RECORD, Volume 31 No. 2*

New Orleans Health/Pension Spring Meeting
June 15–June 17, 2005

Session 62PD
Valuation Issues Update

Track: Health

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Summary: Panelists discuss recent critical issues regarding valuation processes for health plan liabilities. Topics may include deficiency reserves, RBC levels and capital planning, rate increase models and their effect on valuation analysis, gross premium valuation techniques, statements of actuarial opinion—differences for various statement types and reserving techniques for self-funded plans.

MR. JAMES T. O'CONNOR: I'll tell you about our panel members. Mark Yoest works for Deloitte out of its Chicago office. He's been there for four years and has been active in working on Sarbanes-Oxley (SOX) projects for a number of large insurance companies. He will talk to you today about some of the SOX considerations that he has seen in the area of health insurance. Laurel Kastrup will be our second speaker. Laurel is an actuary with KPMG in its Dallas office. She is the manager in the health practice where her clients are insurance companies in health plans. She's been with KPMG for six years. Our third speaker, John Heins, is an actuary with PolySystems. He's been there for seven years and has been involved in health valuation for at least 15 years. John is going to talk to us about internal replacement Standards of Practice (SOP) and long-term-care developments. I'm with Milliman in our Chicago office. I've been there for about 16 years. Before that, I worked at an insurance company. I have a lot of exposure to valuation issues. With those introductions, we'll start with Mark to talk about SOX.

Note: The chart(s) referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/neworleans-june05/062_combined.pdf.

MR. MARK YOEST: I'll tell you a little more about my background. My experience has been more on the audit side, although a lot of the audit firms are involved in consulting insurance companies on how to properly establish a set of Sarbanes controls. I'm going to talk from this perspective of somebody who has audited insurance companies and has taken part in the Sarbanes audit. I'll go through the key points of Section 404 of Sarbanes and give you some tips on being prepared for your Sarbanes audit.

Here's a brief introduction to the Act. Sarbanes was drafted in 2002, presumably as a reaction to some major accounting scandals, such as the Enrons, Sunbeams and WorldComs. The point of Sarbanes, as you can see, was a keyword. It was drafted to protect investors by improving the accuracy and reliability of corporate disclosures. The major points of Sarbanes are as follows: Section 302 is the section that requires an attestation by management of the control environment. Section 404, which is the meat of this presentation, requires that companies make an assessment of their internal control environment, identify GAAPs and constantly remediate. Section 409 addresses the need for companies to be current on their control environment. Section 802, another big one, talks about retention and protection of audit documents.

How many people here work for insurance companies? Of those people, how many of you work for SEC-registered companies? Non-SEC registrants? Yoest Slide 5 is intended for all the people who just had their hands up. The Sarbanes, you might think, can ignore my presentation, but we've done a few things. First of all, the NAIC is helping out by maybe making your life a lot more difficult by considering incorporating key points of Sarbanes Section 404 into the NAIC model audit regulation.

As a matter of fact, this week, the NAIC was meeting in Boston. Maybe some of you are watching this closely, and maybe some of you aren't, but the powers that be of the NAIC met some serious opposition from people acting through the National Association of Mutual Insurance Companies, who are fighting tooth and nail the incorporation of these provisions into the NAIC model audit rule. Effectively, they argue that the costs do not justify the benefits. Furthermore, 5 percent of all insurance companies in solvency since 1991 have been for mutual companies. There's not necessarily a huge insolvency risk among mutual companies. Finally, they're also arguing that the Sarbanes was drafted to protect investors, of which there are none in mutual companies.

This slide is a little bit dated. We had to submit data about two months ago, and I think the fight is a little more intense. We had a bullet point that said the finalized regulation was expected by year end, and maybe that's not the case. The NAIC will reconvene in August in Philadelphia to discuss this, but it seems like it has been moving along a bit.

In terms of whom it applies to, it does apply to all insurance companies with direct

and written premiums of $25 million or more, and again, the bulk of what we'll be incorporating are these assessments of internal controls. Adoption by states was considered likely as the audit rule regulation is required for a state to be eligible for NAIC accreditation.

Going into the big section of Sarbanes, the one that I think scares everybody the most is Section 404. Here are some highlights. The key point is that management must accept responsibility for the effectiveness of its internal controls over financial reporting. It's up to management to evaluate the effectiveness of the controls, support the evaluation with sufficient evidence, present a written assessment that it believes the control environment to be effective and then state that its auditor also concurs with that assessment.

Auditors are required to assess the management's assessment, and we're also supposed to make an independent assessment of the internal control environment.

For all of you SEC-registered company actuaries, I think a lot of you probably have already gone through this in the first year because for all financial institutions for fiscal years ending subsequent to November 15, you already had to make an assessment. For smaller companies with less than $25 million market capitalization, your day is coming. Your next year end subsequent to July 15, you will have to have gone through this whole process.

The ultimate goal of Sarbanes Section 404 is to make the following statement (see Yoest Slide 9). A lot of my slides are going to be relatively wordy, and I think it's with the fact that a lot of you will take this home with you and maybe read it. I won't belabor the point and read the entire thing. If you look at the bold words, that's the key to this statement. First of all, the management has to state its responsibility for maintaining adequate internal controls. The next big statement is that management assessed the controls as of a certain date. Management believes that the company maintains effective controls. Finally, the public accounting firm that audited your company has issued an attestation report on management's assessment of controls.

Yoest Slide 10 is pulled straight off of the Public Company Accounting Oversight Board's (PCAOB's) Web site, which gives its official definition of an internal control. I'll let you read that at home.

In summary, internal control is the process by which an entity manages risk. Sarbanes is particularly concerned with those controls relating to an entity's financial reporting process. While a company may have a series of controls in place to ensure it's profitable or that its legal liability is reduced and things like that, those are potentially out of the scope of Sarbanes, which is a more financial reporting-focused act.

There are essentially two types of controls. The preventive controls prevent the

occurrence of a negative event in a proactive manner. Detective controls are reactive.

We have a simple example that I took from an internal Deloitte presentation. I thought it was too basic, but you'll see.

In this example, we have a wildlife preserve that contains 200 extremely rare deer. To safeguard the deer, there's a fence surrounding them. However sometimes animals escape, so the wardens patrol the edge of the park to ensure that the fence is intact and to recapture any escaped deer. That nice little picture for you in Yoest Slide 14 represents the situation. In this case, both the fence and the wardens are considered controls over the situation. The fence would be a preventive control. It may not always be effective because the fence may fall down, or maybe the deer eat through the wood. A detective control, which would be the wardens, is necessary. If there were no fence, the wardens couldn't recapture all the deer left in the park.

Neither control independent of itself is necessarily an effective control, but the combination of the controls is effective. That illuminates the point that there's not one control for every single process. Usually it's set of controls that effectively mitigate against certain process risks. Another example might be the level of controls necessary to mitigate a risk. If instead of storing rare deer we instead had giraffes, the wardens might be a little more effective with a fence that they could step right over. It wouldn't be as necessary. Conversely, if we had hundreds of thousands of little bunny rabbits, those wardens wouldn't be useful because it's tough to spot all the bunny rabbits.

It's time for some real-world examples that apply to health actuaries. In the category of preventive controls, there are physical controls. An example of a physical control might be checking the totals between a valuation system and an administrative system or a claims system. In other words, if, for example, you are a disability insurer, and you're calculating a disabled life reserve, and you know that as of the evaluation date, you had 110,000 open claims, you want to make sure that the number of records that get passed to your valuation system is equal to 110,000, and you want to verify that the output of the valuation system is 110,000. That would be an example of a physical control. That example would apply to both information processing and physical controls.

A good example of segregation of duties might be when you're producing GAAP deferred acquisition costs (DAC). You're calculating your DAC, and the valuation area relies on the pricing area to provide certain assumptions in the DAC calculation. There might be some collaboration between valuation area and the pricing area to discuss what the appropriate assumption is.

In terms of application security, there might be an example where once a reserve is calculated, there's only one person within the valuation organization who has the

rights to upgrade the reserve balance to a general ledger status. Finally, there might be application software, embedded checks and validations. John, I don't know whether PolySystems has any controls that maybe parameterize what a valid interest rate is, but for your discount rate on a disabled life reserve calculation, if you try to input -0.05, it might make sure that it's a positive number, or if the interest rate you input is more than 100, it might say it should be between 0 and 100 or something like that. That would be an example.

An example of detective controls is direct function reviews. If the function here is maybe the calculation of an active life reserve or of a medical claims incurred but not reported (IBNR), it might be the recalculation of the reserve by a second party. If it's a disabled life reserve calculation on disability policies, it might be pulling a sample from your 110,000 records that just got run through your valuation system and calculating the reserves in the spreadsheet. Another detective control example is a top-level review. This might be evaluating trends of reserves over time.

Controls can be automated or manual. An automated control is built into the network infrastructure and software applications. Usually, it relates to protecting who can touch the numbers by passwords; having data validation checks, which I just addressed; and having some controls for automated batch processing. Manual controls, obviously, require action to be taken by employees: verifying that reserve adjustments feed financial systems or validating that a certain column from a claim triangle in a medical IBNR calculation ties to the total of claim checks that were cut by your claims department.

This is a bad result from a Sarbanes audit, but it's not the worst. Significant deficiency refers to an internal control deficiency that adversely affects the company's ability to initiate, record, process or report external financial data. A significant deficiency could be a single deficiency, or it could be a set of deficiencies, the sum of which results in more than a remote likelihood that a misstatement of the annual or interim financial statements that is more than inconsequential in amount will not be prevented or detected. The key phrase, to make a distinction between significant deficiency and our next term, material weakness, is that the case of a significant deficiency is more than inconsequential.

The material weakness is a subset of all significant deficiencies, and these are the ones that result in a preclusion of management or the auditor from concluding that the internal control over financial reporting is effective. In a material weakness, it's a significant deficiency where the key is that it results in more than a remote likelihood that material misstatement of the annual or interim financial statements will not be prevented or detected.

A material misstatement is probably the amount that needs to be quantified at the onset of your Sarbanes project. Usually it's a function of surplus at your company.

The last two concepts we're going to talk about are key controls. At some point

during the course of preparing for your Sarbanes audit, you'll look at all your processes. Within all your processes, there are going to be controls, some of which are going to be key and some of which are going to be nonkey. A key control is a control that could lead directly to a material weakness if it were to fail.

Going back to our deer example, we have a wildlife preserve that contains deer, and the number of deer in our wildlife preserve is material to our financial statements. In this case, we have two controls. One is a fence to prevent the deer from escaping, and the other is a head count of the deer at the end of each accounting cycle. Are either of these controls key or both? The head count is the key control. The fence is not itself a key control. Remember that Sarbanes is related to the controls around accurate financial reporting. Take, for example, a scenario analysis where the fence fails. A few animals escaped during the month, but the head count is effective. The number of deer reported would still be correct, even though the control failed. The monthly head count is a key control. However, if the fence fails, we can still count the deer, so that doesn't result in a misstatement. It's a negative impact on the earnings of the wildlife preserve, but it won't result in a material misstatement.

The last section of my presentation is a little outline of how to prepare for your Sarbanes audit. The first step is to scope out and plan your audit. You'd set timelines and understand who the responsible parties will be, etc. The next step is to assess and define where you're going to put your focus during the course of the Sarbanes audit. You would identify which accounts you deem material, which processes are material, and which controls within those processes are key versus those that are nonkey.

The next step is to identify and document, in which case you create process flow charts and narratives. That's common from what I've seen. One of the benefits of Sarbanes is this documentation process forces you to consider your process and assess any gaps there may be in your set of controls.

The last bullet point within the identifying document section says that inadequate documentation equals deficient internal controls. This is an important step, and your auditors will probably be hounding you for adequate documentation.

The next step is to test and remediate all your processes and controls. It starts by performing initial tests of effectiveness. Are the controls operating as documented? Typically, a part of this step is going through a walk-through. The walk-through is when there is a tester who sits with the person running the process and starts from A and goes all the way through to Z and assesses whether or not all the right controls are in place and whether or not the process as documented is consistent with what the tester has witnessed during the walk-through. The tester then identifies any spots where there might be a gap in controls and whether new controls were needed.
Subsequent to or during the process of this testing and remediation, it's a point

where gaps are identified, like I said. It's time to implement those new controls and perhaps go through many iterations of the walk-through.

Finally, the last step is to monitor, certify and assert, and this is the point where the CFO or CEO gets buy-in and understands the control environment. It finally concludes on the testing, and the independent auditor gets involved and reviews management's assertion.

MS. LAUREL A. KASTRUP: I'm going to speak on reserving for self-funded plans.

The first question is: What are we talking about today? A self-funded plan would be where an employer has decided to fund the benefits for health insurance on its own instead of buying insurance and paying premiums. Typically it would get a stop-loss cover to protect it from catastrophic losses. The reason to use one is you're more in control. That's our first topic. We're also going to talk about how GAAP valuation works and about actuarial involvement.

Why use a self-funded plan? The employer maintains control of the funds to pay the benefits. It's responsible for setting up the reserve, so it can choose how to invest the money itself. It doesn't give the money away to an insurance company.

Self-funded plans are usually group medical. Other benefits such as dental, vision or prescription drugs can also be covered under self-funded plans. Usually TPAs administer the benefits for companies since they're not insurance companies. They're not in the business of paying claims and dealing with claimants. The data usually come from the TPAs, which is both good and bad. The TPAs are good at organizing the data. However, the employers sometimes have to wait awhile before they get their data back, and there are some lags in that.

The basic advantages are that the funds eliminate state-mandated benefits, premium tax and the insurance carrier's profit margin, and the companies can have their own claim experience, which is good when it's good, and when it's bad, they hope they have the stop-loss cover in place.

Under a GAAP valuation, self-insured plans are covered under FASB Statement 5, "Accounting for Contingencies," which says a liability should be established for any unpaid claims that are probable and reasonably estimable. FASB 5 is old. There's nothing more recent than that. The reserve should be for the gross liability, and amounts receivable under reinsurance contracts such as the stop-loss cover would not be noted against the liability. They'd be handled separately in recovery.

On the GAAP side, a new concern has come up, partially that the PCAOB will be the company accounting oversight board that we talked about earlier, so it expects that companies have adequate processes and controls for underlying claims data and that auditors will perform sufficient tests of the data, processes, controls and loss accruals. For some SEC-registered companies, this might mean that your self-

funded plan is now part of your SOX 404 scope, which is not something that a lot of people intended in the past. On the audit side, usually before SOX 404, the self-funded plan was possibly even not part of the audit scope, which has changed in the post-SOX world. This year I think I've looked at triple the number of self-funded plans than I used to look at.

The other thing that comes up is actuarial involvement. Actuaries would be involved in the valuation of these plans, especially where the liability is significant. We've looked at Actuarial Standard of Practice (ASOP) 5, "Incurred Health & Disability Claims," and the newer one, 42, "Determining Health & Disability Liabilities Other Than Liabilities for Incurred Claims," which will cover things such as loss-adjustment expense (LAE).

Actuarial models and techniques would be used to do the unpaid claims and the claim adjustment expense. Claim development methods are most commonly used to estimate the unpaid claim liability. Typically we're using historical lag factors and per month per member (PMPM) or loss ratios for the most recent months.

Margin may or may not be added. This is a Pandora's Box. GAAP accounting based on that old FASB I just quoted requires a best estimate. The question has come up: Does best estimate under GAAP include or not include margin? That's another discussion that would take more time than we have. It depends on what the stance is on that. The Health Practice Financial Reporting Committee is coming up with a white paper on that and is working in hand with other actuarial bodies.

The issue comes up with small plans. The unfortunate thing with small plans is many of those don't have any actuarial involvement in the reserving. As actuaries, we're going to say, "How did you do your reserves without an actuary?" But there are plenty of them out there that are doing that. The good news is that our experience has shown that the small plans tend to err on the side of conservativism. Perhaps that's to offset the fact that they didn't have an actuary come up with it, so they put what they thought was good and then added some more just because. If it's a small plan that's part of someone who is filing DAC, though, that comes back to now it had even more margin than just best estimate. It went above and beyond that.

I'm an advocate of hindsight testing. I think that's the best way to judge the adequacy of the reserves, especially when you see these other methods that some people have come up with that are not the development method or the loss-ratio method. I've seen some creative ones. In hindsight, testing will tell you if that's working or not.

The biggest issue with these self-funded plans is they tend to have a lot of changes in benefit design, or they tend to change TPAs frequently. They're not as stable as insurance company reserves or health plan reserves. The biggest issue when looking at the valuation is to be mindful of changes in the benefit design and TPA

changes, which further adds to the trouble with getting data. If you had one TPA and switch to another TPA, I've seen a case where the first TPA won't give you the data without charging a fee. You come up to things like that.

A lot of the small plans that aren't using actuaries are often using things like X months in reserves. They may hold three months of paid claims as their reserve, and you can always go back to the hindsight testing when you get the full data and validate this. In some cases, it is a reasonable reserve that falls within the range of reasonable estimates. Hindsight testing tells the whole story about whether what you're doing is working or not.

MR. JOHN K. HEINS: My task today was to cover the long-tailed health benefits, specifically disability income (DI) and long-term care, and I partly succeeded in doing that. I will have a question at the end of my scheduled comments for you all. I'm covering two items on long-term care and one on health benefits in general, but I don't have anything specifically related to DI.

What will I be talking about today? As Jim mentioned, I'm going to talk about the draft SOP on internal replacements; new long-term-care experience forms, which are currently in progress and for development; and the long–term-care minimum standards, which became effective at the beginning of this year. It's a topic that's been around for a while, and most of you are probably familiar with it if you work with long-term care, but since it's only recently become effective, I thought I'd spend two minutes covering what the changes were.

I'm going to start with the internal replacements SOP. There have been a number of presentations on this topic by Webcast and other things, so if you've sat in on one of those, I don't have anything new here for you. The technical title of the SOP is "Accounting by Insurance Enterprises for Deferred Acquisition Costs on Internal Replacement," which we will notice references DACs in the title and therefore can lead us to believe that this is specifically relating to how you treat your DAC on these replacements.

The last exposure draft was November of last year. It has been submitted to the Life and Health Actuarial Task Force (LHATF), and I will get to more specifics about where it's going in the future toward the end of this discussion. Currently it's expected to become effective for fiscal years beginning December 15, 2006, which effectively means January 1, 2007. The original proposed date was December 15, 2005, but between the haggling and the realization that the systems changes that will be required to comply with this are going to be a bit more onerous than they originally envisioned, it moved the date back a year. That's not expected to change, however.

The SOP applies to all FAS 60 and FAS 97 products, short and long duration, although most of the discussion on this SOP has related to life insurance, and there are a number of specifications about it that will clearly be relating to life insurance

and FAS 97-type products. It is fully expected. There is no reason anybody who's been involved with it believes that it will not also apply to health insurance, although they haven't said it in so many words.

The SOP defines an internal replacement as a modification of product benefits, coverages or features that occurs by the exchange of a contract for a new contract, amendment, endorsement or rider to a contract, or the election of a feature within a contract. There is nothing particularly complicated about that. If you sat down for long enough, those are probably the words you more or less use—there's just a little more tech speak there.

The other key component of this is how you define whether or not the contract has been substantially changed or unchanged. If the contract is substantially unchanged, the unamortized balances continue prospectively amortizing whatever the balance is, as of the date of change. While assumptions will change, for example, perhaps your morbidity will change once the contract has been exchanged, and therefore your amortization slope will change, on the date of change your DAC should not change.

Previously, what many companies have done is simply zero out their DAC at this point. It's the conservative thing to do, and a lot of companies are still asking why they can't still do the conservative thing. Well, they can't. That's just the answer. This is, by the way, where the systems problems are going to come in.

Your handouts say "substantially unchanged if." Luckily when I was rehearsing yesterday, I noticed that that was something of a problem. It didn't make a lot of sense. So it's substantially changed if there's a significant change in mortality or morbidity, and there's rarely going to be a significant change in mortality for health insurance. Understand a lot of these requirements are more in consideration of life exchanges than they are health. There's a change in the nature of investment return rights, again, far more likely to be involved for life. There's an additional deposit, premium or charge required. That will happen more often than not, and that will be interesting. We're going to look at some examples later of where it becomes a little dicey to decide whether or not even though that requirement is there it still defines a contract as substantially changed.

It's also substantially changed if there's a reduction in account value or cash surrender value, a participation/dividend features change and a change in amortization method or revenue classification. That last one is likely a life, especially the revenue classification is a life issue. I believe that relates to whether you're going from a FAS 60 to a FAS 97.

If the contract is substantially changed, the original contract is considered extinguished, so what's going to happen is you'll treat the new contract as though it were issued new, your DAC will start from zero, and you'll begin building your DAC as you would if you had a new issue and defer your expenses and amortize them.

Let's look at some examples on this. I made these up. Frankly, I don't know the right answer. I think we're going to have to get into some experience on this for the auditors to tell us whether or not we've made the right choice on whether we consider something substantially changed or unchanged. We're replacing a long-term-care nursing home only with a comprehensive. Who thinks that's substantially changed? You're exchanging a policy with long-term care with nursing home only with a policy that has comprehensive long-term-care benefits. Under most circumstances, there would be an increase in benefits for that kind of an exchange, and often you'd be reunderwritten. I would consider that substantially changed based on the definition. I don't know, and as I said before I'm going to show you an example where the benefit will change, but I think there's a serious question as to whether or not that constitutes a substantially changed contract. This would be it.

What about an increase or decrease in the earned premium or benefit period? If you're decreasing your elimination period, or you're increasing your benefit period, there will in most cases be an increase in the premium, and by the definitions that have been offered, that would be considered substantially changed. If you increase your elimination period or decrease your benefit period, there would be a decrease in premium, and they don't cover that. They only talk about whether it would be an additional premium. Does that then constitute if you have a reduction in benefits it's substantially unchanged, but if you have an increase in benefits, it's substantially changed? That doesn't seem to make a lot of sense to me.

We're talking about a change in the elimination period. This is not a significantly changed contract coming. If I were the actuary trying to make a decision on this, I would consider this substantially unchanged, but, again, we'll have to see what they say.

We replace a DI policy with a life contract with a DI rider. I think that one is pretty obvious, and I put it in there for that reason. Because you're bringing in an entire new line of business into play, that would be substantially changed.

Replace Medicare Supplement with Medicare Advantage. I have no clue at all. Medicare Advantage, for those of you who are not involved in Medicare, is the new term for Medicare+Choice, the pseudo-managed care private company that takes over all of the payments for Medicare in return for getting a stipend from the government. I put that one in because I honestly don't know. I don't even have a good guess for that one.

Moving forward, the draft is expected to be approved later this summer by the AICPA. I have not been directly involved in the development of this thing, so if you have questions, I probably won't be able to answer them, but I will discover answers for you if you e-mail me. There will be substantial changes to many systems. A lot of companies, as I said, have simply zeroed out their DAC, and they don't have the capability of remembering what the DAC was under the old benefit

structure at the date of change and using that going forward to amortize using the new benefit structure or the new policy structure. There isn't necessarily a change in benefits. There could be other things going on.

The calculation process itself is a relatively simple iterative process, but a lot of companies don't have that in place or don't have in place, more likely, the ability to print somewhere off of their system and remember what the DAC was as of the date of change.

I mentioned this before, but the conservative election of letting it go to zero is not an option. It seems counterintuitive, although it is a GAAP issue, since the emphasis is on earnings development and not on conservatism. I suppose that's not so hard to understand.

Let's move on to talking about long-term care. We're going to talk about the minimum valuation standards, and I'm going to take just a couple of minutes to talk about this because, as I said, it's been out there a while. Most of you if you work in long-term care probably already are aware of what's going on.

The new standards became effective January 1, 2005. The review of the standards for long-term care came about because there were a fair number of companies that in their valuations were projecting improvement in morbidity. They were looking at their experience and were saying, "Over the past 10 years, we've averaged a 1 percent improvement every year in our morbidity, so we're going to be conservative. We're going to assume that that improvement goes forward because we have a whole history that says it will, and it's been consistent. We're going to assume a 0.5 percent improvement going forward." The regulators who got together to talk about that were all uncomfortable with that concept. That was the driving force behind the review of the new long-term-care standards for valuation.

However, once they opened the jar, they decided to tinker with a few other things. We'll look at that. It's not retroactive, so it's for benefits contracts issued January 1, 2005 and subsequent. There was some strong feeling by some of the regulators to make it retroactive, the reasoning being we believe the reserves are simply inadequate at this point if you have this improvement built in, but there was a great to-do among the industry representatives, saying that they were going to put almost all health insurers out of business by having them retroactively take this apart. They won that battle.

The changes are to morbidity, lapse rates and mortality. There's one other minor one that I'm not going to highlight or discuss, partly because I don't remember what it is. It's some technical thing, and it doesn't have much effect in my opinion.

Regarding morbidity, you're no longer allowed to project morbidity improvements. What does that mean? What it means is you may not project into the future improvements in morbidity beyond the date of valuation, improvements that have

not in fact been realized. If between the time you've issued a contract and the date of valuation you have documentation that suggests to you your morbidity is improved, you can change your assumption at that point for valuation. You can unlock at that point, but you cannot project it any longer.

I believe the old standard for mortality was the 83 Group Annuity Mortality (GAM). The new standard is 94 GAM. There was some sentiment by some of the regulators to go to the 2001 individual annuity. Is that the right year? I know individual annuity is right; I just don't know the last year that they produced the table. But again, there was an outcry from the industry that suggested that there was no reason to believe that the mortality was going to be that good for long-term care.

For lapse rates, policy year 1 is 80 percent of pricing, or 6 percent; for policy years 2 to 4, it's 80 percent of pricing, or 4 percent; for policy years 5 and later, it's 100 percent of pricing, or 2 percent of the upper bounds on your lapse rates. Again, Mr. Dino of the Florida Department of Insurance wanted to make this more onerous. I think he wanted 1 percent or 1.5 percent ultimate. For many companies, that wasn't unreasonable, but there were enough companies out there for which it was unreasonable. He lost that one also.

The third and last thing I'm going to be talking about is the new long-term-care experience forms that are part of the annual statement exhibit that must be filed. They have not been passed. They are in progress. The Accident & Health Working Group asked the Academy to put together a task force to look into it. This was work that the working group got to once it figured out the long-term-care minimum standards because that tied it up for about a year doing little else. Having put that to bed, it turned its attention to a number of other things, and this was one of the things it wanted to look at.

The driving force behind this is that the experience forms are effectively a requirement to show actual to expected. How are you doing compared to what you expected to do? But the expected in the existing forms is based on pricing assumptions, which relates to the fact that a lot of the regulation, a lot of the review of how things are going, was based on loss ratios for health business, and that's not the reality anymore for long-term care. The process of getting rate increases and other things has come totally away from looking at loss ratios and having that as a requirement to a number of other things that I won't get into today. That's why it wanted to look at whether or not basing the expected values in those forms on pricing assumptions was still reasonable or valid.

By the way, I neglected to offer my thanks to Rick Farrell of Ernst & Young, who assisted me in putting together a presentation for the SOP, and Warren Jones of AEGON, who helped me with this part.

Here are the similarities to the current requirement. There are still three forms, and they still essentially do more or less the same thing. The detail information by form

was moved from Part 1 to Part 2, which will come in later slides. Part 1 is still experience by duration. Part 2 is experience by line of business form. Part 3 has little if any change.

Part 1 columns removed from the current form are policy form, first-year issue, incurred and paid, and reserve for incurred but unpaid, so there's a development shown in the current forms for the total incurred claims that they've removed altogether. They don't need you to show the development of it anymore. They just want the total incurred claims now. Change in reserves and the anticipated loss percentage also were removed.

The new columns added are the valuation expected incurred claims, the actual to valuation expected incurred claims, open claim count, new claim count, expected lives in force at the end of the year and actual to expected lives in force.

There are other changes in Part 1. They've added separate reporting for integrated, facility only and home health only, which given the way long-term care has gone seems to be an improvement. The summary does not report by duration. There is some detail in Form 1 that still does, but the grand totals at the bottom are no longer by duration. There's a durational refocus. The current forms show duration 1, duration 2, duration 3, durations 4 to 5, 6 to 10, something like that. The newly proposed forms refocus on the most recent duration, so it's the current duration, the prior duration to that, the prior duration to that and then further grouping down the line. As they say, you should put the most important stuff at the top, which this tends to do, and which seems like a valid and valuable change to the forms. There is also an inception-to-date line added for Part 1.

Part 2 columns removed are incurred and paid and reserves for incurred but unpaid. The same development that was in Form 1 is removed from column 2. The first Part 2 column added is policy form. As I said, they've shifted the detail stuff from Part 1 to Part 2, so we're going to find all the detail stuff is here. This is interesting to me. They added the loss ratio to Part 2. Since the whole point of this is to get away from the comparison-to-loss ratio because it's not that meaningful of a statistic anymore in terms of regulating what's going on with your long-term care, I'm curious as to why they opted to leave it in there. My suspicion is it's the analness of regulators wanting to keep it, to keep holding on to that. I don't know.

Also added are the ratio of net to gross premiums, the current year net premiums, the in-force count at the beginning of the year, current year new issues, the in-force count at the end of the year, the ratio of the beginning of the year to the end of the year, the experience policy reserves based on valuation assumptions, reported policy reserves and the ratio of the reserves.

What's happening? Where are we now with this thing? The new forms were submitted by the Academy subgroup to the working group in April, as it says, and they were expected to discuss it in June and submit the forms for industry

comment some time during this year. They were expected to approve what was submitted, although you never know. That's the expectation, but who knows? Presumably it'll be released for comment sometime this year. My best guess is the middle of next year it'll finally get approved by all of the levels of the NAIC that need to weigh in on it.

I promised you a question, though. I didn't prepare anything specific. I am aware of the fact that the SOA has been working on new morbidity tables to update the 85 Commissioners Individual Disability Table A (CIDA) table. Does anybody know the status of that, since the point of this is to give everybody a quick update and educate us all on what's happening? Can anybody weigh in on what's happening with those new tables? The last I heard, most of the data processing has been done, although they've had some problems with that. I just can't speak authoritatively to it. I just wondered whether anybody was familiar with it. It wasn't a serious omission then, was it?

MR. O'CONNOR: The Academy has a committee called the Health Practice Financial Reporting Committee, and there are many activities that this committee has been involved in that may be of interest to you. I've listed four that we're currently looking at, and some of these we've been discussing these for a while.

The first one, which Laurel mentioned, is the best-estimate paper. The genesis of this came out of a concern that many of us health actuaries had as to whether we really need to put up a best-estimate reserve without any conservatism in it. The draft of the codification was largely done by casualty actuaries. One of the things that I have learned in working on this best-estimate issue is that though our vocabulary is similar, we say a lot of the same words as casualty actuaries, we don't necessarily have the same meanings of those words. Best estimate is one of those areas. One of the things that I learned is that when a casualty actuary is saying that he has put up a best estimate for his long-tailed reserves, he is not mentioning the fact that they are not discounting those reserves at all, whereas if we're putting up a disability reserve or a long-term-care reserve, we're discounting our estimates of future claims. The casualty people don't. When they drafted the codification, since it was largely a product of casualty actuary input, the notion of best estimate was different from when we received that notion of best estimate as health actuaries in that we have these discounts on long-tailed reserves; they are not establishing those types of things.

There are a number of other issues, certainly with short-tailed liabilities, that we get into, slight differences here and there as to what best estimates are. I think most of us are comfortable today that best estimate does allow us to recognize that there should be some conservatism in our assumptions. Some of us may disagree with that, but I think in general that's been largely accepted.

There was this draft of the best-estimate paper between the casualty actuaries and a group of health actuaries, and there is a lot of discomfort between both sides,

largely because of the differences in vocabulary. We established a joint subcommittee between the casualty and the health actuaries who were involved in this, and they're drafting a white paper on this subject. The paper will get into GAAP issues, as well as the statutory issue and FAS 5 issues fairly broadly. It won't be a guide for establishing reserves but will be more a principle paper. It's something that the NAIC had been interested in, and now there's been involvement by the AICPA and some other accounting bodies, as well, to give some input into this process. It's been two years in the making. We expect it out this summer. We'll see whether that happens.

Another activity of the committee is Practice Notes updates. You should all be familiar with the Practice Notes that are out on the Academy Web site. There are a number of them, and we have been in the process of revising them. I list seven of them here (O'Connor Slide 2, page 31). These are the Practice Notes that are directly related to some kind of valuation issue. They're largely divided by product segment, and then there is a general note that tries to encompass all the common elements and issues that should be addressed when setting up reserves.

In recent months, the small group medical business note and the individual medical note have been exposed to you. Some comments were received. I don't know how many people looked at these things because we didn't receive many comments, I'll tell you that much. Right now, there's the individual disability income note that's being exposed, so now that you know, you can go back to your office and look this up and give us any comments that you might have regarding your practices. Keep in mind Practice Notes are basically telling you what other actuaries are doing regarding certain issues related to setting up your reserves. They are not formal requirements but are guides to what prevailing practice has been by other actuaries.

The last four are being drafted. As a matter of fact, just yesterday, I submitted what we think is the final copy of the Medicare Supplement business to the Academy. It'll get its legal review, and then that will be exposed to you, so you'll have an opportunity to look at two of them probably in the next couple of weeks. The final three (large group business, group long-term-disability business and general considerations) are still in the drafting stage.

A third area, and this is probably geared to a number of your hearts, is the issue of premium deficiency reserves. If you look at the *Health Reserve Guidance Manual* and at SSAP 54 and 55, there are a number of ambiguities at a minimum. There are some conflicts between what these documents have stated, and because of that, there's a lot of confusion as to what should be done. Some of the other things related to them that are issues are groupings. What products can be grouped together? What shouldn't be grouped together? How long should the projection period be for a premium valuation? What's going to dictate the length of time? Should individual plans be treated any differently from group plans? If the answer is yes, which it probably should be, what about group plans that are sold to

individuals but happen to be in group form?

Those types of issues are issues that the committee is grappling with, and it's working with the NAIC. This grew out of a NAIC request because it realized that there have been some issues and ambiguities related to this, and so that's been going on since 2002, with the first reports in the NAIC. It came back and asked some questions. Our committee provided a response to these requests, and then the NAIC came back and asked us for some examples of where some of this confusion can be and where some of these ambiguities are. The committee drafted 15 examples. We provided the first four, at which point it seemed to not be sure exactly what direction it wants to take this now.

It's thinking of perhaps going to a principle-based reserving approach for health insurance. That's in initial discussion within the actuarial working group. We don't know where it's going to go.

I'll tell you what our committee has decided to do. If any of you are interested in providing input, feel free to get involved. Rowen Bell is the current chairman of this committee, so you can contact him with any interest that you might have. We've decided that we're going to try to take a proactive approach to this premium deficiency reserve question. Who better to know and understand some of the problems related to premium deficiency reserves and growth premium valuations and the differences between them than the health actuaries out there who are doing the work and facing these questions? Your input will be welcome, at which point we plan to write a report on what we think best practices should be for establishing premium deficiency reserves.

The final area that I want to speak to is international accounting. This is something that hasn't touched many health actuaries at all, since we're pretty insular. However, you should be aware that FASB has agreed to expose the International Accounting Standard Board (IASB) decisions for comment in the United States. It's likely that the IASB's decisions could dramatically or maybe not so dramatically change GAAP, and that will likely have some impact on what we do as health valuation actuaries.

Up to this point, the health insurance industry hasn't seemed to be actively engaged in the process, and that's not surprising because most of the issues don't directly affect health, but because there are going to be decisions made, if they're made without health actuarial or accounting input, we could be affected, and we're going to be stuck with whatever decisions they are. My main point is that you need to be aware that this activity going on potentially could affect you. At a minimum, if you're in a company that has life insurance, you may want to try to stay in touch with whoever in your company is following this to give your input as to whether any of this stuff is going to be affecting you as health valuation actuary.
With that, I'll open up the floor for questions for any of our speakers.

MR. GARY MONNIN: On the internal replacement issue, if you either have something with substantial changes, it would be simple. Why is this solution amortization of the new policy substantially replaced?

MR. HEINS: You can. That still may be substantial work for some companies, unless you're going to do stuff like that off-system and do it in the spreadsheet or something like that, which, in the world that Mark introduced us to with Mr. Sarbanes and Mr. Oxley, would be something that might be a problem.

MR. YOEST: I think audit fees increased by about 60 percent. It's increased expense. In terms of what I've seen from company to company, even in terms of administration of the audit by the accounting firms, I probably shouldn't say it, but there's been some inconsistency in terms of whether or not actuaries have been involved. That has always been at the request of the audit partner. If any of you are having difficulties during the course of your Sarbanes audit and would feel like you benefit with an actuarial interpreter, I would request that of your auditor.

I've seen some statistics, and unfortunately I don't have them with me, but there were I want to say more than 50 internal control failures per audit. It's pretty common to have control failures, and remediation of them has typically been pretty quick.

FROM THE FLOOR: Did you find there was any commonality of problems?

MR. YOEST: I would say commonality of problems was documentation. One of the things that I did not say and was hoping to was that I would highly recommend that in advance of your audit you prepare an evidence book. A lot of times there would be controls in place where the control was another actuary using an actuary's work. Often we didn't see evidence that that review had taken place. If you send an e-mail to the reviewing actuary or have one from the reviewing actuary to the producing actuary saying, "I've reviewed your reserves that you calculated and find them to be reasonable," print it off and store it in an evidence book. That would be helpful. Those sorts of things, the human touch areas, are where we saw a lot of control deficiencies.

By the way, Laurel works for KPMG and has been through probably more of these than I have.

MS. KASTRUP: The biggest problem we saw was the spreadsheet. While we as the actuaries understand these spreadsheets, you're going to have the computer guys coming in and tearing apart your spreadsheets, and they're not going to be nearly as forgiving or friendly about the use of spreadsheets as we are. Controls around spreadsheets was the biggest deficiency that we saw.

MR. VINCENT L. BODNAR: On the subject of internal replacements, is there an intent or any discussion around being consistent between DAC and benefit reserves? In other words, if you have to write off DAC and set up a new DAC, do

you do the same thing with benefit reserves?

MR. HEINS: That would seem logical, but my understanding is this SOP only addresses DAC, so I don't know what the intent is for the benefit.

FROM THE AUDIENCE: I've run into situations where there are inconsistencies between setting up DAC and releasing DAC and benefit reserves.

MR. HEINS: That would make no sense, would it? I'm totally onboard with you.