HEALTH SECTION NEWS

"For Professional Recognition of the Health Actuary"

NUMBER 38 AUGUST 2000

Chairperson's Corner

by Bernie Rabinowitz

I often wonder how our profession can play a greater role in today's healthcare industry.

When I was an actuarial student in South Africa, the CEOs of the major insurance companies were actuaries. Business acumen and intellect combined with a practical knowledge of risk and adverse selection theory put actuaries at the forefront of the insurance business. In fact our actuarial risk models were a major driver of the business.

Today things are more complicated. We are operating in a changing healthcare environment. Our industry has to effectively manage provider networks, satisfy

(continued on page 7, column 1)

A Health Insurance Insolvency Case Study

By Bill Howard

Editor's note: Portions of this article originally appeared in the *NOLHGA Journal.*

The Centennial Life Insurance Company was a Kansas-domiciled group health and long-term disability insurer that was placed in rehabilitation and then liquidation in 1998 by the Kansas Insurance Commissioner. Licensed in the District of Columbia and all states except Maine, New York, and Rhode Island and previously licensed in Puerto Rico, Centennial presented new challenges to the life and health insurance guaranty association system. It was the first major health insolvency that the guaranty association system faced since the passage of the Health Insurance Portability and Accountability Act of 1996.

What Happens When a Health Insurance Company Fails?

Life and health insurance guaranty associations are organizations created by state legislatures to protect the policyholders and beneficiaries of an insolvent insurance company, up to specified limits. By

(continued on page 20, column 1)

In This Issue

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Editor's Column

by Jeff Miller

Jeff Miller, Editor

I'm writing this letter on a fateful day for health actuaries. Today is Thursday, June 22, 2000, and the *Wall Street Journal* features an article on the front page entitled "Shaky Policy – Unexpected Rate Rises Jolt Elders Insured for Long-Term Care." While actuaries aren't mentioned often in the article, our work is its main focus.

The article makes some very interesting statements, such as:

> The insurers erred in the complex business of figuring out how low they can make rates and still have sufficient capital and reserves to pay claims….
>
> "It's a complete deceit for seniors to spend hard-earned money to buy these products, trusting the companies to be there when they need them, and then find out later that they cannot afford to keep the benefits in place," says Bonnie Burns, who advises seniors on insurance for a California program.…
>
> The…insurers…deny intentionally underpricing policies to gain market share. They blame their own miscalculations. A key one was assuming that a substantial number of new policyholders would change their minds and let their coverage lapse early on, thus ceasing to be a liability….
>
> The former actuary … responds that problems arose from [the company's] determination to charge the same low premium to healthy people and sick ones alike.

Could there be a more graphic demonstration of the importance and danger involved in the work we do? While all health actuaries are not long-term care experts, we all know the problems that actuaries face in pricing long-term care policies. We know about uncertain patterns of future treatment. We know about potential adverse selection, especially when underwriting standards are compromised. We know about competitive pressures for lower and lower premium rates. And finally, we know about the aversion of marketing people to fully disclose complicated policy provisions. Ours is a very complex business.

We hope that this edition of *Health Section News*, as well as other activities of the Society of Actuaries, will help you to do a better job at this very challenging profession we have all chosen.

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New Assessment Program for PPOs

By Louis Lana

The National Committee for Quality Assurance (NCQA) has for nine years rated health maintenance organizations (HMOs) based on customer satisfaction, access and availability of care, health plan stability, use of services, cost of care, and effectiveness of care. This year, the NCQA will embark upon a similar assessment program for preferred provider organizations (PPOs). This article will explain the rationale behind a rating system for PPOs and compare the performance measurements used to rate PPOs with those used for HMOs.

Why PPOs?

In 1998, for the first time, PPO plan enrollment exceeded HMO plan enrollment. Approximately 100 million Americans are covered by PPOs. The reason for the rising popularity of PPOs is probably due to the increased choice: there are fewer restrictions on specialist care and PPOs offer better out-of-network coverage than HMOs. The NCQA thus believed the time was right to measure the quality of PPOs.

The Measurements

The tools to measure quality for PPOs will not be as stringent, at least initially, as those used to measure HMOs. PPOs will not be required to submit Health Plan Employer Data and Information Set (HEDIS) effectiveness-of-care results that HMOs are required to submit for accreditation. These measurements, covering such services as antidepressant medication management, cervical cancer screening, and comprehensive diabetes care, involve a thorough analysis of administrative, enrollment, and medical record data. For this reason, most companies with large data warehouses utilize a third-party vendor to handle compliance with HEDIS effectiveness-of-care requirements.

Another component of measuring quality of care for managed care organizations is the use of customer satisfaction surveys. PPOs will be required to comply with this measure. These surveys, known as CAHPS (Consumer Assessment of Health Plans), assess patient satisfaction with the experience of care. A random sample of members is asked about their overall satisfaction with the plan and its doctors; key areas such as claims processing, customer service, and physician communication are targeted. Managed care organizations are required to contract with an NCQA-certified vendor to administer the surveys, to ensure unbiased reporting.

PPOs must submit a CAHPS survey to NCQA every year in order to maintain accreditation. Evaluation is done by product line (commercial and/or Medicare). The results are then compared to national benchmarks and thresholds based on previous surveys. There are three possible scores: Accredited, Provisional, and Denied. Accredited means a score of 65-100%, Provisional signifies a score of 55-64%, and Denied is a score of 54% and below. Only PPOs earning Accreditation status will receive an accreditation seal from NCQA.

Conclusion

The accreditation standards for PPOs are still in the nascent stage. At the time this article was written, a draft of the accreditation program could be found on the NCQA Web site *www.ncqa.org* for public comment. As more employers provide PPOs as an option for their employees, there will be a rising demand to know how well the doctors in those PPOs perform comparable to doctors in other managed care organizations. The NCQA has taken that first step in objectively measuring the quality of care of PPO plans.

In 1998, for the first time, PPO plan enrollment exceeded HMO plan enrollment. Approximately 100 million Americans are covered by PPOs.

Louis Lana, ASA, MAAA, is actuarial manager at Group Health, Inc. in New York. He can be reached at llana@ghi.com.

Benchmarking to Maximize Managed Care Performance

By Sue McQuillian

Today's managed care marketplace is extremely competitive. Plan sponsors insist upon measurable value from managed care organizations (MCOs) in return for their health care dollars. In addition to fulfilling a role as a yardstick for plan sponsors, targets for medical management and network reimbursement can help MCOs identify weaknesses within the organization, develop an action plan and set incentives for performance.

The value of benchmarking is in its creation of a basis for action. The keys to successful benchmarking are:

- Analysis at a level specific to what the user wants to measure
- Follow-up by appropriate personnel to research the reasons behind undesirable results
- Formulation of alternate strategies for improvement

This article will show how benchmarking actual performance to a published source is a useful tool in assessing the value added by a particular program or MCO. It will examine uses of benchmarking, as well as the actual benchmarking process.

Uses of Benchmarking

Benchmarking can be done at numerous levels, depending upon the purpose of the analysis. Table 1 is a directory designed to assist a plan sponsor or MCO in determining the type of benchmarking relevant to the organization's specific situation.

One consideration in determining the appropriateness of benchmarking at any of these levels is credibility, both in terms of reliability (i.e., accuracy and consistency) of the data being used for the analysis and of having enough data to produce meaningful results. Benchmarking should be performed only when the volume of data is such that results will not be unduly affected by a few chance fluctuations.

The Benchmarking Process

Benchmarks are only meaningful if they have as their basis accurate, consistent data in sufficient volume to ensure credibility. There must be some flexibility to allow, for example, adjustments to reflect different member cost-sharing provisions and varying reimbursement structures.

Cost and utilization targets for the plan under analysis can be set somewhere in between benchmarks representative of a loosely managed healthcare system — characterized by plans with significant member cost sharing and little medical management intervention — and well managed benchmark standards — representative of best practices for utilization management and reimbursement contracting. Comparison of plan experience data to the two extremes (minimal versus optimal medical management and provider contracting) shows the analyst where the plan lies in the managed care spectrum. The final targets will be based upon the current level of health care management and the goals of the plan.

To compare benchmark utilization and cost data to the actual experience of the

Table 1
Directory
Benchmarking Types

Benchmarking Type	**Why** Perform This Type of Benchmarking?	**What** is Being Measured?
Benefit Plan Type	• Align benefit plans • Compare one MCO's plan to another • Assess plan viability	• Utilization • Reimbursement levels • Cost per member per month
Provider Network	• Determine effectiveness of medical management by network • Measure effect of discount arrangements • Create tool for provider incentive programs	• Utilization • Reimbursement levels • Cost per member per month
Plan Sponsor	• Test experience of membership against targets • Determine effectiveness of initiatives • Assess impact of pilot programs	• Utilization • Reimbursement levels • Cost per member per month
Medical Management Entity	• Assess performance of separate medical management entities within an MCO • Develop employee/ subcontractor incentive programs	• Utilization
Provider Group	• Assess performance of a specific provider group • Create tool for provider incentive programs • Use in capitation development	• Utilization
Vendor	• Determine whether outsourcing is cost effective • Assess vendor performance	• Cost per member per month

plan to be benchmarked, the benchmark data must be modified so that the effects of network and medical management are isolated from other, unrelated influences. Adjustments must be made to account for:

- Differences in the demographic composition of the population under study
- Geographic location of the population
- Member cost sharing
- Capitated services
- Industry
- Underwriting and pre-existing exclusions
- Network discounts
- Trend
- Special populations not included in the benchmark data

An Illustration

The Sample Plan, a hypothetical HMO, was concerned about losses incurred by its Medicare HMO product and the product's competitive position. The Plan was already charging a premium to its members, in addition to payments received from Medicare, and was concerned that an increase would make the product unsalable. A reduction in reimbursement was not considered politically expedient, and Medicare payments are not subject to the Plan's control.

The only other option available to the Plan was to effect a change to utilization of services; that is, to shift care to more cost-effective settings and eliminate unnecessary utilization. The Plan reasoned that the best approach would be to assess the performance of their medical management against best practices to determine if more effective patient management was possible, to the extent that losses could be eliminated.

This is an example of benchmarking by benefit plan type where actual experience is compared with a best practice standard; in this case, utilization for a well managed healthcare system model. Benchmark costs are determined by combining well managed utilization targets with the Sample Plan's provider reimbursement levels. These costs are then compared to a competitive net premium.

Per member per month (PMPM) output from a cost model containing experience of the Sample Plan for calendar year 1998 is shown in Table 2, along with the adjusted cost models for loosely managed and well managed healthcare. Table 3 compares utilization for inpatient services. The Sample Plan was unable to identify utilization separately for service types other than hospital inpatient, so comparisons for the other coverage categories were made only at the PMPM level.

Table 2
Sample Plan
Medicare HMO Product
PMPM Comparison
Center Date: 7/1/1998

Type of Service	Actual Plan Experience	Illustrative Loosely Managed Benchmarks*	Illustrative Well Managed Benchmarks*	DoHM
Inpatient Hospital	$125	$138	$45	14%
Outpatient Surgery	21	35	18	82
Professional/Other	198	214	180	47
Mental Health/ Substance Abuse Capitation	3	7	7	100
Skilled Nursing Facility, Home Health, Ambulance	40	63	36	85
Total Claims Cost	$387	$457	$286	41%

*Sources: Milliman & Robertson, Inc. *Healthcare Management Guidelines*™ and *Health Cost Guidelines.*

Table 3
Sample Plan
Medicare HMO Product
Inpatient Utilization Comparison
Center Date: 7/1/1998

	Plan Experience	Illustrative Loosely Managed Benchmarks*	Illustrative Well Managed Benchmarks*	DoHM
Annual Admits/1,000	294.00	264.00	142.00	0%
Length of Stay	5.89	7.11	4.31	44%
Annual Utilization/1,000	1,732.00	1,877.00	612.00	11%

*Sources: Milliman & Robertson, Inc. *Healthcare Management Guidelines*™ and *Health Cost Guidelines.*
The Plan's net premium for 1998 (member plus Medicare premium, less administrative expenses) was $346.

Tables 2 and 3 also present the calculated Degree of Healthcare Management (DoHM). The DoHM is a statistic that compares the Sample Plan's actual experience results to both a well managed and loosely managed standard. It illustrates numerically where the results of the Sample Plan fall in the spectrum of loosely managed to well managed healthcare.

Analysis at a more detailed level or a different split by service type than that shown in Table 2 is possible. The detail level chosen will depend upon the data available for the Plan being examined and the purpose of the analysis.

Results

As a general guideline, the analyst must look at experience for the entire Plan before conclusions can be reached about any one service category. This will be evident as we explore some observations based on the results shown in Tables 2 and 3:

- Total medical costs for the Plan are $387 PMPM, versus $346 available from member and Medicare premiums. The result is a $41 PMPM loss.
- The DoHM in the last column of each table varies significantly by service type. In this example, the DoHM for the Plan as a whole is 41% [($457 - $387) / ($457 - $286)]. The DoHM for inpatient care using cost PMPM is

continued on page 6

Benchmarking to Maximize Managed Care Performance

continued from page 5

only 14%, while the DoHM for skilled nursing facility, home health, and ambulance is 85%. This kind of variation between coverage categories is not unusual. Breaking the DoHM analysis down by service type can help to pinpoint the cause of a low overall DoHM and illuminate some possible solutions.

- The DoHM required for the Plan to reach a breakeven position is 65% [($457 - $346) / ($457 - $286)]. An improvement in the Plan's financial position is certainly possible, with a potential reduction of $101 PMPM ($387 - $286) in costs, with medical management at the well managed level.
- It is apparent that there is an excellent opportunity for improvement in inpatient days/1,000, particularly by focusing on unnecessary admissions. The Plan's admission rate exceeds that of a loosely managed system, making it, in essence, unmanaged. Since this is the category with the greatest potential for cost reduction, this is where the Plan should focus its medical management efforts.

  The effect on cost from a reduction in days/1,000 is dependent upon the Plan's hospital contracts. If reimbursement is on a *per diem* basis, a reduction in inpatient days, whether in admissions or length of stay, will have a direct impact upon total cost. A reduction in admissions in a system that reimburses on a DRG-basis would also see a direct cost reduction. A shorter length of stay only will have no effect, as the same payment is made per admission regardless of length of stay. A capitated system will see no immediate cost reduction regardless of the source. However, through physician education and other initiatives, hospital capitations can be reduced as days/1,000 are decreased.
- The Plan's results look good for outpatient surgery with a DoHM of 82%, but this could be misleading if taken alone. It is very important when benchmarking not to do it in a vacuum; that is, not to isolate one item for analysis at the exclusion of all others. The analyst must look at experience for the entire Plan before conclusions can be reached about any one service category. Often, the poor or exemplary performance of one service category will be due to a problem or clinical action taken in another category.

  The low DoHM in the illustration for inpatient care could indicate a need to shift some inpatient surgery admissions to an outpatient setting, thereby increasing the inpatient DoHM and, to a lesser extent, decreasing the outpatient surgery DoHM. Such a shift may also result in an increase in the average inpatient length of stay, necessitating closer examination of this benchmark category and possibly skilled nursing and home health as well, as the DoHM for that category is very high compared to the Plan's overall DoHM. This could be indicative of a need to review criteria for transfer of patients to recovery care.
- The Plan's mental health and substance abuse capitation appears to have been a very effective cost management initiative.

Plan Options

Several avenues are available to the Sample Plan as a result of the analysis shown above:

- First, it can take action based upon the information it already has. Inpatient admissions are too high. One way to reduce them might be to use treatment guidelines for admissions by condition. If guidelines are currently in place, they should be reevaluated in terms of their effectiveness and whether they are indeed even being followed. Implementation of new guidelines should be preceded by an organizational assessment to review current structure and processes to determine how the proposed guidelines may be used to effectively manage care.

  Successful execution of any treatment guidelines requires a buy-in from physicians, the Plan's medical management team and hospital staff. Communications between affected parties while evaluating proposed guidelines and during implementation is essential to success.
- Another possibility for the Plan to consider is further research and analysis to identify the reasons behind the high admissions rate and high overall days. To accomplish this, the Plan might want to consider a retrospective chart review by a physician or a nurse of inpatient records. This process includes an evaluation of patient status and care for a sample of actual admissions on a day-by-day basis with comparison to benchmark standards.

A chart review can help a Plan determine whether it is experiencing inappropriate admissions or perhaps a high readmission rate due to early discharge. It can also help in obtaining physician, medical management staff, and hospital buy-in necessary for implementation of any medical management program.

Conclusion

Real, attainable goals are essential for any organization if progress is to be made. It is very easy to continue to "maintain the status quo" if objectives are not identified and communicated. On the other hand, setting goals that are unrealistic because information about internal cost and utilization levels and the competitive environment was not fully understood and used in the goal-setting process can yield frustrating and even counterproductive results.

An assessment of a plan's current Degree of Healthcare Management, combined with an analysis of current reimbursement levels in the targeted marketplace, can provide a plan sponsor with a tool to measure plan performance and a managed care organization with benchmarks, enabling it to achieve its goals of competitiveness, profitability, and growth.

Sue McQuillian, FSA, MAAA, is a healthcare management consultant in the San Diego office of Milliman & Robertson, Inc. This report is an excerpt from a Milliman & Robertson, Inc. Research Report. *The full version of the report can be found on Milliman & Robertson, Inc.'s Web site,* www.milliman.com.

Considerations in the Development of Area Factors

By David Reichlinger

Adjustments based on geographic location cause more variability in rates than any other factor except age. Whether they are developed internally or externally, a number of issues should be considered. Unfortunately these considerations are often subjective and may even be in conflict with each other. As a result, the process is both an art and a science.

This article presumes that an initial set of area factors is already available. Before making any modifications, it is important to understand how these area factors were developed.

It is a good idea to review your block of business for any circumstances that may require a special adjustment. For example, there may be a concentration of business in the fringes of a metropolitan area. This could result in a lower factor. If you specialize in a particular industry or affinity group, it could also impact the area factor.

Adjustments should also be made for any demographic differences. Rural areas are more likely to have larger families. Census data is a good source for this information. Depending on the nature of your business, there may be other demographic considerations.

Legislation and the regulatory environment must be reviewed carefully. The impact will vary considerably depending on the product and jurisdiction.

Consideration must be given as to the location and composition of the services. The most expensive procedures are generally confined to major hospitals in large metropolitan areas regardless of where the patient is located. As the deductible increases, hospital stays generate a greater percentage of the cost. In pricing high deductible business or any form of excess reinsurance, the impact of the shift in location and composition of services must be carefully considered.

Competitive pressures play a role. If possible, avoid rapid increases in area factors. It is a good idea to carefully examine the factors in key markets.

As indicated above, this is an art and a science. Therefore it is necessary to rely on instinct. Don't be afraid to make adjustments if you feel they are appropriate. If possible, have an associate review your work.

If your pricing is based on your own experience, the application of area factors should have a neutral impact. Develop a composite area factor by taking a weighted average of the area factors against your block of business. If the composite isn't near 1.00, an adjustment is needed. If you rely on external sources for your pricing, this step isn't necessary.

In developing the process outlined above, consideration was given to a wide variety of products. You may find that some steps are not needed or have additional issues.

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Chairperson's Corner

continued from page 1

customers with quality healthcare, create the necessary information systems, and still perform traditional insurance functions.

Although actuaries perform important technical risk functions, are we still the major force in the industry? I believe that to be the major force we have to be regarded as the MBAs of the healthcare industry. As the famous British actuary Frank Redington once said, " An actuary who is only an actuary is not an actuary." Questions that therefore come to mind are:

- What do we need to know?
- How do we learn it?
- How should this relate to our current education program?

Please let me know your thoughts, comments, and ideas on this challenge. These will be incorporated in a discussion paper for further comment and ultimately for submission to the Society's health practice and E&E committees, if appropriate. Please contact me by e-mail at BRabinowitz@radixhealth.com.

Currently MCOs are earning inadequate returns on capital; more providers are in financial difficulty than ever before; political and litigation threats against managed care are gaining momentum; prescription drug costs are rapidly increasing; there are 44 million uninsured plus many underinsured; the population is aging; medical claim cost trend has now reached double digits. Where is our healthcare system headed?

For answers read *Institute for the Future: Health and Healthcare, The Forecast, The Challenge 2010.* The Robert Wood Johnson Foundation has placed a copy of this 217-page book on its Web site *www.rwjf.org.* Just click on libraries. This book may also be ordered from Jossey-Bass Publishers at *www.josseybass.com.*

The Health and Pension Spring Meeting in Las Vegas (May 22-24, 2000) was a great success with about 1,100 attendees. All 39 sessions sponsored by the Health Section were well attended.

The success of the meeting was due in large part to the efforts of many volunteers including our program representatives Bob McGee and Dan Skwire, Section Council members, moderators and the panelists. Also thanks to the Society staff for their dedication and hard work.

Bernie Rabinowitz, FIA, ASA, MAAA, is executive vice-president and chief actuary of Radix Health Connection LLC in Chicago. He can be reached at BRabinowitz@radixhealth.com.

Medical Aggregate Stop Loss Claim Frequencies

By David Olsho and Mark McAllister

When I first got involved in medical stop loss in the mid-1980s, there was an expectation that there would not be any medical aggregate stop loss claims and aggregate claims were, in fact, rare. In recent years, aggregate claims have become much more frequent. Almost all of the Merrill Lynch / Howard Johnson & Company (ML/HJ) clients have reported increased claim frequencies.

I believe there are two reasons for this increased frequency: selling aggregate stop loss to smaller groups and selling aggregate stop loss at lower margins.

Both of these are related to the increased number of stop loss providers (managing general underwriters, insurers and reinsurers), all of whom want to increase (or at least maintain) premium volume. While premium volume is more directly related to specific stop loss (typically 90% of total stop loss premium), aggregate stop loss is usually sold in conjunction with specific. The aggregate attachment point (AAP, equal to expected claims plus margin) is often an important factor in the sale of the entire stop loss package.

To show the effect on claim frequency of these two assumed causes, I examined the results of the Monte Carlo simulation used to produce the premiums in the ML/HJ aggregate manuals. The simulation is based on our standard medical claim cost distributions (one adult, one child), and the number of dependents (spouses and children) per life (employee). We assumed each group had appropriate specific coverage, based on the ML/HJ guidelines. We simulated claims for 31 different group sizes, ranging from 25 lives to 10,000 lives, 35,000 times for each group size, and counted the number of times the simulated claims exceeded the expected claims, at margins ranging from 0% to 50%.

Table 1 illustrates the results of the simulation for nine group sizes. It clearly shows the increasing frequency as both group size and margin decrease. At the industry standard 25% margin, our simulation did not produce any claims for group sizes above 2,000 lives. Not until we reduce the group size to 300 lives, do we get a claim frequency of greater than 1%. At a group size of 75, the expected frequency is almost 10%, and at 25 lives, the frequency is almost 20%.

When the margin is decreased from 25% to 20% (a decrease in the AAP of 4%), claim frequency increases over 10 times at the higher groups sizes (at 1,000 lives or more), and reaches a 1% frequency at 700 lives (more than 4 times the frequency at a 25% margin). At 25 lives, the frequency increases to almost one in four, or 25% greater than at a 25% margin.

Chart 1 shows frequency by group size at both a 20% and 25% margin.

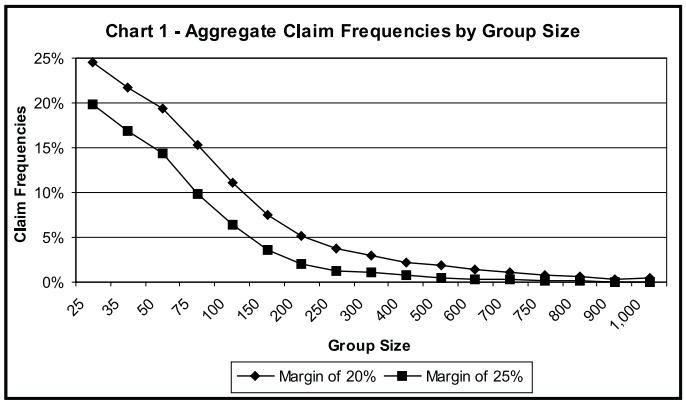
TABLE 1

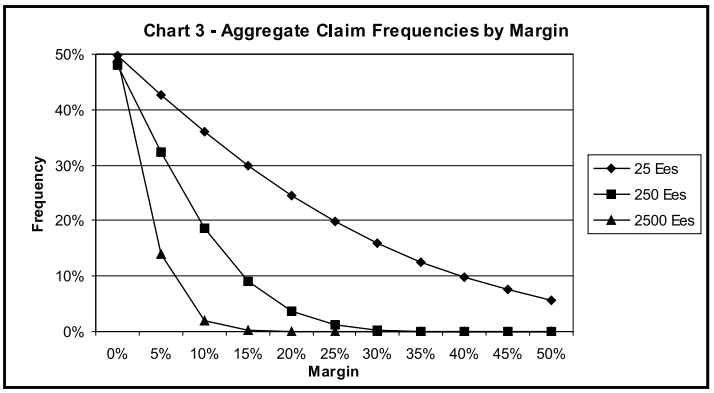
Merrill Lynch/Howard Johnson & Company
Expected Aggregate Claim Frequencies

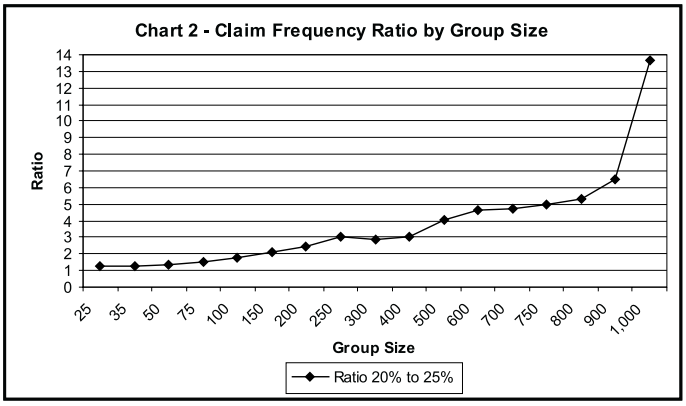
Group Size	Margin										
	0%	**5%**	**10%**	**15%**	**20%**	**25%**	**30%**	**35%**	**40%**	**45%**	**50%**
25	49,757	42,737	35,963	29,866	24,494	19,903	15,874	12,503	9,840	7,629	5,583
50	48,577	40,234	32,400	25,397	19,434	14,363	10,383	7,266	4,929	3,234	2,003
100	49,300	38,331	27,460	18,160	11,137	6,329	3,469	1,831	934	409	160
250	48,143	32,289	18,654	9,171	3,714	1,209	334	91	29	3	-
500	45,214	26,980	13,454	5,691	1,917	474	100	17	-	-	-
1,000	48,546	23,589	8,583	2,354	469	34	-	-	-	-	-
2,500	49,289	13,854	1,954	197	3	-	-	-	-	-	-
5,000	50,017	7,451	357	-	-	-	-	-	-	-	-
10,000	51,900	2,103	3	-	-	-	-	-	-	-	-

Note: Frequencies are per 100,000 groups using ML/HJ demographic assumptions and selected Specific Deductibles.

2000 Stop Loss Manuals — Health and Welfare Actuarial Services — October, 1999







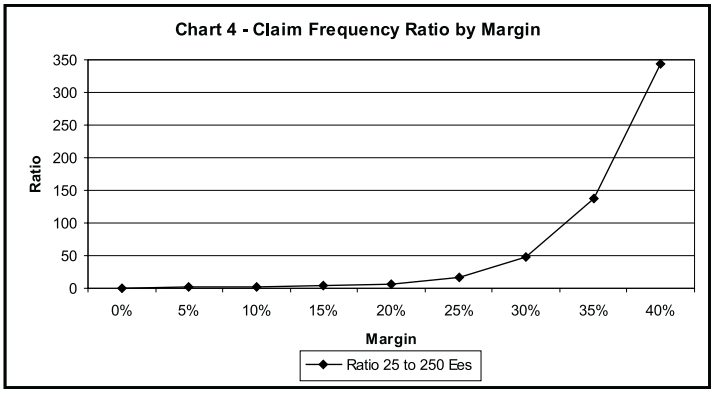


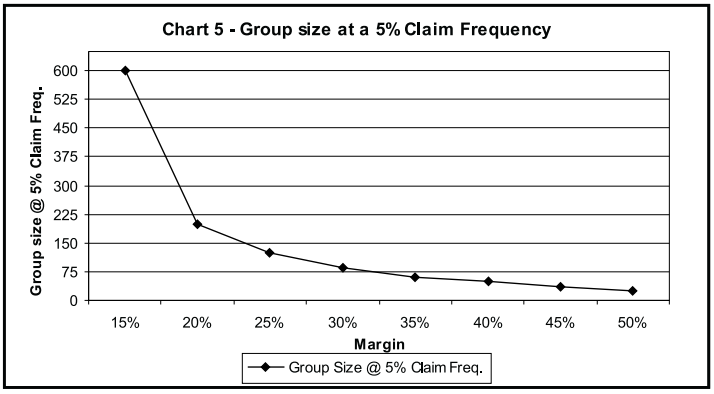
Chart 2 shows the relative frequency at those two margins.

Chart 3 shows frequency by margin at group sizes of 25, 250 and 2,500. Chart 4 shows the relative frequency of the 25 life group to the 250 life group.

Finally, Chart 5 shows the approximate group size that would produce a 5% claim frequency at various margins.

The results of the Monte Carlo simulation show that medical aggregate stop loss claim frequencies would be expected to increase, as group size decreases and as margin decreases. While this is not an unexpected result, the extent to which frequency increases may be. Frequency is 40 times higher for a 50 life group at a 20% margin than it is for a 500 life group at a 25% margin.

With aggregate claims expected to be frequent, the aggregate premium calculation becomes as important as the aggregate attachment point calculation.



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Association Group Disability Coverage: Past Lessons for a Profitable Future

By Raza Zaidi and Steven Siegel

Association group coverage has played a crucial role in providing members who had few or no alternatives with an affordable means to meet their insurance needs. In the accident and health arena, the coverage that has traditionally been purchased through associations is group medical. In the days before managed care, carriers found this coverage attractive because it usually represented the largest portion of premium dollars for a member's overall insurance needs. In addition, as this was one of the few avenues of access available for many self-employed members, there was often little or no competitive pressure to reduce premium below adequate levels, with plans typically experience-rated.

With the advent of managed care and increased federal and state-level legislative momentum to provide access to health care insurance, many of these association plans suffered losses as members found alternatives for coverage. Carriers were left with the least healthy members and those who adamantly resisted even slight levels of managed care. As a result, many carriers decided the market was not viable and exited, usually by either selling their existing block or seeking reinsurance partners for any remaining business.

With the future of association group medical coverage uncertain given the current political environment, a shift in focus to other lines of health-related coverages for associations has occurred among several carriers. Carriers see new opportunities in these other types of businesses that include disability income, long-term care, critical illness, and accident coverages. Of these, disability income typically receives the most attention given that it commands the highest amount of premium dollars after group medical. Additionally, disability income coverage generates large reserve fund balances, which carriers can invest at attractive long-term rates. However, carriers that want to succeed in this market should heed the advice of the philosopher George Santayana, who wrote, "Those who cannot remember the past are condemned to repeat it."

Past Profitability Issues

Similar to their experience with group medical, carriers have not been immune to losses in the past decade on the group disability income portion of their association portfolios. Problems with profitability for disability income coverage can be traced to several factors:

- Inadequate pricing
- Contract deficiencies
- Less restrictive underwriting standards
- Lack of risk (occupation) diversification

Inadequate Pricing

One of the primary causes of profitability challenges on disability income coverage has been inadequate pricing. Pricing problems stem from a variety of factors related to misaligned rate structures and unforeseen trends. Among them:

- *Elimination Periods* — Termination rate tables used for premium rate development did not account for the ability of highly compensated professionals to self-insure their earnings loss during the early durations of their disabilities. This resulted in premium rate structures with overly steep discounts for longer elimination periods. In addition, anti-selection in the shortest elimination periods was evidenced as healthier lives opted for longer elimination periods where substantially lower rates were charged. This anti-selection was usually not anticipated and therefore, not factored into the premium rates.
- *New Business Assumptions* — Some products were priced assuming a consistent level of new business underwriting (i.e., inflow of select morbidity risk) that did not materialize. This effect was most pronounced for carriers who substantially grew their blocks of business through takeovers and acquisitions. Existing insureds in these takeover situations typically are not re-underwritten (either financially or medically) by the new carrier.
- *Specific Disabling Conditions* — Insureds were less likely to feel stigmatized and, as such, sought treatment for disabling conditions related to mental health and nervous disorders as well as substance abuse. This trend was usually not considered in the premium rate development.
- *Regional Differences* — Many carriers did not recognize geographic differences in claim costs due to regional economic conditions, unemployment rates, and other factors. This led to severe rate inadequacies in certain regions.
- *Interest Rates* — Some carriers did not accurately forecast declining interest rates that resulted in decreased investment income on reserve balances. In turn, these carriers did not act quickly enough to subsidize the investment income loss through increased rates.
- *Age Banding* — Age banded rates were not always sloped properly, resulting in anti-selection and insufficient subsidization between bands. Furthermore, the predominant use of 10-year bands as opposed to 5-year or less bands did not as effectively track the increase in morbidity risk correlated to increasing ages.
- *Gender Mix* — Most rating structures were based on unisex ratings that did not reflect the changing dynamic of the labor force. As women entered the workforce in greater numbers, unisex rate structures became severely misaligned.

- *Optional Benefits* — Several optional benefits, such as Cost of Living Adjustment (COLA) riders were mispriced. Claimants with these optional benefits were less motivated to return to work resulting in lower than anticipated termination rates.
- *Impacted Professions* — Certain professions were greatly impacted by changes in practice and overall work environment. For example, many health care professionals did not easily adapt to the additional paperwork and peer review imposed by managed care. This led to job dissatisfaction and increased incidence of disabling conditions most notably seen in mental and nervous disorders. Many carriers were slow to react to these trends.
- *Rate Guarantees* — Excessive usage of long-term rate guarantees prevented carriers from taking action when necessary. Carriers were often left waiting anxiously for guarantee periods to expire as the gap between adequate rates and guaranteed rates widened.

Contract Deficiencies

The primary purpose of disability income insurance is to insure against earnings loss precipitated by accident and sickness. Several developments occurred in the past decade where the standard disability contract was found to be ineffective at maintaining this primary purpose or preventing abuse.

- *Disabling Conditions* — In the past, societal prejudices associated with certain disabilities such as mental/nervous disorders and substance abuse caused many insureds to not seek treatment. As the stigma related to these conditions diminished, a rapid rise in incidence was experienced primarily in occupations where job satisfaction was low or suddenly reduced by outside forces. In general, disability income contracts did not clearly define such conditions and were subjected to potential fraud and abuse. Similarly, contracts were not well equipped to manage disabling conditions manifested by self-reported symptoms such as chronic fatigue syndrome and fibromyalgia.
- *Definition of Disability* — Problems were encountered with the contractual definition of disability most commonly referred to as "specialty own occ." Contracts with this provision defined disability as the inability to perform the material and substantial duties of the insured's specialty. For example, a surgeon might be unable to operate because of carpal tunnel syndrome, but still have significant earnings from a consulting practice or academic appointment. Regardless of these other earnings, a full disability income benefit would be payable under the specialty own occ definition. Thus, a surgeon would have no incentive to undergo physical therapy or other forms of rehabilitation as his income had actually increased from that before the disability. This unintended consequence of the specialty own occ definition led to poor experience on contracts with this provision.
- *No Integration Provision* — Along with an association group policy, insureds can purchase coverage under individual and employer group policies. Traditionally, association policies have not been integrated with either individual or employer group policies. Consequently, without strongly enforced issue and participation limits, overinsurance resulted. By adopting integration provisions such as those included in employer group disability contracts, association group carriers would have had a useful tool to prevent such instances of overinsurance.
- *Renewability* — Many association group policies had been written on either a guaranteed renewable (GR) or conditionally renewable (CR) basis. With these contractual provisions, carriers did not have the option to either unilaterally modify benefit provisions or cancel coverage for a particular association. Without the recourse of these options, carriers often found themselves with extremely difficult blocks of business to manage.

Less Restrictive Underwriting Standards

Due to aggressive growth targets and competitive pressure, many carriers relaxed their normal underwriting standards. The consequences of this trend were seen primarily in liberal plan designs and increased coverage amounts. For example:

- *Elimination Periods* — Short elimination periods — 0/7, 15/15 or 30/30 (accident/sickness) days — were issued to professionals with high incomes. These professionals had no immediate need to return to work and extremely poor experience followed at these shorter elimination periods.
- *Benefit Periods* — Lifetime benefit periods were offered without accounting for potential overinsurance due to retirement plan and social security benefits.
- *Monthly Indemnity/Optional Benefits*— Excessive monthly indemnities ($15,000 or greater) along with riders such as guaranteed purchase options (option to purchase additional coverage without producing evidence of insurability) and cost of living adjustments (COLA) led to increased malingering.

Lack of Risk (Occupation) Diversification

Among the primary buyers of association group coverage have been professionals in health care-related fields. As mentioned earlier, these professions saw rapid changes due to managed care and other influences. Carriers with particularly high concentrations of these professionals were left greatly exposed and usually suffered losses. Similarly, those who focused primarily on legal professionals were also vulnerable. In either case, a well-diversified portfolio of occupations would have minimized

continued on page 12

Association Group Disability Coverage

continued from page 11

these carriers' exposure to any profession that experienced dramatic shifts in disability risk.

Future Outlook

How can carriers succeed in the future with association group disability income coverage? By learning from past mistakes and reemphasizing underwriting fundamentals, carriers should be solidly positioned for future profitability. Carriers will benefit by focusing on a solid strategy that incorporates a carefully considered plan of pricing, contract design and underwriting philosophy. Weaknesses in any one of these three areas could leave a carrier vulnerable.

Especially encouraging for carriers in this market are continued strong economic forecasts and labor force reports. As more professionals (white-, gray- and blue-collar) pursue entrepreneurial aspirations and begin working as sole proprietors or in small groups (less than 10 lives), the need for income protection through the association group mechanism should grow rapidly.

Finally, any well-conceived strategy will contemplate the enormous potential of e-commerce. As association group coverage has typically been marketed through mass mailings, distribution through the Internet appears to be a natural fit. In the past, disability plan offerings to association members were rather inflexible due to the constraints of mass marketing primarily through a brochure. The ease of customization afforded by e-commerce technology should prove very appealing to potential buyers.

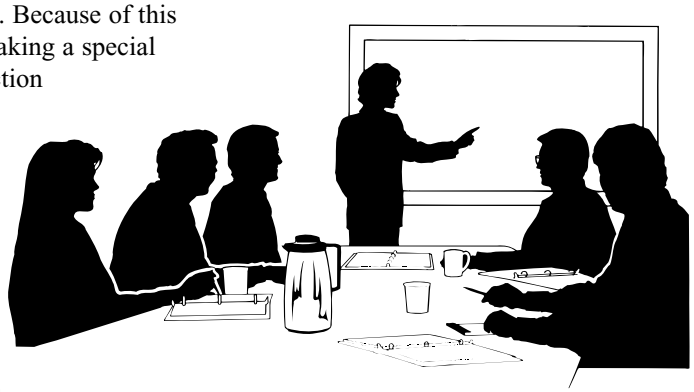
Steven C. Seigel, ASA, MAAA, and Raza A. Zaidi, ASA, MAAA, were both actuarial directors of the Disability Product Management Team, Group Benefits, at CNA in Chicago. Seigel is still with CNA in Chicago and Zaidi is now disability product manager at Metropolitan Life Insurance Company in New York.

Why You Should Join the Long Term Care Insurance Section Now

By Jim Glickman

The Long Term Care Insurance Section (LTCI) was spun off from the Health Section to achieve more focus in this important specialty. Although we have grown to more than 600 members after our first year, we still need to substantially increase our membership to help carry out our ambitious plans and programs. As you will see below, an important by-product of our activities will be the promotion of the actuarial profession as experts in this field.

There is a close relationship between our Sections in that we are both involved in the financing and management of the delivery of health care. Because of this relationship, we are making a special offer to the Health Section membership who are not yet members of the LTCI Section. If you join our Section now by e-mailing *LTCjoin@soa.org*, you won't have to pay the $10 annual subscription until 2001.



The LCTI Section sponsored nine sessions for the SOA spring meeting in Las Vegas and is sponsoring six sessions for the SOA annual meeting in Chicago.

This July, *Brokers World* magazine will be publishing its 2nd Annual Long Term Care Insurance Survey. Last year's highly successful survey was co-sponsored by the National Association of Health Underwriters (NAHU) with the assistance of our newsletter editor, Bart Munson. Due to staffing changes at NAHU, they will not be participating this year, so the LTCI Section has offered to replace them as co-sponsor and technical advisor of the *Brokers World* survey.

LTCI Section is also providing authors for a series of articles for *ADVANCE*, a publication for providers of post-acute care. The first one, "Covering Our Crisis" written by Loida Abraham, appeared in the June issue and focused on LTC legislative issues.

Work is continuing towards bringing to fruition a national LTCI conference. Tentatively dubbed "The First Annual Intercompany Long Term Care Insurance Conference," this conference will be co-sponsored by the SOA and the LTCI Section. It will feature five educational tracks: 1) Actuarial, 2) Marketing, 3) Claims, 4) Underwriting, and 5) Compliance/Government Relations. In addition, the conference will feature an exhibition hall where both insurers and vendors can display their wares for an audience that will include many of the major LTCI national marketing organizations and most of the major LTCI insurers. Also, substantial time is planned for networking.

Please join our new LTCI Section by e-mailing *LTCjoin@soa.org* now. Please note that I belong to the Health Section as well.

James M. Glickman, FSA, MAAA, is president and CEO of LifeCare Assurance Company in Woodland Hills, CA. He is chair of the SOA Long Term Insurance Section and can be reached at jim_glickman@lifecare.to.

Academy Health Practice Council Activities

By Tom Wilder

Work groups of the American Academy of Actuaries' Health Practice Council were involved in a number of projects during the first half of 2000. The Academy members dealt with a variety of public policy initiatives at the state and federal levels. The Health Practice Council initiatives were in response to health insurance proposals from Congress, federal regulatory agencies and the National Association of Insurance Commissioners, as well as health care issues raised during this year's presidential campaign.

Medicare Reform

One of the major health issues before Congress this year involves Medicare. A wide range of legislative proposals has been introduced, from a complete overhaul of the Medicare program to initiatives providing a limited prescription drug benefit for beneficiaries. The Academy's Health Practice Council has undertaken a series of efforts to educate public policy makers on the impact of changes to Medicare.

The Medicare Reform Task Force, under the direction of Jay Ripps, authored a series of three monographs discussing proposals to reform the Medicare program. The first paper, *Evaluating the Fiscal Soundness of Medicare*, deals with how Medicare solvency is measured and discusses several proposals to strengthen the financial basis of the program. The second monograph, *Using Private-Sector Strategies*, examines ways in which competitive pricing techniques used in the private insurance market could be applied to Medicare. The third paper, *Providing Prescription Drug Coverage for Medicare Beneficiaries,* discusses the potential impact of a Medicare prescription drug benefit.

On February 10, the Health Practice Council sponsored a Capitol Hill Forum on Medicare issues, which featured several panels of Congressional, actuarial and health policy experts. More than 50 attended the briefing. The keynote address was given by Senate Republican Whip Don Nickles (R – Oklahoma) who offered comments about the Medicare reform proposals sponsored by President Clinton. Other speakers included the Academy's Medicare Reform Task Force Chairman Jay Ripps, Dr. Stuart Butler (Heritage Foundation), Guy King (former HCFA chief actuary), Dr. Marilyn Moon (Medicare trustee) and Deborah Steelman (Steelman Health Strategies). A political perspective was provided by Representatives Benjamin Cardin (D – Maryland), Tom Coburn (R – Oklahoma) and Jim McDermott (D – Washington).

In addition, Academy member Carol McCall testified on two separate occasions before Congress concerning proposals to include prescription drug coverage as part of the Medicare program. On February 16, McCall addressed the Health Subcommittee of the House Commerce Committee about the need for an overall reform of Medicare before adding a prescription drug benefit. McCall also testified before the Senate Finance Committee on March 29 on how pharmacy benefit managers work in the private market and how they might operate in a Medicare environment.

Capitol Hill Visits

The Health Practice Council was involved in visits with Hill staffers. On January 12, Academy members met with staff from the Senate Finance Committee to discuss prescription drug coverage for Medicare beneficiaries. In addition, on January 19, members from the Health Practice Council and the Federal Health Committee conducted 23 meetings with Capitol Hill staffers and representatives from the U.S. General Accounting Office, Congressional Research Service and the Congressional Budget Office.

Medical Records Privacy

On February 17, Jim Murphy, the Academy's health vice president, sent a letter to the Secretary of the Department of Health and Human Services providing comments on regulations proposed by the agency to protect the privacy of health records. The Academy's comments noted that in order for health and life actuaries to do their jobs, they need access to health records. The letter outlined suggested amendments to the regulations that would allow use of medical records without sacrificing patient confidentiality.

Genetic Testing

An Academy task force under the direction of Tom Wildsmith completed a policy paper, *Genetic Information and Medical Expense Insurance*. The paper outlines the impact of genetic testing on the health insurance market. The task force is currently working on another policy paper looking at implications of genetic testing for disability and long-term care insurance products.

NAIC Projects

A number of the Health Practice Council's projects concerned issues under study by the National Association of Insurance Commissioners (NAIC). The Academy was asked by the NAIC's Life and Health Actuarial Task Force to undertake an analysis of the Medicare supplement insurance market in an effort to determine if there are any factors that were driving up the cost of policies. The Academy formed the Medicare Supplement Insurance Task Force that collected claims data from 11 insurance companies (representing about one-third of the market). The Academy made its final report to the NAIC Task Force at their June meeting in Dallas. The report outlines studies of claims information as it relates to coverage by Medicare Supplement insurers for disability,

The Academy also responded to a

continued on page 14

Academy Health Practice Council Activities

continued from page 13

NAIC request for assistance in developing guidelines for filing health insurance rates. The Health Insurance Rate Filing Task Force has joined with a group of insurance department actuaries and insurance industry representatives to draft proposed revisions to the NAIC model rate filing guidelines and rating regulations.

The Academy's Health Organizations Risk-Based Capital Task Force continues to work on several projects dealing with changes to the health risk-based capital formula. The Academy has undertaken an extensive study of information from insurers in an effort to develop new risk-based capital factors for stop-loss, disability and long-term care insurance products. The final recommendations should be made to the NAIC this fall.

A task force headed by Donna Novak developed an initial draft of a manual providing guidance on reserving for health insurance products. The manual, which is intended for insurance company and insurance regulatory agency actuaries, has been further refined by the NAIC's Life and Health Actuarial Task Force. The Academy is also monitoring NAIC work on proposed revisions to the Long Term Care Model Regulation, the development of liquidity ratios for health insurers and managed care companies and possible changes to the Actuarial Opinion and Memorandum Model Regulation.

Copies of public statements of the Academy can be obtained on the American Academy of Actuaries' Web site (*www.actuary.org*). If you would like further information on any of these projects or would like to volunteer for a Health Practice Council committee or task force, please contact Tom Wilder, director of public policy, at the Academy's office (202 785-7875 or *wilder@actuary.org*).

What the Examination System Doesn't Teach about Health Insurance

By Karl G. Volkmar

I consider myself a health actuary. Though I have had some experience in other areas of actuarial practice, health is "home" for me, and I intend to stay there for the foreseeable future. The majority of my career has been devoted to supplemental health products (e.g., Medicare supplement/select, LTC/HHC, cancer insurance, accident coverages), which certainly impacts my view of the examination system.

Given the above, I have little basis for knowing whether my opinions about health practice education also apply to other practice areas. The opinions I present may apply to all areas of actuarial practice. My impression is that they do not, at least not to the same extent.

Based on my credentials, one might argue that my opinions are based on an incomplete picture of the examination process. To clarify, I passed 420 credits under the pre-2000 system, and my post-math exams were focused primarily on the group benefits track. This should indicate at least adequate exposure to the examination materials as they relate to health actuarial practice.

While I have attempted to present my opinions in a positive manner, it may appear that I'm just another problem-finder. As you will see, I have attempted not only to identify issues, but also to propose possible solutions that will hopefully lead to further discussions.

Reality

Although the examination process helped prepare me for a general actuarial career, there were, in retrospect, a number of incorrect impressions that I gleaned from the examination process. In these areas, I had to be un-taught and re-taught by work experience, sometimes pitting (as I saw it) my experience versus what I thought I had learned from examination materials.

The following sections outline the issues referenced above and contain some related material where deemed appropriate. As a caveat, please note that I did not re-review all of the study materials; I'm just summarizing the issues as I remember facing them in "real life."

Standards

I left the examination process believing that there were standard methodologies, and assumption-setting processes. In practice, no two actuaries seem to completely agree on methodology and assumptions as they relate to any area of practice. There seem to be as many methodologies and assumption-setting processes as there are health actuaries, and this applies even more to some health coverages than others.

Do you want a real-life example? Ask health actuaries from different companies and/or health practice backgrounds to provide their or their companies' definitions of "loss ratio" or "active life reserve" or to define their renewal rating process, including any related detail regarding assumptions or assumption-setting processes.

Internal Data

Many times, the precise company-specific data you need to do your job (as defined by the examination system materials) does not exist. This may be true because it has never been recorded, or because no one has ever requested or used it before (including the actuary that preceded you). This can make an actuary's job extremely difficult or even impossible from a purist viewpoint.

As if this is not difficult enough, attempts to establish the infrastructure needed to collect, record, and report needed data will be met by another fact of life that the examination system does not (and probably cannot) prepare you for: the majority of home office personnel do not want to collect, record, and report what they view to be additional data. In fact, they are generally incented to do otherwise.

Much External Data and Many Experts

Many times, examination materials left me with the impression that the selection and appropriate revision of data/input to be used for a given project would be a routine and not difficult task. This is certainly not true in practice.

The amount of external data available for review and consideration, especially in the age of the Internet, is staggering. In addition, anyone who has ever had an experience with either U.S. health care delivery or financing (which is everyone) becomes an "expert" on one or more areas of health care finance and delivery. Given the reams of available external data and the multitudes of "experts," it is very challenging to develop a methodology and key assumptions that specifically account for all available data and opinions.

How should an actuary sort through and prioritize all of the available information and advice?

Control

Through the examination materials, I did not develop the impression that many factors key to the success of the health business were out of my control. There are, in fact, a number of key factors that cannot be accurately predicted or directly controlled by a health actuary that can significantly impact the financial performance of a health product. Following is a sample list of these factors:

- Medical trend (e.g., increases in utilization, cost, intensity)
- Changes in internal company processes/procedures (e.g., changes in underwriting or claim processes)
- Changes in the marketplace (e.g., introduction of different products and/or competitors, shifting demographics)
- Changing field dynamics (e.g., within a company or versus competitors)
- Regulatory forces (e.g., new laws/regulations/interpretations, changes in insurance department personnel, political forces)

Through experience, I had to learn which factors I could influence and which factors I could merely predict. The latter I would learn to monitor and report on constantly, making revisions as necessary based on emerging experience.

The health business is a high risk/low reward business. It must be aggressively, comprehensively, and constantly managed in order to be profitable.

It's a Tough Business

The examination system, as I remember it, did not teach me that the health business is a tough business. I realize the following statements may not apply to every situation or type of health coverage, but these statements summarize my view of the health business from a purely business perspective:

- If everything goes well, small-to-moderate margins can be made.
- If you experience even slight slippage in one or more key areas, the results can be disastrous.

The health business is a high risk/low reward business. It must be aggressively, comprehensively, and constantly managed in order to be profitable.

Proposed Examination System Solutions

The following are a few subjects that could be incorporated into examination materials that would help address the issues presented above.

Actuarial Peer Review and Accountability

This could include guidelines outlining when to obtain peer review and could provide sample input and decision processes. It could also provide guidelines for reviewing work. Implementing this could help to ensure reasonable and consistent use of methodologies and assumption development processes, balanced by a review of overall results. It could also help to ensure compliance with applicable professional guidelines.

Assumption Development

This subject could include information on the identification of needed data and the establishment of the internal infrastructure needed to collect, record, and report that data. It could also include information on sources of external data and advice and the process of assumption development given all available data. In my opinion, this could be taught most effectively through extensive case study review, which would suggest ways of developing assumptions given a variety of data scenarios.

The Business of Financing Health Care

This subject could include information on the identification of key business factors, how to monitor them, and how to respond to emerging experience. It would include information that would answer the question, "How do you make money in this business?"

In addition to the above, the SOA should continue to emphasize problem solving on all examinations, which has been the case for some time.

The primary goal of this article is to generate discussion on a subject that is important to all of us. Obviously, I have only scratched the surface; there is much room for research and further discussion.

I welcome comments regarding any of the above. Please feel free to forward written comments to me by fax (317- 580-8651) or e-mail *(kvolkmar@tici.com).*

I hope that the ultimate result of this article will be a positive impact on the education of health actuaries.

Karl G. Volkmar, ASA, MAAA, is consulting actuary at United Actuarial Services in Carmel, IN.

Don't Forget the Data

By Robert Bachler

Frequently, we actuaries tend to fall in love with our models, causing us to ignore data that could lead to results with less uncertainty if it were properly accessed and summarized. Using my own story as an example, I'll show how my company fell into this trap in determining reserves for unpaid medical claims. I'll also discuss how we are now using more data, more detail, and new models with a different perspective to determine reserves with greater certainty.

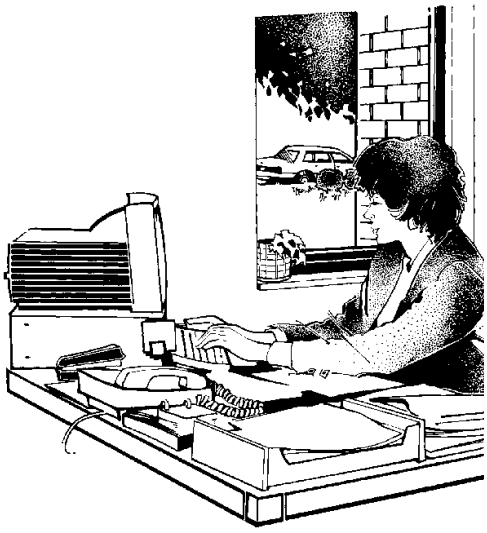
For several years, we calculated our unpaid claims reserves based solely on lag triangles. The reserve was split into two parts:

- **Incurred Prior, Paid After**—This amount represents claims with incurred dates prior to the valuation date, with paid dates between the day after the valuation date and the calculation date (inclusive). It is known with certainty.
- **Incurred, but Unpaid**—This was calculated based on estimation of completion factors (percent of ultimate paid to date) using past data. Completion factors were estimated for each incurred month and applied to claims paid to date to determine ultimate claims. As a check of "reasonableness," estimated ultimate claims were compared to exposures and premium. If the results seemed unreasonable, the estimates were changed. This amount is almost completely estimated (known with almost no certainty).

This methodology had two major problems. The first was the "reasonableness" check. Given the subjective nature, there was a fine line between actuarial judgment and reserving at a level that was desirable from an accounting or similar standpoint. Despite our best efforts, it is likely that this line was crossed on occasion, though subconsciously. The second problem was the tendency to ignore available data. When our model was first implemented, it was the best methodology available. Because claims were generally entered and adjudicated manually or semi-manually (on-line, but with significant human intervention at the point of entry), unpaid claims consisted almost entirely of stacks of paper claims and unreported claims. However, with the increase in EDI (electronically submitted) claims and truly automated adjudication, more claims systems have claims pending in the system, waiting for some form of mild intervention to allow for final adjudication. Many properties of these claims can be quantified. We know the total submitted charges. With the submitted charges, we know or can estimate with great accuracy the covered charges, contract discounts, and insured cost-sharing. Based on historical data, we know the likelihood of the claim being denied, given the reason for pending. In retrospect, it was very naïve to ignore all of this data. We missed subtle shifts in processing patterns and as a result. our unpaid claims reserves were not as accurate as they could have been.

To minimize these problems, we altered our reserve methodology. The "Incurred Prior, Paid After" claims are still calculated as above. However, the "Incurred but Unpaid" claims, previously lacking any certainty, can be split into the following:

- **Pended Claims** — Claims pended in the adjudication system. Based on our system configuration, the ultimate paid amounts are calculated as follows (different system configurations would require different breakdowns):
  - ◊ Claims are divided into groups based on reason for pend.



  - ◊ Likelihood of outright denial is determined for each pend group.
  - ◊ Final paid amounts can be calculated or estimated directly (as described above) or paid amounts as a percentage of submitted charges can be estimated based on past data.
  - ◊ The ultimate paid amount is (1 - the likelihood of denial) X (final paid as a percent of submitted).

  Any uncertainty regarding number and size of submitted claims is eliminated from these claims. The only uncertainty remaining is related to final adjudication/paid amounts. Our experience has shown that, with one month's runout (e.g., the year-end reserves are calculated using claims paid through the end of January), these claims make up 60-70% of the "Incurred but Unpaid" claims.
- **Submitted but Unprocessed Claims**— If there are very few paper claims waiting to be entered, these claims can be counted, and the total submitted amount can even be calculated. An estimate of final paid as a percentage of submitted charges can be used to estimate the final payment amount. Although the final payment for these claims is less certain than

with the pended claims, there is still less uncertainty than with the "Incurred but Unpaid" of the previous model. With one month's runout, these claims have made up about 10% of "Incurred but Unpaid."

- **Incurred but Not Reported** — These are the claims that have yet to be received from the service provider. These claims need to be estimated based entirely on historical data showing submission patterns. This data has uncertainty similar to that of "Incurred but Unpaid," which would have a traditional lag triangle. Because we are now looking at the lag in reporting, not payment, we changed our models accordingly and estimated counts of claims which were IBNR. To estimate the dollar value of these claims, we used the same method as described above with the submitted but unprocessed claims.

With this new methodology, we have been able to reduce the uncertainty on 80% of previously uncertain claim amounts. This has allowed us to reduce the subjectivity of our reserve estimates while increasing the accuracy.

Not all claims processing systems will provide data to allow breakdowns exactly like those described above. However, hopefully this discussion has illustrated the potential of using available data for us as actuaries to become better practitioners of our craft.

Robert Bachler, ASA, MAAA, is vice president, actuarial at Educators Mutual Insurance Association in Murray, Utah. He can be reached at BachleRo@educatorsmutual.com.

Disability in the New Millennium - A UK Perspective

By Sue Elliott

In the United Kingdom in recent years, a great deal of attention has been given to all health care products. As the "cradle to grave" welfare state has slowly begun to disappear; people are realizing that they will need to provide for themselves. As an industry, we need to be in a position to supply products that suit the needs of the consumer and are flexible enough to cope with their changing needs. The government has the right idea, focusing on "ability" and what people can do, not what they cannot do. As an industry, we should follow suit.

The Last Decade

During the '90s, key health care products have had mixed fortunes.

Critical illness insurance has been available in the UK since 1986 and has enjoyed exceptional sales in the last decade, as can be seen from the chart below.

Year	New Policies
1992	177,3356
1993	230,800
1994	251,407
1995	302,245
1996	470,468
1997	626,584
1998	694,263

Income protection, on the other hand, has often been referred to as "the Cinderella product that has never made it to the ball." It has suffered several false dawns, as providers failed to maximize its potential in lukewarm responses to various government initiatives. Independent Financial Advisors (IFAs) complained that the product was too complicated and too expensive. Rates rose due to the poor experience that came about because of less than optimal risk management.

As can be seen from the following chart, income protection sales have been relatively flat, although there has been a small increase since 1996.

Year	New Policies
1992	153,000
1993	152,177
1994	116,405
1995	117,212
1996	127,514
1997	143,553
1998	156,424

As in the United States, the leading causes of income protection claims are now stress-related illnesses, which because of their duration are very costly. The key question is: how do we provide some sort of protection and at the same time, minimize our exposure to such risks?

Long-term care insurance (LTCI) has been available in the UK since the early '90s. It is still undersold, mainly due to a lack of awareness of the need and to confusion about what the product is intended to cover. Efforts have also been made in the UK to link LTCI with pensions, as both are providing funding for the retirement years. A Royal Commission to investigate the funding of long-term care in the UK was initiated in December 1997 and reported back on March 1, 1999. Many recommendations were made, but as yet none have been implemented.

Year	In-force Policies
1995	15,598
1996	16,637
1997	22,924
1998	29,257

The above table shows very low penetration of LTCI in the UK, but similar growth patterns have been observed in other markets.

The reform of the welfare state and

continued on page 18

Disability in the New Millennium - A UK Perspective

continued from page 17

the resulting change in the benefits system will most certainly have an impact on income protection and long-term care insurances. As the state withdraws provision, there will be an increasing role for private insurance. However, we need to realize both that there is no one compelling solution and that change will be a long, drawn-out process.

The main issue that needs to be addressed is that of "definition drift" on the ADL (Activities of Daily Living) criteria. Although what constitutes failure of an ADL is clearly stated in the policy wordings, offices are under pressure to pay claims that do not entirely satisfy the claims criteria. This could be a result of failing to manage customer expectations at the point of sale, which is vital. The message at outset must become a "claims reality" if we do not want to suffer another mis-selling scandal. The "care element" of the product also needs to be emphasized at the point of sale; it is a product that allows policyholders to grow old with dignity and to maintain their independence for as long as possible.

Government has become much more consultative, so we need to work with them to develop solutions that benefit both the public and private sectors....

Current Issues

For critical illness, the main concern is the durability of claims conditions to a changing environment. What will be the impact of legal challenges and, more importantly, medical advances? The claims criteria are based on "diagnosis." So, for example, increased screening for certain cancers could adversely impact our claims experience. On the plus side, the industry has just introduced benchmark definitions for both the core diseases and 13 further diseases. Such standardization should increase IFA confidence and improve consumer understanding.

The main concern for income protection (IP) is the low penetration in the market. It is undersold and poorly understood, often being confused with other healthcare products. As an industry, we have also suffered from poor claims experience, but we have slowly come to realize that to write a profitable book of IP business, sound risk management with a holistic view across all disciplines is needed. Offices with this type of focus have been very successful.

Like income protection, long-term care insurance has suffered from low penetration and lack of understanding.

Key Drivers into the New Millennium

One of the key drivers going forward is the role of the government. The welfare reform agenda will be shaping and developing over the next few years, focusing on what the state will and will not provide. Consumer research shows that people are becoming more aware and more willing to provide for themselves. Government has become much more consultative, so we need to work with them to develop solutions that benefit both the public and private sectors, such as public/private partnerships.

An increased focus on preventative care — encouraging qualitative improvement in the lives of older people through exercise, constructive leisure pursuits and education — in both the public and private sector will benefit the industry. Rehabilitation also has a major role to play in the management of our health care products.

Technology and medical advances, too, will have an impact on our industry. We need to be able to anticipate changes and quantify their potential financial impact

Last, but certainly not least, changing consumer attitudes and expectations must be addressed. Generational differences should be recognized. For example, "baby boomers" will have a different attitude about who should take care of them in old age than the current elderly population, who have grown up believing that the welfare state will provide.

Summary

Customers are becoming more financially astute and aware of the products available. They are looking for simplicity of purchase and to have confidence in that purchase. They will attach different priorities to different products as their life stages change, and the whole process will be about "relationship" rather than "transaction." We must understand our clients' needs and seek to meet these needs.

Sound risk management with a holistic view across all disciplines is vital for the success of our healthcare products going forward. We need to recognize and appreciate what each discipline brings to the table.

There are still issues that need to be addressed, but we need to view these as opportunities to continue the development of a successful health care market in the UK. As Einstein said, "Behind every difficulty lies an opportunity."

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HCFA & Medicare + Choice: Contract Year 2001 Changes

By Anant Galande

The Health Care Financing Administration (HCFA) has made major changes to the Adjusted Community Rate Proposal (ACRP) process, the annual vehicle Medicare+Choice Organizations (M+COs) use to receive approval from HCFA to offer products to Medicare beneficiaries.

Starting in contract year 2000, which spans the calendar year, the ACRP is comprised of two sections. One is a detailed description of benefits to be offered to Medicare beneficiaries, which has been known as the Beneficiary Information Form (BIF). The other is the Adjusted Community Rate (ACR), an Excel-based spreadsheet program that HCFA uses to compile information about premiums and cost sharing to be charged to beneficiaries for the benefits offered in the BIF, as well as the cost of those benefits.

HCFA held a training seminar on April 4-5, 2000, at its Baltimore headquarters to inform M+COs about the ACRP filing process for contract year 2001. While the process is similar to the one used in contract year 2000, significant differences exist. They include:

- HCFA has replaced the BIF with the Plan Benefit Package (PBP). While the PBP asks for information similar to the BIF, the format has been expanded. The PBP provides greater flexibility to describe benefits and has been designed to more closely coordinate with the ACR format. Also, the data entry process will automatically populate Medicare Compare fields, eliminating the need for duplicate entry.
- HCFA no longer requires non-Medicare costs to be detailed by type of service in the ACR.
- HCFA has added a standardized worksheet to calculate the Average Payment Rate (APR) to the ACR. The APR is the average capitation payment the M+CO expects to receive for the beneficiaries it enrolls.
- HCFA has discontinued the use of relative cost ratios to determine contract year 2001 Medicare costs. Instead, trends will be used.
- HCFA now allows a M+CO to file one plan for all Part B-only enrollees within its service area. Previously, a M+CO had to link Part B-only enrollees to the Part A/B plan(s) available in the Part B-only enrollee's geographic area.
- HCFA requires COB costs to be reported on a potential recovery basis, rather than an actual recovery basis.
- HCFA has added color-coded cells to the ACR spreadsheets to differentiate input items and errors from other calculated cells.
- HCFA has created a pre-upload validation tool to identify process errors, including coordination between the PBP and the ACR, which would otherwise delay the submission and approval process.
- HCFA has reduced the amount of paper-based documentation required to be submitted as part of the ACRP.
- A M+CO can upload its plans one at a time instead of all at the same time.
- More than one person within a M+CO can upload the ACRP

While the changes HCFA has made to the contract year 2001 ACRP will enhance an M+CO's ability to manage the process, the ACRP will require significant resources to complete. Important considerations include:

- If applicable, out-of-network and in-network benefit listings for POS products will need to be entered separately by type of service in the PBP.
- The ACR determines contract year 2001 Medicare costs by applying non-Medicare trend to contract year 1999 Medicare costs. M+COs will need to consider any potential differences in the level of Medicare trend versus non-Medicare trend. These differences could include utilization, cost, contracting arrangements, utilization management, or cost sharing, to name a few.
- M+COs will need to identify potential COB recoveries instead of actual COB recoveries
- Costs and premiums for benefits provided exclusively to beneficiaries belonging to employer-based groups need to be excluded from contract year 1999 Medicare data.
- If applicable, capitation payments must be appropriately allocated by type of service.
- M+COs must receive HCFA approval to deviate from the type of service classification included in the ACR.
- M+COs must tie the data included in the ACR to their financial accounting systems.
- M+COs must calculate the effect of risk adjustment on the APR (last year this effect was calculated by HCFA)
- M+COs must appropriately classify out-of-area members.
- M+COs must develop appropriate documentation for use during a potential HCFA ACR audit
- M+COs should identify a single point of contact for the upload process.

Some important dates to keep in mind:

- April 10: The PBP and the ACR are available for download from the HCFA Web site.
- May 1 (or thereabouts): HCFA will provide the pre-upload validation tool to M+COs.
- July 3: The last day an M+CO can successfully upload electronically its ACR and PBP via MDCN. Any associated paper documentation is also due to HCFA by this date. HCFA has strongly encouraged M+COs to file in advance of this date because the upload process is lengthy and any potential problems with the upload process may not be immediately discovered.

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A Health Insurance Insolvency Case Study

continued from page 1

law in each state, the District of Columbia and Puerto Rico, all insurance companies licensed to write life or health insurance or annuities in a state are required to be members of the guaranty association. If a member company becomes insolvent, money to continue coverage or pay claims is obtained through assessments of other insurance companies writing the same lines of insurance as the insolvent company.

Life and health insurance guaranty associations cover individual policyholders, their beneficiaries, and certificate holders of insurance issued under group life or group health insurance policies. State law establishes limits on benefits and coverage.

All life and health insurance guaranty associations protect residents of their own states, provided the company was ever licensed there, regardless of where the failed insurance company is headquartered. If a policyholder has moved to a state where the company was never licensed, the guaranty association in the state where the company is domiciled provides protection.

Guaranty association coverage limits vary by state. The NAIC model act that most states follow sets limits of $100,000 for health insurance benefits, including disability benefits.

Guaranty associations provide coverage when a company has been declared insolvent and ordered liquidated by a court of law. Before benefits can be paid, associations must perform due diligence on who is insured and the type of coverage issued. Guaranty associations obtain this information from the receiver who has taken control of the failed company.

In most cases guaranty associations provide coverage as long as premiums are paid. They may do this directly, or they may transfer the policies to a solid insurance company. In any case, policyholders must continue making premium payments to keep their coverage in force.

How Does the Guaranty Association System Work?

The insurance commissioner, charged with monitoring and regulating insurance activities, determines when an insurance company domiciled in his state should be declared insolvent. The commissioner obtains authority from the state court to seize control of the company and operate it pending resolution of the insolvency.

When the insurance commissioner obtains control of a company, he is, by law, the rehabilitator of the company and may retain someone to serve as receiver to supervise the company's activities. The receiver may be either an independent professional or an employee of that state's department of insurance.

The guaranty association cooperates with the receiver in determining whether the company can be rehabilitated. If the receiver determines that further operation of the company would be hazardous to the policyholders, and that further efforts to rehabilitate the company would be futile, the company must be liquidated. When the court issues a liquidation order, the guaranty associations are "triggered" and step into the shoes of the failed insurance company to pay claims and continue coverage.

To obtain funds to pay claims and continue coverage, the guaranty associations assess the member companies in their state, typically up to 2% of premiums per year, averaged over the three years before the insolvency.

All 52 guaranty associations are voluntary members of the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), a non-stock not-for-profit Virginia corporation with offices in Herndon, about 30 miles west of Washington, D.C. When an insolvent company is licensed in multiple states, NOLHGA establishes a task force of representative guaranty associations, whose members and their accounting, actuarial and legal advisors work with the receiver to develop a plan to protect policyholders.

What Is An 'Ideal' Insolvency?

NOLHGA has been involved in more than 30 multi-state insolvencies in the past 10 years. In reviewing their experience, NOLHGA staff and consultants identified 10 characteristics of an "ideal insolvency."

The "ideal" insolvency has the following characteristics:

1. Good relationships between the task force and the receiver
2. Good policy records
3. Few uncovered obligations
4. Facts and solution are clear and agreed on by the receiver and the task force
5. Joint solicitation of proposals and negotiation of an assumption reinsurance agreement with a strong reinsurer
6. No resistance to a court order of liquidation with a finding of insolvency
7. Prompt regulatory approvals of agreements among the receiver and the affected guaranty associations
8. Quick closing to move policyholders to a solid insurer
9. Guaranty associations obligations fully satisfied at closing
10. Task force involvement in asset recovery

How Did NOLHGA's Experience in the Centennial Life Insolvency Compare to the Ideal?

Because Centennial was NOLHGA's most significant national health insolvency, the task force faced many complicated legal, financial, and administrative issues that had not been faced before or even if they had, not to that magnitude. Centennial presented a variety of claim types, difficulty in calculating benefits, and complexity of valuing blocks of business. Centennial also demanded time and resource consuming efforts at processing and adjudicating claims. Customers were understandably dissatisfied during the delays in claim payments.

Interestingly, none of the insolvencies analyzed to produce the "ideal insolvency" criteria was a major health insurance insolvency.

What are the differences between an insolvency involving primarily group health insurance from one involving primarily life insurance or annuities?

How did the fact that most of the health insurance in Centennial was cancelable complicate, rather than simplify, the work of the task force?

1. From the beginning, the relationship between the Centennial receiver and the NOLHGA task force has been very effective and productive. This relationship began before the task force was formed, with meetings among NOLHGA staff, the MPC chair,[1] and the receiver. Soon after the task force was formed, a working group met with the receiver to discuss how the task force and receiver could best work together, and how resources could be shared.
2. Data on in-force coverages was adequate, but good data on the existing claim backlog, the number of claims processed per week, and duplicate claims filed did not exist at the beginning of the Centennial rehabilitation. This insolvency has remained "information challenged." The lack of solid information on how long before a particular claim would be processed was a continuing source of frustration for policyholders, benefit providers, guaranty association administrators, the task force and the receiver. In recent life and annuity insolvencies, basic policyholder records have been readily available. Even where the insolvent company's systems were inadequate, the task force could obtain accurate data on in-force life insurance and annuity policies, from which it could develop its own database. The wide variety of health insurance coverages in the Centennial health block (approximately 200 policy forms, with approximately 2,000 variations) resulted in claims showing a high error rate, which slowed claim processing, due to the need for internal review (initially) of 100% of claims over $100.
3. Centennial had only a small number of completely uncovered health claims, arising from policies sold to foreign nationals. Until the last health claim is filed, we will not know how many claims may exceed individual guaranty association limits. Fewer than 50 LTD claims exceed guaranty association limits. Some of these LTD claims are substantially over limits, however, and had the estate not recovered significant assets, these claimants faced significant reductions in monthly payments once the guaranty association limit was reached. Nonetheless, more than 90% of policyholder claims were 100% covered by the guaranty associations.
4. The urgent problems facing the receiver and the guaranty associations were clear, and the receiver and the task force quickly reached agreement on the solution. It was essential for guaranty associations to begin payments to the approximately 900 LTD claimants with minimal interruption. Less than 15 days after the May 27, 1998, liquidation order, guaranty associations began making LTD payments. The first claim payments on the Centennial Health block were made within 60 days of the liquidation order date. The need for prompt payment of health claims had to be balanced with the guaranty associations' perceived duty to make the correct payment. This inevitably caused delay, because the initial claims audit revealed an unacceptable error rate on claims that had been processed before the liquidation order and were awaiting payment. Again, the facts and solution were clear and agreed on. Because of the extensive variety of coverages, no commercial third party administrator could offer a promise of expedited claims adjudication. The receiver and the task force agreed that the best – indeed, the only – solution was for the receiver to process claims using the former Centennial claims personnel who knew the products and the system.
5. There were only two blocks of insurance that could be transferred to another carrier: the LTD block and the "other block" consisting of a small number on juvenile life policies, hospital indemnity policies, medical conversion policies, and live conversion policies. The receiver and the task force agreed on a plan to place these blocks, and the receiver agreed to fund the transfer with an early access distribution.[2]
6. Fortunately for the policyholders, there were no objections filed to the rehabilitator's April 21, 1998 petition for liquidation, and the liquidation order was approved from the bench the day of the hearing, May 27, 1998.
7. The liquidation court promptly approved the service agreement and the early access agreement negotiated between the task force and the receiver. The court also promptly approved the assumption reinsurance agreement for the "other block."
8. To the great frustration of policyholders, regulators, guaranty associations, the receiver, and the task force, this solution, which presumes an assumption reinsurance agreement for most if not all the guaranty associations' covered obligation, is simply not feasible when most of the health insurance is cancelable. Instead, the guaranty associations must act within the constraints of HIPAA[3] and their state laws regarding cancellation of group health insurance coverages. Although the guaranty associations have the same rights to cancel or non-renew group health coverages as do the companies, perceived political pressure often causes state insurance departments to delay approving cancellation.
9. Because most of the business could not be transferred by assumption reinsurance, the guaranty associations faced a long tail of health claims, stretching more than 18 months beyond the liquidation order date. Instead of a single closing, guaranty associations had to fund payments

continued on page 22

A Health Insurance Insolvency Case Study

continued from page 21

monthly to LTD claimants and health insurance claimants.

10. The Centennial estate's largest asset was a $35 - $40 million receivable from its primary reinsurer, who had stopped claim payments before the rehabilitation order due to a dispute with Centennial's former owners. The receiver and the task force negotiated a common interest agreement, under which the receiver was able to discuss his litigation strategy with the task force. This enabled the receiver to draw on NOLHGA's experience in other insolvencies. The receiver and the reinsurer ultimately settled for a $36 million payment by the receiver to the Centennial estate.

What Lessons Did Centennial Teach Us?

A few words of caution. First, this article has room for only a few highlights of what the task force, in cooperation with the Kansas receiver, did to satisfy guaranty association obligation under Centennial's health block and to get the thousands of claimants paid as promptly as possible. Second, no two insolvencies are alike, and it is impossible to take the task force's experiences in Centennial and try to establish a set of "rules" to follow in the future. Third, the guaranty associations have not yet satisfied all their obligations. Although virtually all the group health insurance claims have been adjudicated, and fewer than 100 certificates remain in force, the LTD claims are still being paid monthly by the guaranty associations. The task force and the receiver have only recently turned their attention to seeking a long-term solution to administering and paying those claims. Fourth, any opinions expressed are those of the author and do not necessarily reflect the views of the Centennial receiver, the task force, or NOLHGA.

Unlike life insurance or annuity coverages, where there is little demand for cash value benefits, LTD and health claims require that the guaranty association begin making payments immediately. When a new insolvency involves health coverages with immediate payment demands, there are five important elements of the task force and receiver joint work plan. Each of these elements includes issues, factual and legal challenges, and financial implications for receivers, guaranty associations, and the policyholders and claimants on whose behalf the receivership guaranty system toils.

First steps must include the following:

1. Policyholder communications— Inform policyholders about the current situation and plans for stabilizing it.
2. Claim payments — Start paying claims, and pay them regularly.
3. Short-term administrative arrangements — Rely on existing servicing relationships while conducting due diligence on policy forms, in-force lists, etc.
4. Long-term administrative arrangements — Select a claim processing servicing agent for the long term.
5. Improve administrative arrangements — Enhance claim-processing procedures and institute an audit or quality control process.

More specifically, here are my views on the priorities and order of decisions:

1. The task force must make a quick assessment of the situation to determine:
   - Status of claim handling and backlog
   - Quality and reliability of existing external relationships
   - Adequacy of estate assets to pay current claims
   - Number and amount over-limits claims
2. The task force must develop short-term plan with the receiver, under which the receiver would process claims over short term.
3. The receiver and the task force must develop joint communications with policyholders, claimants and providers.
4. Source of funds for claim payments:
   - If estate assets are to be used to pay claims, negotiate an early access agreement and implement procedures for guaranty association approval of early access claim payments.
   - If guaranty associations are to fund claim payments, implement procedures for guaranty association review, approval, and funding of claim payments.
   - Work closely with claim processor on initial claim batches to ensure correctness of matching explanation of benefits (EOBs) with checks and guaranty association or receiver reporting. Establish a procedure for guaranty association review of EOBs and inclusion of guaranty association name on the EOB or check as the source of funds.
   - Establish a mechanism for restricting claim payments to guaranty association limits early in the liquidation.
5. Evaluate and continue or revise or terminate existing external relationships with drug card providers, discount service providers and third party administrators.
6. Evaluate the receiver's ability to provide long-term claim processing; consider outside third party administrator alternatives.
7. Evaluate methods to reduce any claims backlog.

What Lessons Were Learned?

1. Health insurance company insolvencies bring a potential for claimant complaints and anxiety that does not exist in a life insurance or annuity company insolvency. The best (and maybe only) way to mitigate that potential is to have sound communication to all interest groups and to make timely claim payments. Reducing the claim backlog should be the number one goal.

2. Another goal should be minimizing the number of changes to pre-insolvency policy service and claim handling procedures so that policyholders and claimants do not suffer unnecessary confusion or disruption of service. Significant administrative changes can cause communication headaches and repetitive claim handling steps that may contribute to payment delays. It is also important to create a system for reviewing disputed (or appealed) health claims in such a way that the initial processing of original claims is not interrupted.
3. The administration of health business is almost always more complex and difficult to manage than anyone thinks at the beginning of the process. That usually leads to an underestimation of the time required. It is very important that the receiver and task force take the time to evaluate all external relationships the insolvent company had (such as discount service providers, drug card providers).
4. Given the amount of guaranty association money being disbursed periodically to claimants, the task force should consider some kind of outside audit or quality control process to give comfort to the guaranty associations. The guaranty associations in a health insolvency where no transfer of obligations is feasible must fund their obligations every month until all claims are paid. The guaranty associations writing the checks need assurance that the process is producing reliable data.
5. Any agreement that is reached with a servicing agent, either the receiver or an outside TPA, should clearly specify the accounting of post-liquidation premiums, including unearned premiums on the liquidation order date. Those premiums belong to the guaranty associations, which must assure its proper accounting and protection.
6. A task force should consider having a representative on site at the beginning of the process to monitor the policy service and claim handling functions and to give appropriate feedback, both to the servicing agent and to the task force.
7. As with so many other areas of insolvency practice, coordination between the receiver and the guaranty associations leading up to the entry of a liquidation order is very important in a health insolvency. The short-term nature of the health policy obligations calls for quick communications with policyholders and claimants on policy service and claims handling to prevent massive confusion, even panic, among policyholders, claimants, providers, regulators, and others. The receiver and the guaranty associations have to be on the same planning and communication page so that the stage is set for a thorough examination of the situation once the initial communications have stabilized the situation.
8. Another question that should be examined initially is whether there will be any kind of temporary moratorium and if so, whether there should be a set of hardship exceptions sanctioned by the receiver or the receivership court. If so, the task force should attempt to preserve as much flexibility as possible to accommodate state-by-state guaranty association requirements on hardship payments, since decisions about which claims should be paid in the face of a post-liquidation moratorium rest ultimately with the affected guaranty associations.
9. A single claims-paying procedure will not satisfy all guaranty associations, hard as task forces might try. Communication is important in insuring that the multiplicity of guaranty association payment procedures does not cause problems for everyone, including the receiver. A task force should recommend to the guaranty associations one payment method and explain clearly how uniformity is a plus in reducing the policy service and claim-handling backlog that almost always accompanies a major health insolvency. Nevertheless, any plan must accommodate the requirements of individual guaranty associations.
10. In a health insolvency, the servicing agent, whether the receiver or an outside third party administrator, should receive clear instructions from NOLHGA on what should be said and not said about guaranty involvement, procedures, limits, and coverage.
11. Policyholder communications are particularly important when there is a significant claim backlog and policyholders and claimants are calling the insolvent company constantly asking about the delay. There must also be consistent uniform and clear communications with providers.

The above summarizes some of the lessons NOLHGA learned in one major health insolvency. The atmosphere is markedly different from what the guaranty association faces in a typical life insurance or annuity company insolvency. The on-going experience in Centennial should serve as a guide for future health insolvency task forces.[4]

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[1]The NOLHGA Members' Participation Council consists of the guaranty associations affected by an insolvency. The MPC meets quarterly to hear progress reports by task forces and to take action on task force recommendations. The MPC chair is a guaranty association administrator, elected by the guaranty associations, and serves for one year.

[2]Under the liquidation act in most states, the receiver may make distributions to guaranty association before final determination of the amounts payable to the claimants in each class under the state's priority scheme. The guaranty associations and the receiver negotiate an early access agreement, under which the guaranty associations agree to return funds to the estate if the receiver needs them to make payments to claimants of equal or higher priority than the guaranty associations.

[3]The federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-91, 110 Stat. 1936 (codified as amended in scattered sections of 29 U. S. C. and 42 U. S. C.), places restrictions on the cancellation of health insurance. This act establishes minimum standards; each state may establish more restrictive standards.

[4]One year later, the task force for a smaller health insurance company insolvency benefited from the lessons learned in Centennial to fully satisfy virtually all guaranty association obligations in 99 days.

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