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Health Regulatory Update

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Summary: Panelists share their perspectives on valuation-actuary-related issues, including issues that are hot from a regulatory standpoint. Topics discussed include health risk-based capital (HRBC), impact of codification and current areas of focus of the NAIC Life and Health Actuarial Task Force (LHATF). At the conclusion, participants have a better perspective on various regulatory issues.

MR. ROWEN B. BELL: I'm an actuary at the Blue Cross Blue Shield Association (BCBSA) in Chicago. My primary work there involves financial regulatory issues, such as monitoring various developments at the NAIC that have a financial, actuarial or solvency-related flavor and advocating on those issues on behalf of the nation's 42 BC/BS plans. My co-panelist this morning is Bob Yee. Bob is a long-term-care specialist, most recently with GE Capital, but Bob tells me that he will shortly be commencing work at Milliman's San Francisco office.

The structure we have for this morning's talk is that I'm going to start off with some general issues, and then Bob is going to follow up with some interesting things that are going on in the long-term-care area.

I tried to group the various small topics I'll be talking about this morning into five general categories that should be of interest to health valuation actuaries: statutory accounting developments; annual statement reporting developments; risk-based capital (RBC) developments; reserving developments; and finally some potpourri items.

The first of the statutory accounting topics I want to discuss is the cost-containment expense paradigm. This is something that actually counts both as a statutory accounting development and an annual statement reporting development.

If you go back a couple of decades, health-care financing was generally in more of an indemnity model or service model where, from a financial reporting standpoint, there was a fairly clear delineation between a health insurer's incurred claims—its contractual benefit obligations—and its administrative expenses. There weren't too many concerns about whether something was a claim or an administrative expense. With the advent of managed care and its evolution over the past couple of decades, things have gotten a lot fuzzier. There are many activities that health insurers currently do, not because they're contractually obligated to do them and not because they are technically necessary to administer the health insurance benefit, but because by doing them, the health insurer believes that ultimately the cost of claims is being reduced, and hence premiums are being reduced.

The cost-containment activities that we're talking about include network development, utilization reviews, case management and disease management. These activities are in some sense optional, although people have come to expect them; so in a practical sense, they may no longer be optional. From a technical standpoint, however, they're not called for in the contract but are being done in an effort to keep the cost of claims to a minimum.

Current practice among health insurers varies widely with respect to reporting of these items. In a paradigm where a two-part division is made, namely claims versus administrative expenses, there may be incentives to show as high of a loss ratio as possible, or as low of a loss ratio as possible. Some of these cost-containment items may be currently reported in claims by one carrier and in administrative expenses by another carrier.

The NAIC has spent a couple of years kicking this around and decided that rather than the current two-bucket system, it would be appropriate from a financial reporting standpoint to acknowledge that there is a middle ground. With that, it has come out with the notion of cost-containment expenses as a separate reporting category. Cost-containment expenses are defined as expenses that actually serve to reduce the number of health services provided or the cost of such services. There's been a little bit of angst over the word "actually," and I think that the intent was that the health carrier would periodically study the efficacy of the expenses that it believes to be cost-containment expenses so that, if called upon, it could demonstrate that the items it considers to be cost-containment expenses have had more than a 1:1 benefit-to-expense ratio.

Statement of Standard Accounting Practice (SSAP) 85 is the accounting guidance relevant to cost-containment expenses. It was passed in June 2002 and contains a list of items that are examples of cost-containment expenses, including case management and utilization review costs, consumer education relating to health

improvement (disease management may or may not fall into that category), and network access fees and other provider contracting costs.

One point to make here is that it shouldn't matter whether you do a function internally or externally to your organization. For example, if you are a commercial carrier and pay a per-member-per-month (PMPM) access fee to a third-party PPO, the finance reporting treatment of that expense should be the same as if you are a Blue Cross plan and develop your own network internally using your own personnel to negotiate contracts directly with providers.

SSAP 85 was an amendment of SSAP 55, which is the guidance on the unpaid claim liability and the claim-adjustment expense liability. Technically speaking, SSAP 85 says that when you as actuaries are setting up your unpaid claim liability and your unpaid claim-adjustment expense liability at the end of the year, you need to follow the cost-containment expense paradigm in deciding which items go into which buckets. For example, if you have unpaid PPO access fees or pharmacy benefit manager (PBM) access fees at the end of the year, that is now considered a cost-containment expense. Cost-containment expenses are viewed as being a subset of claim-adjustment expenses. Hence, that liability would be part of the unpaid claim-adjustment expense liability line, as opposed to being part of the unpaid claim liability line or part of your liability for unpaid general administrative expense.

From an actuarial opinion standpoint, those of you who sign a health blank opinion are opining on the unpaid claim liability and on the unpaid claim-adjustment expense liability. You need to know that starting at year-end 2003, there may be some items in those lines that were not in those lines in the past, or there may be some items that are in one line, as opposed to the other, starting in 2003.

That's the accounting aspect of cost-containment expenses, but there's also an annual statement reporting aspect. Although SSAP 85 deals only with the allocation of liabilities, there will be blanks changes starting in the first quarter of 2004 to address the allocation of cash items. This applies not only to health blank companies but also to blue blank life companies. Starting in the first quarter, there are going to be instructions saying that the way in which you allocate your cash items between incurred claims, incurred claims-adjustment expenses and incurred general administrative expenses needs to conform to the definition in SSAP 85 on what a cost-containment expense is.

For example, on the health blank, where in the past you've had claims expense versus claims-adjustment expense versus general administrative expense, you now have four categories, and in Exhibit 3 of the Underwriting and Investment Exhibit on the health plan (for those of you who are life blank companies, that's the health blank analog of the old Exhibit 5 expense breakdown, which has now been renumbered Exhibit 2), there's now going to be a column showing your cost-containment expenses separately from your other claims-adjustment expenses. On the Statement of Revenue and Expenses, there will be a separate inset item

showing what your cost-containment expenses are. Similarly, on the five-year historical page, going forward for 2004 and future years, you'll be able to see the loss ratio of the company stated on two bases: First, the pure claims, incurred claims over premium; and second, the incurred claims plus the cost-containment expenses divided by premium.

What the NAIC is trying to accomplish here is to create a more consistent reporting paradigm going forward so you can pick up two different companies' blanks and hopefully know exactly what you are comparing with respect to looking at their loss ratios and their administrative expense ratios. Today, it's more difficult to do that because you don't have any guidance or disclosure as to what items a company is reporting in claims rather than reporting in administrative expenses. That's what's going on here, and those of you who work for health insurers are probably familiar with this because I would assume that to adopt this new reporting requirement in the first quarter of 2004, there would have had to have been some internal discussions by now. For those of you for which health is a minor line, it may be news.

A second accounting item I want to address has to do with valuation of subsidiaries. This is more of an accounting item than an actuarial item, but there's one particular actuarial component, so I wanted to bring it up. A new accounting standard on how you value your subsidiaries for purposes of your statutory financial statement has just been exposed. It's called SSAP 88. There will be a public hearing in December, and it has an intended effective date of January 1, 2005.

The main thrust of SSAP 88 has to do with how you value your noninsurance subsidiaries, and I want to talk about this briefly because it is a major change, so I think it's something you should be aware of.

Currently, if you have a noninsurance subsidiary—which could be a TPA, a PBM, a health clinic, an insurance agency or any business like that—assuming that it's not publicly traded, there are two valuation methods you would use for it. The one that you would naturally think of using is taking the GAAP equity of that company and carrying the asset on your statutory books at that value.

However, if you were allowed to do that for all noninsurance companies, there would be some obvious gaming opportunities. For example, you could take any asset that was nonadmitted under statutory accounting, put it in a downstream company that was not an insurer and then hold your equity in that company on the GAAP basis. You've now gotten around nonadmission of things like EDP equipment.

To protect against that potential loophole in the accounting guidance, there's an alternate valuation method where you have to take the GAAP equity of the subsidiary and revalue it according to a statutory basis of accounting. In the example that I just constructed, this would mean that you would have to look at

that computer and apply the statutory accounting guidance in terms of admissibility of that asset and amortization of that asset.

Today, we have a subjective principles-based differentiation between when you apply the GAAP equity method versus when you adjust the equity to a statutory basis. The test is whether or not the subsidiary is primarily acting for the benefit of the parent and for the other regulated companies in the parent's group. That's subjective, and it's easy to make a convincing argument with respect to any subsidiary that it doesn't primarily serve your benefit. For example, let's say that you have a TPA and that 40 percent of that TPA's business comes from you, the parent company, and the other 60 percent comes from external customers. Most people today looking at the subjective rule would say, "That's not primarily for my benefit. I should be allowed to use GAAP equity to value that company."

Although when the current guidance with this subjective rule was passed five years ago the regulators were happy with it, in reality it seems that regulators have had difficulties interpreting it and concerns about inconsistent application. As a result, in the exposure draft of SSAP 88 they have moved to a bright-line approach. If you think about what's going on in accounting right now, it means the NAIC is swimming upstream. FASB and the International Accounting Standards Board are doing more to move toward principles-based approaches for standard setting and away from bright-line thresholds, and instead the NAIC is saying, "We can't handle the principle. We need to go back and put in a bright-line threshold."

The threshold it has chosen is a very high bar, in terms of the burden of proof to permit the use of GAAP equity. Under SSAP 88, if only 20 percent of the revenues of your downstream company come from you or from other regulated companies in your group, that's enough to deem that the subsidiary is primarily acting in your benefit, and therefore you would now need to make adjustments to its GAAP equity. A lot of health companies have reason to be concerned about this. It's a possible downward adjustment to your statutory surplus position, but technically speaking, I suppose it's not an actuarial issue.

What is an actuarial issue is that this new standard would introduce for the first time explicit guidance on how you value an insurance subsidiary that is not domiciled in the United States. It's saying basically that you use its GAAP equity, with one particular exception that applies if your foreign insurance subsidiary is reinsuring policies that were originally written in the United States. In that case, you need to take those policies and adjust the actuarial reserves on those policies so they conform to U.S. statutory accounting principles (SAPs). If you have policies that were originally written in the United States but were ceded to an offshore reinsurance subsidiary, now in carrying the value of that offshore company on your own books, you would need to recalculate the reserves held by that offshore company and make sure that the interest rates being used for discounting conformed to U.S. standards. If any of you have offshore companies, once this new

guidance comes into effect, there may need to be a little bit of actuarial oversight on this particular line of the asset page.

I'll mention one other issue from an accounting standpoint, and I think that it's probably more of a life issue than a health issue by virtue of the fact that mutual health insurers tended not to have dividend-paying participating policies. If you go back three years ago, the AICPA released some accounting guidance, Standard of Practice (SOP) 00-3, that talked about GAAP accounting for demutualized companies. Once new GAAP guidance is released, eventually it is considered by the NAIC. Sometimes the NAIC rejects it out of hand, and sometimes it partakes in projects to study it. In this case, it did study the guidance and released a document called Issue Paper 117. The initial draft of that document retained the notion found in the GAAP guidance of a policyholder dividend obligation with respect to the closed block.

The recently demutualized life insurers protested vigorously, and the issue was referred to the LHATF at the NAIC, which has now provided guidance back to the accountants saying that, in most cases, industry was right. That is, this policyholder dividend obligation isn't an appropriate liability in the context of statutory accounting, but there is one particular situation where it would be appropriate, namely when the closed-block assets exceed the sum of the closed-block liabilities and any asset valuation reserve (AVR) or interest maintenance reserve (IMR) attached to the closed-block liabilities.

This issue is still in abeyance. The Statutory Accounting Principles Working Group has not yet acted on the input received from the actuaries, but it's something that you may see further development on in the near future.

Turning now from statutory accounting to annual statement reporting, I already discussed the more important of the issues, namely the blanks changes in 2004 for cost-containment expenses. Something that you'll see in your year-end 2003 blank that was not there before is called the health statement test. This was adopted back in 2001 but (in typical NAIC fashion) is only now just percolating into the blank. The concept is that when the health blank was introduced in 2001 out of the ashes of the old HMO and HMDI blanks, it was felt that it would now be an appropriate time to take companies that were pure medical insurers or pure dental insurers but which for historical reasons filed either the blue life blank or the yellow property and casualty (P&C) blank and move them over to the new orange health blank.

This was discussed at length at the NAIC, and the final formulation is that now there will be a health statement test in the blank, and it's a general interrogatory. All companies will be filling it out, and it asks you to calculate a couple of ratios, namely involving your net of reinsurance reserves and your net of reinsurance premiums. If 100 percent of both of those numbers are coming from health lines, you would migrate from your existing blank over to the health blank in two years,

unless your domiciliary commissioner objected. It is important to note that, for purposes of the health statement test, "health" excludes products like disability income and long-term care—the focus is on medical, dental, vision and similar products.

So, suppose you're a life blank company and all you write is medical insurance. In the 2003 life blank, you would fill out this test. A notification would go to your domiciliary regulator that you passed the health statement test. If it did not object, starting in the first quarter of 2005, you would file the orange blank instead of the blue blank.

That would also happen if you had a little bit of nonhealth business up to 5 percent, unless you were licensed in too many states. There was concern that if you had a national company that was 97 percent health overall, it might be 99 percent health in some states, and 20 percent health in other states, so the regulator in that other state where there was the concentration of non-health business might not be happy about no longer receiving the various exhibits found in the life blanks. That's why there is a little bit of a caveat there.

In practice, since it's been known since 2001 that this would be happening, a lot of companies have reached an agreement with their regulators to move over to the health blank earlier than 2005. So, by the time it comes on board, it may affect relatively few companies, since most of the companies it affects may have already migrated.

Once a company migrates, it's still going to be subject to some of the regulatory restrictions of its original form of organization. For example, if you're a life company and move to a health bank, you're still subject to the Actuarial Opinion and Memorandum Regulation (AOMR). There are some technical concerns over this right now. If you look at the AOMR, it explicitly refers to various line items in the life blank that you need to opine on. And if you're filing a health blank now but still are technically subject to the AOMR, what do you do? There are discussions going on about how to make this technical correction to the guidance.

Another thing I should mention is if you are a life blank company and migrate over to the health blank, it does appear that you would get to release your AVR and IMR into surplus because that is an annual statement instruction and not a consequence of your regulatory form. Similarly, you would still be subject to the life RBC model act since you're organized as a life insurer, but you would file the health version of the RBC formula.

An emerging development with annual statement reporting has to do with the accident and health (A&H) policy experience exhibit. Those of you who are health blank filers may never have heard of this. Those of you who are life blank filers are probably familiar with it. It's a supplemental filing that provides information about A&H policies on a policy-form-by-policy-form basis. It dates back quite some time.

Concerns arose in the Accident and Health Working Group at the NAIC over trying to get better consistency between the disclosures that life companies writing health business make and the disclosures that health companies writing health business make.

When the new health blank was launched, it contained an analysis of operations that has a relatively fine detail of line-of-business information, at least medical versus Medicare Supplement versus Medicare risk versus dental versus vision. However, if you are a life company with health business, all we have is the information on Schedule H on renewability class. You can't even pick up a health blank and figure out whether it's a disability company, a long-term-care company or an individual medical writer. It's difficult to do intelligence-gathering on life blank companies that write health business.

Various approaches were discussed over how to resolve this inconsistency, and the item that came out of those discussions was to have a common disclosure for both sets of companies, to not tinker with Schedule H and to not tinker with the health blank Analysis of Operations, but rather layer on a new disclosure on top of the old.

The type of disclosure being contemplated is to give specific information by line of business (for example, even down to medical, distinguishing small group from large group, and for individual medical distinguishing policies that have contract reserves versus policies that don't have contract reserves), but to do this only for premium claims and membership as opposed to the approach taken in the health blank Analysis of Operations, where you have to do a full income statement down to underwriting gain for each line.

This is still in the exploratory stages. The idea is to take the old A&H policy experience exhibit that's in the life blank and modify it along the lines as I described and also require the health blank companies to file it. It will be a long time before this will come to pass, and there's going to be ample opportunity for additional input of the process. I just wanted to make you aware of it as an emerging development.

Turning to RBC, Bob will be talking about the work that's going on in long-term-care RBC, so I'm not going to address that here. What I am going to talk about are some of the concerns that regulators have had over the efficacy of the RBC process in general.

For about a decade, we've had RBC standards in place for life companies and for P&C companies. It did come along for health blank companies several years after that. If you look at the data that the NAIC provides every year, only a small percentage of companies fall under one of the four RBC action levels. In both the life and P&C industries, this varies a little from year to year, but it's steadily in the 2 percent to 4 percent range.

On the other hand, with the P&C industry especially, there seems to be anecdotal evidence of companies that were on one day well above the RBC action levels and then suddenly plummeted through the entire action level system overnight and became insolvent. Of course, those sorts of anecdotes relate more to reserving issues than to anything else. At any rate, regulators from Wisconsin wrote to the NAIC almost two years ago, saying "Look, we have this tool. We have RBC; we have these action levels. It's in our laws; it's a nice tool. We're not able to use it very often. Maybe we need to think about recalibrating the formula so that more companies would fall under the RBC action levels."

To refresh your memory, here's what we mean by recalibration. The way the RBC formula works at the end of the day is there is a number that comes out of the black box called RBC after covariance. The number that drives the action levels is the authorized control level (ACL) RBC, which is set as a percentage of the RBC after covariance. Currently in each of the three flavors of the RBC formula, that calibration factor—the ratio of ACL to RBC after covariance (RBCAC)—is 50 percent.

However, there is nothing in the model law that specifies that number. What does this mean? It means that if you wanted to effect a change in raising the bar with respect to companies falling under the RBC action levels, changing the calibration factors is an attractive means of doing that because you don't need to go back and modify the model law or the laws in the various states. You just need to make it an administrative change with the RBC formula and that can be done on relatively short notice.

What is currently going on is only a P&C industry issue, but I think it's an important one. In June, the NAIC, after having spent several quarters behind closed doors thinking about this issue, finally came out in public and said, "We have concluded that we don't think there's a problem with the life formula or with the health formula, but we do think that the P&C formula needs recalibration." It's talking about changing the factor from 50 percent to 75 percent, which, if you invert it and think about it in terms of ratios of total adjusted capital to risk, would have the effect of reducing everyone's ratio by one-third. There is a possibility that there might be a phase-in period, but it did not explicitly mention that in the exposure.

The P&C industry, as you might expect, is up in arms over this and has been aggressively lobbying this summer in opposition to it. The comment letter that it sent to the NAIC a couple of weeks ago had three main arguments against this change. The first was that fundamentally the purpose of RBC is to be a minimum capital system, period, which is an interesting point of view. I think that most people on the life and health side may not agree with that. I think there's more of a perception in the life and health communities that there is value in the different RBC action levels as an early-warning mechanism. You dip into an action level, and there's a regulatory correction mechanism and hopefully companies come back out of that. On the P&C side, the business is more volatile. There is, as I mentioned a few minutes ago, the possibility of shocks to the system to a far greater extent than

is true in life or health, and it may well be true on the P&C side that the most important aspect of RBC is the fact that it sets a new floor.

There are two other arguments in the P&C industry letter. The second one is that if you have a higher capital requirement, that raises the cost of capital, and capital is already scarce in the P&C industry, so if you do this, you may end up restricting the availability of P&C products. I think that's a reasonable argument. The third argument is that other tools are out there that are better-suited for evaluating solvency: insurance regulatory information system (IRIS) ratios, FAST scores and other regulatory techniques. RBC was never intended to be the be all and end all of regulation. Again, there is more than one grain of truth in that statement.

This is where things sit right now. The NAIC is starting to meet on Saturday in Chicago, and there will be a public hearing on this issue on Sunday afternoon. The early indications are that the P&C industry's lobbying may have had some effect, and that the NAIC may turn its attention away from recalibration and toward another concept that it discussed in June, namely the idea of expanded trend testing.

In June the NAIC did charge the Academy to look at the idea of whether some sort of trend test would be appropriate, not only in P&C RBC but also in health RBC. Those of you who follow the life RBC formula are probably already aware that there is a trend test in life. The notion of trend testing is to take a company that is not already in the company action level—it has a ratio that's above 200 percent of ACL, but it's close, or maybe its ratio is between 200 and 250, and under certain assumptions based on recent financial results it would fall below 200 in the foreseeable future—and put it under the company action level today rather than waiting for them to fall in.

The NAIC came up with some data showing that there are many different ways you can think about doing this, and that's why it decided to bring the Academy in to explore the issues and see whether it is possible to build a better mousetrap. Can we do better than the existing life trend test in terms of trying to find a vehicle that brings into the company action level today the companies that are in jeopardy of insolvency, without creating a lot of false positives? From an industry standpoint, there are concerns over any expansion that would create a lot of false positives. Bringing companies into the RBC action levels that aren't troubled is driving a lot of the P&C industry's concern over the recalibration proposal.

The Academy is already involved in this issue, but I think the P&C industry is also going to be mobilizing down this road in the near future. I'm bringing all this up not only because I think it's interesting, but because it could affect the health industry in the end. However, I think there's less of a feeling that there's a need for a health RBC trend test. For one, the health RBC data are a lot less mature. We have only a handful of years of data, so any conclusions drawn from looking at the data would be a little bit more suspect.

Second, the whole regulatory concern over RBC efficacy was driven by the fact that so few companies fall under the action levels in the life sector and in the P&C sector. That's not true in the health sector. If you go back as recently as two years ago, 24 percent of all the companies in the United States that filed a health blank reported an RBC ratio below 200 percent.

In 2002, that number has fallen over two years from 24 percent to 16 percent and now to 12 percent because the health industry has had good times the past couple of years. Still, at 12 percent—one out of every eight health companies being below 200 percent—it's hard to argue that health RBC is an ineffective regulatory tool. I think that it's likely to forestall talk of reform of the health formula to add trend test in the near future.

As part of the exposure process of the recalibration proposal, the NAIC for the first time released some aggregate industrywide data on RBC ratios. The 2002 weighted average industrywide health RBC ratio was 460 percent, which is a number that I think was in line with that of people who had been trying to construct it themselves without access to the NAIC database, but we've never seen that number formally published before.

That's in line with the P&C RBC average, but with the life companies, there seems to be more capital in the RBC formula relative to the RBC formula than to the other formulas. If you were to go back a couple of years before the deferred tax changes were made to the life RBC formula, you would probably see a life RBC weighted average ratio that was more in line with the health and P&C ratios.

Health RBC has now been adopted in 25 jurisdictions. Now that 25 of the 51 jurisdictions have passed the health version of RBC, I think we will start to hear murmurs again as to whether health RBC should be made an NAIC accreditation standard. As you may know, the NAIC has a financial solvency accreditation agenda. There are certain pieces of guidance, such as statutory accounting, the annual statement, life RBC, etc., that are accreditation standards. If you're in an insurance department and want to be an accredited member of the NAIC, you need to have passed those laws.

I think that 48 of the state departments are currently accredited, and consequently, that helps explain the fact that life RBC has been passed everywhere. Health RBC is not yet an accreditation standard, and again, that helps to explain why it hasn't been passed everywhere. All companies are required to submit their RBC ratios and report them in a statement, but they may not be subject to regulatory action based on those ratios at this time.

One last RBC-related issue that again is an emerging development has to do with the treatment of medical products that have contract reserves or active life reserves (ALRs). If, for example, you're in the state of Florida, and regulation requires you to issue your Medicare Supplement policies on an issue-age-rated

basis as opposed to an attained-age-rated basis, you now have a medical product that builds up ALRs. The RBC formula currently makes no distinction between whether or not you have ALRs. You have the same risk charge against your formula.

One carrier has gone to the NAIC and said, "Our statutory surplus is negatively impacted by the fact that we have to hold these ALRs. We think that we are a less risky company by virtue of the fact that we have these ALRs, and we think that it would be nice to get some credit for that in the RBC formula."

If you think about it from a theoretical standpoint, there are three ways that you can do this. You can make a direct adjustment to total adjusted capital, which is similar to what is done with the ABR and IMR. You could add back in part or all of the ALRs. That would be Option A.

Option B would be to do something similar to what's done with premium stabilization reserves and within the C-2 part of the life formula or the H-2 part of the health formula have a negative risk factor apply against the ALRs. Today you take your premium stabilization reserve and apply a negative factor of 50 percent, and that goes to reduce your underwriting risk. You could do something similar with ALRs. That's Option B.

Option C would be to go back and try to develop new factors that would presumably be lower for medical products having an ALR, as opposed to medical products that don't. The original Academy modeling from which we get the current C-2 and H-2 factors did not presume that there were ALRs around. The current factors would be correct with respect to non-ALR medical business. The issue would be developing new factors for ALR.

The carrier that proposed this liked Option B the best because it was the simplest to implement and probably was optimal with respect to its particular situation. It did convince the NAIC to add this proposal to its agenda; the NAIC referred it to the Academy, and the Academy is about to study it. The Academy's Task Force on Health Risk-Based Capital, of which I am vice-chair, is the body that's going to be looking at this.

Moving on from RBC to reserving, a key issue I want to talk about has to do with how you calculate your claim-adjustment expense liability in the situation where you use TPAs or other third parties.

I think everyone has always felt that if your management contract with the TPA is such that you compensate it on a percent-of-premium basis, that makes it and not you responsible for the run out. If you were to terminate your relationship with the TPA on December 31st, you've already paid it everything that you're obligated to pay, and technically it needs to perform the run-out of the claims on that business out of the money it has already received from you.

So, if you have a TPA and you've compensated it on a percent-of-premium basis, it has commonly been believed that you don't need to take that business into account in setting up your loss adjustment expense (LAE) reserve. *The Health Reserves Guidance Manual*, which the NAIC published a couple of years ago, does contain a statement to that effect.

However, the accountants for the NAIC have taken a contrary view. In December they adopted an interpretation called INT 02-21, which came up as a P&C industry issue. Apparently, if you go back in time, there was P&C industry guidance that said the opposite of what I just said. It said you always need to hold an LAE that contemplates your having performed administrative tasks on all of your business, regardless of the fact that you may have already paid other people to do it on a percent-of-premium basis.

Once the NAIC realized that it had forgotten to incorporate this guidance into codification, they not only adopted it for P&C but also said, "If it's good enough for P&C industry, it's good enough for the health industry." In INT 02-21 it adopted the sentence, "The liability for claim-adjustment expenses on indemnity accident and health contracts should be established in an amount necessary to adjust all unpaid claims irrespective of payments made to" TPAs, etc.

The word "indemnity" in that sentence did not originally appear in the draft. The NAIC threw that in to assuage the concerns that have been raised both by industry and by the Accident and Health Working Group with respect to capitated business. One of the concerns that was brought up when we saw this was that if you are paying an HMO or provider group on a capitated basis, you report that capitation right now strictly as a claim. However, there is some implicit administrative responsibility that goes along with that capitation. If you're capitating an individual practice association (IPA), that IPA then has to turn around and pay all the doctors, so some part of the money that it is receiving from you in the capitation payment is a prepayment of administrative obligation. As industry, we were concerned that if you took literally the statement that the NAIC was proposing, it might force you to set up a claim-adjustment expense liability with respect to a contract, namely a capitated contract, for which you had no unpaid claim liability. We thought that was silly, so we pointed that out, and the NAIC decided to make its current interpretation, which it passed in December, applicable only to indemnity contracts.

The NAIC also asked the Accident and Health Working Group to go back and think some more about what should be done with respect to managed care contracts. It has been discussing this issue, and, in addition to the capitation issue, it realized there are some other ambiguities. For example, what if your percent-of-premium management contract is with a TPA that is itself a regulated entity? It would seem that if I'm compensating another insurer to do administration for me, that insurer is going to have the obligation to set up a claim-adjustment expense liability on the work it's doing for me. Consequently, I shouldn't need to hold a liability for that, because it's going to hold that liability.

The Accident and Health Working Group has been in the process of making recommendations to the Emerging Accounting Issues Working Group (EAIWG) that originally made the interpretation on this. In fact, it's meeting today in Chicago and will, I believe, finalize its recommendation to the EAIWG. The extent to which the NAIC accountants will pay attention to the NAIC actuaries on this issue is still an open question. The accountants have not always been particularly keen on following actuarial input, but time will tell.

Another reserving-related issue that is still in development has to do with the guidance in SSAP 54 that talks about premium deficiency reserves (PDRs) versus the guidance in the Health Insurance Reserves Model Regulation that talks about the gross premium valuation (GPV) requirement. Again, this is a situation where the accountants in crafting codification ended up doing something that was not entirely in sync with traditional actuarial guidance. FAS 60, the GAAP guidance for short-duration contracts, has a PDR requirement. When the NAIC accountants were creating SSAP 53, which is a P&C standard, using FAS 60 as a base, they integrated into SAP53 the PDR requirement found in FAS 60 with some minor changes.

In going from SSAP 53 to SSAP 54, they copied over the guidance in SSAP 53 on P&C PDRs and put in for the first time an explicit A&H requirement for PDRs, again making some minor changes. SSAP 54 also contained some language that was carried over from the health insurance reserves model regulation talking about the fact that a GPV needs to be performed to insure adequacy of all reserves. I think there is a lot of confusion over how the PDR requirement integrates with the requirement to do a GPV and hold an additional contract reserve in case the GPV shows there is a deficiency.

There's been some back and forth between the Academy's Health Practice Financial Reporting Committee and the Accident and Health Working Group on this over the last couple of years. The Accident and Health Working Group indicated that the regulatory objectives that it is trying to accomplish with respect to PDRs and GPV requirements are twofold, namely trying to insure both long-term solvency of the entity writing the business and short-term sufficiency of premiums with respect to that business.

The Academy, I think, earlier this week finally got a letter over to the working group with some input on this, so you may be able to find a letter on this subject from the Academy Web site in the next couple of days. In that letter, one of the key concepts the Academy feels is important is that there is a distinction as to whether the policy in question ordinarily has contract reserves. If you're talking about medical business that doesn't have contract reserves, a GPV requirement doesn't make a lot of sense, and the PDR is the relevant animal, although you would be typically using GPV methodologies to determine the PDR.

Part of the problem is a linguistic one. When some people say GPV, they mean the methodology, and when other people say GPV, they mean the additional contract reserve that you set up when you apply that methodology. There's a jargon issue.

With respect to business such as long-term care, where there are contract reserves, there are situations where you might have both of these requirements interacting at once. For example, you could do a GPV and discover that your contract reserve basis is not sufficient, so you need to set up additional contract reserves. But even after you've done that, it might be possible that you have a short-term deficiency in premiums that will require a PDR on top of the GPV contract reserve to get over that hump in the meantime. I would encourage you to check that letter out. It's certainly not the last word on this issue. There are going to be additional discussions with the working group, and I think there's the possibility in the end of having the actuaries make recommendations back to the accountants on how to clarify SSAP 54.

Before I turn it over to Bob, I have some miscellaneous items I want to bring to your attention.

First is the *Health Financial Analysis Handbook*. This is a new NAIC document that I think will be formally adopted by the NAIC at this week's meeting. Consequently, I think it will be available for sale from the NAIC some time in the fourth quarter.

There are currently handbooks that the NAIC has written to help out financial analysts at regulatory departments. There is a life version of the *Financial Analysis Handbook* and a P&C version, but there was not in existence guidance that was specific to the analysis of health industry companies. Once the health blank was adopted, a group at the NAIC decided to take up the charge of crafting from scratch a financial analysis handbook for the health industry. This has been done over the past year or so. An actuarial consultant was brought in to help write the handbook, and industry and the regulators worked closely together to get this done.

The handbook is about 250 pages long and makes interesting reading for a couple of reasons. First, there are a lot of narratives in the handbook that are meant to educate regulatory analysts about the health industry. This might make interesting reading for younger actuaries in your companies, and there may even be some potential for part of this to be integrated into the education and examination (E&E) curriculum at some point. More important, as you're dealing with analysts at the regulatory departments, it's nice to know what they've been told, and this is a source of guidance for them.

Second, there are a lot of checklists in the handbook, and this is the meat of it from the analysts' standpoint. You get a sense of what the analysts are looking at with respect to your financial statement. Those things aren't necessarily entirely the right things that you would look at in trying to analyze your own company, but you at least have a better sense of what they've been told to look at.

As I said, this has been adopted. As regulators are doing analysis of companies using year-end 2003 annual statements, they'll have this tool available to them.

The HMO Model Act has been around for quite some time. I think that it had been several years since there had been any major changes to it, and for the past couple of years, a project had been undertaken to revise the model act that was finally adopted in June 2003. Of course, this is just a model act. The NAIC has adopted it, and it's now up to the individual states to decide whether or not to make changes to their own laws with respect to the governance of HMOs. Nonetheless, it's important to know what's going on from the NAIC standpoint.

There are new minimum capital provisions in the HMO Model Act. You may remember from actuarial exams, if you took them prior to the cessation of nation-specific material, that there was an old-fashioned capital requirement in the HMO Model Act where you had a minimum floor and various things that you had to calculate, and the capital requirement was the highest of four things.

Now that we have HRBC, even though it hasn't been adopted everywhere, it was felt that it was the saner approach, so the Act is assuming that you've adopted HRBC, and in that case, the minimum capital provision is now a $2.5 million dollar floor or whatever your HRBC requirement is. There's also a suggestion that the $2.5 million floor should be inflated over time. The current minimum floor in the HMO Model Act was only $1 million. There is, however, another clause saying that if your state hasn't adopted HRBC, we would suggest that you use this formula: $2.5 million minimum floor or, alternatively, 4 percent of managed care type of hospital claims plus 8 percent of your other claims.

One of the meatier aspects of the HMO Model Act is the new downstream risk provisions that govern the relationships between an HMO and risk-bearing entities (RBEs). This is a new phrase that's defined in the HMO Model Act. It's defined as an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health-care services to covered persons of the HMO. Again, we're talking here about IPAs or any downstream entity that is not an insurer but that is a provider entity and that has been accepting risk from an HMO under capitation.

There are many different state-specific approaches to these RBEs today. Some of them range from something close to full regulation, to minimal oversight. The HMO Model Act takes a middle ground. It would create a requirement for any RBE to register annually with the regulator. This is not full regulation. There is no annual statement for these RBEs, but there is a registration requirement and there is some financial information that would need to be provided to them. The Act would also indicate that an HMO is allowed to contract with only a registered RBE. There are certain requirements that are imposed on the relationship between the HMO and the RBE in terms of information to the HMO, which is now obligated under the Model Act to provide to the RBEs with which it contracts. There are also some

oversight responsibilities for the HMOs and the notion that even if the RBE fails, the HMO is still the entity that is responsible for the provision of care that is part of the Model Act.

I think that the industry felt that in the end this was an acceptable compromise. I was not involved in this myself. We have different lobbyists who were dealing with this issue, but in the end we at BCBSA felt that this was a piece of legislation that we could live with.

One last thing I would mention, and again I don't have a tremendous amount of direct familiarity with this issue, but I'm aware that there are revisions to the Coordination of Benefits Model Act that are currently being debated. Probably the largest area where they're thinking of making a change, and it's still not clear what they will do on this, has to do with individual policies. Currently, the Coordination of Benefits Model Act deals only with group-on-group coordination. There's talk that it might be nice to have group-on-individual coordination.

There is anecdotal evidence of people who had been self-employed and had purchased individual major medical insurance, later went back into the workforce where they had a group policy, but kept their individual policy in force and ended up getting windfalls when they were sick because there was no coordination between the two policies. They had their full coverage under one policy and all their claims were paid, and then they received cash under the other policy.

There were some suggestions that the absence of group-on-individual COB might be something to rethink at this point. When there is so much concern over the health of the individual market, this would be one possible way of keeping individual premiums down by virtue of introducing coordination. There's some appetite for that to the extent that there's never been in the past. Discussions on this issue are ongoing and will continue at this week's NAIC meeting. If you're interested in this issue, if you go to the NAIC Web site, you can download a copy of the current draft of the Coordination of Benefits Model Act.

Lastly, with Medicare Supplement business, there is a refund formula that's in Medicare Supplement. It's never had a lot of impact. I think there are a small number of companies that have had to file refunds, but largely, it has not been a well-used regulatory tool.

The Centers for Medicare & Medicaid Services (CMS), formerly Health Care Financing Administration (HCFA), last year commissioned Reden & Anders to do a report on possible reforms that could be made to the refund formula to make it a better regulatory tool. That report was shared with the NAIC, and probably one of the more interesting aspects again has to do with these states that require issue-age rating on Medicare Supplement, namely the suggestion that it would be appropriate actuarially for there to be a separate refund calculation for issue-age-rated policies as opposed to attained-age-rated or community-rated policies. There

were also a number of other technical revisions suggested in the Reden & Anders report.

The NAIC is continuing to talk about this, and as it's talking about it, it's thinking of it from the standpoint of whether it wants to go down the path of doing all this technical work to the refund formula without first checking to see whether the refund formula is the right regulatory approach. As there have not been a lot of refund filings, maybe it's not an effective avenue. Maybe there's some other regulatory tool that could achieve the underlying objective which it presumed that Congress imposed the refund formula to make sure that there was not going to be gouging in the Medicare Supplement market. Are there other ways in which we can ensure that rates are reasonable?

Another issue here concerns any change made to the refund formula. It appears that there would need to be federal legislation in order to do that, and that gets to be questionable as to whether that can be implemented.

I'm now going to turn it over to Bob, who will focus on some more interesting issues that are going on with respect to long-term care.

MR. ROBERT K. YEE: My talk is going to cover three areas: rate stability, statutory reserve and RBC. I want to get back into rate stability because the model regulation passed a couple of years ago—in late 2000, I believe, but the ramification is just starting to show up because they are taking their time adopting them. I'll show you a bit later that there are still a number they haven't adopted yet. It creates an issue for insurers because essentially they have to deal with the old regulations because most rates are essential on a nationwide basis.

The statutory reserve development happens this year. RBC has been going on since the beginning of last year, and it's going to keep on going for a while. It's not quite clear at the moment what NAIC is going to do about RBC. I'm just going to touch briefly on just one or two developments in the disability income area.

I'm going to review quickly the model regulation for rate stability. Some states have adopted them, but not all of them. There are two components to rate stability regulation. The first one is the initial filing, and the second one is what happens when you go for a rate increase. On the initial filing, this is something novel in health insurance. There's no requirement in loss ratios. Basically, a regulator recognizes that for long-term care, loss ratio is the type of regulation that doesn't work. It doesn't work because it creates low-ball pricing in the industry, and a couple of years ago, they decided to do away with loss ratios. That means that as long as you never go for rate increases, they don't care how much you charge.

The other thing they require is that your premium has margins for what they call moderately adverse experience or conditions, and that's a controversial subject because nobody wants to define what that means. Is that 5 or 10 percent over your

expected? The regulators on numerous occasions have asked the Academy to help them to define that, and the Academy for antitrust reasons and so forth didn't want to define it. Various state regulators have some notion what moderately adverse conditions means, and this applied to premium. That means your premium should be able to sustain this kind of adverse condition, and you still don't need a rate increase on that.

It also applied for reserves. For you valuation actuaries out there, you have to pay attention to new products now. You must have an adequate margin on your assumption for reserves.
When you decide you need rate increases, there are restrictions now. Instead of the traditional 60 percent loss ratio, the loss ratio on the increased portion of premium has to be at least 85 percent. The idea is to discourage companies from paying commissions on a portion of their rate increase. They don't want the consumer to pay for a windfall for their agents because the company happens to go for a rate increase.

The other subtlety in the regulation is that your loss ratio discount rate has to be equal to the valuation interest rate. Before, it was undefined in terms of how you calculate loss ratio over the lifetime of the policy. Some companies would use valuation interest rates, and some companies would use a pricing interest rate, which is typically higher. The new regulation basically mandates that you calculate your loss ratio at the valuation interest rate. The implication is that if your investment return is not as you expected, you're out of luck. You cannot use that as an excuse for a rate increase. At least that's my interpretation.

If you go for a rate increase, you are required to report your actual expected experience for the next three years so that the state can have a better handle on how your experience is going. If you have a repeated rate increase, and the commissioner or the regulator thinks that you have a rate spiral, he'll require more monitoring. You have to submit the actual expected for every five years, and in the most extreme situation, there's a clause in the regulation that says the commissioner can stop you from selling new business for up to five years. It could get into a severe penalty.

As far as I can tell as of today, seven states have adopted the regulations basically unchanged, except California. They're uniform. Five states are pending, so maybe in the next couple of months, you'll get another five states. Four states are basically saying that they won't adopt them for a couple of reasons. One is that they don't want to give up their loss ratio requirements. Some states think they have a good rate approval process in place. They don't need something like that. Some states are concerned about the excessive premium issues. These are the states that won't adopt it. There's no industry opposition to the rate stability regulations, so eventually all the states will adopt them.

The states that have adopted them are the more populous states, where companies have quite a bit of long-term-care business. I mentioned before that companies now define a new product, and typically they are products with nationwide rates. There may be some minor regional variation in the rates. They have to deal with essentially two sets of regulations. Some states do require you have up to 60 percent loss ratios, and some states don't have regulations. However, they may have more requirements on certification and have to do more work upfront to document what they have done relative to filing.

The regulations are relatively uniform by state, except California. In California a couple of years ago, there was a bill that was supposed to make long-term care noncancelable. That means you cannot change rates. The industry lobbied for something like the NAIC model regulation, and the law in place in California is a little different from the model regulation essentially in two respects. One is that the initial filing needs to have an independent review. That means that you have to get a consultant, and they somehow assign the consultant to review your rates so that you make sure you have essentially double certification. The company actuary and the consultant have to certify that the rates are adequate.

The other major difference is that after the first rate increase, you have to pool all your long-term-care experience in terms of looking at a possible rate increase, and that's controversial. I believe that one expires after five years. Hopefully, nothing will happen, and that piece of regulation will disappear.

My impression in looking at some of the filings is that rates have gone up relative to when the states adopted the regulations. That could be for two reasons. One is that companies are taking this regulation to heart and building up some margin in their rates, and the other reason is that experiences are changing. Most companies are experiencing lower lapse rates, so they have to adjust the rates.

I'm going to switch to what is happening in statutory reserves. Earlier this year, the NAIC started a discussion on what needs to be updated in the long-term-care statutory reserve standards. It came up with three areas it's going to focus on. Right now, there's a proposal in draft form, and industries are beginning to react to it. I'll talk a little bit about what the Academy work group has done so far.

The first thing that area looks at is morbidity assumptions. Right now in long-term care, there's still no standard valuation morbidity table, but companies have started putting in the pricing, and what they're concerned about is the valuation area and some assumption of morbidity improvement. Typically, there would be a 1 percent or 2 percent morbidity improvement every year. It's consistent with population data. Population data show that the rate of disability over the past 10 years has slowly decreased. Unfortunately, it's not clear whether in the next 30 or 40 years this is going to happen or not. It's tied primarily to the improvement in mortality.

The NAIC is concerned about this, so it basically proposed that in reserve valuation, we cannot use that assumption. One of the pieces that is hotly debated right now is whether this prohibition is retroactive. As of today, I think the drafter of the proposal has conceded the point that if the commissioner approves your prior filing that has a morbidity improvement, you can use that. Otherwise, it's not clear whether with your in-force block of businesses—where you used a statutory morbidity assumption and have incorporated morbidity improvement—you might have to take it back.

The other area the NAIC wants to update is the mortality assumption. The standard today is the 1983 group annuity table. It wants to move it to the 1994 group annuity table or perhaps the annuity 2000 table, which is even more conservative than the 1994 table. Later on, I'll show you what the industry's common practice is.

The third item it wants to update is the lapse assumption. Currently, the assumption on the reserve is 80 percent of pricing assumption or 8 percent, whichever is less, the first four years, and 100 percent of pricing or 4 percent, whichever is less, after four years. You want to move it to 80 percent of pricing before your margins, or the lesser of that, all year, or 6 percent and 4 percent and ultimately 2 percent after four years. For group, the NAIC does allow a slightly higher ultimate lapse rate.

Early this year and throughout the summer, the Academy formed a work group, and basically worked on morbidity improvement, credibility, persistency, experience forms and long-term objectives trying to help the NAIC to provide some information and also data so that it can perhaps come up with a reasonable change in the valuation standard.

I'm not going to talk about morbidity improvement and credibility. Morbidity improvement is a dead issue. The NAIC is basically saying it's not going to talk about it. Credibility is a question of doing a review of how it sometimes is difficult in long-term care to reach a conclusion on some of the morbidity issues because of the low frequency of claims.

I am going to talk briefly about the persistency experience form and the long-term objectives. Concerning the long-term objectives, there's a subgroup that wants to make sure that we have a solid blueprint of where we need to go in terms of valuation for long-term care.

Regarding persistency, the subgroup has looked at and reviewed some of the filings, and this is on the Web site. It's public information. We looked at 43 filings from maybe 35 companies and tabulated from a pricing perspective what kind of lapse rates companies are using. For ultimate lapse rates, companies on average are using close to 2.5 percent, so 80 percent of pricing is pretty close to 2 percent.

One thing we're not sure about from reviewing these filings is whether these lapse rates are before and after the margins. There's a little bit of confusion there, but generally, the companies are moving at least on the pricing side to fairly low lapse rates. I think these filings are from a Florida Web site, so they're recent.

Regarding mortality, we looked at the same group of filings. Companies are moving away from the GAM table. About one-third of them still use the '83 GAM table for pricing, not for valuation. Valuation is prescribed as the '83 GAM table, so there's some argument that we may need to update the table for valuation.

Switching to the experience form, the NAIC asked the Academy to review the loss experience form, which is a specific reporting for long-term care. Any of you who have experience in preparing the form would probably agree with me that it's a difficult form to fill out. The form shows essentially actual-to-expected claims by form group and by duration. It's done on a cumulative basis and on a state-by-state basis.

The focus right now is on the fact that long-term-care markets are growing. Previously the regulators were more concerned about how pricing matched with experience, and that's why this form came about 10 or 12 years ago.

Right now, the concern is on reserve adequacy. The subgroup of the Academy proposed to calculate what we call an experience reserve, which is when you adjust a valuation net premium with actual experience. We proposed having four forms instead of three forms, but it's not as bad as it sounds.

Form A will stay as is. It is a calendar-year experience form. It shows actual-to-expected claims. We're going to keep it this way, but in the reporting output we proposed not showing the experience by policy duration, although companies will probably have to keep the durational piece.

Form B is revised. It's an inception-to-date experience form, and it's going to compare the experience reserve, the one that I just described, to the capital reserve. The experience reserve is trying to get to whether your net valuation premium, along with your experience and your actual persistency, is able to fund the tabular reserve. There's a big enough difference, and we're not saying that this means your reserves are deficient. It's saying that you need to look deeper into what the cost of it is.

Form C is relatively unchanged. It's still a cumulative form of actual-to-expected experience, but it's going to be on a state-by-state basis.

Form D is new. We're trying to put out the Schedule O type of analysis and isolate long-term care, so that people can see specifically how adequate the long-term-care claim reserve is year to year. That's the experience form.

I'm going to describe briefly the long-term objectives. There are five or six areas. The first one is that regulators are concerned when there's a premium increase. What is the mechanism to look at your reserves? The underlying reason why you have an increase is your adverse experience. How is that going to affect your reserves? They're interested in any mechanism or process or maybe just a review so that whenever there is a rate increase, the company looks at the reserve.

The second one is a shift not just on the liability side but also on the asset side because long-term care is a long-tail business. The investment component of the product management is significant, and they want to make sure that there is more than cash-flow testing and that the company is doing rigorous cash-flow testing on long-term care.

The third one is the feedback mechanism on how the company monitored its experience and used that knowledge or information and how it looked at reserve adequacy or premium adequacy.

The fourth item is something that's been brewing for a while. There is under the SOA, I believe, a valuation committee. It's a group of actuaries who, from industry data, look into whether to come out with a valuation morbidity table. It's a challenging task because product features have changed, and it takes a long time in long-term care to develop experience, so the committee has data, but they are mostly nursing-home-only data. Today's products are integrated plans that have nursing home and home care. It's quite challenging for the committee. I believe the schedule is that it will come out with some table and recommendation some time next year.

The other thing the Academy is working on is assessing the industry's capability. We come out with different new reserve types of mechanisms. There is a lot of talk about integrating RBC and reserve and looking at total capital adequacy in long-term care.

Currently, because of the proposed standards that just came out on long-term care, the Academy group is looking at what the impact of all these changes is to reserves and on the marketplace. We're going to measure some of the changes in these proposals, and hopefully the regulators will have ideas before they decide to finalize them and know whether that's something they want to do. Again, what is the reserve level and what is the impact on the pricing?

I'm going to go quickly on to the RBC interim report the Academy published in June. We call it interim because it's not finalized. We didn't make recommendations as much as we demonstrated what we have done to it. We have taken the disability income (DI) model and adopted it for long-term care. In the DI model, there's a stationary assumption that the loss ratio doesn't move because it's a stable market. In long-term care, it's a growing market with a growing loss ratio, so we made modifications for that.

Some data we used are from the loss experience form, and we ranked the company by size in terms of premium; the top 15 or 17 companies are close to 90 percent of the premium. We calculated the standard deviation and the change in loss ratio, and the smaller companies predictably have larger standard deviations. Some of the assumptions that we used are from a company survey. Some of the assumptions are what the future growth of business is and what the mechanisms are to change rates. For instance, at what loss ratios would that company go for a rate increase, and how long would it take to get the rate increase? We didn't model a policy termination. We split the companies by their size. In theory, the RBC for smaller companies would be higher and for the larger companies would be much lower.