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How to Prepare a Health Actuarial Memorandum That Makes Your Regulator Smile

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One of the most important roles of the state insurance regulator is monitoring the financial health of insurance companies by analyzing and evaluating the company's statutory financial statements. The actuarial items (liabilities and assets) included in the financial statements are oftentimes some of the largest on an insurer's balance sheet and are particularly difficult to assess without detailed documentation of the methodology, assumptions and calculations used to determine them. The actuarial memorandum (AM), which is prepared in support of the annual statement of actuarial opinion (SAO), provides the missing link. It allows the regulator to gain insight into the reasonableness of the actuarial items included in the annual financial statements, the appropriateness of the type of actuarial opinion (unqualified, qualified, adverse and inconclusive) and ultimately the determination as to whether regulatory action needs to be taken to improve the financial health of the company.

Regulators usually have to review several companies within a short time frame. A well-written AM, which provides sufficient support for the actuarial assets and liabilities included in the scope of the actuarial opinion, will allow the regulatory actuary to efficiently analyze these items. This reduces the number of follow-up questions that the appointed actuary may have to answer, streamlines the regulatory decision-making process, and creates a win-win situation for both parties.

Currently, health actuaries do not have detailed or prescriptive guidance for preparing AMs in the form of an Actuarial Standard of Practice (ASOP) or model regulation published by the National Association of Insurance Commissioners (NAIC) to ensure that appointed actuaries consistently prepare the AM with information that is sufficient to satisfy the target audiences.

Of the guidance available on AMs, the definitive guidance is found in the NAIC Health Annual Statement instructions ("NAIC instructions"). However, these instructions are not detailed enough to ensure consistency among appointed actuaries preparing AMs. Additionally, the focus of the instructions is on the unpaid claims liabilities and they do not adequately address all of the actuarial liabilities and assets that may be included in the SAO. Therefore, actuaries are left to determine for themselves what should be included in the AM. The result is that AMs prepared by appointed actuaries can vary from a two-page letter to a voluminous tome that would make *War and Peace* look like a pamphlet.

The ensuing discussion provides the perspective of two regulatory actuaries, based on our experience reviewing a large number of AMs, which represented the entire spectrum: the good, the bad and the ugly. We hope that this discussion will be helpful to appointed actuaries and their staff as they prepare AMs in support of the health annual statement (Orange Blank).

COMMON MISPERCEPTIONS

We acknowledge that there are a few widely held misperceptions that tend to create a gap between what appointed actuaries and regulators believe is a well-crafted AM. We would like to address these misperceptions before presenting our suggestions for creating a well-written AM.

The AM is for the Board of Directors

One misperception is that the AM is intended for the insurance company's board of directors (BOD), so the less detail the better. They will not understand it anyway.

The AM is a regulatory requirement that provides important information for the regulator to evaluate insurance companies' financials. Further, it is an actuarial communication, subject to the requirements of ASOP 41, Actuarial Communications. While the NAIC instructions state that the appointed actuary must report to the BOD or the Audit Committee of the BOD on the items within the scope of the actuarial opinion, and make the SAO and the AM available to the BOD or the Audit Committee, there is no prescribed format for the report to the BOD. Therefore, the appointed actuary may choose to prepare a separate report to the BOD/Audit Committee in a format that specifically serves the needs of that audience. However, that report does not replace the need for an AM that complies with the requirements of the NAIC instructions.

The Regulator Does Not Really Use the Actuarial Memorandum

Another misperception is that regulators only look at the AM every three to five years, during the financial examination. The appointed actuary is only required to provide the AM to the

state upon request and some states never request them. So why bother? The BOD requires a report every year so the appointed actuary should make sure that the memorandum satisfies their needs. If a state requests additional information, the appointed actuary can provide it at that time.

While it is true that some regulators only request the memorandum during the financial examination, some do request it every year. Additionally, the memorandum is supposed to provide support for the analysis performed in determining the actuarial items that are included in the scope of the annual actuarial opinion regardless of how the memorandum is actually used. Therefore, it should be prepared to fulfill its intended purpose and include the required level of detail.

The AM Might Disclose Confidential or Proprietary Information

A third misperception is that the AM will provide proprietary information to competitors, so less detail is better.

The NAIC instructions state that the AM is expected to be held confidential. If confidentiality is a concern, we recommend that you contact your regulator to determine how best to protect the confidentiality of the AM.

The Appointed Actuary is Not Responsible for Information Provided by Another Actuary

An additional misperception is that if some of the information included in the actuarial opinion is provided by another actuary, the appointed actuary does not need to review it.

There is only one actuarial opinion for each company's annual statement. The appointed actuary is signing the opinion with regard to all of the actuarial items included in the scope of the actuarial opinion.

AM GUIDANCE

The NAIC instructions define the AM:

> "Actuarial Memorandum" means a document or other presentation prepared as a formal means of conveying the appointed actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the appointed actuary's opinion or findings and that documents the analysis underlying the opinion.

The NAIC instructions require the AM to include both narrative and technical components:

- The narrative component of the AM provides a high-level description of the appointed actuary's findings, recommendations, and conclusions for the regulator and company management.

- The technical component of the AM provides sufficient detail so that a reviewing actuary, such as a regulatory actuary or auditing actuary practicing in the same field, would be able to evaluate the work performed and the conclusions reached by the appointed actuary. However, it is not

intended to be a dump of data; it should be well-organized, providing a clear roadmap of the actuarial analyses, starting from the basic data to the conclusions. For appointed actuaries, this has proven to be the more challenging of the two components.

The AM must also include:

- An exhibit that ties to the annual statement and compares the actuary's conclusions to the carried amounts
- Reconciliation of the data used for analysis to the NAIC's Underwriting and Investment Exhibit, Part 2B
- Other follow-up studies documenting the prior year's claims liability and claim reserve run-off as considered necessary by the actuary
- Documentation of the assumptions used for contract reserves and any material changes to those assumptions from the assumptions used in the previous AM. Such documentation should address any studies that support the adequacy of any margin in such reserves
- Language regarding any deviation from the ASOPs

> The AM is an important tool for both regulators and company management to understand the appointed actuary's conclusions and recommendations.

Recommended elements of a well-written actuarial memorandum include:

- Use clear and accurate language. Attention to detail is important. Grammatical or typographical errors undermine the credibility of the author.
- Follow any state-specific guidance for preparing the AM—there could be differences from the NAIC instructions.
- Identify the audience and clearly indicate the technical and narrative components. Using a letter format addressed to company management incorrectly suggests that the AM is intended for use by the company's management only. Using a report format with specific section(s) for the narrative and technical components is recommended.
- Include all of the required items listed in the NAIC instructions.
- Include sufficient detail in the AM so that a qualified health actuary would be able to form an opinion regarding the analysis and conclusions. Each of the examples we included illustrate different aspects of this issue.
- Include an analysis of each item within the scope of the actuarial opinion, regardless of the numerical value. Since the AM is intended to support the SAO, it is a good idea to include a discussion of each item in order to ensure the reader knows that each item, even the zero items, was explicitly determined, using sound actuarial principles. Example 2 illustrates this issue.
- Where appropriate, provide a lookback (or hindsight) summary of historical actuarial estimates such as unpaid claims, risk adjustment, medical loss ratio (MLR), compared to actuals and provide a discussion of the analysis that supports the methodology and assumptions used for the current estimate.
- Document the assumptions used and any significant changes to those assumptions. Provide support for all material assumptions. Examples 1 and 2 illustrate this issue.
- Provide sufficient detail regarding the appointed actuary's review of information when part or all of the analysis is provided by another party. See Example 3 for an illustration of this issue.
- Document any material deviation from prescribed wording on the actuarial opinion along with the reason(s) for the alternate wording, in accordance with Section 4.1 of ASOP 41.
- Document and justify the type of opinion. Since the type of actuarial opinion is an important conclusion of the SAO, even an unqualified opinion ought to be documented and justified in the AM.

TIPS FOR PREPARING AN EFFECTIVE AND COMPREHENSIVE AM

The following examples are intended to show some common issues that we have encountered in reviewing AMs, along with suggested questions for the appointed actuary to consider when deciding what information to include in the AM.

Example 1: Documenting Unpaid Claims Estimates

Facts

In addition to the specific items identified in the NAIC instructions, documentation of the development of the unpaid claims liability (UCL) included the following:

- Due to the size of the groups, the final incurred claims were determined by taking a weighted average of actual claims and estimated (smoothed) claims experience.
- Smoothed claims were determined by applying completion factors to the average per member claim. A six- to 12-month average was used, depending on circumstances.
- A margin was applied to the reserves to cover potential unknown events and fluctuations.

Discussion

Since one of the goals of the AM is to provide enough detail so that another actuary, practicing in the same field, can evaluate the work, the explanation of "smoothing" is inadequate and the reason for using it is unclear. The actuary notes that the size of the groups drove the need for the smoothing process, but the size of the groups involved may be immaterial, if the total population is credible.

The application of a six- to 12-month average completion factor, "depending on circumstances," does not provide adequate explanation of how the completion factor was chosen for each month. What circumstances determine which average factor is used?

In determining the unpaid claims, were there any offsets used, such as reinsurance recoverables or risk-adjustment receivables? What were the considerations in determining the amount of these offsets?

According to ASOP 5, Incurred Health and Disability Claims, a provision for adverse deviation, or margin, may be appropriate, but the level of margin used is an actuarial assumption that should be documented and supported. How was the margin selected? What were the considerations? Was historical experience used? How does the margin compare to prior years? The margin should be consistent from year to year, unless there is a reason for making a change. One of the statements in the *opinion* portion of the SAO is that the items in the scope are "computed on the basis of assumptions and methods consistent with those used in computing the corresponding items in the annual statement of the preceding year." This AM did not state the actual margin used, nor if it was consistent with the prior year's margin. If it was changed, the actuary needs to include the rationale for the change in the AM.

Example 2: Documentation of Actuarial Items With $0 Amounts in the Opinion

Facts

The following zero dollar amounts might result in incomplete documentation.

- No documentation of $0 premium deficiency reserve (PDR)
- No documentation of $0 MLR rebate liability
- No documentation of $0 Affordable Care Act (ACA) risk-adjustment amounts
- The company writes significant ACA-compliant business

Discussion

Every item included in the scope of the SAO should be documented in the AM, even when the amount is $0.

The $0 amounts in the opinion may be appropriate. However, unless the appointed actuary's analysis is documented, the reviewing actuary has no basis for evaluating the reasonableness of the actuarial estimate.

In justifying a $0 PDR, it is not sufficient to say that the company expects to make a profit in the following year; therefore, no PDR was needed. The PDR is one of the components of the aggregate health policy reserves (page 3, line 4). While the aggregate health policy reserves may be reported as a single number in the SAO, it is good practice to itemize each of the components in the AM and provide documentation of the analysis performed to determine each component, regardless of the numerical value.

Other actuaries or even non-actuaries may have calculated the MLR and risk-adjustment amounts, but they are considered to be actuarial items and must be included in the scope of the actuarial opinion and documented in the AM. The opining actuary is expected to review the work of those who prepared the estimates, document the level of review, and provide sufficient detail in the AM so that the reviewing actuary is able to judge whether the estimate is reasonable.

Example 3: Reliance on Other Parties

Facts

At times, the company may need to use outside resources to complete the analysis.

- Excerpt from AM: "In forming my opinion on the ACA risk-adjustment payable (part of the aggregate write-ins for other liabilities), I relied upon data prepared by Reliable Actuarial Consulting Inc., as certified in the attached statements."

- No documentation is provided regarding the information provided by Reliable.

- No further discussion of the risk-adjustment transfer payment estimate is provided in the AM.

Discussion

The ACA risk-adjustment transfer payments receivable or payable is a particularly challenging item for an actuary to estimate because it depends not only on the risk attributes of a company's membership but also on the statewide average risk and premiums. Therefore, it is particularly important for the actuary to document the assumptions and methodology used to determine this estimate.

Many valuation actuaries do not have the requisite expertise for calculating this estimate and therefore rely on the expertise of other actuaries. This reliance is generally appropriate. However, it does not absolve that actuary of the responsibility for determining that the actuarial reserve or asset is reasonable. If consultants provided a range of results, how was the final estimate chosen? What, if any, adjustments were made to reflect specific circumstances that may have emerged since the consultant's estimate was determined?

It is good practice for the appointed actuary to include details of his/her review of the risk-adjustment transfer payment, or any other estimate provided by other parties, which are included in the scope of financial opinion.

CONCLUSION

The AM is an important tool for both regulators and company management to understand the appointed actuary's conclusions and recommendations. It is intended to be kept confidential, so appointed actuaries should not be concerned with sharing proprietary information. In preparing the AM, the appointed actuary should always keep in mind that he/she must provide enough detail, within the technical component of the memorandum, to allow an actuary practicing in the same field to evaluate their work.

It is a good idea for actuaries to review applicable ASOPs prior to preparing or documenting actuarial liabilities, reserves and assets that will be included in the SAO. The actuary should review ASOP 5 and ASOP 42, Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims, to ensure recommended practices are followed in developing the estimates included in the opinion. ASOP 41 should also be used as a guide to ensure clear and appropriate communication. ASOP 28, Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets, includes guidance to actuaries issuing a written statement of actuarial opinion regarding health insurance liabilities and assets, and is a good resource for appointed actuaries.

A well-written, thoughtfully prepared AM will ultimately save time for the appointed actuary and the regulatory actuary who is reviewing the opinion and memorandum. ■

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ADDITIONAL RESOURCES

For more information, please refer to:

Actuarial Standard of Practice (ASOP) 5, Incurred Health and Disability Claims

Actuarial Standard of Practice (ASOP 28), Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets

Actuarial Standard of Practice (ASOP) 41, Actuarial Communications

Actuarial Standard of Practice (ASOP) 42, Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims

American Academy of Actuaries. 2007. Premium Deficiency Reserves Discussion Paper.

CMS MLR instructions

National Association of Insurance Commissioners. Annual Statement Instructions

National Association of Insurance Commissioners. Health Insurance Reserves Model Regulation (# 10).

National Association of Insurance Commissioners. 2007. *Health Reserves Guidance Manual (HRGM)*, Feb. 14.

National Association of Insurance Commissioners. Statement of Statutory Accounting Principles (SSAP) No. 54.

State law