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Impact of Codification on Health Reserves

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MR. ROWEN B. BELL: My name is Rowen Bell, and I'm an actuary with the national Blue Cross/Blue Shield Association in Chicago. The focal point of my work at the Association is monitoring and lobbying NAIC developments, particularly with respect to accounting and actuarial regulation. I have what I would call a very "ivory tower" viewpoint of this subject. I read all the things that are coming out, trying to understand the information, and talking with people about it. At the end of the day, I don't need to be a practitioner, or to go through my data, to figure out how to conform to some of these requirements, or to sign my name to a piece of paper. You in the audience are the folks that are obviously doing that, or you probably wouldn't be here to learn. I might be talking theory, and what I hope you have to offer in this session is a little bit of practical perspective.

The first thing I want to do is make sure that everyone is on the same page and is familiar with the same basic information on codification. If you have been to sessions like this one over the past three or four years, you've probably heard several different variations on this aspect of my remarks. I'll give you mine anyway.

Codification is one of these words that I think will be a very turn of the century phrase. We will eventually have stopped using it, and it will have a certain rustic character to it. What we have now is statutory accounting. It's a volume; it's written down; it has statements; and it looks kind of like GAAP from a pure hierarchical standpoint. The process of getting to this point was what

was called codification. It was the process of taking the combination of vague and contradictory instructions and folklore that represented what statutory accounting was up through the mid-1990s. The codification project turned that into a formal body of accounting guidance, much like the GAAP statements.

This process took several years, and it was a joint effort between regulators and industry. When I say industry, I'm really thinking primarily of folks from the life and the property/casualty industries. Health was, so I'm told, very much an afterthought in the development of codification, which had some interesting side effects. In particular, it explains why there is so much activity now regarding health-related accounting issues. Most of the life issues have been more or less resolved in the past.

The new version of statutory accounting, called the Accounting Practices and Procedures Manual, took effect at the beginning of 2001. Again this is an NAIC document; as such, it doesn't really have any force. It's what each state does to implement the manual that has the force in that state. You probably know there is an accreditation program at the NAIC. That's the "carrot and stick" approach by which the NAIC gets the states to adopt some of the more important financial and actuarial models. The NAIC designates the model as an accreditation standard and says to states, "If you want to keep your "Good Housekeeping seal of approval"—your NAIC accreditation status—then you need to have adopted this." They announced early on that codification was going to be an accreditation standard and that for the state to keep its accreditation, it would need to adopt the accounting guidance. Consequently, even though the accounting isn't yet formally an accreditation standard, it's basically in effect everywhere.

That isn't to say that a particular state won't have done some tweaking to it. A state still has the ability to prescribe certain accounting practices—things that apply to all companies in that state that are different from the NAIC norm. Or, on a company-specific basis, the state can permit an accounting practice. Here the company might go to the state and say, "We would like you to allow us to use particular accounting practice in our statements." The state writes back and says, "Yes, we'll permit you to do that." At any rate, the NAIC manual is the norm.

It's important to realize that the Accounting Practices and Procedures Manual is very much a living and breathing document. The manual itself is formally published once a year, in the spring. However, changes are made to it continuously, on a quarterly basis, at the NAIC meetings. There are various actions taken to make changes to the accounting guidance. Some changes are trivial; some are quite substantive. The types of changes that are made to the accounting guidance on an ongoing basis really fall into three categories.

The first category consists of interpretations of existing guidance. In this case, some company, a regulator, an accounting firm, or a trade association writes to the NAIC and says, "We're having difficulty understanding how a particular piece of the accounting guidance applies to this specific set of fact circumstances." There's a group at the NAIC called the Emerging Accounting Issues Working Group. If you're familiar with FASB, this is kind of the statutory equivalent to the FASB Emerging Issues Task Force. This NAIC group reads these fact-specific submissions and issues interpretations of the existing guidance.

There is a second category of changes that are made to accounting guidance, which are what they call nonsubstantive changes. They are changes in wording that do not really change the original intent of the accounting guidance. They might add clarity or cover up a loophole, but they are not something that doesn't really affect what the intent was all along.

The third category is substantive changes; these are things that the regulatory accountants believe are significant. They are modifications to the existing accounting guidance. Those typically take the form of new Statements of Statutory Accounting Principles (SSAPs) to either add guidance that wasn't in there before because it hadn't been thought about, or amend portions of old SSAPs. Now, when FASB does this, they issue a new FAS statement, which might amend the old FAS statement. FASB doesn't go back to an old FAS that was adopted 15 years ago and amend it internally. It actually adopts a new FAS statement that says, "This statement supercedes paragraph X of FAS Y." Statutory Accounting Principles (SAP) have the same structural framework. Although there were only 73 SSAPs when the manual first came out, Number 87

was recently adopted, and that number is only going to keep growing. Many of the things between SSAP 73 and 87 were not particularly noteworthy; they were just amendments to earlier pronouncements. By contrast, some of them actually were substantive, and we'll talk about some of those.

That's a little bit of background. What do you need to know if someone in your company is interested in these issues? There are really three key classes of documents within the manual that I think people need to pay attention to. The first are the SSAPs themselves. The second is Appendix A. Appendix A consists of various excerpts from NAIC model laws and regulations that have some bearing on accounting. Examples of these models include the Health Insurance Reserves Model Regulation and the Actuarial Opinion and Memorandum Regulation that applies to blue blank filers.

The structural choice the NAIC decided upon in developing the accounting manual was not to make reference to any of these model laws within the SSAPs. They instead decided to do the following: for each model that they thought was relevant, they excised a certain set of paragraphs. They put those paragraphs in an appendix to the manual, and then referenced that appendix within the SSAPs. What this means is that other NAIC working groups change model laws or regulations, and conforming changes need to be made within the Accounting Practices and Procedures Manual. We'll talk about that issue again later.

The third key class of documents that's important to know about are these interpretations (INTs) that come out of the Emerging Accounting Issues Working Group. They're found in Appendix B to the manual. Once an interpretation is made, it's immediately considered to be authoritative guidance. Inasmuch as these things can be made within the year, it's important to keep track of that. I'll dwell on this point because it came up in another session. Even though the manual is published once a year, it is continuously updated. As it's updated, those changes are immediately effective from an NAIC standpoint. Whether or not those changes are also immediately effective in your state is a function of how your state chose to implement codification. I think that the most normal situation is the state said, "Our basis of accounting will be the most recent NAIC Accounting Practices and Procedures Manual." Wording like that would mean it's up to the

minute; in other words, whatever the NAIC decides yesterday is effective in our state today. I think there are some states that instead made reference to the Accounting Practices and Procedures Manual as of March, 200X. In that case, it really is what's published in March that governs throughout that year, as opposed to the changes that were made throughout the year. Again, I think that's a relatively rare situation.

To conclude the background portion of my talk, I want to list the relevant pieces of accounting guidance that I think are important to health valuation actuaries. We'll first start with some of the relevant SSAPs. The two most important are SSAP 54 and 55. SSAP 54 talks about individual and group accident and health contracts and covers premium reserves, as well as contract reserves, and also claim reserves as distinct from claim liabilities. This latter point is a jargon distinction that appears in codification. It's basically the old accrued versus unaccrued benefits distinction. If you're a life blank filer, it is the difference between things in Exhibit 9 versus things in Exhibit 11. (Of course, those exhibits have been renamed since then, but we probably still think in those terms.) If you're a medical writer, then claim reserves are insignificant, but it's obviously of much more importance if you're writing disability or long-term care. The SSAP 54 claim reserves are the benefits that you'll need to pay out in the future. SSAP 55 discusses what's called the claim liability which, for the medical writer, is the bulk of your liabilities. It is everything that was incurred and that actually happened prior to the evaluation date. Those two SSAPs are clearly the most important, but several others also apply in ways that I'll discuss later. There are two relevant SSAPs that you might not have seen in lists of this sort before. SSAP 84 on health care receivables was finalized in late 2001 and was immediately effective at that time. SSAP 85 was approved earlier in 2002, but will not actually be effective until year-end 2003. We will discuss both of these later.

We'll move on to the segments of Appendix A that are most relevant to health insurers. Again, these all basically correspond with particular models. I mentioned the Health Insurance Reserves Model Regulation earlier. It's incorporated into statutory accounting as Appendix A-010. So for example, in SSAP 54, you'll see a reference saying, "In addition to everything above the reserves here, the reserves contemplated in this accounting principle must comply with the requirements of Appendix A-010." A-205 is a disclosure requirement. I mentioned before the fact that states

can prescribe or permit practices that aren't based on pure codification. There is a requirement that if insurers are using one or more of these prescribed practices, not only do they need to disclose that in their statement, but they also need to disclose the impact that using the nonstandard accounting practice had on both their income statement and their surplus. When it comes to reserving, that could have some interesting implications that we will discuss. If you're involved in reinsurance, you're probably familiar with the model regulation on that topic. Appendix A-791 incorporates most of that. In addition, it has a number of question and answer paragraphs.

One last section to mention is Appendix A-822, which is based on the life insurer Actuarial Opinion Memorandum Regulation. A-822 had been brought into codification so that it only applies to the companies that it would normally apply to. References to A-822 were amended in 2001, so that after each reference in the accounting it says, "If applicable." The point of that was to reinforce that if you're a health insurer (an HMO, a HMDI company filing the orange blank) or a property and casualty (P&C) insurance company that writes health business, then you would not be normally subject to the Actuarial Opinion and Memorandum Regulation, and you wouldn't be subject to those asset adequacy analysis requirements. It wasn't the intent of codification to kind of impose those requirements through the back door. The asset adequacy analysis is still strictly something that applies to life insurers at this time.

Finally, there are some interpretations that have come out that are particularly relevant. INT 00-31 talks about subrogation and coordination of benefits issues expect the health entities how you are supposed to report those. We'll talk about that, and we'll also talk about the INT 01-28, the margin for adverse deviation in the claim liability, which is a very interesting topic. Something else that just happened at the September 2002 NAIC meeting is that they announced their intent to issue an interpretation on accounting for prepaid claim adjustment expenses.

That finishes the background. There are the five things that I really wanted to talk to you about today, now that I've given you a little bit of structural background on codification to make sure that we all have the same knowledge base. There are five current issues where either codification has clearly made changes in what health reserving practice needs to be, or where there are still

some open issues. I'd like to lead off these topics, but I really would appreciate some heavy audience participation as we talk about these issues.

The first issue is premium deficiency reserves and the extent to which the premium deficiency reserve requirements are or aren't in conflict with gross premium valuation requirements. I'll start with my standpoint, and then hopefully we can have some discussion.

Look at SSAP 54, which is the guidance for all of the reserves on health business, with the exception of the unpaid claim liability. There are two different paragraphs in SSAP 54 that, if you line them up next to one another and try to comply with both of them, you might wonder what you're trying to do. The accountants who put SSAP 54 together took somewhat of a piecemeal approach. They took one ingredient from over here, and they took another ingredient from over there, and they just stuck them both in the same recipe and didn't really think about it any further.

SSAP 53 provides guidance on property/casualty contracts. One of the things that was introduced there during codification was a premium deficiency reserve requirement. Here's what this means. Suppose you have business that you know is going to be unprofitable for periods after the valuation date, but you've already locked in unprofitable premiums for that business. This could apply to business that is existing business and that continues past the valuation date. It also could apply to business that you're writing for January 1st where you already know you've written it at an unprofitable rate. In either case, if you have that type of business, you're going to need to think about setting up a liability, a premium deficiency reserve, in order to accelerate the future losses into the current accounting period. Language was developed for the P&C insurers in SSAP 53, which said that you have to consider groups of policies consistent with how the policies are marketed, measured, and serviced. I've talked to some of my counterparts in the P&C trade associations, and they seem to believe that what the language in SSAP 53 was doing was replicating the GAAP requirements for premium deficiency reserves. The regulatory accountants then said, "Accident and health has certain similarities to property and casualty. It

seems that we should adopt this guidance in the health context as well." That was done in SSAP 54. If you compare the paragraph in SSAP 54 to the corresponding paragraph in SSAP 53, you'd see that it's very similar, although there are some slight differences that were made to the health portion.

At the same time, if you go back and read the Health Insurance Reserves Model Regulation, you'd see a requirement in there that gross premium valuations be performed as the ultimate test of reserve adequacy. The gross premium valuation requirement in that regulation was mostly contemplated in the context of policies with contract reserves. The idea is that, with these long duration policies, even though you had contract reserves, you need to bump them up if a gross premium valuation would indicate that the contract reserve basis is no longer appropriate and that you're not adequately reserved to cover future benefits. This requirement was also brought into SSAP 54. You have these two different things that are going on there. As an industry, we have tried to grapple with complying with SSAP 54. The NAIC Health Reserve Guidance Manual has provided some substantially useful guidance there; nonetheless, there's still a lot of queasiness among us as far as what these things mean and whether or not, in some sense, they really serve the regulatory interest.

The Health Practice Financial Reporting Committee of the Academy was formed in 2001. One of the first reports it produced was a report for the NAIC Accident and Health Working Group that talked about this issue and a number of the other issues that we're going to talk about. I would suggest that report as a potentially useful piece of information if you have an interest in these subjects. Some of the questions that were raised in that Academy report concern this whole issue of the premium deficiency reserves versus the gross premium valuation. What do they mean? Are they the same? The Accident and Health Working Group has asked the Academy to analyze this issue more. The Working Group has come up with what, in its mind, it believes are the appropriate regulatory objectives for why you would want to have a premium deficiency reserve as a type of liability. Namely, they want to make sure that rates and reserves are sufficient in the short-term and that they provide for long-term solvency.

As vice-chairman of the Academy Committee, I'd appreciate hearing any opinions that people have on this whole idea. I think that the issues involved are very different for medical business than they are for disability and long-term-care business. Another question that I think is very interesting for those of you that file both statutory and GAAP financials is, do you think about premium deficiency reserves in the same way? Are the groupings different somehow? As I indicated earlier, the P&C folks had a mindset that all that the premium deficiency reserves language was doing was making SAP and GAAP consistent. I've talked to a number of health actuaries, and some of them agree. Others disagree, saying that the GAAP grouping criteria are more lenient; and still others say the GAAP grouping criteria are stricter. There doesn't seem to be a tremendous amount of consensus.

I want to raise a related point that you may have noticed if you have read the Health Reserves Guidance Manual, but I'm not sure that it's well disseminated throughout the industry. Let's say you are writing nonunderwritten business, either administrative services only (ASO) or administrative services contracts (ASC), where, in either case, you're not at risk for claims. For example, perhaps you've written the state group in your state, and for political reasons, you've chosen to write this jumbo group at a loss. You're not going to get as much out of the administrative retention you're collecting from the state. The retention isn't going to be sufficient to cover your actual marginal administrative costs. SSAP 5 is the general guidance in codification on liabilities and loss contingencies. It says that if you know you're going to incur a loss in the future, and that it's probable that that loss is going to occur, and you can estimate it with some reasonable degree of accuracy, then you need to book that loss contingency liability on your statement of the valuation date. That concept applies here to nonunderwritten business. I say it's a PDR-like liability. It's not called a premium deficiency reserve; and it's not reported in the same part of the blank as a premium deficiency reserve would be reported. In particular, it's unclear in my mind as to whether or not the actuary is supposed to be opining on it. Nonetheless, if you do have a sufficiently large unprofitable block of ASO business, then the recognition of the future losses need to be pushed up into the current period.

Let's move on to talk about the second topic, management's best estimate. I think this was an issue that received quite a bit of attention while codification was being developed. The SSAP 55 guidance on unpaid claims and losses is common area guidance, meaning that it applies equally to health, life, and P&C. The historical reserving practices in those different areas have been somewhat disparate. When we as health actuaries set up claim liabilities, it has been our historic practice to include some form of margin, some form of provision for adverse deviation. On the property/casualty side of the fence, I believe that has been less true. Crafting language that was common to both areas, and that was written by people that were much more heavily influenced by the P&C viewpoint than by the health viewpoint, appears in SSAP 55 Paragraph 10: "that management shall record its best estimate of its liabilities for unpaid claims."

Some of us in the health industry looked at that language and said, "Well, does this mean that they're trying to force us to no longer put any form of margin in our reserves?" Doing so would obviously raise some issues of compliance with Actuarial Standards of Practice. Most people would interpret the ASOPs as saying that you do need to put some form of provision preference deviation in there.

There has been a lot of discussion on this issue in recent years. I think people concluded in the end that Paragraph 10 wasn't really meant to force us to change the way in which we have been traditionally doing business. In 2001, the Emerging Accounting Issues Working Group addressed this issue and came up with the following extremely Solomon-esque wording in INT 01-28: "The conservatism is inherent to the estimation of reserves, and as such, should not be specifically prohibited in the consideration of management's best estimate." You can put in conservatism if you want, but you don't have to. On the other hand, and I'm paraphrasing here, INT 01-28 did not impose a specific requirement to include a provision for adverse deviation in claims. That was not as definitive a position as I think that the Academy would have liked. It is important to note that this interpretation was specifically in the context of accident and health unpaid claim liabilities. The intent was to get an interpretation that specifically focused on the health issue to try to divorce it from the P&C issue. Even so, the regulatory accountants were not willing to go quite so far as to say that yes, you do need to have a provision for adverse deviation.

The health and the P&C financial reporting committees of the Academy are teaming up to prepare a white paper that might ultimately turn into a practice note on the subject of this language, what it is supposed to mean, and how we are suppose to deal with it. This Best Estimates Work Group is getting started this fall.

MR. STANFORD B. HERMAN: Is there a requirement that the best estimate with/without margin be consistent from year to year? If you can have it or you don't have to have it, this is a potential source of earnings manipulation.

MR. BELL: I think that's a fair point, and I think it is a potential source of earnings manipulation. To answer your question directly, the answer is no, there isn't anything that has been said by the NAIC to prevent you from adjusting your conservatism in that fashion from year to year. As the opining actuary, you might be comfortable signing it one year when you have an 8% margin, but not comfortable signing it the next year if management asks you to reduce that margin to 0% or to 2%. That's more of a professionalism issue than anything that is required by the accounting.

MR. EDWARD W. O'NEIL: Since this is somewhat new, having some of our old standards like a flat percentage being our margin may be inappropriate going forward. Maybe it will take a little bit of adjustment and a little creativity in how we state our margin in order to be able to comply with some of these things. For instance, one company I know uses 10% as their margin, but it has adopted an attitude that, because of the variations in how that reserve can go up or down based on backlog at the end of the year, for instance, you wouldn't want a margin on that. However, that would be part of your liability. Thus, they have the margin in two parts now: a dollar amount, and a percentage of reserves, so that you don't overstress your earnings in any particular year. That gives management some latitude to operate on the best-estimate basis for public release of earnings also.

MR. BELL: I think those are good comments. Maybe a show of hands would be appropriate. How many people here are involved in setting the margins in their claim reserves with their company for medical business? It looks like a couple of dozen of you. How many of you keep

your margin consistent as a percentage of claims from year to year? It looks like maybe ten of you. How many of you keep a flat dollar margin that's consistent from year to year? No one is doing that. Is anybody trying to do some sort of statistical methodology—something like a confidence interval around what you think your best estimate is? I see a handful of people are doing that. I think it would be an interesting approach, but I'm not sure that we, as a profession, have the quantitative standards yet to do that.

MR. HERMAN: We actually tried doing this about five or ten years ago, using some kind of standard deviations. We abandoned that because our reserves began to be whipsawed. When things were really very good or very bad, the numbers just moved so dramatically that we overexaggerated what was happening. We felt more comfortable going back to a percentage that maybe represented the average standard deviation over a longer period of time.

MR. KEVIN M. LAW: Some years ago we reached an agreement with our actuarial auditors to set up a margin conceptually such that the reserve for medical claim liability would be adequate 80% of the time—for four out of five years. We did some different types of analysis to try to figure out what that margin would be.

MR. BELL: So it's something where you did the work once several years ago, and you're just relying on that statistical work.

MR. LAW: That's why we haven't changed it since the initial analysis.

FROM THE FLOOR: All of us set margins. Do we change those margins for GAAP as opposed to statutory? I do; I go to the best estimate for GAAP.

MR. BELL: That's an interesting question, any comments?

MR. HERMAN: We did address this with our accountants a few years ago; at that time, we had 10% statutory margins on our medical reserves, and the accountants were very uncomfortable with that from a GAAP point of view because they really viewed GAAP as requiring best

estimate. We did come to a compromise of using 5%, but basically there are much smaller margins for GAAP than for SAP.

MR. BELL: Let's try a show of hands approach again. How many people in this room are filing both SAP and GAAP books? Maybe a couple dozen. If you have lower margins for GAAP then for SAP, put your hand down. I saw some hands go up; I'm not sure what to make of that. Anyone else?

MR. JOSEPH D. BOGDEN: We have a number of HMOs across the country, so one thing that I grappled with in keeping the same margins for SAP and GAAP was that smaller sized blocks of reserves on a legal entity basis in one state had more volatility than a GAAP perspective, which would have you taking a national picture.

MR. BELL: You're saying, once you consolidate for your GAAP statements, you feel that you can get away with a lot less conservatism than the sum of the parts.

MR. BOGDEN: Yes, if it is under the 80% of the time being adequate type of test. We ultimately reduced our 10% load. It's more advantageous to be consistent having SAP and GAAP somewhere in the middle between very conservative and somewhat conservative.

MR. BELL: The third issue for today is to discuss ways in which codification has either forced us to include certain items in the unpaid claims liability or prevented us from including those items in the unpaid claims liability.

Many Blue Plans historically have this product called administrative service contract (ASC) business where the claims are funded by the employer but are actually paid out of the insurer's bank account, and then the insurer goes after the employer to fund the claims. At the Association, we've traditionally thought of that as being underwritten business. SSAP 47 is quite explicit in saying that this is not insurance business for accounting purposes, and there is to be no

claim liabilities reported for such business. Inasmuch as some carriers might have been including the ASC business in their unpaid claim liability prior to codification, that's obviously a change of practice.

The rest of these items are a little bit more local. There are certain little items that you, as the person signing on the liability, need to be aware of, especially how you're suppose to treat those items. One such item involves SSAP 35, on guaranty fund and other assessments. If your state high-risk pool is getting its funding by making assessments to insurers based on the volume of business they have in the state, then that sort of liability is considered a claims liability under SSAP 35. This means that it should be appearing in your statutory statement as part of the unpaid claims liability. You are opining on that, so it's important for you to simply be aware of that. You may give to your finance folks a claim liability number to put in the blank, but there might be additional things that, according to codification, they have to tack on to what you give them. This is one of those. If it's in the number you were planning on, then it's up to you to have a certain degree of comfort with that liability.

Another such item has to do with the interpretation that I mentioned earlier on salvage and subrogation recoverables. As I mentioned before, SSAP 55 is a common area paper. It makes reference to salvage and subrogation because P&C carriers have it. Does that mean that anyone, including accident and health writers, can apply the salvaged and subrogation guidance in SSAP 55? The initial interpretation from the regulatory accountants was that no, salvage and subrogation doesn't apply to health; it's just a P&C issue. That just goes to show you the extent to which the accountants at the NAIC are not necessarily entirely up to speed on the health industry and our issues. The final interpretation says this. If you want to do your salvage and subrogation on a cash basis, that's fine. If you want to do it on an accrued basis and have some sort of anticipation of recoverables in your statement, that's fine too. However, if you do the accrual basis, you don't set up a separate asset on the asset side of your balance sheet for anticipated salvage and subrogation. You instead just net it out of the unpaid claim liability.

Again, depending on what you were doing prior to codification, this might not have been a change in reserving practice for you. If, for some reason, you were grossing up your balance sheet and putting the salvage and subrogation recoverables up as an asset, that's no longer an acceptable accounting practice.

The same is true with respect to coordination of benefits. If there are any recoverables from that, you, as the actuary, need to be taking that into account when coming up with the unpaid claim liability number.

The last couple of items related to mandated inclusion or exclusion emanate from SAAP 84, which is the health care receivables guidance that I mentioned earlier. Let me first give some background on SSAP 84. This was an issue involving several different asset classes that had not been taken into account when codification was developed. The assets involved are receivables that health insurers often have as part of the way in which they do business.

The way in which SAP guidance is drawn in general is that you can't put an asset as an admitted asset on your books if you can't point to somewhere in the accounting manual that says you can. These health care receivables had never been discussed by the NAIC. As a result, health insurers were in a real bind when they filed their first quarter 2001 statements. They weren't allowed to admit these assets unless they talked to their state and received special permission to do so. In late 2001, uniform accounting in SSAP 84 for these types of assets was passed. It may not have been the best accounting from an industry standpoint, but at least there is some accounting now.

With respect to a couple of the items that are included in here, especially pharmaceutical rebate receivables, you now have to account for rebates on an accrual basis. I think a lot of people might have been using cash accounting in the past, and that's no longer an acceptable approach. Moreover, you have to actually set up these receivables as an asset. You can't just deduct them from your unpaid claim liability (UCL) the same way that you would be doing for coordination of benefits (COB) as discussed earlier. So this could be a change in reserving practice. One of the interesting implications here is that when the rebates are paid, they do flow through claims. So you now have a bit of a disconnect between your year-end claims liability and the paid claims

that flow in your runout going forward. As you go back and do things like Schedule O type testing, comparing prior year reserve to current runout, there is this disconnect. Some items like these rebates weren't included in the liability, but are included in the paid runout.

The guidance for claim overpayment receivables is very similar. Say that you have specifically identified a claim payment that you made that was in error, and you've contacted the provider, and you're making arrangements to get that money back from the provider, but you haven't gotten it back by the valuation date. Under SSAP 84, you don't just take that into account in your unpaid claim liability. You actually have to setup a separate asset. Again, there are rules in the accounting for when you can and can't admit those assets. Advances made to providers also fall into this framework. Again, in some cases, those might have been, in the past, deducted from the claim liability rather than booked as a separate asset. That's no longer allowable. A separate asset treatment is now mandated. These are minor technical issues, but it's an example in which codification is impacting your work as health valuation actuaries.

MR. HERMAN: I did have a question on the health-related assessments. What we've typically done when we've paid these things is we don't book them through claims. They've been going through miscellaneous taxes. I wondered whether there's any flexibility in basically setting up an accrual on the tax side as opposed to putting them into the unpaid claim liabilities?

MR. BELL: The SSAP I referenced earlier is pretty explicit in saying there are two different types of assessments. One type is assessments that are deemed to be health related. The example they give is the state high-risk pool type of idea. Those assessments are to be considered claims both in the liability, and as they are paid they're considered to be a claim. That's in contrast to many other types of assessments that would be treated in the way that you indicated. So I would suggest that you point your finance folks to that accounting guidance and take a look at it.

The fourth of the five issues that I wanted to cover involves changes to the appendices. I mentioned earlier the process that the NAIC implemented. Rather than making explicit reference

to model laws, they were instead just going to take relevant pieces of those model laws and put them as an appendix to the codification manual and make references to that appendix within the SSAPs.

We're starting to see some interesting examples that show this infrastructure really is, in effect, an early adoption of certain models with respect to accounting. I've heard people talk about one particular example in other sessions at this meeting. Let me give my viewpoint on this issue. This only applies if you're a life filer, but I think the principles involved could have other implications on health filers in the future.

Several months ago, a new version of the Actuarial Opinion and Memorandum (AOMR) regulation was approved by the NAIC Life and Health Actuarial Task Force. The new AOMR means no more Section 7 opinions. However, from what I heard at another session, people don't believe that any state will have approved the new AOMR as a regulation in their state by the end of 2002. It's an NAIC model; and states are eventually going to have to formally adopt the new AOMR in order to keep their accreditation, but they don't have to do that for a couple of years, and no one has done it yet for 2002. However, soon after a model law is approved by the NAIC's Plenary Committee, the regulatory accountants take those changes and they incorporate them into the accounting manual. At the recent NAIC meeting, amendments were made to Appendix A-822. The nature of those amendments is such that there were parts of A-822 that basically replicated the Company A, B, C, D conditions in the old AOMR for determining when you were exempt from having to do an asset adequacy analysis opinion. Those paragraphs are now gone, and in their place are some corresponding paragraphs from the new version. This means that, at year-end 2002, if you file a Section 7 opinion with your state, then you are not following NAIC statutory accounting. Your state may still allow you to file the Section 7 opinion, because the old AOMR is still the regulation affecting your state. But, if they allow you to do that, then that really constitutes a prescribed accounting practice. You are no longer following pure codification accounting, because pure codification accounting requires that the reserves have been subjected to an asset adequacy analysis.

Earlier I mentioned Appendix A-0205, which talks about the disclosure requirements needed when you're using the nonstandard accounting practice. It says you have to disclose the existence, which is fine. If you're still doing a Section 7 this year, you can include in the footnote of one of your annual statements something like, "in accordance with the existing regulation in my state, we are following the AOMR. We're getting a Section 7 exemption, and we've done this instead of what was required by Appendix A-822." That's fine. The second aspect of that is you have to disclose what difference this made on your surplus. I think that creates a bit of a quandary. How can you know what difference doing a Section 7 versus a Section 8 opinion would have been unless you actually do the work you would have needed to do the Section 8 opinion? The whole point of having the Section 7 exemption is to not have to do that work.

Quite frankly, we're in a very strange box right now. Two weeks ago at the NAIC meeting, they actually took a vote to say, "Let's delay making these changes to A-822 for a year." That vote didn't pass. They instead passed the vote making those changes effective this year. We have an interesting quandary, and I've given you my view on it. I think that we're likely to hear more about this issue in the next couple of months. If I were an actuary signing a life blank, and I had been anticipating doing a Section 7 opinion this year, I think I would want to open a dialogue with my domiciliary regulator. I'd say, "Here's what's going on at the NAIC. We're not ramped up to do a Section 8. Your state regulation still says Section 7 is okay. Let's talk about it or permit or prescribe the accounting practice to allow me to continue to do the Section 7." The disclosure issue is a different kettle of fish. That's my opinion on this issue.

Even if the Section 7 issue isn't relevant to you, the point is that very similar issues can happen with respect to health reserving changes. The potential here is less about the medical stuff and more about things like disability income (DI) that involve or prescribe morbidity tables as minimum reserve standards. I'll talk about another example from disability, and I'm not a disability actuary, so something I say here might not be entirely sensible. I'm trying to give you a flavor for things.

In 2001, a new claim reserve standard was incorporated into the Health Insurance Reserves Model Regulation where the 1985 CIDA table was modified in some fashion. They're now calling it the 1985 CIDC table. Your state might or might not have adopted those changes to the reserves regulation yet. Nonetheless, the changes are in codification. Let's say that, regardless of the reserve basis you're using now, the 1985 CIDC would lead to higher reserves, but your state is still allowing you to do what you've been doing because it hasn't adopted a new regulation yet. That's a deviation from codification, if you're booking reserves that are based on something that would give you a number that's lower than what applying the information in Appendix A-010 would give you. You would need to: (1) talk to your state about getting a permitted accounting practice in order for you to continue to comply with the version of the health model regulation that's enforced in your state; and (2) calculate the reserves on the new basis and disclose that amount in the footnotes of the annual statement. These sorts of things will continue going forward. There's going to be this perpetual disconnect when changes are made to the model regulation. The changes might not be adopted in your state, but they are adopted in codification, which affects what the standard is, which creates disclosure problems. It's an awkward regulatory construct, but for now, that's the world we live in, and we need to be aware of this issue.

MR. MARLIN M. MUELLER: I just want to point out something, and maybe give you a heads up as you represent the industry. For a health plan, in a Section 8 opinion, if the majority of your liabilities are in fact medical claim liabilities, you would not use cash-flow testing. You'd instead use a conservatism standard as your asset adequacy test. I think that further complicates the other issue in terms of the issue of conservatism and claim reserves or claim liabilities.

MR. BELL: I think those are good comments. Thanks.

The last subject that I wanted to brief you on today involves the liability for unpaid claim adjustment expenses. I think that prior to codification, many companies, if not most, were establishing some sort of separate liability for the cost of doing the administration on the claims that are reflected in your unpaid claim liability. I think there were some companies that weren't

making an explicit provision, but were just having it as part of the conservatism. At any rate, the new accounting guidance, SSAP 55, does say you have to specifically set up this unpaid claims adjustment expense liability. If you weren't doing that before, you should be now. There are some issues here that are kind of developing, and you need to become aware of them.

There's this new piece of accounting guidance I mentioned earlier called SSAP 85 on cost containment expenses. Although it's not effective until year-end 2003, I think you need to be made aware of it.

If we were starting financial reporting over again, given the sort of world that we live in now where managed care techniques are very much in vogue, we might do something different than what we've done in the past. What we've done in the past is, there have been benefits and there have been expenses. In today's world, however, health insurers spend lots of money on things that aren't, strictly speaking, contractual benefits. But they also are not strictly expenditures to get the claims paid, get the business marketed, and do the billing. They're not pure administrative expenses, and they're not really incurred claims. They are "cost containment expenses." I'm speaking of utilization review. I'm speaking of network access fees. I'm speaking of the cost you pay to your provider contracting folks internally to develop your own proprietary networks. I'm talking about disease management. I'm talking about anti-fraud efforts. These things really represent a middle ground. Current practice among health insurers is all over the map in terms of how these items are reported. Some carriers report some or all of these items as incurred claims; therefore, they have higher loss ratios and lower administrative expense ratios. Other carriers report them all in administrative expenses, so their numbers look different.

The regulators were unhappy with their state of inconsistency. After a couple of years of thought, they decided that a middle ground approach was appropriate. Hence, they have adopted SSAP 85, the accounting guidance, as well as some related changes to the annual statement blanks. The blank changes are going to be contemplated next month for an effective date in the first quarter of 2004. Instead of just having this bifurcation into benefits and expenses, it will really be more of a trifurcation, where you have your incurred claims, and then the broad set of

expenses are broken into the cost containment expense, and your other general administrative expenses. This latter category, general administrative expenses, includes the normal cost of processing the claim.

The point of this is to get better consistency, and it is going to result in some change of practice. When the accounting guidance in SSAP 85 takes effect, which is not until year-end 2003, it's going to clarify that inasmuch as you're setting up a liability for cost containment expense items somewhere on your balance sheet, the place where you need to put it is within the unpaid claim adjustment expense liability. That might be a change from current practice. For example, if you're a company that has been reporting PPO access fees as claims, then hopefully you've been including any unpaid PPO access fees from the end of the year in your claims liability. Now you would need to include them in the claim-adjustment expense liability.

So the new paradigm will start with the year-end 2003 reserves, and then, assuming that these blanks changes are implemented, it will really take effect in the first quarter of 2004, when all the cash basis items will be done this way. Going forward, you might think that you have two different loss ratios. I believe the five-year historical page of the blank is going to be modified in order to show two different loss ratios. One is the claims over the premium, and the other is claims plus the cost containment expenses over the premium. As I said, if we were starting statutory reporting from scratch, this might be what we'd come up with. It's only by historical accident that we haven't had this sort of splitting out before.

The other issue on the claim adjustment expense issue is a pending interpretation, INT 02-21, which was just discussed for the first time at the September 2002 NAIC meeting. The issue they're talking about is as follows. Let's say that you have business with a third party administrator, or even business with an individual practice association (IPA) under a capitation arrangement. In any event, the terms of your contract are such that the third party, whomever it is, bears the responsibility for physically paying the claims runout after the valuation date. If you have a contract where you're compensating the TPA on a percentage of premium basis, your

contract would often be written in that fashion. By accepting that percentage of premium, the TPA agrees to pay all the future claims that relate to that premium without receiving additional remuneration from you.

If you have a contract like this, I think the typical actuarial practice in looking at the claim-adjustment expense liability would be to say, "I don't need to set up a liability for that piece of my business. I've already paid them this money; it's their obligation. There's theoretically a chance that they're not going to be around to satisfy that obligation, but that's not really my problem. I'm fine with not having the liability on that piece of the business." The accountants are now saying, "That's not conservative enough." The accountants' proposal says that you need to consider all of your business in setting the claim-adjustment expense liability, even if you have made this sort of prepayment to a third party that would get you off the hook. They want you to have a redundant liability there.

My own view on this is that it is a little bit too conservative. Since the actuary is opining on the claims adjustment expense liability, I think it might make more sense for the Actuarial Standards of Practice to reflect that the actuary needs to take into account potential insolvency of the third party. Under this framework, the actuary might say, "Okay, if we had to do the claims administration ourselves, it would require 5% of additional liability." Assuming a 20% chance of nonperformance, this is sufficient, so I'll put up a 1% liability. I think it makes sense for us to be able to use our professional judgment given it's an item that we're opining upon. It's not clear that the accountants are going to take kindly to that type of argument. As I said, this is a pending interpretation. It's possible they will finalize their interpretation in early December 2002 at the NAIC meeting in San Diego. If they finalize an interpretation, that's authoritative guidance from that point forward. It's quite possible that we will have guidance of this nature in effect on December 31, 2002.

FROM THE FLOOR: On the last point, if in fact they do require us to set up a liability for prepaid expenses, shouldn't we be able to set up an asset?

MR. BELL: There is a SSAP on prepaid expenses, and the general rule is that prepaid expense assets are nonadmitted. I think that they're thinking of this situation as being similar to that. They see it in this way: if you don't set a liability up for this situation, that's effectively the same as allowing admission of this prepaid asset. They don't believe in admission of prepaid assets, so they want you to set up a liability. As I said, I think there is excessive conservatism being contemplated here.

MR. HERMAN: Following up on that, how do you draw the line between that and capitation?

MR. BELL: I'm glad you came back to that thought. That was brought up in September, and I think that will be the focal point of the health industry comment during this quarter. Let's say you have capitated somebody. Implicit in that capitation is administrative responsibility on the part of the capitation recipient to make sure the providers get paid. Again, I would think that we, as health actuaries, are not setting up administrative runout liabilities on pieces of business that have been capitated. The way the current consensus reads, we would be required to do that, and I don't think that's right.

MR. HERMAN: Let me just draw that a little further. If you have a capitation agreement, and if you assume that they're not going to have the money to pay to handle the administrative part, then they might not have the money to pay the doctors for the claims themselves. It just seems very absurd to require a liability for the administration but not for the claims.

MR. BELL: Well, the problem with voicing that argument is the accountants may say, "Yeah, you're right."

MR. JOHN M. FINLEY: We have a lot of capitated providers where we provide the services to them to pay the claims. For that particular category, we include that in the loss adjustment expense. On another note, we do not have a loss adjustment expense for GAAP, and I'm wondering if that's pretty common practice?

MR. BELL: Raise your hand if you file both GAAP and SSAP statements. Now let's take your hand down if you don't have a separate loss adjustment expense liability in your GAAP books. It looks like maybe a third to a half of the people that had their hands up indicated they don't have that liability. That's interesting. Anybody want to comment on why that is?

FROM THE FLOOR: It's a going concern.

MR. BELL: There are going concern considerations. I guess that makes a certain amount of sense.

MR. BOGDEN: I have one more point on the loss adjustment expenses. What if you're the third party administrator and it's ASO business? The states have specifically said, "Don't include the claim liability on your balance sheet." Now they're saying to potentially include the loss adjustment expense."

MR. BELL: I think you'd need to go back and look at SSAP 47. I looked at this recently, but I can't remember what I concluded. I think one of the later paragraphs in SSAP 47 talks about how you're not establishing any claim liabilities, but let's say that your own folks are doing administration. You may or may not have some liabilities there, depending on the nature of your contract. Again, I would think that if you have accepted that administrative responsibility going forward, then you would need a liability in conjunction with that. If you've already booked the revenue that corresponds to that, then it would seem to make sense to have that liability. Any other comments or thoughts?

FROM THE FLOOR: Yes, I have a question on cost containment expenses. If we have a global capitation, like a percentage of premium capitation, such as you described, and all those services are delegated, is it now the carrier's responsibility to unbundled that from a financial statement standpoint?

MR. BELL: That's a great question. I don't think it is. This was discussed to a certain extent. The carrier might have no way of getting information necessary to do that unbundling. If there's an intermediary involved, and you've globally capped somebody, and then they're outsourcing things, how are you going to get the information necessary to unbundle that? I don't think that that is going to be considered necessary under SSAP 85. I guess from a consistency standpoint, you're not going to get complete comparability of financial statements if you don't do that unbundling. There's probably a point at which practical considerations have to take over.

FROM THE FLOOR: We were talking about the fact that we have to include the cost containment expenses with the loss-adjustment expenses for accrual purposes. Is there any direction as to what you have to do with your actual paids throughout the year?

MR. BELL: There is none in the accounting guidance, but I'm expecting that there will be such guidance in the annual statement instructions. The blanks task force is soon going to be considering changes to both the health and the life blanks starting from the first quarter of 2004 forward. That will be split into two pieces anywhere where there's a reference to claim adjustment expenses. It is a matter of whether it be a reference to the cost containment expenses, and a reference to the other claim-adjustment expenses. I expect that the instructional wording will indicate that what you put in the cost containment expenses column should conform with the definition of cost containment expenses found in SSAP 85. That's how the cash guidance is going to get into the system. The cash part is a financial reporting question as opposed to an accounting question. That's why it's not addressed in SSAP 85 itself. It will be addressed in the blanks instructions.

MR. HERMAN: It still affects another regulatory issue, and that's minimum loss ratios. I serve on a couple of state boards, and we've wrestled this whole issue as to whether and what part of claim adjustment expenses should be counted as claims and determining whether a carrier has met a minimum loss ratio or not.

MR. BELL: I think that this concept will bring clarity to that. Inasmuch as you've already been having a discussion of the realization that some of the claim adjustment expenses should be considered, I think that the answer would be cost containment expenses are exactly the things that you should be considering. It's a tautological issue. That's what the definition is being set up to provide. As I said earlier, two different loss ratios being presented in the annual statement is reflective of that philosophy. As to how that's actually going to affect the minimum loss ratio standards is another kettle of fish, and it hasn't been addressed yet at any NAIC level. It is something we're going to have to keep an eye on in the next year.

MR. FINLEY: Wouldn't the inclusion of the loss adjustment expense at a higher level also work its way into PDR? You'd really have to have a separate calculation including that expense.

MR. BELL: I don't know. If you were actually doing the PDR calculation, you would assume that you've already paid for the administration. Say you have a block of business with a third party administrator (TPA), and you think that TPA block is going to be unprofitable going forward. You would probably use some sort of gross premium valuation technique to set up the PDR. In doing that, you would say, "I don't have any administrative runout because I've already paid them for that." I don't know that you'd necessarily take this liability that I put up on the books into account in doing the PDR. That's just one person's view. It's a relevant thing to think about.