make it publicly available.

As part of preparing for this paper, we thought we would need to see where we're starting from. We sent out a survey to a number of companies and received answers from about 43 companies. I have to tell you that this is preliminary; these numbers may change. However, I think the direction is important to what I'm going to say here, because there's clarification needed to some of the answers that we got and not all of that scrubbing has been done. Don't take these to the bank as the final numbers.

Of the 43 companies that sent us replies, not all of them had either lines of business or categories of liability that applied to them. When I list these percentages (Chart 1), it's only for those entities for which that particular line actually applied. If 10 companies were not even in medical and dental at all and were LTD carriers, they would not be in this number. Otherwise, we wouldn't have 100 percent, because they obviously don't have that line item. I pick these

categories and I'm saying, "Well, these are more or less consistent." But, as you can see, the percentage gets pretty low. As you'd expect, for medical and dental claims payable, mostly the IBNR, 100 percent of the companies that have that line item report that as part of MCBP. For pharmacy, for some reason, only 97 percent have it. Only 84 percent of them included explicit margin. Seventy-nine percent included extended benefit reserves. Sixty-five percent included provider disputes or incentives, and 63 percent included COB recoveries.

Other categories are even more inconsistent. Life reserves, including waiver of premium, are not in there as a liability for 62 percent of the entities that had this as a line of business. Disability, including disabled life, was 55 percent. Forty-three percent had LAE or CAE in, and so on down the line. You can see the inconsistency of what we're reporting just in the one item, MCBP. Now MCBP is used as the numerator for days claims payable that the analysts use to then try to figure out if companies are playing around with their liabilities.

Here is the formula for MCBP. The denominator is average claims paid per day. It sounds pretty straightforward. We had a question that also said, "Okay, so now we know the inconsistencies of MCBP. Let's look at the inconsistencies in health-care claim costs." The numerator and denominator pieces are not necessarily consistent with each other. I'll pick a really obvious one, which I don't think ever happened. If somebody had MCBP and they included that in the numerator, but didn't have it in the denominator, that would really be extreme. It was smaller items, but that's the point. If it's in the numerator, you probably ought to have it in the denominator to calculate that denominator that's going to divide into the numerator, and that wasn't consistent.

Seventy-four percent of the companies used the ending MCBP as the basis for the calculations; 21 percent used the average; and 5 percent must have used something else. For the definition of days, 79 percent used actual calendar days, including weekends and holidays. That means the other 21 percent either used number of working days or an assumption of 30 days per month. There's a lot of inconsistency.

We're putting out these numbers. Analysts are looking at us and making judgments. The stock goes up and down based on this analysis. How can you compare one company to the other when you have so much inconsistency? We are providing more disclosure. Obviously, there's a lot of inconsistency. Maybe the analyst's confusion is warranted here, and we need to provide that clarification. Hopefully the white paper gets us on the right road, so look for it. We ask for your support on it.

MR. JOHN W. C. STARK: One of the things we've seen in explicit margin is that at the beginning of the year, everything is fine, but by the fall comes the message from above, "Oh, we don't have enough money." If you have too much margin in the reserves, you can be responsible for job cuts and all kinds of things that will

weaken the company. That's just a real practical matter that we try to keep aware of.

The other thing you talked about was asset adequacy. I had to fill out one for a health company this year. First of all, I didn't take it very seriously because it didn't make sense. Then I had it shot back to me and I had to fill it out some more. It's a very strange process for a health company, and part of it is because that's not the way we run a company. I have never heard anybody in our company in all the time I've been there say, "Oh, interest rates fell. Oh, woe is me." It's trend and things like that.

In Virginia we fill out the blue blank, and there was a change in the regulations that required this. That's just something to think about in your states. I don't know if anybody is doing it. But if anybody tries it, fight it all you can.

FROM THE FLOOR: I'd like to ask a question about the actuarial opinion and the wording modifications that you were discussing. I've never been exactly sure who reads all the opinions that we send with these financial statements. I wonder if you can comment on any reactions you had to opinions that you've written where your wording deviated significantly from whatever form has been prescribed and how you dealt with those reactions.

MR. SNOOK: That's a good question, because Bob and I talked about that when we talked on the phone on Monday. Sometimes it seems like opinion statements don't even get read, or maybe they get a cursory review. Bob and I both experienced where we've had what seemed to us material qualifications in our opinion statement, and nothing ever came of it. That's certainly not always the case, but let's call that one extreme of a possible reaction.

The other extreme of the possible reaction is where a regulator has come back and said, "Take that out of your opinion statement." At that point, it almost gets into a negotiation process where we'll sit down and try to first educate the regulator why it's in there. If the regulator has a good point or if it's something we can live with taking out, like a caveat, we will. There's a wide variety.

MR. BELL: I can provide a slightly different perspective on that. I'm not a regulator and have never been one. However, at the Blue Cross/Blue Shield Association, until a couple of years ago, we used to require that all of the Blue plans provide us with an actuarial opinion every year. We did actually go through the exercise of reading those opinions and expressing concerns over the wording. The main thing we were concerned about was "good and sufficient provision." If the actuary deviated from that language and said "reasonable provision," that was very much a red flag from our standpoint. The reason why we were requiring the opinion was to make sure that the reserves were truly adequate and in line with the standards that the NAIC would require from a company filing the health statement.

We also were concerned about making sure that the amounts the actuary was opining on were actually the same as the amounts that were in the statement. It kind of goes back to my comments on geography earlier. I've seen a lot of actuarial opinions where the numbers in the actuarial opinion are different than those that are in the statement. The valuation actuary was opining on the numbers that he sent to finance, and then what actually got into the blank may have been different because of some of the issues I was talking about before. Whether the regulatory actually was reading the opinion and made the same catch we did, I have no idea.

MR. SNOOK: That has actually happened to me as well, where I opine on a set of numbers that I worked on and developed with the client. We always require that we get a copy of the statement blank, and that's part of our work program. We check the numbers that were booked against the reserve statement, and there have been differences.

MR. ANTHONY J. WITTMANN: When you change the wording or issue a qualified opinion, do you bold it or put something in the heading so it would actually trigger a review, or do you just send it in?

MR. SNOOK: I have not.

FROM THE FLOOR: It seems to me that years ago there used to be some standard that if you issued a qualified opinion, you had to have it bolded or issued in the heading of it. Does anybody recall that at all? It's not common for a qualified opinion that you would actually make it apparent to the regulator.

MR. SNOOK: I don't do that, and I don't think at Milliman we tend to do that.

MR. FRITZ: I think they usually get read at least at the triennial exam.

FROM THE FLOOR: Are there any universal standards for when a PDR would be required, outside of maybe a jumbo group with a multiple-year rate guarantee? I don't think it's any clearer now than it was 10 years ago.

MR. SNOOK: In its regulations, Texas has specific requirements. This is what you need to book, this is what's required, and this is how you do it. That's the only state I'm aware of, but there could be others.

FROM THE FLOOR: Colorado.

MR. BELL: That's a good point about the Texas standard, but from the NAIC standpoint it is very much an actuarial professional judgment issue. There's guidance in the *Health Reserves Guidance Manual*, and there's now ASOP 42 to look at, but I know actuaries have tremendous differences of opinion as to whether a PDR is needed in certain circumstances.

There is an Academy project that is going to get under way very shortly. As Tom mentioned earlier, I'm vice chair of the Academy's Health Practice Financial Reporting Committee, and we're putting together a work group to develop and flush out a number of examples on PDR situations. The NAIC's Accident and Health Working Group is trying to muddle through these issues, and they'd like some examples. If there are any actuaries in the audience that would have an interest in working on that project, I'd appreciate if you would come up and talk to me afterward.

MR. SNOOK: The other issue on PDRs is that while this is in the standard, often the auditors will say, "This is how we would like to see it done."

FROM THE FLOOR: You mentioned in your Deep Pockets Mutual example a PDR on the individual lines, which I don't think is common practice. Is it more common than I think it is?

MR. SNOOK: I don't want to speak on how common it is. But when I do that, I include it as a block.

FROM THE FLOOR: That would be like a closed product type of thing?

MR. SNOOK: Yes. I'm not projecting new issues when I calculate a PDR, so it would be like a closed book.

MR. BELL: The whole grouping issue for PDR practices varies quite widely.

MR. MARTIN E. STAEHLIN: I will present an alternative opinion. John Fritz said something about inconsistencies and filling the statement out, and point "E" that you say is computed on the same basis as last year. Since I work for an accounting firm, they are more interested in that one. They want to make sure that it was consistent with last year-end. I don't agree with putting all the zeroes down on what you opine, because often there are nonactuarial liabilities, and you just have to make sure everything is covered. Putting a whole long list with a lot of zeroes might require more coordination with accountants as you're doing the liabilities. It also requires you to say that each one of those you listed is the same as it was last year, which is a lot more research than probably is necessary.

MR. FRITZ: On the zeroes we see a whole long list, but it doesn't have to be such a long list if one were to confine that to the obvious actuarial items, the five or six I listed. Are you saying then, if, for example, my client doesn't have any policy reserves, that we should just exclude them?

MR. STAEHLIN: What I'm saying is you might get whatever is—page one, page two or page three so you can do your work— and one year two items are filled out, and the next year eight are filled out. To me, one year, one annual statement has two filled out, and the other one has zero. You know the eight are filled out now.

You've done your research to say why the six weren't there last year, but I don't think you need to heighten that by putting the whole long list in both statements. The point is that it's generally consistent with last year, and if a zero was appropriate it's the point of insignificant. Yes, if something significant was added you should do something to verify that, but I don't think it needs to be heightened in the statement of actuarial opinion. If they got into a new line of business and all of a sudden had policy reserves, and never had policy reserves before, I think you put that in your internal documentation, but you don't write it in the statement of actuarial opinion. Or they start a new line of business, so they have policy reserves. That's the way I feel.

MR. BELL: I would think the area you need to be particularly concerned about here is policy reserves. As I said, the place where premium deficiencies are generally put in the health blank rolls up into the line on page three that includes policy reserves. Say you're dealing with a company that only writes group medical coverages and would not normally have policy reserves; that line would normally be zero unless there were a PDR situation. Let's say it has always been zero in the past. If you just ignore it, then the actuary may not have investigated the reasonableness for PDRs, but yet that investigation is something that's probably an important aspect of the opinion.

MR. FRITZ: I will agree on the PDRs, because the practice is not consistent. If PDRs appear and disappear and reappear, some comment needs to be made.

Chart 1