2004 Valuation Actuary Symposium*

Boston, MA
September 20–21, 2004

Session 2PD
Health Regulatory Update

Moderator: Karen Bender

Panelists: Karen Bender
Leslie M. Jones
Jinn Lin
Donna Novak

Summary: Panelists share their perspectives on valuation-actuary-related issues, including the hot issues from a regulatory concern.

MS. KAREN BENDER: At this session we have four speakers. Leslie Jones is a regulator from South Carolina, and she's going to speak on the background, history and status of what the regulators are trying to do to achieve consistency in financial reporting, specifically on health care blanks, and how they're trying to get consistency between health care blanks and the life and casualty blanks as much as possible. Jinn Lin is from PricewaterhouseCoopers, and she's going to be speaking with us on the status of best estimates for incurred-but-not-reported (IBNR) claims and how much or how little margin we should or should not include in our IBNR reserve estimates.

Donna Novak from NovaRest is going to be giving us the status on the ongoing saga called deficiency reserves. And my name is Karen Bender. I'm with Mercer Oliver Wyman, and I'm going to be speaking on what the health proposals are for each candidate and what we can expect at the federal level if whichever candidate of the two major parties gets elected. So mine's a little different from the other three. We'll start with Leslie Jones.

MS. LESLIE M. JONES: I was laughing with the ladies this morning about the consistency issue. I'm the chair of the NAIC's Life and Health Actuarial Task Force, and when Karen called me to talk about consistency issues I have to admit there

are other regulators who would be much better than I to speak on this topic, but not one of them would come to speak on it. I can't imagine why, but at any rate I'll do the best that I can.

We look at all these inconsistencies. I think that something that will help us grapple with them a little better is just identifying the source of the inconsistencies—at least we can get some grounding there—and then what the NAIC is doing actually to achieve consistency, slow as that process might be. One aspect of that is the life and health blank filing requirements. While I have the podium, I'd like to talk about some recent activities of the Life and Health Actuarial Task Force and the Accident and Health (A&H) Working Group that you might have an interest in.

I guess the first question that comes up is where did all these inconsistencies come from? If you think about how our insurance code evolved over the years, there are at least three different types of companies that all write health insurance, and each of those companies has a separate regulatory framework at the state level. Life insurers have one set of laws. HMOs have a whole separate chapter in our code. Property and casualty (P&C) companies write health insurance, and they have a different set of laws. And the Blues—the hospital, medical, and dental indemnity (HMDI) plans—used to have a whole different set of codes. We have eliminated that in our law, but many states have not. Each company has a separate regulatory framework and was required to file a separate blank, and I think that is really the root of the vast majority of inconsistencies that we see.

Another area that the inconsistencies arise from is that there are lots of different sources of guidance and requirements. Again, many of these sources arose from the fact that these entities had different regulatory frameworks, and many of them are not consistent. So we get guidance from the Standard Valuation Law, the actuarial opinion memorandum regulation (AOMR) and the HIRMR, and I am going to be using those acronyms throughout the presentation; those apply to life and health companies. We have the HMO model act that applies specifically to HMOs; and then we have the *Accounting Practices and Procedures Manual*, which attempts to apply one set of rules to all companies; and finally the *Health Reserve Guidance Manual*, which is an interpretation of the health insurance reserves model regulation (HIRMR) and health regulation for life and health insurers.

There are other sources of guidance. We have Actuarial Standards of Practice (ASOPs) and the related health practice notes, and under state law and the model laws at the NAIC, actuaries are required to opine that they have followed the ASOPs. So if there's an inconsistency between an ASOP and state law, then that creates issues. The Financial Accounting Standards Board (FASB) does not really impact tremendously on what we do except that the *Accounting Practices and Procedures Manual* relies on FASB in developing whatever interpretations we have of the various accounting principles.

Let's talk about state law. State law is of primary importance; that's another thing. You have all these different sources of guidance. How do they interrelate, and what are you supposed to do? The most important thing is that you follow state law, in particular the law of the state of domicile of the company that you may be working with. Many states adopt NAIC models. How many of you are familiar with the NAIC? Okay, good. So, of course, the mission of the NAIC is to kind of coordinate the activities of the states so you aren't out there having to follow 50 different state laws, and to some extent they are successful in that. But the bottom line is the NAIC spends all this time, we adopt these models, and the states may or may not adopt them, and they may or may not adopt them consistently. They might have a health actuary who says, "Well, I like this, but I want to add a margin." So there may be variations within state laws.

Accreditation standards: are you all familiar with the accreditation standards? Every state is required to be accredited by the NAIC. States primarily regulate their domiciliary companies from a solvency perspective, and if we didn't have accreditation standards, then any state at any time could come into a company and say, "I want to examine your books," and that would just be ridiculous. So, as long as the state is accredited, then the other states will accept the reports on examination of that state for a company for financial purposes, which is a good thing. The problem is our accreditation standards include a set of laws that states must have on the books to be accredited. The Standard Valuation Law and the AOMR are included in that set of accreditation standards, but the HIRMR is not. There are about 17 states that have adopted the model regulations—South Carolina being one of them—but not all states have, and it's not an accreditation standard. So not all states are going to get it on the books; there's variation there.

Codification is a comprehensive basis of accounting that prevails in the absence of state law and if a state has adopted codification. Well, I think codification is probably the furthest that the NAIC has gone in creating sort of a level playing field among the states, but, again, all states have adopted codification. It is an accreditation standard, which has encouraged that. If a state has a law that differs from what codification says, though, then that state law prevails. So codification is a comprehensive set of accounting principles, and it prevails in the absence of state law, but where there is state law and it conflicts, then state law still prevails. That creates inconsistencies. Again as we just talked about, ASOPs have to be adhered to from both a professional perspective and a regulatory perspective, and where there are conflicts issues are created.

Attempts to achieve consistency: we all have these sources of guidance and laws and so on that have created this inconsistency. What are we doing to try to fix that? Like I said, I think codification and accreditation have gone a long way. Accreditation is sort of the vehicle that forces the states to get laws on the books. If you don't get that law on the books, you're going to lose your accreditation. All your domestics are going to get examined by 50 states. Everybody has that incentive to get them on the books, and codification was included as an

accreditation standard. So by now all the states have a reference to codification, and the codification standards, also known as the *Accounting Practices and Procedures Manual*, are updated at the NAIC level. I think that as guidance comes out it's uniformly applied unless a state happens to have a state law that conflicts with codification.

At the A&H Working Group we are also working on several projects to attempt to achieve greater consistency, and let me talk about two of the teams. The Life and Health Actuarial Task Force has an A&H Working Group, made up of accident and health regulatory actuaries. Julia Phillips from the State of Minnesota is the chair of that group, and there are two subteams working on achieving consistency. The HMO HMDI subteam, as we used to fondly call it—I chaired that team when it first got started, and Donna and I spent many hours working on these issues—the charge of that group is to review the relevant statements of statutory accounting practices and appendices to the *Actuarial Practices and Procedures Manual*, that is, codification, and relevant model laws and regulations to determine what changes are needed to promote consistency in financial reporting between HMOs, HMDIs and life and health insurers.

Back in 2001 we got that charge because there were some differences in the Statements of Standard Accounting Practice (SSAPs) and even our HIRMR. Initially we asked the Academy to take a look at the various sources of guidance that were out there—the ASOPs, SSAPs, NAIC models—and identify the primary areas of inconsistencies. They came up with three, one of which we are still talking about today: premium deficiency reserves (PDRs) versus gross premium valuations. We are kind of stuck on that one, and Donna's going to spend a lot of time talking about that. I'm not going to steal her thunder, but just suffice it to say two-and-a-half years later, we're still trying to define the regulatory goals. Is that fair, Donna?

MS. DONNA NOVAK: Oh, yeah!

MS. JONES: At any rate, that was one of the primary areas that we've identified as an inconsistency. Items to be included in and excluded from unpaid claim liabilities: again here, actuarial practice, this is really an issue of are things like salvage and subrogation implicit in the numbers that you're using to develop your claim liabilities, or do you have to set up a separate liability for those things? What should be in? What should be out? Another issue that came up that the Academy identified in this list was whether or not you should use a best estimate for your claim liability or whether there should be some margin. Let's suffice it to say that has been another very controversial issue, and Jinn is going to spend some time talking about that issue because, of course, in the SSAPs, which were developed with the involvement of P&C actuaries, it says best estimate, but in the ASOPs and in the HIRMR we require that if you're doing a blue blank opinion, it has to be moderately adverse, good and sufficient.

The last major area that they identified was Appendix A-10, which is an appendix of the *Accounting Practices and Procedures Manual* that references the HIRMR. The problem with Appendix A-10 is not all the words. They didn't just take the HIRMR and bring it in, and accountants actually did codification. They took specified sections and put them in specified places within the SSAPs. Well, as it turns out, the HIRMR is referenced in SSAP 54, which talks about contract reserves and that sort of thing, but it's not referenced in SSAP 55, which talks about claim liabilities and IBNR. So that creates issues. All companies have to comply with the *Accounting Practices and Procedures Manual*. It doesn't matter if you're P&C, health, life, HMO, whatever. But the question is, well, does that mean that only life and health companies have to comply with the HIRMR for claim liabilities? What's the deal? The same thing is true with the ASOPs—the ASOPs are not referenced in SSAP 55, but they are referenced in SSAP 54.

In the material that I sent to the Society for this presentation I included a copy of that report from the Academy, and if you have an interest in this, if it's confusing you, know that you are not the only actuary struggling with that. The Academy's struggling with it; the regulatory actuaries are struggling with it. I think that paper gives an overview of some of the issues you may be encountering. The subteam also asked the Academy to look at updating the HMO model act at the time—some language was inconsistent there—as well as the issue of differing actuarial certifications and opinions.

As I alluded to earlier, if you're filing the orange blank, you do a state of domicile, good and sufficient opinion. If you're filing the blue blank, you do moderately adverse. So there's a difference, but why and should there be? Also on the blue blank it's kind of a modified state-of-filing opinion that you have to give now. I guess the bottom line is that the subteam is focusing on the area of the PDR. We have all these issues out there. We still can't get past step 1, which is the PDR. They have recently changed their name to the Premium Deficiency Reserve Subteam. So if you have an interest in gross premium valuation versus PDR, you can get on the NAIC Web site, talk to Dennis Hare at the NAIC, but look for the Premium Deficiency Reserve Subteam. We had to narrow our focus a little bit just to get that one done.

That has been challenge, but I'd have to say we have had some successes. There was another subteam that was formed under the same kind of charge to promote consistency, and this one had a more focused mission. I'm happy to say that we have completed that. The NAIC's Life and Health Blank Subteam's charge was to identify changes to the orange blank and the blue blank that will produce greater consistency in the reporting of health products between the two blanks. I don't know how many of you fill out both orange and blue blanks, but if you do, then you know that the orange blank has greater product detail than the blue blank, and the blue blank does a better job of capturing things around renewability and that kind of thing.

So there were inconsistencies. Health companies could be doing the same thing. We're talking about the policy experience exhibit, that everybody should be consistent. What they did is they started on the blue blank and expanded the product categories, to mimic what's in the orange blank or what the regulators found useful about the orange blank, and then they eliminated some of the information because companies were saying, "Well, this is an administrative burden. Why are you making us give you all this information?" And the actuaries said, "Okay, we'll take back some of the information that we don't think is necessary." So they went through the blue blank and eliminated the information that nobody used, but they did keep the renewability. Apparently there was a tax issue with that, so they kept that reporting. But I'm happy to say that we voted to adopt the exposure drafts at the meeting in Anchorage last week.

There were exposure drafts that I included if you went on the Web site and got your handouts for this, the A&H policy experience exhibit and instructions, analysis of operations by line of business, the gain and loss exhibit, underwriting and investment exhibits, Parts 1, 2, 2(a) and 2(d), exhibit of premiums, enrollment and utilizations and instructions for all health exhibits. Those exhibits that were actually sent were exposure drafts at the time that I prepared my presentation, but those exposure drafts were adopted without amendment. They will become a part of the blue blank as well as the orange blank; there will be consistent reporting between those two blanks. We also referred them to the Casualty Actuarial Task Force for consideration for inclusion as the experience exhibits in the yellow blank. So we are trying to get some consistency. It's going to be a project, but at least this was one success in that area.

One thing that I think is confusing in terms of all these different companies filing all these different blanks is, well, who completes which blank? How do you know? That's largely driven by state law. Life and health companies generally submit the blue blank. P&C companies generally submit the yellow blank. It used to be that HMOs did only the orange blank. One thing that I didn't know, but I found this out as I was researching for this talk, is our Blue Cross/Blue Shield files a yellow blank. Why?

There were apparently tax advantages to health companies if they filed the yellow blank, and those went away in 1986. Now more of the health companies file the blue blank. So you do see that. But you also see a lot of what you would consider to be a health company filing the yellow blank, and I think that's kind of a holdover from that. One thing the NAIC has done to really work on that issue is we have developed a health blank for companies who write primarily health insurance. So the orange blank was changed to the health blank in 2001, and the current blank replaced that.

Now, the question is: Who uses the orange blank? Well, if you're licensed as a health company in a state (then again, it's all dictated by state law), you'll likely be using the orange blank. Then anybody who files the orange blank, blue blank or

yellow blank has to complete what's known as the health test, and that test was completed effective year-end 2003. Again, a significant component of passing the health test is whether your health insurance premiums and reserves equal or exceed 95 percent of total premiums. And there are certain excluded products. Disability insurance (DI), long-term care, accidental death and dismemberment (AD&D), workers' compensation are excluded from the health test. But basically if you're writing health insurance, you're going to pass that test.

What happens if a company passes the test? If you pass the health test, you have to begin filing the orange blank beginning with the first quarter statement for the second year following the reporting year in which the entity passes the test. If you failed the test this year (2004), in the first quarter of 2006 you have to begin filing the orange blank. So there's an opportunity for companies to get ready to start filing a different blank. If you fail the test, same thing; you have about two years. The first quarter in the second year following the second year you fail, then you have to go back to the other blank, with the exception of a company that's licensed as a health company, and its state of domicile will continue to file the orange blank. Again, I caveat all that by saying that's at the discretion of the state. So I would definitely check with whatever state you're doing business in and make sure the orange blank is out there, but make sure you understand which blank they expect you to be filing.

Recent activities of the Life and Health Actuarial Task Force and A&H Working Group that you may have an interest in: recently we made revisions to the HIRMR that deal with DI insurance, claim reserves and single-premium credit disability minimum reserve requirements and long-term-care insurance reserves. Just briefly with respect to claim reserves for DI, there is a provision within the HIRMR that says a company gets to use its own experience in the first two years, or in the first five years with the approval of the commissioner. Well, come to find out, people can interpret those words differently.

Some people would say that would mean in the first two years or five years, whatever you're talking about, you could use the company's experience for all durations. Of course, if you've been approved to use your own experience for the first two years, when you get to year three and then have to start using tabular reserves, all of a sudden there could be a significant increase in reserves. The other interpretation is that during the first two years or five years you get to use your own experience for those durations only and then tabular reserves thereafter. The NAIC thought that the second approach made more sense in terms of continuity of reserves, and so that's the interpretation that was spelled out in the recent amendments with respect to claim reserves.

Single-premium credit disability minimum reserve requirements: what happened in 2001 was a morbidity table was developed for contract reserves for DI. It used to be that you would use the unearned premium reserve as the minimum reserve. So the intent was when that morbidity standard was developed, that would become

the reserve, and the unearned premium reserve would no longer be the floor. But when we did the change in 2001, we didn't quite make that clear. So there have been recent amendments that have made it clear that the contract reserve developed with the new morbidity standards is the reserve. That change was just within the past year made to make that clear, and that is consistent with the way the SSAPs related to that topic read.

Long-term-care insurance reserves: of course, with the new rating standards requiring moderately adverse, there have been some current concerns about reserves for long-term-care insurance. In December of this past year, the NAIC adopted revisions to the HIRMR that would require that total contract reserves for all health insurance products incorporate provisions for moderately adverse deviation. One more thing to throw into your mix: we prohibit the use of future improvement in morbidity assumptions for contracts for which tabular morbidity tables are not specified in the regulation, and we updated mortality and voluntary lapse assumptions applicable on or after January 1, 2005. So for those of you who are dealing with long-term-care insurance, you might want to have a look at those recent revisions to the HIRMR.

The last topic that we had been looking at and that Karen thought you might have an interest in—and actually the A&H Working Group isn't looking at this, but the Life and Health Actuarial Task Force is—is the whole issue of fair value. I think it's fair to say that heretofore the Life and Health Actuarial Task Force has not really paid attention to what's been going on at the international level. We've been so busy just taking care of our own shop with our 19 charges that we have floating out there that we have not really been looking at what's going on at the international level. Well, luckily we're not the only group at the NAIC that's dealing with international issues, and we do have a representative. Commissioner Gross from Virginia represents the International Accounting Standards (IAS) Working Group. The NAIC's IAS Working Group interfaces with the Accounting Subcommittee of the International Association of Insurance Supervisors (IAIS), which is like the NAIC at the international level. So we do have a group that interfaces with that group.

Recently, I think, the IAIS has finally accepted that they are going to have to grapple with this issue of valuation of liabilities. They call it future measurement of liabilities; they're not willing to call it fair value. They're calling it future measurement of liabilities because the International Accounting Standards Board (IASB), which is the international equivalent of FASB, of course, is developing standards for insurance contracts at the international level, and one of those very important standards is going to be measurement of liabilities. So that's on the table again, and the IAIS has finally decided we can't just say no. We have to say what elements of a future measurement of liability system we can accept, and what we cannot accept.

So the IAS Working Group took that charge and said, well, there are six common themes that we see out there, and we want to weigh in on those themes, not say

no, but say what can we live with, and what we cannot live with. The IAS Working Group is currently grappling with that. I'm not going to go through all of the issues, but just to give you an idea, one thing upon which everybody agrees is that an insurance company should not use its own credit rating in determining the value of liabilities. That's kind of a universal thing, that all regulators say, no, that's not acceptable. Your liability under an insurance contract is what it is regardless of what your credit rating is. So that's one thing that the NAIC is weighing in on.

Other things that we're looking at are issues that come up with fair value even though they're not calling it fair value. What is the market value? Is there a secondary market? Generally a secondary market does not even exist for an insurance liability. So those are the types of issues that we're weighing in on, but if you're interested in that, then the interface is the NAIC's IAS Working Group.

MS. JINN LIN: I'm a senior manager at PricewaterhouseCoopers in the Chicago office. One of my major responsibilities on a daily basis is to work with our audit team to review the actuarial liabilities for health insurance companies on the Blues side as well as for HMOs. As you know, on the health insurance company's balance sheet, the unpaid claims liabilities represent one of the largest reserve items and also balance sheet items. So personally I'm very interested in this best estimates topic because I have to deal with it on a daily basis. This brings us to our topic of the day, best estimates. I'll start by introduction of the background and history of best estimates and go into some inconsistencies, as Leslie talked about, with the best estimates. Then last I'll talk about the recent developments taken up by our industry members, to try to bring some standardization or consistencies to best estimates.

If we look at the background of best estimates, we're seeing there are inconsistencies across the GAAP guidance as well as the statutory guidance. I'll talk about some of the issues that were raised by different industry groups. Also we are seeing there are differences in the practice, the variations by industry among the P&C, life and health actuaries. Starting with GAAP, U.S. GAAP thinks that a best estimate is unbiased estimates. Also it's the most likely estimate that represents a single value and not a composite value, and it specifically calls for a value within a range. If there is no single best value within a range, GAAP asks for the minimum of the value within the range to be accrued, and that's very different from on the statutory side, where in SSAP 55 it calls for if there is a range of values, you use the midpoint of the value. So that's different between GAAP and stat.

Going to some of the guidance on best estimates, the guidance is very sparse but generally requires the recording of best estimates, but the rules are not totally consistent with regards to the risk margin and liability estimates. If you look at FASB guidance, such as FAS 5 or FAS 97, it appears to exclude such a margin with the exception of FAS 60, but if you recall, FAS 60 really is for policy reserves, and it does allow for provision for adverse deviation on the FAS 60 long-duration policy reserves. For others, for unpaid liability, they really did not specifically go into that

detail, but it did not look like the risk margin is allowed. If you go into AICPA guidance or the industry-specific guidance on audits, it also appears that a knowledge of some risk margin or conservatism is not uncommon in practice. And specifically to GAAP, it's really hard for actuaries who work in accounting firms, because we feel like we're kind of caught in the middle. We're trying to seek the fine line between the financial reporting consistency and the fair financial reporting versus the adequacy, as well as how high is too high on the risk margin.

I also want to touch on the inconsistencies for statutory guidance. As Leslie talked about, the U.S. statutory accounting guidance provides detailed direction specifically to unpaid claims liability; it also specifically talks about this unpaid claims liability. When you look at SSAP 55, it says for each line of business and for all line of business in the aggregate, management shall record its best estimates for its liabilities for unpaid losses, unpaid claims and loss/claim adjustment expenses. It also mentions that you should include an analysis of variability for the estimate. But one thing they forgot to mention is how do you define management's best estimate? Does that include a margin, or does it not include a margin? When you look across other guidance in the statutory literature, you can see for NAIC's health blank instruction that it calls for the opining actuary to put a statement in the actuarial opinion saying that the reserves make good and sufficient provision for all unpaid claims liability. In the AOMR in Section 6 it also asks for all reserves to be adequate. Also, if you look at the *Health Reserve Guidance Manual*, there is actually a specific section talking just about conservatism. It also says the reserves can be implicit or explicit. And under various ASOPs there are specific mentions of conservatism such as moderately adverse conditions or margin for adverse deviation. It's mentioned across the board. So, as you can tell, SSAP 55, when it uses the management's best estimate, really is somehow inconsistent with all the rest of the guidance that we can get from other sources.

Going into the issues raised by different industry groups, the first of such is the memo that was written by the Life Insurance Financial Reporting Committee to NAIC's Emerging Accounting Issues Working Group in May 2001. There it basically outlines the inconsistency we saw just now with regards to SSAP 55 in conflict with the current practice as well as the concept of conservatism, ASOP and *Health Reserve Guidance Manual*. So this issue was taken up by the Emerging Accounting Issues Working Group in 2001, and they did provide a ruling on this, which basically said that the risk margin in recorded reserves is neither prohibited nor specifically allowed. Basically it's saying it's allowed but not required; it really didn't really get very specific. And, instead, the working group ruled that the decision is based on management, but the management needs to go through a very careful judgment before they can determine whether they're putting a margin or not putting a margin. That ruling is under SSAP 55 Interpretation 01-28, if you want to look at the details on that.

Next is a memo that was written by the Health Practice Financial Reporting Committee, responding to, I think, Leslie's request from the A&H Working Group to

try to address all the inconsistencies that can be found in various sources of statutory accounting guidance and industry practice. A lot of this was already touched on. The best estimates look like they're supposed to exclude a margin, but the actual practice is that all health actuaries are trying to include a margin in their number and also talk about Interpretation 01-28, where it states allowed but not required.

And now going into the variations in practice by industry, if you look at what P&C actuaries do for unpaid claims liability versus life and health actuaries, they are actually very different. The P&C actuaries view the paid claims liability as an unbiased estimate; they often use mean on the number, the average or expected value, and there is no margin for adverse deviation. But one thing to note is that for their long-tail business such as workers' compensation, they do not discount. So there is really some implicit conservatism in their number. Where you compare that to the life and health actuaries, they viewed the unpaid claims liability as amounts that must contain a margin, and so there really is some difference in how this estimate is being viewed. If you look at the actuarial opinion, again you can definitely see the difference between P&C versus life and health. For P&C they have to comment on whether the reserve is reasonable, that implying there is no risk margin in the number, and when you look at the life and health requirements for the opining actuary, you are required to comment on whether a reserve is adequate or if it's good and sufficient.

The Academy also is doing something about its best estimates. A subgroup within the Financial Reporting Committee of the Academy drafted a White Paper in early 2004; the charge of the group was to catalogue the current definitions and guidance regarding the use of best estimates and risk margins and to try to evaluate the differences and similarities among the current practices. It's intended to serve as an educational first step in getting more clarity and consistency of the application and the definition of best estimate, along with the risk margins. The working group is not trying to change the guidance, and they are not trying to advocate any particular approach. They just want to provide a resource so people will understand what the current inconsistencies in the number are as well as all the relevant guidance with regard to best estimates.

The highlights from this particular White Paper include things such as a brief discussion of statistical terms often mentioned in relationship to best estimates such as mean, which is used mostly by the P&C folks, versus the mode of the distribution, which is mostly used by the life and health folks. The next thing is a definition of best estimate and reference to risk margin found in the U.S. GAAP and U.S. statutory accounting guidance and actuarial guidance contained in the *Actuarial Standards of Practice and Principles Manual*. If you look through the ASOPs, you can see there are lots of mentions of risk margins and conservatism in ASOP 5, 10, 20, 28, you name it. There is a lot of referencing there, implying different levels of conservatism. It really depends on the application. There are different levels of conservatism that have been named in the ASOPs.

They also talked about current practice among different disciplines such as life, P&C and health, and there's a discussion of the different things that the fellow actuaries are doing in the different practice areas. Some of the updates of the White Paper include that an early draft was released to AICPA early this year, in March, to their insurance expert panel, and the AICPA really did not provide too much comment. They really don't have a lot to say about this. But there were major differences in the points of view among the working group members as well as the Health Practice Financial Reporting Committee with regards to that draft. Therefore, the working group has withheld the release of the paper until consensus can be reached among all the working group members and by the health representatives.

So there is a working group that was formed to address the health actuaries' concern on how health reserve practice is being described in the draft and to work on a new draft that more accurately reflects the consensus from all practice areas. Since March several conference calls were conducted. They also updated the draft a few times, and the new draft was shared among the working group and discussed. The current discussion includes—and some of this already is in the current draft—the best estimate definition and other references and the use of statistical accounting concepts. Right now I think they are still hung up on this research on FAS 5 and how that relates to paid claims liabilities, but once that one's resolved, I think it's ready for release, and the release date should be either fall or by the end of this year.

MS. NOVAK: In the continuing saga of creating deficiency reserves, I'm going to go through the latest NAIC guidance manual and the ASOPs and talk a little bit about what the NAIC and the Academy of Actuaries are doing right now. First, just a little bit of history, which will mirror some of what you've heard already, but I think it helps to understand where we are. Leslie and I are going to be very interested in going to Session 11 because maybe that will clear up the inconsistencies in guidance by reviewing specific examples, but, if that doesn't happen in Session 11,the confusion may continue .

What happened at the end of the 1990s changed health actuaries' deficiency reserves. Prior to the late 1990s potential deficiency reserves **existed as part of a** gross premium valuation, but health actuaries always contended that if the business were really losing money, they would just stop selling that product. So they didn't have to set up deficiency reserves for a losing block of business. Two things happened in the late 1990s. One was codification, which was written by P&C accountants and actuaries, and so they wrote it for what was appropriate for P&C, but that doesn't quite fit health. Another thing that happened was the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at the federal level. HIPAA made small group and individual guaranteed renewable. So now you can't just drop those product lines.

So those two things happened, and they then implied then or resulted in health actuaries' having to consider setting up deficiency reserves. The Academy of Actuaries and the NAIC talked about what the implications were and what guidelines we could create for health actuaries to help us deal with these changes, and we had a number of choices. On the Academy side we could prepare a standard of practice. We could put together a practice note, or on the NAIC side we could prepare a guidance manual. Well, standards of practice take a very, very long time to create. Anyone who has been involved with them knows that there are endless discussions, changing words from this to that and back again. So that really wasn't going to be a very good short-term solution. Practice notes, ironically, document the current practice, so they're not good for changing the practice. All we would be doing is documenting what had been done, and that wasn't appropriate anymore.

So it was decided that we would partner between the Academy and the NAIC, and the Academy of Actuaries would create a *Health Reserve Guidance Manual* that would include deficiency reserves as well as other reserves. Karen and I worked on this for quite some time, and we developed the first draft of the *Health Reserve Guidance Manual*. But then it was taken to the NAIC who went through a fairly lengthy process of refining it, and the best thing that was added to the manual was documentation of all of the guidance because we couldn't change codification with the manual. We couldn't change anything. All we could do was document the issues and the conflicting guidance. So that's how the work group proceeded and how we got to a point where we didn't really have answers. We just had the issues, and we had a little bit more guidance involvement with the *Health Reserve Guidance Manual*, which was then adopted by the NAIC but still had really no teeth in it because it was just guidance. As a matter of fact, it was a draft for a very long time.

But then the Accounting Committee at the NAIC included a reference to the *Health Reserve Guidance Manual* and the *Accounting Practices and Procedure Manual*, which added a lot more teeth to it. Still all of you who have read the *Health Reserve Guidance Manual* know that, again, it documents a lot of issues, but it doesn't have a cookbook on how to do the PDRs. What it does do is give some guidance on how to calculate the reserves. It does talk about documentation, which I will talk about later, and it does give state examiners something to look at to ask what you have considered, what have you done here. And that will get back to documentation.

ASOP 42, which was finalized just recently, also provides some actuarial standards on the calculation of a PDR. It talks about assumptions, time frames and groupings, which we will get into in a second because some of the biggest issues with the PDRs are how they relate the gross premium valuation, blocks of business, time period of the calculation and assumptions that you use. Assumptions are maybe a little less controversial than these other things.

The next issue relates to gross premium valuation and how it relates to a PDR. I think what's been sorted out in a series of conference calls that gross premium valuation is really two things. It's what, I think, we all think of as a gross premium valuation, which is a liability at the company level to protect solvency if there's going to be a deficiency in the long term.

But a gross premium valuation is also a process of looking at that present value of future premiums as well as current reserves and future claim payments and future expenses. That process, when applied on a shorter-term basis and on a smaller block of business in the whole company, is what a PDR is. So I think we're saying that gross premium valuation is (1) a potential liability on a whole company for the long-term, but (2) it's also a process that then can be adapted to a smaller time frame, a smaller block of business in order to determine if there's a PDR needed. We can find a number of examples of grouping of contracts to determine if a PDR is needed both in the *Health Reserve Guidance Manual* as well as in the ASOP. The basic issue with groupings, is that the NAIC guidance covers all of the possibilities, and there's a lot of freedom within the guidance for actuaries to use different groupings—the basic question concerning groupings is: Can you have one block of business subsidizing another block of business? For example if you sell your health business along with life coverage, and you plan on the profits from the life coverage subsidizing any losses on the health side, if that's your business plan, can you take those two dissimilar blocks of business and aggregate them for the calculation of a PDR? Some would say yes. Some would say no. You can also group by size—individual, small group large group—your mega-groups. Again, there is some allowance for creativity there.

Time period of the calculation: the guidance says until the end of the contract period or the block of business is no longer deficient. So if you have a block of business that is going to lose money the first half of the year, maybe renews at the beginning of the year, or maybe it's just that type of business and then makes money the second half of the year, do you set up a PDR for the first six months, or can you look at the whole year because you could make enough money in the second half of the year to make up for losses at the beginning of the year? When does the contract end? If you have small group or individual that's guaranteed renewable, does the contract end at the end of what is the signed contract in the file, or is it ongoing? If you have a Medicaid block of business that's going to be losing money for an extended period of time, but the contract's only a one-year contract, is it for that one year, or is it until the deficiency would be predicted to end?

One important point, though, is again getting back to you can't say, "Well, we'll just drop that line of business if it's deficient. So if we're still losing money next year, we're just going to get out of the business so we don't have to set up a deficiency reserve after that; even though we don't, there's a good chance we're not going to make money after that." Until you've told the regulator that you're getting out of the line of business, until you've called the groups and said you're going to cancel,

the current guidance would say that you cannot assume that you're going to drop the line of business. You would have to continue the PDR.

The assumptions are fairly straightforward and realistic. "Just use realistic assumptions" is what all the guidance says. The only slightly tricky thing here is expenses. You can do a PDR for only the expenses that are allocated to the line of business and do not have to include overhead. You can do direct expenses as long as the overhead is covered somewhere else. I reviewed at least one filing with one line of business where they didn't include all the expenses because they said, "Well, but we have to include only direct expenses." If you have one line of business, there's no place else that's going to cover it. All of the expenses have to be covered somewhere. But if you're doing a PDR for one line of business in a multiple-line company, you can use just the direct expenses.

Documentation: we have documentation standards as actuaries. There is additional guidance as to what needs to be documented when considering a PDR. There are the instructions to the blanks that say actuarial opinions have to include about eight items. I have yet to see an actuarial opinion that included all eight items. One of the items is contract reserves, which include any PDR. It doesn't say you have to include in your opinion a deficiency reserve, but it does say you have to include Line 3, and if Line 3 is zero, by implication you have a zero PDR, and zero is a number. You've decided not to set up for a PDR.

So there should be some documentation somewhere as to why it wasn't set up, and that could be very simply that you've never lost any money in any line of business in the whole history of the company, which is fine, but if you have a line of business that for the last five years has lost money, I think some additional documentation would necessarily be required. I'm not seeing it, and it's something that, I think, is going to start hitting regulatory radar screens fairly soon on some of these companies that have continuously losing lines of business.

The NAIC and the Academy are continuing to work on the PDR issues. The Academy has developed an inventory of 18 situations that they feel are unclear between deficiency reserves and gross premium valuation, and they are providing that documentation. I think we've given Leslie two or four of them so far at the meeting in Anchorage, and we're documenting what we think the issue is with each situation, what we think the alternatives are. What's sorting out is a handful of issues mostly around grouping and time frame, but also around what the goal of the PDR is from a regulatory perspective, because, as I explained in the history, this didn't start with "We have a goal, so this is what we're going to define as the guidelines for PDR." We had codification, and we had some model laws that all gave conflicting guidance. Leslie's group is going to face a very interesting task of having a set of 10 or 12 regulators determine what the real goal is for PDR. I think it's going to be a very entertaining discussion at the NAIC meetings in the next few quarters, and I think an excellent effort because, as some of the actuaries on our conference calls will say, "Well, what could their goal possibly be in making me do

this? What are they thinking?" Leslie's group is going to step back and ask, "What is our goal with this?" And it will help. That was kind of a preview of Session 11 and an update of where we are, and so we'll all be very interested in Session 11.

MS. BENDER: As I said, my presentation's on a little different topic. It's a comparison of the two presidential candidates' health plan proposals, and we have to submit our presentations quite far in advance for these Society meetings. So there will be some changes from what I present here and what has come out since then. For one thing, each candidate has had an opportunity to maybe enhance his position a little more. When I prepared this, the Republicans had not had their convention, and since then we've gotten some more information from them. Also, I make a disclaimer right now. I took the information from essentially what the candidates had prepared. I make no comment one way or the other regarding their estimates or their cost estimates or if these are accurate or not accurate. So we'll go from there.

First, I'm going to present the Kerry plan. The Kerry plan has three major themes, shall we say, the first one being controlling health care costs, expanding coverage and making health care affordable for every American. Under controlling health care costs, Kerry is proposing the creation of a premium rebate pool, which I will talk briefly on. "Make prescription drugs more affordable," but who's going to say we should make prescription drugs more expensive? I mean, some of these goals, which you'll see with the Bush plan, too, are sort of like apple pie or something. "Make malpractice insurance more affordable," which is very interesting, especially considering Senator Edwards. Then there's a quality bonus. "Reduce the administrative cost with technological bonus." Who's going to say we're going to increase the administrative cost? "Encourage a healthier America as opposed to encouraging a sicker America. And disease management programs." You will see that Bush has some of these same themes, so I'm not just picking on Kerry right now.

Under the theme of expand insurance coverage Kerry has proposals to insure every child, expand coverage for working parents and expand coverage to single and childless adults. I don't know who else is left actually. If you can come up with someone, I don't know if I want to know. And then the last theme is, again, to make health insurance care affordable for every American as opposed to making it unaffordable for every American, but this one is going to be mainly through his plan to expand the Federal Employees Health Benefits Program (FEHBP).

Controlling health care costs—and I'm just going to pick out certain things to discuss. Probably one of his most talked about or the issue that's probably gotten the most press is what we call the premium rebate pool. Kerry is proposing essentially a reinsurance-type mechanism for employers, and ultimately the federal government or this reinsurance pool would pick up 75 percent of all catastrophic claims exceeding $50,000 per individual per year. That's what I got off Kerry's Web site. Actually I guess that is to be in 2016 or something. They're estimating right

now it might be at the level of $36,000. Whatever is needed, the goal is to reduce the cost of health insurance by 10 percent. And in order for employers to be eligible for this, they would have to demonstrate that they are providing "affordable premiums." I don't know what that is. I'm not going to make any statement on that, but the savings must be passed directly to the workers. That's very important. Again, their estimates are 10 percent or $1,000 per family per year.

Another integral part of this is that they're going to encourage disease management programs to improve quality care and decrease cost of care. I believe it's probably fair to say most employers' health programs now, or most insurance companies right now, are actively trying to introduce the disease management programs. The next one is to make prescription drugs more affordable, and probably the big thing here is that manufacturers are going to have to disclose the costs that they are charging the pharmacy benefit managers and maybe to disclose the little-known or dirty little secret called rebates, and to negotiate real discounts as opposed to negotiate "unreal discounts."

"Make malpractice more affordable": the Democrats oppose capping damages in malpractice losses, which probably is not surprising considering Senator Edwards' previous experience prior to coming to the Senate because they are saying that it will not reduce premium costs. I'm just quoting what they say, folks. But they will prohibit individuals from bringing suit unless a reasonable claim exists. I think that's probably in the state laws right now that you can't bring suit unless there's some sort of reasonable claim. Also, make available nonbinding mediation. Notice "nonbinding."

Kerry opposes the award of punitive damages unless there's intentional misconduct, gross negligence or a reckless indifference to life: my understanding is that's pretty much what the standard is today. They're going to incorporate a quality bonus providing financial incentives for purchasers and providers to improve quality. The details are sort of sketchy on this, which is reasonable at this stage of the game. The quality bonus is also going to try to encourage health organizations, including providers, to invest in information systems—you're going to see this on the Bush side, too, that there's a real push to having electronic medical records; in this day and age does seem almost unbelievable that you can know what's on your charge card, but if you get sick in one state, they don't know your medical history in a different state.

Again, another way of controlling the health care costs is to reduce administrative costs with this technological bonus. There's a lot banking on using technology to reduce the administrative costs of health plans. Probably the big driver here is that they would require private-sector insurers to use these systems. In other words, any private-sector insurer that's doing business with the government would have to adopt paperless claims or improve their IT. They're going to encourage a healthier America. One of the things here, again, the goal is if you expand insurance coverage for all these people, then obviously you would reduce uncompensated

care cost by definition, and by expanding coverage to all these people you also have invested in a safety net. Again, with the disease management programs, there's a lot invested on both sides for the Kerry program and for the Bush program, both to expand disease management and to get a painless way of expanding coverage without paying a cost for that.

On expanding insurance coverage, which is his second theme, Kerry is going to make every effort to insure every child, and one of the means that he's going to use is to expand the State Children's Health Insurance Program (SCHIP) to enroll 20 million children. He would automatically enroll every eligible school-age child, have eligibility workers available, family clinics—almost like when you go in and have your service done we'll enroll you for insurance. States would have to expand the eligibility for children to families of 300 percent of poverty. Just to give you an idea of what that means, that would be almost $57,000 for a family of four, so for any family of four making less than $57,000, all their children would be covered under SCHIP, which is sort of Medicaid.

He'd expand the coverage for working parents. Now, the children would be covered in these families. If the family were making the $57,000, the children would be covered. The parents would be covered if they were making 200 percent of poverty, and that is $37,000 for a family of four in 2004. Then once the states get back on course, and this is a quote from their Web site, they would expand Medicaid to cover single adults and a childless couple at or below the poverty level. They feel that it would be enough savings in the program to be able to fund this.

The third theme of Kerry's health plan is to make health care affordable for every American, and they are going to do this by essentially expanding access to the FEHBP. It will be called the Congressional Health Plan. This would be for small businesses, self-employed and individual coverage as well as workers in large businesses. Again, I'm not sure who else would be left. Small businesses would be eligible for the premium rebate that we discussed before—remember that, that pooling?—and eligible to receive 75 percent of claims over x, whatever we decide x to be. In addition they would be eligible for refundable tax credits, up to 50 percent of the cost of the coverage for small businesses and their employees, and the combination of the premium rebate and a tax credit will reduce costs by almost two-thirds. Now, I'm just adding these together. The one before said 10 percent. This says 50 percent. I get 60 percent, but that's close to two-thirds, I guess.

It would also expand the Congressional Health Plan to include self-employed and individual coverage, and Kerry's plan would provide assistance of costs above 6 percent of income. I guess shall we call that above the line for people who maybe don't have enough expenses to itemize, or I also think that you are limited in how much you can declare as a deduction, that you have to take away the first 6 percent. So that would truly help in assistance. Self-employed and individual coverage would also be part of the premium rebate pool, and, again, this would end discrimination that individuals have faced when purchasing private health plans. It

doesn't say how. So I don't know if we're talking about guaranteed issue for these people who want to go buy into the Congressional Health Plan for self-employed and individual coverage. Otherwise I don't know how you're going to end this discrimination, because I think the perceived discrimination generally has to do with medical underwriting.

Workers in large businesses would also be eligible to participate in the Congressional Health Plan. There are some conditions. They must maintain the same employer base contribution. In other words, they can't use this to lower their costs, and they can't selectively segment their workforce to put all the sick ones in the Congressional Health Plan and keep the healthy ones, the ones that they're going to be paying for. Again, they would be eligible through the premium rebate pool. Workers between jobs would be eligible to receive 75 percent tax credit for the Congressional Health Plan as a way of enabling them to pay the premiums.

Retirees and Americans aged 55 to 64 would be included—I don't know, I mean, earlier we talked about self-employed and individuals. I take it that retirees and Americans fall under that category, but for some reason they segregated retirees and Americans aged 55 to 64 into a separate category. They would also be eligible for the premium rebate pool because they would be part of the Congressional Health Budget Plan tax credit, and they would have access to a variety of plans. I would assume that this is something like a purchasing pool when they mean access to a variety of plans similar to what the FEHBP has available to them now. The cost would be $653 billion over 10 years. That's an estimate from Emory University Professor Ken Thorpe. Bush supporters say it's closer to $900 billion. I have something else that I think says something like $1.6 trillion. It's expensive. We all agree that Kerry's is expensive. Whether it's $700 billion or $900 billion, it will be funded through the reversal of tax reductions for the richest Americans, and it will cover 27 million people who had been previously uninsured. Again, those are the goals there.

The Bush health plan—and I'm probably going to be referring more to notes on this, like I said, because I put this together prior to the Republican convention—they have come out with some more precise descriptions since then. Again, Bush has three things. "Make health care more accessible and affordable," not just more affordable but more accessible and affordable. "Care for those in need and support health care innovation and technology." Again, when I was putting these together, he was emphasizing more of his accomplishments to date as opposed to a new health plan. So I'll go through these really fast. Obviously as part of the Medicare Modernization Act, a huge change in the law, there was the introduction of health savings accounts and high-deductible health plans. How many people in this room are familiar at least tangentially with those? Okay, so enough said on that. So you understand the tax advantages, and they estimate that at least 1 million newly insured Americans will result from that.

Obviously the prescription drug program, the Part D under Medicare, whether you like it or dislike it, they're saying that that is definitely an accomplishment to date, and it will offer drug benefits to 40 million seniors. For the people who have very, very high drug costs, it will save them the most money. In the interim they offered the prescription drug card with anywhere from 15 to 30 percent savings. I think there's only, though, about four to six million people so far who have enrolled in that. They're saying their accomplishments to date are that they have expanded SCHIP to make 2.6 million more children eligible and that they've improved the benefits for more than 8 million since 2001. I don't know if these numbers are right; I'm just taking them off their Web site. Another accomplishment to date is the encouraging of the competitive pricing in Medicare. Well, they're saying it's an accomplishment to date, and it has been passed. We haven't really seen the impacts yet of how this will work, but the Bush plan is relying mainly on market-based reforms as opposed to government programs.

Their second theme: make health care costs more accessible and affordable, reduce drug costs by increasing access to generic drugs, and that they have preserved rural access by increasing the Medicare provider reimbursement rates in the rural areas. They've provided health insurance tax credits specifically in the trade bill, and they're encouraging the creation and the expansion of risk pools. Caring for those in need: they're saying that their accomplishments to date are increasing funding for the safety net hospitals, and, again, they refer to their support for the low-income Medicare participants. Again, the Bush plan is saying instead of just passing reforms for everyone, let's identify those who are in the most need and concentrate our dollars on those. They say that their accomplishments to date here are, again, protecting children through SCHIP, increasing the community health centers and encouraging medical volunteers.

There's the third theme of supporting innovation and technology. I have several quotes associated with reducing medication errors. Again, there is a lot of emphasis on electronic medical records and hoping that they will get some savings from that. Also adding new Medicare choices that they sincerely believe will result in savings due to improvements in technology. Now, on an ongoing basis you'll see Bush is really relying on the market for market reform. They're talking about informing and empowering the consumers. There's a lot of reliance on health savings accounts and high-deductible health plans. Bush is also proposing association health plans. How many people are familiar with the association health plan legislation? Enough said on that.

Also, they're proposing grants to states to create insurance purchasing pools, which are, in my opinion, similar to but maybe not quite the same as association health plans. One that is probably very, very interesting that hasn't gotten a lot of play is permitting purchases of individual coverage by insurance regulated in any state, which is, again, similar to the theme of association health plans where you can choose a state. That's going to be a situation where I'm going to—I will say domicile—even though I may not even be in that state, but I'm going to follow the

rules of that state, and then I can sell nationwide. They'll remove all of these perceived barriers, the theme being then that states will have an inducement to compete with each other regarding regulatory efficiencies, whether you accept that or not.

Again, Bush is relying more on tax incentives. This is the one that, when I was doing this, they didn't have quite highlighted out, but he would provide 90 percent of the cost of a nongroup policy, and the maximum credit would be $1,000 for a single adult and $2,000 for a family. Again, they would make sure that health savings accounts are user-friendly and widely available, and when we're talking about user-friendly, we're talking about access to information, which gets into the transparency of costs and providers making their costs available and that people would be able to easily access this information so that they can make informed health care decisions. They estimate that through all of these reforms they would cover about 17 to 25 million more Americans compared to the Kerry plan of 27 million more Americans.