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Health and Long-Term Care Regulatory Update

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Summary: Panelists share their perspectives on emerging valuation-actuary-related issues and topics, including issues that are "hot" from a regulatory standpoint. Topics may include current areas of NAIC Life and Health Task Force focus; current areas of SEC and AICPA focus; current areas of International Accounting Standards Board focus; current Academy activities; and updates on risk-based capital, best estimates, health blank, premium deficiency reserves and statement of actuarial opinion.

MR. ROWEN BELL: My co-panelist is Allen Schmitz, an actuary with Milliman, Inc.. We're going to parcel our topic into two separate presentations. Mr. Schmitz is going to start, focusing on long-term-care (LTC) regulatory issues. I will follow up with a presentation that focuses on issues of interest to medical insurance.

MR. ALLEN SCHMITZ: I'm going to give you LTC regulatory updates. The regulations in LTC are changing rapidly. I'm going to focus on a valuation actuary point of view, to the extent possible. Three specific things have changed or are in the process of changing: reserve regulations, risk-based capital (RBC) and new experience forms, which will be coming out.

If we start with the reserve regulations on a statutory basis, the reserves are driven by the NAIC model, although each state adopts its own version of this. Since January 2005, contract reserve rules have changed in the model regulation. The contract reserves in the model regulation specify your interest rate, the mortality that you can use, the lapse rates (the limits on the lapse formula) and the method that you can use, but they do not specify morbidity, although the new model has parameters regarding the level of morbidity that you can use.

Note: All charts referred to in the manuscript can be downloaded at:
http://handouts.soa.org/conted/cearchive/valact05/027bk.pdf

In terms of interest rates, the model regulation mandates the maximum rate permitted by law in the valuation of whole life insurance. As we know, that is changing to 4 percent in 2006. Schmitz page 2, slide 2 shows the impact that might have from a pricing basis. It shows a sample cell for an issue age of 65 under the current valuation rate at 4.5 percent. If we had that price for our 15 percent return and a premium of $3,000 dollars, changing that valuation rate (only the valuation rate) to a 4 percent maximum would take that internal rate of return, that profit measure, from 15 percent down to 13.3 percent. Alternatively, to keep the profit the same, you'd have to increase your premium to $3,100 dollars. Also under the pricing, according to the LTC model regulation, you need to certify a net-to-gross test. This 4 percent rate makes it more difficult to satisfy that test, particularly in states where you have to meet that test at every age. Inflation is something to keep in mind when you're examining the change in that valuation at the younger ages.

The mortality that's specified in the model regulation as of January 2005 has changed from the 1983 Group Annuitant Mortality (GAM) Table to the 1994 GAM Table. Schmitz page 3, slide 1 shows this sample cell again. The baseline is the 1983 GAM. We had a 15 percent return in the $2,900 premium. By changing it to the 1994 GAM (only the valuation, only on a reserve basis, not what you were using in pricing), isolating it to the statutory reserve issues, your profit would go down to 13.15 percent. Alternatively, you could raise premium to $3,000 to keep that profit level.

The lapse rates also have changed. Prior to 2005, the ultimate lapse rate that you could use for statutory reserves was 4 percent. After 2005, that ultimate lapse rate for individual policies is 2 percent. That's the big difference. There's also a change that limits year one to 6 percent. Schmitz page 4, slide 1 shows the impact of that regulatory change on our pricing cell. If we had priced for a lapse rate of 9 percent in year one, 7 percent in year two and going down to 1.5 percent on an ultimate basis, there isn't any impact on pricing. The new regulation limits you and mandates that you can't use anything greater than 2 percent. However, had we priced with a different ultimate lapse for whatever reason—we were more aggressive and had priced starting at 9 percent, going down to an ultimate of 3 percent, and we used the regulation prior to 2005 with a 15 percent return—our premium would have been $2,640. Limiting that ultimate lapse rate to 2 percent has an impact from reserves, lowering your profit down to 12.8 percent, or they'd have to increase your premium to $2,750.

The last items that I will mention with respect to statutory reserves are regarding the method. It has been the one-year preliminary term since January 1992. However, there are a number of states that still have two-year preliminary terms as the minimum method. Generally, one year is what gets used in practice. Model regulation mandates that the morbidity that you can use is "valued using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner." It also goes on to say that you need to make sure that those

reserves follow the underlying pattern of morbidity and should be developed just for the purpose of minimizing reserves.

The new model says that "in determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience, but shall not incorporate any provision for future morbidity improvement." Some look at that as somewhat contradictory, in that a best estimate might include morbidity improvement, and the regulation is not going to allow you to put that in there. However, on a statutory reserve basis, for which you're expected to have some conservatism, it may not be unreasonable to state that you cannot use morbidity improvement.

I'd like to discuss the current and the new formula for the C-2 risk for RBC, effective January 2005. It probably should be stated as the new one and the old one, because the new one already has been adopted. The current formula requires 25 percent of premium for the first $50 million, 15 percent of premium in excess of $50 million and 5 percent of claim reserves.

The new formula breaks it apart a bit differently. It lowers the amount that's applied to premium. In developing this formula, the Academy committee decided that your risk of LTC, relative to when you issue a block of business, probably is greater later on. If we do everything as a percentage of premium, the amount of capital that we're holding actually decreases over time. They decided to make at least a part of that a function of incurred claims, that is, 25 percent of your first $35 million in incurred claims and 8 percent of claims in excess of $35 million. It still uses 5 percent of your claim reserves. There's a noncancelable charge of 10 percent if you sell noncancelable LTC.

If we had based results under the old formula, when everything is based on premium, the amount of RBC that you would hold would decrease over time, whereas if you keep part of it as a percentage of claims, a small deviation in durations 20 and greater could hit your bottom line. That's when maybe your risk might be greatest in terms of needing that additional capital. That's the reason for that change.

Taking this back to the pricing cell example shown in Schmitz, page 5, slide 2, the new RBC formula helps you when you're looking at new-business issues. For that 15 percent return with the $3,000 premium, your profit will go up using the new formula. Because a lot of the capital that you're holding will occur further in the future, discounting it back at an internal rate of return actually helps that profit picture. So the new rate of return was 18.5 percent. Alternatively, you could decrease the premium.

There are several issues that the new formula brings up. One is in-force business. With the new formula, if you have a block of business that's 10 years old, you're out further in that claim duration and you have a fair amount of incurred claims,

the new formula may cause you to increase the RBC that you're holding. That could lower the embedded value of the in-force business.

Another thing to keep in mind is the modeling that RBC impacts on either a pricing basis or an in-force embedded-value basis. Under the old formula, you had that $50 million breakpoint. What should you do about that? Should you hold capital just on a marginal basis if you have another block of business that's more than $50 million? You really only need to hold the marginal rate on a new-business pricing exercise. The new formula brings in one extra layer of complexity to that. Now you need to try to estimate when your total incurred claims for all of your LTC business will go above $35 million. That's not quite as straightforward a formula or calculation exercise because you're not exactly sure when that might happen. That creates a bit of complexity in modeling under the new formula.

The last thing that I want to mention about this is the rating agencies. We've heard that some of the rating agencies have not examined the formula or are still in the process of examining it. We have heard that Standard & Poor's (S&P) does not like the new formula and is going to stay with the old one. If you're a company that wants to keep your S&P rating, you probably need to look at how much capital you need to hold under the old basis, but you also need to hold what's required under the new basis, from an NAIC standpoint. Unfortunately, it ends up that you almost have to hold the greater amount.

New experience forms will come out, probably for the year 2006, although, that's not certain any more because the NAIC was supposed to meet on this in New Orleans and that got postponed. I am talking about Form A, B and C. They are quite a bit of work, and most companies have taken a lot of shortcuts in filing those forms. The current forms are pricing basis. They examine loss ratio compliance. They make sure that companies comply with whatever minimum loss ratios were filed. The new forms are more valuation focused on new pricing model regulation. They do a much more detailed job of examining your actual-to-expected claims experience and your actual-to-expected persistency, as well as the funding and experience reserves that you may hold.

The old forms did an actual-to-expected morbidity based on your original pricing distribution. If I assumed a much older issue age or without very much in place on the old forms, your actual-to-expected may not make a lot of sense if you issued a lot of younger business with inflation. Early-duration loss ratios are much different. The new forms tried to correct for that. The regulation calls for your actual-to-expected. They don't want your actual distribution of business. Just to emphasize, Form A dealt with claim experience by duration, Form B dealt with that on a cumulative basis over time, and Form C did that on a state-specific basis.

With the new Form I, II and III, we no longer have to worry about the state-specific basis. However, Form I is going to be a more detailed examination of actual claims and actual persistency against expected. Form II asks you to calculate experience

reserve and compare that to your actual reported statutory reserve. Form III examines your claim reserve adequacy, which is going to be more detailed than Schedule O. The new forms, hopefully, will help industry folks examine other companies' experience and get a better understanding of what's happening. However, initially, it probably will be even more work than the current Form A, B and C.

Currently, at the interstate-compact level, the model regulation has a section for which you can have attained-age rating in LTC up to age 65. The interstate compact, primarily driven by Florida, wants to remove that from the model regulation. We don't think that that's appropriate for LTC. You shouldn't be able to attain-age rate somebody to age 65 and then have a level premium. We think that LTC is something that needs to be and should be pre-funded.

The industry has said two things about that. One, you're stifling innovation if that is something that's appropriate or that's how people would like to pay for it. The other issue is that nobody currently offers it. There isn't any attained-age-rated LTC. It's a hotly debated topic right now. But at the same time, nobody is doing it.

With respect to new products, the current model regulation says that if you'll cover a new type of provider on your new business, any type of provider that you may add to your new business you need to add to your in-force business. That may not be unreasonable. They're trying to stretch that even further to say that if you offer any new benefit in new business, you need to offer that on your in-force business. That's another issue that could end up stifling innovation. Why would I put a new benefit on new business if I know that I can't afford to give it to all of my in-force policyholders? That's another issue that's being discussed at the NAIC level.

FROM THE FLOOR: I believe that there's a group working on experience studies. Can you let me know what's going on with that?

MR. SCHMITZ: At the SOA level, there are intercompany experience studies and reports that come out periodically. They're on the Web site. There's also a group that is looking at developing a morbidity table for LTC. The model regulation does not specify a morbidity table. The SOA has a group that is charged with developing that table. That committee has been around for quite a while. They are making progress, but it's a very slow process. We're trying to do it based on the intercompany study, and there are a lot of problems with data. We go back and forth with the Medical Information Bureau, which is the keeper of all of the data. We get some very strange anomalies. We'll find experience on substandard cases that looks better than standard, or we will get much different results by benefit period or elimination period than you would expect. The big struggle with that is trying to get through the data issues. We had intended to have an initial draft report out at the end of this year, but I don't believe that that will happen.

MR. BELL: In the non-LTC part of the presentation, there are three major topics

that I want to cover. Whereas Mr. Schmitz had the good fortune to be able to talk about events that have happened recently and are about to be of practical interest to valuation actuaries, the majority of the things that I will talk about today are regulatory developments that are still in process. Therefore, while they are not things that you may need to think about actively at year-end 2005, they are things that will affect our business in future years.

The main items that I'll talk about include a variety of recent activity regarding the new Medicare Part D program. I'll focus more on financial reporting issues, in particular, RBC and statutory accounting for the product. After that, I'll talk about other issues going on at the NAIC relating to accounting, statement reporting, RBC, etc. Finally, I'd like to talk about developments in regulatory bodies other than the NAIC, in particular, things that are going on at the international level to which we, as health actuaries in the United States, should pay attention.

I'll start by talking about Medicare Part D, focusing on financial-reporting aspects. I'll start with RBC. If you look at the current RBC formula, it takes a fairly nongranular approach to examining health business. Things are broken into a fairly small number of categories. In particular, things like the existing Medicare Plus Choice program and managed Medicaid are lumped in with commercial major medical policies for RBC purposes. All three of those types of programs receive the same treatment. Whether you think that's appropriate for your own company capital model is a different question. From the NAIC standpoint, in order to keep the formula relatively simple, it made that design decision back in the mid-1990s.

When talking about Medicare Part D, the first question that might come to mind is, why would we need to worry about it at all from a RBC standpoint? The answer to that is found in the way that the RBC formula currently treats stand-alone prescription drug plans. In the current marketplace, such plans are very uncommon. Drug benefits almost always are sold alongside major medical benefits. In that context, if you have a major medical program that has a drug card attached to it, you would combine the drug claim experience with the major medical experience and report that in the category used to assess what you receive from major medical.

There is a small piece of instructional guidance in the current RBC formula that says that if you happen to have a stand-alone prescription drug plan, you would report that in a catch-all category called "other health." The factor for things that are in this catch-all category is much higher than it is for major medical. With major medical, although the factor starts at 15 percent of claims, it quickly grades down to 9 percent of claims. So unless you're a very small writer, your average RBC factor for major medical is somewhere in the 9 to 10 percent range.

On the other hand, this "other health" column is assessed a 13 percent charge with no reduction for scale. Consequently, if nothing were done to the RBC formula, the default would be that Medicare Part D would fall into "other health" and receive a

RBC charge that, on the percent-of-premium or percent-of-claims basis, is much higher than what currently applies to major medical. That result doesn't seem reasonable on the face of it. You shouldn't have the same fluctuation risk with Medicare Part D as you would have with major medical, for a couple of different reasons. First, there is the existence of government risk-sharing. Second, there isn't the potential for catastrophic $500,000 drug claims, as there is with major medical claims.

For this reason, earlier this year, people started thinking about the fact that it might be necessary to change the existing RBC formula in such a way that there would be a treatment that would make sense for the new Medicare Part D program coming online in 2006. Bell, page 2, slide 2 shows the timeline of activities relating to RBC treatment for Medicare Part D. It was earlier this year that the Academy work group was formed. The NAIC gave a formal charge to the Academy, asking it to look at various treatments. In August, the NAIC received an initial report from the Academy subgroup. This report talks about structural changes that would be required to implement a new treatment but at this time does not provide the actual factors that would be applied.

Let me give you a bit of background about the procedural elements related to RBC changes. The RBC formula is applied once a year. The 2006 formula will apply to year-end 2006 financial reporting. That formula will not be completely final until approximately June 2006. So there's a possibility, in general, in any year, that a factor change could be made in the first half of the year that would affect the RBC that you would file at the end of that year.

However, when it comes to making structural changes to the formula (i.e. the ability to assess a new type of factor that hasn't been there before or other things that would affect the mechanics of the calculation), the NAIC's practice has been to make those changes by December of the year before the change would take effect, because the organization and the software vendors need time to integrate the changes into their programs. So by December 2005, the structure used for the 2006 formula needs to be locked in place, even if the actual factors themselves haven't been fixed yet. That's the reason for this two-step approach. The Academy needed to act by August in order to give the NAIC the ability to change the structure of the formula by year-end 2005, but the actual factors applied do not need to be locked in until June 2006. Obviously, that creates a practical problem for companies that are interested in knowing what their cost of capital on this product is going to be, particularly for reinsurers, who are probably more likely to be concerned than direct writers trying to use cost-of-capital implications in their pricing. For the first year of the program, unfortunately, we'll have to live with a bit of uncertainty.

The intent would be for the NAIC to adopt the structural changes in the formula by December. Because of Hurricane Katrina, the September NAIC meeting that had been scheduled to be held in New Orleans was cancelled. The NAIC members are

having conference calls this month in order to address some of the key items. That would keep it on line to be adopted in December, and, therefore, the holder will be in place for the new factors. With regard to the new factors, the Academy is continuing its work into fourth-quarter 2005 and may stretch it into early 2006 to come up with proposed factors to put into the new formula. That could be adopted in June and effective in 2006.

It has been the NAIC's practice that when it makes changes in the RBC formula's extent policy, it tries to make parallel changes to the annual statement in order to minimize the reliance on company records rather than annual statement values as inputs to RBC. That is, it would like as many as possible of the inputs used in the RBC formula to be numbers that actually are appearing in the annual statement. For that reason, I expect that, probably for 2007, we will see some annual statement changes in order to facilitate reporting of financial information on Medicare Part D. However, that effort to think about what sort of statement changes would be necessary is just getting underway.

Before I can talk more about the RBC situation with Medicare Part D, it's necessary to take a detour into accounting. As a general rule, I think that it's important to realize that RBC standards are intrinsically related to the underlying accounting basis. That's most clear-cut when it comes to asset RBC values, but it's true on the underwriting side, as well. You have a paradigm in which you're applying factors against premium claims values. You need to know what's going to be counted as premium and what's going to be counted as claims, if you're to have any hope as to what sort of factors you should be setting. That isn't to say that the RBC consideration should drive the accounting. However, it's necessary to understand the accounting before the RBC can be developed. As the Academy was thinking about developing RBC factors from Medicare Part D earlier this year, it quickly became aware that it wasn't entirely clear how you would account for Medicare Part D product under statutory accounting. There have been some discussions regarding that.

You might think that statutory accounting for a medical product is a clear-cut issue. But in this case, there's a lot of complexity and novelty in the Medicare Part D program, not only in terms of the benefit design, but also in terms of the role that the government plays in the program. It makes the nature of the accounting question a little different from other health products.

We now need to talk about the technical details on Medicare Part D. The diagram in Bell, page 3, slide 2 attempts to represent how the standard benefit design in Medicare Part D works. The white regions are areas that are the enrollee's responsibility. There's a $250 deductible; the enrollee is responsible for everything below that on an annual basis. There's a 25 percent coinsurance; the enrollee is responsible for the next $2,000 of claims. There's then this famous piece called "the donut hole"; the enrollee is responsible for between $2,500 and $5,100 in claims for 2006 in the standard design. Once the annual drug costs have exceeded

$5,100, the enrollee is only responsible for 5 percent, the carrier is only responsible for 15 percent, and 80 percent of the risk over $5,100 is the government's responsibility.

From the insurer's standpoint, this is a very unusual benefit design. The carrier has a layer for which it is responsible for 75 percent of the claims, a layer for which it has no responsibility and a layer for which it is ultimately responsible for 15 percent but needs to worry about getting government reimbursement for the other 80 percent. In Medicare Part D, there are several different types of cash flows. From an accounting standpoint, you don't have nearly this many sorts of different cash flows that you need to think about separately in a normal product.

First you have the base beneficiary premium, the amount that the enrollee is paying to the carrier. Second you have what's called the "direct subsidy." This is the amount that the government is paying on behalf of the enrollee. The way that they've structured the program, the enrollees only are supposed to be paying roughly 25 percent of the cost of the program. The government is kicking in the other 75 percent. The 75 percent that they're kicking in is what's known as the direct subsidy. There's also the possibility of premium subsidy. For certain low-income individuals, the government will pay part or all of the 25 percent that the individual is supposed to cover. The base beneficiary premium will be paid by the government as a so-called "premium" subsidy.

Then we come to what's known as the "reinsurance subsidy," which relates to the 80 percent region. For the claims for which the government is responsible, rather than have a mechanism whereby the insurer pays the claims and then submits an invoice to the government and gets money from the government, it was decided to have the government fund these claims on a monthly basis instead, based on expected values as you go along, and then have a true-up mechanism. Every month, the carrier will get a monthly payment from the government representing the expected government share of the claims above the $5,100 level. There will be a true-up mechanism at the end of the calendar year, to the extent that the actual experience is different from what the pricing assumptions have been.

Cost-sharing subsidy is similar to premium subsidy in areas such as the deductible and the 25 percent copay for which the beneficiary is responsible. For certain low-income individuals, the government will pay part or all of that. Plus, there is a risk-sharing component in this contract. To the extent that the carrier's actual experience for the calendar year differs from pricing, there may be a sharing of gains and losses between the carrier and the government. As in other retrospective arrangements, there will be a need for a true-up.

There are a couple of potential cash flows that won't pertain to all carriers. Some carriers are participating in a reinsurance demonstration program. For the 80 percent piece above $5,100, rather than having these monthly reinsurance subsidies with a true-up mechanism (in which case, the government is really in the

risk), under the demonstration program, the carrier has agreed to accept capitations from the government. The carrier is bearing the risk if pricing is different from expected.

Finally, it's possible that a carrier might offer supplemental benefits in addition to the standard benefit design and might charge a separate beneficiary premium for that. But again, that's more of an optional component to the program.

From an accounting standpoint, we have all of these different cash flows. We need to think about what's going to be reported as premiums or as claims. Over the course of the summer, a proposal known as a "Form B" was developed and has been submitted to the NAIC Emerging Accounting Issues Working Group. The most likely outcome of that is that it will vote to expose the proposal of the tentative consensus, therefore, offering up a window of public comment. In December, it could vote to adopt the tentative consensus as an interpretation of statutory accounting. That would make it effective in time for first-quarter 2006 financial reporting, the first time that this product will be issued.

In Form B, the group is trying to interpret existing statutory accounting as it would pertain to this type of product. It is saying that the program represents what's known as a partially insured contract. It's a contract that has elements of both an insured plan and an uninsured plan. The risks for which the carrier is ultimately responsible (the 75 percent of claims below the donut hole and 5 percent of claims above the donut hole) are to be accounted for as being a retrospectively rated contract. It's insurance in that you would have premiums, you would have claims, and you would need to true up the premiums to reflect the risk-sharing between the carrier and the government.

The piece for which the government is ultimately responsible (the 80 percent above the donut hole) is to be treated as an uninsured plan under this proposal. Those reinsurance subsidies that are collected monthly by the insurer would not be treated as revenue under this proposal, nor would the claims that the insurer is paying that relate to those reinsurance subsidies be reported as incurred claims. This would make the accounting for that part of the program exactly the same as it would be for an ASO or Administrative Service Contract plan. Nothing is affecting the revenue or claims portions of the income statement. Finally, there are supplemental benefits, which are treated as a normal insurance contract.

It implies that the carrier would report the premiums received, both the premiums received directly from the enrollee and the direct subsidies from the government, as your premium. Your incurred claims are the 75 percent below the donut hole and the 5 percent above the donut hole. The reinsurance subsidy through associated claims aren't premium, and they aren't claims, unless, of course, you're participating in the demonstration program, for which you're receiving capitations and you're in the risk. In that case, you would report the capitations as premium and the related benefits as claims.

In order to try to make this more concrete, I've prepared an example in Bell, page 5, slide 2. I should point out that I am not a pricing actuary. I have not done any work involved in pricing Medicare Part D, and, therefore, these assumptions merely are meant to be illustrative and are not, by any means, a suggestion of a viable pricing model for this product.

Having said that, I've assumed that the population can fit into three groups. One-fifth of the enrollees are relatively high participants, using $750 in drugs every month. One-third of the enrollees consume $300 in drugs per month. I'm assuming that the remainder of the population are fairly light users, consuming $60 in drugs per month. If you put these assumptions through the standard benefit design and do the math, the expected per member per year claims cost to the insurer (that's the 75 percent below the donut hole and the 5 percent above) is $1,082. If we gross that by 10 percent for administration and profit, it would be reasonable to charge $100 per member per month for this product. The way that they designed the program, the enrollee is paying 25 percent of the premium and the government is paying the rest.

That is important, because the low users are consuming $60 in drugs per month. Why would they pay $100 per month if they're consuming only $60 in drugs? The answer, of course, is that they wouldn't and they're not. They're only paying $25 per month, and they're getting more back in benefits than the premiums that they are paying. They're consuming $720 of drugs per year, and they're getting something like $350 of insured benefits out of the program. If I'm assuming that the premium is $100, they're paying only 25 percent of that. They're paying only $300 per year in premiums. So it is rational to assume that these low users would enroll in the program, even though their actual drug spending is less than the annual premium, the all-in premium, both the beneficiary and the drug subsidy.

This is a product with a loss ratio of 90 percent for the year. Looking at the insurer's claims over the collected premium and ignoring the reinsurance subsidies, this is consistent with the statutory treatment. Of course, the reinsurance subsidies do exist. If you do the math on a per-member-per-year basis, Centers for Medicare & Medicaid Services (CMS) would be responsible for $624 of claims, all of which are coming from the high users. The other two groups never get above the donut hole.

What's interesting about the statutory accounting model that we're talking about is that it's going to have very unusual seasonality patterns. On a per-member-per-quarter basis, what will the experience for the carrier look like over the course of the year? Looking at the fourth row in the last column of Bell, page 6, slide 1, by the end of the year, we see a 90 percent loss ratio. However, the loss ratio starts out at an exceptionally high level in the first quarter (154 percent), followed by successively lower quarterly loss ratios, in order to eventually get the annual loss ratio down to the pricing level.

The reason that this is happening relates to the very unusual benefit design. You

have level premiums, but the risks being born by the insurer are decidedly not level. In the first quarter, people are mostly below the donut hole. Later into the year, people have moved into the donut hole, so the insurer isn't paying any claims for those people. By the end of the year, you start to have people that have moved above the donut hole, so the insurer has some residual claims and responsibility.

You can see the impact of the donut hole if you look at the reinsurance subsidies and CMS Obligations line on the chart. In the first six months of the year, under these assumptions, the insurer is collecting monthly reinsurance subsidies from the government but has not yet had to fund any of the claims to which those reinsurance subsidies pertain. Near the end of the year, the insurer has to shell out the money that it had been receiving all along from CMS. An extremely unusual seasonality pattern can be expected with this program under the statutory accounting model. It's interesting to note that if you were to look at the loss ratio on a cash basis (by which I mean, look at the claims of the total benefits that the carrier is paying out—the statutory claims plus the CMS obligations divided by the total funds that the carrier is collecting, the statutory premium plus the reinsurance subsidies), the seasonality pattern is much less severe. However, statutory reporting does not follow that convention, but, assuming that the Form B proposal is adopted, will follow the pattern shown earlier.

This is very interesting, and I'm not certain that a lot of people have explored this yet. Over the next few months, it's possible that people may think about whether there are other accounting models that might be assessable on a GAAP basis in order to prepare a pattern of earnings emergence that is less seasonal than this. However, it will be interesting to see whether or not any such models are validated by the accounting firms.

Understanding the accounting for this is fundamental to having the discussion of what they're going to do with the RBC. The Academy group will proceed under the assumption that the statutory accounting model that I've portrayed will be adopted. In terms of the structure of the formula, the Academy is proposing to split the Medicare Part D product into several different pieces.

Supplemental benefits will be carved out. If you're offering supplemental benefits under Part D, there would be a separate premium charged for that. The standard benefit designs will be split into different categories, as shown in Bell, page 6, slide 2. The Academy has tried to design the different categories to have maximum flexibility, in case the government, at some future point, were to walk away from the risk-sharing aspect of the program or from the reinsurance subsidy part of the program. There's flexibility in these categories to provide for that.

If you're in the standard program rather than the demonstration program, you would fall into the latter of these categories. If you were in the reinsurance demonstration program, you would fall into the first one. The other categories probably are not likely to be relevant in the immediate future. But we don't know

yet what the factors will look like. Hopefully, factors would be exposed in March 2006 for adoption in June 2006, at the very latest.

I now will discuss more general NAIC issues. On the statutory accounting front, other than the issues just described, there are not a lot of new developments to report. Statement of Standard Accounting Practice 85 (SSAP 85) took effect last year, and blanks changes related to SSAP 85 took effect in 2005. SSAP 85 deals with what are called "cost-containment" expenses of things that lie between incurred claims and administrative expenses—network fees, usage-review fees and things of that nature, whether internal or external. The carrier does these not because they're administratively necessary, but because by doing them, it thinks that it will bring down the cost of incurred claims.

These items now need to be recorded separately in the blanks. This could have some minor geographic implications from an evaluation standpoint. For example, if you're signing an opinion in 2005, you might want to talk with your accountants as to whether the geography of certain items has changed. It may have been your company's practice, in the past, to accrue unpaid network fees as part of general administrative expense. Under SSAP 85, they probably would be accrued as part of cost-containment expenses of a subset of claims adjustment expense. That accrual is part of your loss adjustment expense (LAE) liability, which means that it's now inside the scope of your opinion, and you need to understand it in order to opine on the company's statement.

With regard to SSAP 84 on health-care receivables, there are a couple of implications of that guidance on valuation methodology to which people may not have paid special attention. In SSAP 84, there are some items that historically might have been netted against the claims liability, but must be shown on a gross basis as an asset in the statutory blanks going forward. Two things that come to mind are pharmaceutical rebates and claim-over-payment receivables. From the valuation standpoint, this means that, in order to be technically compliant with the new guidance, your claims triangles need to be gross of those items. For example, if you are reserving for drug claims, you should be getting a drug triangle that does not include rebates. If you are reserving for medical claims, in principle, you should be getting a triangle that is net of amounts that were overpaid to the hospital and, subsequently, they pay that money back. In practice, I'm not sure that people are doing this. Because of that, a case could be made that the reserves produced from triangles that are prepared on a net basis are not really compliant with the spirit of what SSAP 84 was trying to accomplish with gross presentations.

Difficulties with the analysis of claims unpaid the prior year relates to these problems in SSAP 84. You may not like the SSAP 84 presentation, in that you have items that are presented on a gross basis. One of the reasons that you may not like it, in particular, is that some of those items end up reported in the income statement as paid claims. For example, you have a pharmaceutical rebate and you book it as an asset at year end. When you receive the rebate, that is reflected

through the claims row of the income statement. If you now are testing your previous reserve, you would need to take into account that some of the items that are reported after the fact as claims were, by design, not included in the beginning liabilities. There have been some growing pains in terms of developing appropriate instructions for the blanks-to-reserve testing in the right way. I would urge you to try to come up with reserve tests that are meaningful, even if the instructions are unclear as to what you should be doing.

From an RBC standpoint, there are LTC developments. We're talking about the prospective probability of having new Medicare Part D RBC. For the last couple of years, there has not been a separate group at the NAIC to look at health-specific RBC issues. That group had been disbanded as part of an aborted attempt at streamlining the NAIC a couple of years ago. The group has been reformed recently, so there will be a specific forum for health RBC issues going forward.

In the last year or two, the NAIC has been developing a new trend test for property-and-casualty (P&C) insurers. You can be above the 200 percent level and still fall into the RBC action levels if your RBC has been falling. Basically, it's an early-warning mechanism. There isn't anything like that in health right now. The NAIC is in the process of adding a trend test to the P&C formula. That is a mechanism whereby a carrier can be above 200 percent but somehow get included in the action levels. The new P&C test is based on the operating ratio of the company, which is claims plus administrative expense over premium. It's conceivable that once it has adopted the P&C version, it will turn its attention to health and try to find some similar mechanism that would be helpful to the regulators in terms of an early-warning mechanism. Your capital position could be fine, but if you are losing money steadily, it may want to include you in the company-action level anyway.

As one last comment on RBC, there's the possibility of a project that would try to assign a different RBC factor to major medical products that have active life reserves, under the theory that those products are more stable due to the presence of the active life reserve. That project has been percolating for a while. There may be some activity over the course of 2006.

One blanks issue that I want to talk about is the A&H Policy Experience Exhibit. Those of you that follow the life blanks probably always have been filing an exhibit with this name, but we're really talking about a completely new one. This is the result of several years of discussion at the Accident and Health Working Group of the NAIC as to the best way of getting consistent financial information across to all writers of health products.

Right now, if you have two companies, one of which files the blue life blank, and the other files the orange health blank, those companies are reporting on their health business in very different ways. The blue-blank company in Schedule 8 is reporting on renewable classifications, whether the business is noncancelable,

guaranteed renewable, etc. The health-blank company is reporting on product definitions in the orange blank, whether the product is medical, dental, Medicare, Federal Employees Health Benefit Program (FEHBP), etc. If you have two similarly situated companies filing different blank types, it's very difficult to compare that information.

The NAIC discussed several alternatives for remedying this. In the end, the approach that it chose was to leave everything in both blanks exactly the way it is. Later on, a new level of reporting—a new supplemental exhibit—will replace it. It is considering repurposing the old A&H Policy Experience Exhibit and adding it to the health and P&C blanks. This is going to take effect for year-end 2006. It's a supplemental exhibit, so it doesn't need to be filed until April, which gives people more time. Its concept is to provide line-of-business-level reporting on premiums, incurred claims and membership. If you need to be able to provide 2006 incurred claims on a fairly granular level, you need to have allocated the year-end 2005 reserve on that basis. The good thing about the exhibit is that you do it once for the entire company; it's not a state-by-state exhibit.

The bad news is that the level of granularity is very high. For example, it's not just medical disability LTC. Within disability, it's broken out between short and long term. With the medical, it's broken out between normal, individual medical and short-term, six-month products. For group, you have to break out your group medical between small group and large group, but also for single employer, a multi-employer trust, an association, etc. It's important to recognize that there's a new regulatory requirement coming that may require you to partition your reserve in different ways than you've historically done it. It's an issue that you'll need to think about over the next several months of developing the programming and/or reserve cell divisions, in order to be able to prepare for this.

There's one other NAIC issue having to do with premium deficiency reserves. I think that the introduction of policyholder dividend reserve (PDR) requirements and codification five years ago created a lot of angst for health actuaries. I think that that angst is related to the fact that statutory reporting is so much more granular than GAAP. Financial Accounting Standard 60 (FAS 60) requires that the company hold a premium deficiency reserve for a group of business for which that group is determining consistently how a product is marketed, measured and serviced. When measured in the context of GAAP financial reporting, that tends to be done at a very high level. When FASB was developing statutory accounting, it put that language into SSAP 54, but now within SSAP 54, a statutory accounting measurement is so much more granular than it is for GAAP. My view is that that has introduced a lot of concerns. People now need to recognize PDR for statutory basis on a much finer level than they ever had to do on a GAAP basis.

Some actuaries have expressed a desire for clarification of the guiding principles that are behind the current PDR requirement in order to explore that further. If we can articulate the guiding principles, maybe we can resolve some of the

inconsistencies that exist in the current guidance between accounting, the model regulation, the actuarial standards, etc. There were some efforts earlier this year to articulate such a set of principles. More recently, that project was taken off of the agenda due to an apparent absence of any sort of regulatory consensus. I think that there's still an interest in this issue. One of the trade associations is planning to bring this issue up some time in the near future.

Many of you may remember the Health Practice Notes that were issued by the Academy in 1995. Over the last couple of years, the Academy has been working on refreshing those to bring them into the 21st century, given the fact that a lot has changed, in particular codification, statutory accounting, health reserves guidance manual, etc. Several of those updates have been released. To date, Small Group Medical, Individual Medical, Disability Insurance and Medical Supplement have been released. There are a couple more that are still in development. I would encourage anyone involved in the valuation of those products to go to the Academy Web site to look for those notes. Again, these are practice notes; they are not standards of practice. You are not required to adhere to anything that is written in the practice notes. They are simply meant to provide guidance to practicing actuaries as to different acceptable practices that exist within the community.

Another Academy initiative is the best estimate white paper. This is an outgrowth of conflicts that became apparent a couple of years ago between how medical actuaries were interpreting the phrase "management's best estimate" in statutory accounting and how P&C actuaries were interpreting that phrase. There has been a joint effort between the Health and P&C Councils of the Academy over the last couple of years to write a white paper describing this diversity of practice. That has been on hold for the last year, but there's going to be a major push to finish that white paper and get it published by the end of 2005.

I now want to talk about some issues going on in the GAAP and international accounting worlds. FASB currently is trying to come up with a definition of "insurance," for the first time. The approximate cost of looking at this issue is all of the nasty press that has occurred in the last several months regarding finite reinsurance and risk transfer issues. If you read *The Wall Street Journal*, or any other business paper, you've seen articles about how some of the casualty companies have subjected to inquiries. There is a renewed interest in trying to figure out an appropriate risk transfer standard. FASB's current plans are to expose some sort of tentative guidance in early 2006. They're going to define things like "insurance contracts" and "insurance risk."

As health actuaries, it's important for us to keep an eye on this. One of the standard risk transfer tests that always has been a rule of thumb is the so-called "10/10 test." Something has to have a 10 percent chance of a 10 percent loss in order to represent risk transfer. My feeling is that many of the direct products written by health insurers would not pass that test. If you're looking at your medical blocks, most of you do not think that there's a one in 10 chance that

you've missed by 1,000 basis points in your loss-ratio estimate. The only reason that I point that out is that if FASB were to adopt something like the existing 10/10 test as a definition of what it meant to be insurance risk, we might find that none of what we write is insurance. I doubt that's the right answer.

Last year, FASB started an annual insurance industry forum for the first time in recent years. The FASB board meets with representatives of the Academy and of the trade associations to discuss a variety of issues. That will be going on again. What's suddenly so different about insurance that FASB decided to liaise with the insurance industry more actively? The answer to that question is found in the international realm.

Most of you have heard of the International Accounting Standards Board (IASB), which is the international counterpart to the FASB. In recent years, there has been coalescence toward developing a set of International Financial Reporting Standards. You could think of this as a global version of GAAP. It's in effect in Europe and many other countries. It has done something called "Phase 1" accounting for insurance in order to put guidance in place, but there was so much contention as it was talking about guidance for insurance accounting that it had to pull the plug and just adopt a stop-gap measure while it tried to develop a permanent model. That's called the insurance contract Phase II project. That has been going on in earnest for the last several months.

The IASB has formed an Insurance Working Group that mostly consists of CFOs from global insurance companies, as well as some partners from the accounting firms. They're meeting on a quarterly basis and discussing a number of issues. I think that they are quite a distance away from anything resembling the final resolution, but they are being good about posting what they're doing on a quarterly basis and giving the world an inside glimpse of what might be coming.

The reason that this is important is that FASB has decided informally and signaled very strongly that it intends to try to converge its standards with whatever the IASB comes up with as a result of insurance contract Phase II. In a couple of years, it's likely that FASB will release an exposure draft based on IASB Phase II that would replace the existing U.S. GAAP guidance on insurance. FAS 60, FAS 97, FAS 113, etc., likely would be replaced by new guidance based on the outcome of the international discussions. For that reason, if you have an interest in U.S. GAAP, it's important to follow what's going on in the international arena.

It's probably also important if the only accounting basis that you have an interest in is U.S. statutory because, in the post-codification world, the NAIC has decided that any time there's a change in the relevant GAAP guidance, it at least is going to consider that and determine whether or not it's something that it should adopt. It's quite possible that it would find things in the new guidance that it didn't think were prudent, but there's a potential that it might consider it. What's happening at the IASB will affect FASB and eventually affect the NAIC.

At this point, the IASB Phase II project is examining the world through two lenses. It has split the world into life versus non-life. That's a model that probably makes sense in every country except the United States. In the United States, we have three distinct industries, not two. LTC and the other long-tailed health products probably fit under the life part of the discussion. However, medical, etc., are much more likely to fit under the non-life part of the discussion.

I want to spend a couple of minutes talking about what's going on on the non-life side. For those of us working in the medical industry, that is what is potentially relevant to our future. Because of that, it's important that the health industry try to pay more attention to what's going on in these IASB non-life discussions. Hopefully, we'll get increased activity on that at the Academy level, but it's also important from the industry level.

I want to share information from some of the current working documents of this ISAB Insurance Working Group with respect to the non-life aspects of its project. With respect to non-life claim liabilities, it is saying that those liabilities should reflect current and biased estimates of future cash flows and should reflect the time value of money (i.e., you would have to discount your claim reserves, which would be a new practice on the medical and dental side), and you should include adjustments to reflect risk. That's probably not a new practice to those on the medical side. Most people are putting risk margins in their reserves. Certainly from statutory standpoints, it's probably prudentially required. From a GAAP standpoint, most people simply are setting their GAAP reserves equal to their statutory reserves.

One of the things that came out of the example that I gave earlier on Medicare Part D was the fact that if you have a nonlinear risk pattern, recognizing premium on a linear basis will lead to funky results. IASB is thinking about these issues, as well. When should an insurer recognize premium receipts as revenue and when should an insurer recognize them as deposit receipts? When should an insurer recognize premium revenue for contracts with nonlinear risks? The group also is thinking about what cash flows should constitute premium revenue and what cash flows should constitute deposit receipts. Again, we saw that in the Medicare Part D example.

UNIDENTIFIED SPEAKER: In addition to the reinsurance subsidy, there's risk adjustment on the revenue. There will be 100 percent risk adjustment, depending on the risk profile of the population that the insurance company is taking on. If you have a high-risk population, your revenue will be adjusted upward. Similarly, if it's a very select group of population and it's low-risk, you'll lower revenue. That will reduce the risk.

The third and probably one of the most important features are the risk corridors. For 2006 and 2007, there's plus or minus 2.5 percent around the loss ratio that you

assumed in your pricing as 100 percent risk for the company. That's for the piece for which the insurance company takes the risk, whether it be that direct subsidy that Mr. Bell was talking about or if someone is participating in the reinsurance premium demonstration for that piece. Outside of the 2.5 percent corridor, there's protection from CMS, which takes 75 percent of the risk plus or minus 5 percent; CMS will take 80 percent. So the risk to the insurance company is from 2.5 to 5 percent above the loss ratio in your pricing. There's only a 25 percent risk above 5 percent; it's 20 percent. Conversely, if your profit is greater by 2.5 to 5 percent, you must return some money to CMS, as well. It's like an experience-rated situation to that extent. That greatly reduces the risk.

The intent of our survey is to poll the actuaries and ask how bad worst-case scenarios could get. How bad could a moderately adverse situation be? Would it be that you miss it by 50 percent in a worst-case example? Would moderately bad experience be a 20 percent miss? Without any risk adjustment and without considering the risk corridors, if you assume that risk adjustment and your answer for worst-case is 50 percent, how much would you reduce that if you know that there's risk adjustment in your revenue? Does 50 percent become 25 percent? Using whatever we come up with as a consensus as a body of actuaries, we will apply the risk corridor factors and determine the risk for the company.

For example, if somebody says that 50 percent is worst-case scenario for missing the pricing (ignoring risk adjustment), the average is that roughly half of that risk would go away. If you know that your revenue will be adjusted, you're down to a 25 percent miss, in terms of what your loss ratio could be. Plug that 25 percent into the risk corridors. Remember, for the first 2.5 percent, the company has the entire risk. For the next 2.5 percent, it's only 25 percent of the risk. For anything above 5 percent, it has only 20 percent of the risk. In the worst-case scenario, that comes out to roughly a 7 percent total risk to the company.

With a 7 percent risk, should we have an RBC factor for 13 percent, which is what the current NAIC model would say that stand-alone pharmacy would fall into? You can see the problem. Right now, pharmacy coverage falls into the "other health" category, which has a 13 percent underwriting factor. That simple example indicates that it shouldn't be there. For major medical comprehensive health, the factors are 15 percent for the first $25 million and 9 percent thereafter.

UNIDENTIFIED SPEAKER: When is the survey going out and when are you expecting results back from companies?

UNIDENTIFIED SPEAKER: My working group is having a call today on a draft that I put together and we're going to discuss that. We're hoping to get that in front of the NAIC by the December 2005 meeting.

UNIDENTIFIED SPEAKER: That will be the result of the implications based on the survey?

UNIDENTIFIED SPEAKER: Yes. But we'll take the results from the survey, apply the risk corridors and come up with our recommendation to NAIC as the factors coming from our group. We have that risk corridor protection for 2006 and 2007. For 2008 to 2011, those corridors become 5 percent increments instead of 2.5 percent increments. But we still have the 25 percent and 20 percent risk above those levels, so it's greatly mitigated. We will gather data and get to the statistical modeling, but it's not going to be for a couple of years. By the time we're in the 2008 to 2011 period, we probably will have enough data to start statistical modeling and refine those factors.