

A PUBLIC POLICY PRACTICE NOTE

Large Group Medical Insurance Reserves, Liabilities, and Actuarial Assets

August 2013

American Academy of Actuaries
Large Group Medical Business Practice Note
Work Group



AMERICAN ACADEMY *of* ACTUARIES

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Developed by the Large Group Medical Business Practice Note
Work Group of the American Academy of Actuaries



AMERICAN ACADEMY *of* ACTUARIES

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Large Group Medical Insurance Business Practice Note

This practice note is a product of the Academy's Large Group Medical Business Practice Note Work Group, chaired by Darrell Knapp.

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Comments are welcome as to the appropriateness of this practice note, desirability of annual updates, substantive disagreements, etc. Comments may be sent to statehealthanalyst@actuary.org.

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Q1. What does this practice note address?

This practice note attempts to address issues regarding the valuation actuary's responsibilities under the NAIC's *Accounting Practices and Procedures Manual*, the NAIC's model *Actuarial Opinion and Memorandum Regulation*, the NAIC's *Health Insurance Reserves Model Regulation*, the NAIC's *Health Reserves Guidance Manual*, the NAIC's *Health Annual Statement Instructions* and the Actuarial Standard Board's actuarial standards of practice (ASOPs) related specifically to determining reserve levels and other actuarial assets and liabilities for large group medical (LGM) insurance coverage. The practice note also comments on GAAP accounting, but the primary focus is statutory accounting. This practice note is not intended to cover liability estimation for self-funded employer groups.

This practice note is one of several health insurance product practice notes that have been developed to provide information to valuation actuaries. While many valuation issues are common to life and health insurance in general, the degree of emphasis varies by type of business and each product type presents its own unique problems, responses, methods, and bases for setting assumptions. Some requirements related to the statutory statement of actuarial opinion for insurance companies reporting on the Life and Accident & Health ("blue") blank differ from those for health plans reporting on the Health ("orange") blank. There is a further complication in that the actuarial opinion requirements for life insurance companies generally are generally found in regulation while the actuarial opinion requirements for the health blank are in the blank instructions. This leads to the possible situation in which a carrier may have conflicting instructions in that it is licensed as a life insurance company but, in light of a portion of the blank instructions known as the Health Statement Test, is filing the health blank. In this circumstance, one of the valuation actuary's first tasks would be to determine the appropriate requirements through a discussion with the regulator of the state of domicile.

The actuary may refer to the health practice note, [*General Considerations*](#), to review valuation issues that are common to many health insurance product lines that may not be addressed in this practice note. Since many of the issues discussed here are not unique to large group medical insurance, there may be some conceptual overlap between material discussed in this practice note and material discussed in other practice notes, particularly the health practice note, [*Small Group Medical Insurance Reserves and Liabilities*](#).

Q2. What is large group medical insurance business?

LGM insurance business includes fully-insured medical plans, such as basic plans, basic with supplemental major medical, and comprehensive coverage (including HMO and PPO coverages, major medical coverage, and consumer driven health plans). LGM business also includes minimum premium plans, as well as specific and aggregate stop loss insurance. In addition, various ancillary programs of a short-term nature such as short-term disability, prescription drug, dental, and vision care may be included. This

material also may be relevant to short-term ancillary products when sold independently of medical coverages.

Generally, this practice note addresses issues related to groups not affected by small group rating reform restrictions (most frequently, groups having in excess of 50 lives), in which prospective experience rating, retrospective experience rating and self-funding are frequently employed and in which individual evidence of insurability generally is not considered at initial underwriting. Under the Affordable Care Act (ACA), large group is defined as group insurance covering employers having an average of more than 100 employees (although different segmentation is allowed for purposes of calculating Medical Loss Ratio (MLR) based rebate requirements prior to 2014).

Q3. What funding arrangements are currently used?

Administrative Services Contract (ASC)—ASC is a contract that differs from administrative services only (ASO) in that, with ASC, claims are paid from a bank account owned by the insurer and the insurer needs to seek reimbursement from the plan sponsor to cover the claim payments. As such, ASC exposes the insurer to plan sponsor credit risk, whereas ASO does not.

Administrative Services Only (ASO)—ASO is a contract for the provision of certain services to a group employer, eligible group, trustee, etc., by an insurer or its subsidiary. Such services often include actuarial activities, benefit plan design, claim processing, data recovery and analysis, employee benefit communication, financial advice, medical care conversions and preparation of data for reports to governmental units. For an ASO contract, claims are paid from a bank account owned and funded directly by the plan sponsor.

Cost Plus—This is an insurance arrangement whereby the policyholder pays a variable monthly premium, typically equal to the amount of claims paid in the previous month plus the insurer's retention. Cost plus differs from retrospective rating in that premiums are adjusted on an ongoing monthly basis rather than via an annual settlement process.

Minimum Premium—The group policyholder reimburses claim payments up to a certain limit and pays the minimum premium to fund the risk for excess aggregate claims, specific stop loss claims, administration and claim liability in some cases.

Prospective Rating—The premium charged is not dependent on the experience during the contract period.

Retrospective Rating—A method of experience rating that adjusts the final premium of a risk in accordance with the experience of the risk during the term of the policy for which the premium is paid.

Self-Funding—This term may refer to ASO, ASC or a medical benefit plan established by an employer or employee group (or, combination of the two) that directly assumes the functions, responsibilities, and liabilities of an insurer.

Stop Loss—This is a method of protecting self-funded plans from unusually high levels of claims, either at the level of an individual claimant (specific stop loss) or at the overall plan level (aggregate stop loss).

Q4. What assets and liabilities related to large group are within the scope of the actuarial opinion?

For the *NAIC Life and Accident & Health Annual Statement*, the assets and liabilities within the scope of the actuarial opinion are defined in the *Actuarial Opinion and Memorandum Regulation* and the instructions for the actuarial opinion of the *NAIC Life and Accident & Health Annual Statement*. For the *NAIC Health Annual Statement*, the assets and liabilities are defined in the *Health Insurance Reserves Model Regulation*, instructions for the actuarial opinion of the NAIC Health Annual Statement, and in the practice note on the [Revised Actuarial Statement of Opinion Instructions](#) for the NAIC Health Annual Statement Effective December 31, 2010 (unless the company is required to file a Life and Accident & Health Annual Statement opinion as discussed above).

The following assets generally are included in the Health Annual Statement actuarial opinion: accrued retrospective premiums (or contingent premium receivables), receivables related to risk-sharing provisions (including provider risk-sharing), pharmacy rebate receivables and other specified actuarial items presented as assets in the annual statement. Some valuation actuaries also include due and uncollected premiums in the actuarial opinion. These assets are referred to within ASOP 28, [Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets](#) as “health insurance assets.” For a life and accident health insurance opinion, some carriers believe health insurance assets may be included in the scope of the opinion.

The following liabilities and reserves generally are included in the actuarial opinion: due and unpaid claim liability, in course of settlement (resisted) claim liability, in course of settlement (other) claim liability, incurred but not reported (IBNR) claim liability, accrued medical incentive pool and bonus payments, unpaid claims adjustment expense (i.e., loss adjustment expense), extension of benefit claim reserve, unearned premium reserve, contract reserves, MLR based rebate liability, premium deficiency reserve, claim stabilization reserve, experience rating refund reserve and any other loss reserves, and actuarial liabilities or related items presented as liabilities in the annual statement.

Q5. What would be prudent to consider regarding the claims processing environment?

Volatility in the claims processing environment can affect not only the accuracy of claims reserves, but also premium reserves for alternatively funded arrangements (retrospective rating, minimum premium, cost plus, etc.), projections of premium deficiency reserves,

and incurred estimates used to determine the liability for certain kinds of provider risk sharing arrangements. As a result, it is important that the actuary have a good understanding of the complete flow of claims information. The claim process may include all or some of the following:

- **Electronic Data Interchange (EDI) Gateway:** The EDI environment allows providers and insurers to exchange data using standard Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set (TCS) requirements. Typically, certain edits are performed at the gateway before transmitting the claim to the processing system, which can result in claims being rejected. The actuary may consider any material changes in the volume of rejected claims as well as changes in the percentage of claims received electronically.
- **Process for paper claims and correspondence:** Paper claims and correspondence typically also are received, scanned into electronic format, and transmitted to the processing system. This “front end” process for paper claims may be handled internally by the company or out-sourced to a vendor, which may be based in the United States or off-shore. Vendor relationships create additional opportunities for risks, so it is important for the actuary to have the ability to monitor vendor intakes and inventories.
- **Authorization and review process:** A delay in processing authorizations for services may result in claims pending that are awaiting that authorization. Depending on the company processes, these claims may be closed after a designated period of time if no response is received from the provider, resulting in a temporary reduction in inventory, but it is likely that these claims will be resubmitted.
- **Claims processing system:** It is important that the actuary understand the organization of the claims processing area (e.g., separate teams for facility versus professional claims, teams by product, dedicated teams for large accounts) and how claims are prioritized (first in first out, tiered by complexity, etc.) The actuary might consider large claim handling, as higher or lower volumes of these claims in a period can significantly distort payment patterns. The actuary might consider tracking changes in claim inventories (using claim counts or billed charges) as well as other metrics such as changes in receipts, volume of aged claims, etc. The actuary may consider if there are separate queues for original claims versus claim adjustments. Claims processing may be outsourced to a vendor; it is important to ensure that there are no unintended incentives for the vendor to accelerate or delay payments into certain reporting periods.
- **Disbursement system:** There is typically an additional delay caused by transmission of claims from the processing system to the check disbursement system. In some cases, claims payments are disbursed on a daily basis; in other cases, claim payments are disbursed at less regular intervals (e.g., weekly, or twice weekly). Claim payment schedules may differ by type of service (e.g.,

facilities, professional providers, prescriptions) for covered subscribers. The actuary might consider the impact of month-end cut-off dates and how that affects inventory reporting snapshots and the volume of adjudicated but unpaid claims.

- Claim recovery process: Changes in the amount or timing of claim overpayment recoveries can affect the overall claim payment patterns, so it is important to understand the timing of requests for amounts from providers, how recovered amounts are recorded and reflected in data sources, and any backlogs in the recovery process. Similarly, the actuary might consider the coordination of benefits and subrogation processes to determine how savings or recoveries under these programs are handled. The actuary also might consider how the company accounts for claim overpayment recoveries under Statements of Statutory Accounting Principles (SSAP) 84.

At a more global level, the actuary might consider how any of the above components may be affected by staffing levels, training processes, system changes or downtime, seasonal influences, or governmental impacts.

Q6. What other operational and product issues might the appointed actuary consider?

There are numerous ways in which operational or product details can affect the level or types of reserves that the company needs. Guidance on this issue may be found in ASOP No. 5, [*Incurred Health and Disability Claims*](#). Benefit structure, such as whether deductibles are calendar-year based or policy-year based, impacts benefit expense seasonality, so it is important for the actuary to understand the mix of benefit structures being analyzed. Benefit language also may contain continuation of coverage benefits for the member if the group terminates while the member is hospitalized or disabled, which may require additional reserves. Understanding when members are notified of benefit changes also can be important; significant product changes can result in an acceleration of discretionary services into an earlier reporting period. Large accounts also may have multi-year rate or trend guarantees that need to be considered in analysis of potential premium deficiency reserves. Self-funding arrangements accounts also may have trend or other performance guarantees that lead to a need for other accruals that may be included in the scope of the actuarial opinion.

In addition to the claim processing environment, a number of other operational areas may affect the actuary's analysis. Backlogs in group set-up can lead to pending claims as well as member and provider abrasion. Highly publicized provider contract disputes can lead to discretionary services being accelerated into an earlier period, and the results of significant negotiations are important for the actuary to incorporate into benefit expense assumptions. Provider terminations may result in payment of services on a non-par (i.e., out-of-network) basis, resulting in a higher cost level. Retroactive provider contract effective dates or provider settlements can be problematic particularly from a reserving perspective. Provider contract negotiations also can result in various types of incentive arrangements that are available to supplement the basic fee schedules, some of which

may require a reserve. The actuary also should consider the type and scope of any capitated arrangements.

Q7. What regulatory and legislative issues might the actuary consider?

State insurance departments, headed by an elected or appointed insurance commissioner, hold the primary responsibility for the development and monitoring of insurance regulations affecting the large group market. Although most states defer to model regulations promulgated by the NAIC, regulations often vary by state.

Regulations do vary, depending on the type of large group business. Rules differ for self-funding arrangements, which have a lesser amount of restrictions.

For the pricing actuary, regulations related to large group health insurance business include, but are not limited to, the following:

- Product design, such as establishing minimum coverage requirements;
- Contractual provisions and wording, such as coverage of newborn children;
- Pricing, such as the necessity to meet MLR based rebate requirements; and
- Rate review, such as restrictions on how often rates can be changed and whether rate changes must be filed and/or approved.

For the appointed actuary, state regulations include requirements to meet minimum valuation reserve standards, prescribed valuation reporting, and actuarial opinion and memorandum requirements. Revisions to the NAIC's *Health Actuarial Opinion* requirements in 2009 and 2010 include some important changes that are covered in a separate document (See the practice note, [*Revised Actuarial Statement of Opinion Instructions for the NAIC Health Annual Statement Effective December 31, 2010*](#)).

Federal regulations include the health care reform law, known as the ACA, enacted in 2010; the Health Insurance Portability and Accountability Act (HIPAA) enacted in 1996; and the Employee Retirement and Income Security Act, (ERISA), enacted in 1974

ACA regulations affect large group health business to a lesser extent than they affect small group and individual business. Regulations implementing health care reform come primarily from the Center for Consumer Information and Insurance Oversight (CCIIO), under the Center for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). However, some relevant ACA regulations are promulgated by other federal regulators, such as the Internal Revenue Service (IRS). Large group effects of ACA regulations include, but are not limited to, the following:

- Establishment of MLR based rebate requirements that can lead to rebates of premium (one can view this as imposing a retrospective rating element on all large group contracts, in which the premium adjustment is a function of the performance of a block of business rather than of the performance of the specific contract), which involve regulations at the federal and state level;

- Coverage requirements, including coverage of dependents to age 26, no pre-existing conditions for children (due to the elimination of medical underwriting), removal of lifetime limits, and preventive benefit requirements;
- Removal of annual limits on “essential health benefits;”
- New rules for patient communications;
- Integration of wellness benefits;
- Introduction of employer “pay or play” rules that will affect employer group decisions about whether to continue existing plans or pay government penalties;
- Auto-enrollment requirements for large groups with 200+ employees;
- Additional reporting requirements for employers and insurance companies; and
- Additional taxes and fees on certain medical supplies and services and insurance companies.

Uncertainty likely will prevail in the period immediately following the ACA’s enactment, until full implementation begins in 2014. Uncertainty is expected to lessen as the post-reform markets stabilize in the next few years following 2014, and as firmer data emerges. Impacts will differ between fully insured business and self-funded arrangements.

Although HIPAA plan provisions mainly affect small group and individual insurance product designs, HIPAA also establishes patient privacy safeguards that affect all insurance record keeping. HIPAA privacy requirements affect how the insurance company uses patient claims data for pricing studies.

ERISA establishes minimum standards for pension and health plans, and large group health plans must meet the ERISA standards. Product design must keep up to date with ERISA regulations that include meeting new standards adopted through ERISA amendments. Of particular interest is the Consolidated Omnibus Budget Reconciliation Act (COBRA) requirement that allows for employees to maintain the original group health plan beyond the employee termination date. COBRA continuation is accompanied by some level of anti-selective behavior.

Q8. How are incurred and paid dates typically defined and reviewed?

The actuary might consider the incurred date and paid date conventions being used in the valuation data sources. While the incurred date is the date that a contractual obligation for benefits has been created, that date may be represented in a number of different ways in claim processing and reporting systems for ease of administration. Likewise, the “paid date” used within administrative systems may vary. It may be the date the claim was finalized or the date that a payment to the provider was made.

Incurred dates typically are defined as the dates on which covered services were initially performed. ASOP No. 5, *Incurred Health and Disability Claims* defines “incurral date” as the date a claim is determined to be a liability of the health plan. Incurred dates must be within the coverage period to qualify for health plan payment.

For most medical coverages the incurred date typically will be the date a service was rendered or, for inpatient facility claims, the date of admission. If a facility creates interim bills for an extended admission, the incurred date may be coded as the earliest date of service on that bill. In addition, certain benefit coverages may consider a re-admission within a specified period after initial discharge as part of a single facility stay. However, lengthy or multiple hospital stays that generate multiple billings may not report the initial incurred date accurately. Succeeding bills may include only the billed date or separate service dates. In this case, the health plan must determine when the initial event occurred in order to establish a proper pattern of incurred-to-report date.

Other examples in which the initial incurred date may not be included on provider billings include therapy or home health care visits. Such bills may report only the dates of service, not the initial incurred date. Consistency of handling the incurred date in these and similar circumstances is most important.

For other than medical insurance claims, the incurred dates may be defined as follows. Under stop loss contracts, the liability may attach to the insurance carrier based on an incurred date as described above, or at the point of claim payment, based on the contractual provisions. For disability coverages, the date a person becomes disabled generally is used as the incurred date, but also may be reflected as the date that payments begin. Under extension of benefits provisions, liability for services may extend to services that are incurred after termination of coverage. For analysis of these costs, it is important to understand how the dates for these claims are coded.

Paid dates typically refer to the date for which a covered claim or liability is paid by the health plan to a service provider or as a reimbursement to the plan recipient. The paid date traditionally refers to the date the organization cut the check for payment, which now includes dates of electronic fund transfers. Another date also is important for tracking claims—the claim reported date.

Reserve liabilities are established based on the incurred date. These liabilities include recognition of claims IBNR and for claims reported that have not yet been paid. Incurred dates must be established when claims are initially reported, primarily to ascertain if the claim qualifies for payment—was the claim incurred within the coverage period?

Tracking of incurred dates and paid dates allows for the health plan to conduct claim payment studies. The difference between the incurred date and claim reported date allows the health plan to identify the period of time between incurred and reporting, which affects the establishment of an IBNR over a time period. This time period usually is tracked over a period of several months. Generally, claims are paid quickly once they are reported to the insurer, delays being the result of incomplete or inaccurate information or for large claims resulting from additional review. Therefore, the amount of IBNR reserve for a specific claim-incurred month is expected to decrease as it ages month after month.

Q9. What claim reserve margins are generally held for large group medical business and does this depend upon the funding arrangement?

For LGM, a contingency margin typically is held, either through the use of conservative assumptions or through an explicit provision. SSAP 55 *Unpaid Claims, Losses and Loss Adjustment Expenses* calls for the establishment of best estimate liabilities. Best estimate generally has been interpreted by health actuaries to include margins in compliance with ASOP No. 5 [*Incurred Health and Disability Claims*](#). Note that the NAIC risk-based capital (RBC) formula was developed based on the health insurance industry practice of holding contingency margins on the claim liability. As a result, the RBC formula does not include a capital charge for adverse development of medical unpaid claim liabilities. Also, it is general practice that the contingency margin is determined in a consistent manner from year-to-year rather than in an arbitrary fashion. The Life Actuarial Opinion Model Regulation requires the actuary to say reserves are adequate. ASOP No. 22 [*Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life and Health Insurers*](#) indicates that the statement of adequacy requires the liabilities to be sufficient under moderately adverse conditions. Likewise, the Health Blank instructions indicate the opening actuary must say the liabilities are good and sufficient, which ASOP No. 28 [*Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets*](#) defines as sufficient under moderately adverse conditions.

Items that the actuary may wish to consider in setting the claim liability contingency margin include, but are not limited to, the following: historical claim fluctuations; recent changes in claims trends, loss ratios, adjudication practices or other claim lag factors; introduction of new benefit designs and products; size of block, lapses, and growth; duration on the block; influenza prevalence or pandemics; and government regulation (actual and anticipated). A contingency margin may be needed to cover variations in the claim runoff experience that may result from any of these factors. Since the liability is often a point estimate derived using deterministic methods, a confidence interval is usually not assigned to the estimate. Accordingly, the actuary may wish to perform sensitivity testing using alternative scenarios and/or methodologies. The use of stochastic methods to estimate the claim liability can produce a confidence interval. Alternatively, the use of more or less conservative assumptions may help produce upper or lower boundaries on a reasonable range of reserves, which then may be used by the actuary to determine an appropriate contingency margin.

For prospectively-rated and retrospectively-rated groups, a contingency margin is established by the methods described above. Explicit margins are generally between 0 percent and 10 percent. In certain circumstances, explicit margins in excess of 10 percent might be appropriate. In addition, for retrospectively-rated groups, the fund balance can be determined for each group to assess the potential for loss. A positive fund balance generally reduces the need to hold contingency margin. Some carriers will hold no margins on retrospectively-rated groups with a positive refund balance because any deficiency in the claim liability would be completely offset by a reduction in the refund liability and hence would not affect the aggregate liability to the carrier.

For stop loss insurance, the elements of such insurance, written in conjunction with minimum premium or self-funding arrangements, can be tracked to determine historical claims fluctuations and the possible need for a contingency margin. Since the only paid claims for stop loss are the high dollar or excess claims, the same level of deviation in total claims will produce a much greater variance in the development of the stop loss liability. As such, the margin in stop loss (either implicit or explicit) generally is greater than the margin in fully insured products.

Additional Suggested Resources:

[ASOP No. 7 – Analysis of Life, Health, or Property/Casualty Insurer Cash Flows](#)

[ASOP No. 22 – Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life and Health Insurers](#)

[ASOP No. 28 – Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets](#)

[American Academy of Actuaries’ Health Actuarial Opinion Practice Note](#)

NAIC Health Reserve Guidance Manual

Q10. What is asset adequacy analysis for large group medical?

Asset adequacy analysis for LGM involves an examination of the underlying liability characteristics, such as product design and contractual guarantees and obligations, expected timing and magnitude of disbursements, sensitivities to various internal (company specific) and external (competitive market position, economic changes, regulatory, pandemics, etc.) uncertainties, and analyzing the likelihood that the company’s asset portfolio attributable to this block of business will be able to meet the various product related demands.

Q11. Is cash flow testing necessary for large group medical?

Cash flow testing may not be necessary, due to the generally short-term nature of most LGM obligations, the relative predictability of medical claims run-out, and the fact that LGM obligations are relatively insensitive to interest rate fluctuations, although cash flow testing is one way to test for asset adequacy under various moderate to severely stressful scenarios.

An additional reason to consider cash flow testing is that many states have passed regulations adopting requirements conforming to the NAIC Model Actuarial Opinion and Memorandum (AOM) Regulation (revised 2001) requiring asset adequacy analysis and often requiring the consideration of specific interest rate scenarios. In the event that cash flow testing is not used, the actuary will have to identify the methodology used to demonstrate how asset adequacy analysis was performed. Even though the company’s

liabilities may be short-term and relatively insensitive, the actuary still has the obligation to review those liability cash flows with respect to expected asset cash flows and address any material shortfalls in the availability of the assets inflows to support the timing of the liability outflows.

In the event that the actuary performs asset adequacy analysis using liabilities and assets valued and analyzed at a point in time other than at year-end, the actuary should consider reviewing the composition and magnitude of both liabilities and assets as of 12/31/xx to ensure that their compositions and characteristics, and the underlying assumptions regarding them, have not changed materially since the asset adequacy analysis was performed, and otherwise ensure that the results of the analysis are still valid.

Q12. What methods other than cash flow testing can be used to demonstrate asset adequacy?

This is really a two-part question—one has to do with the sufficiency of reserves related to LGM, and the other has to do with the sufficiency of assets supporting those reserves. Methods like sensitivity analysis of key assumptions, or a gross premium valuation under moderately stressful scenarios, may provide sufficient information regarding the volatility of liability outflows, including the probability that current reserve levels are adequate. See ASOP No. 5, [*Incurred Health and Disability Claims*](#) and ASOP No. 42, [*Determining Health and Disability Liabilities Other Than for Incurred Claims*](#).

Sensitivity analysis of contract provisions and key assumptions also likely would include measuring resulting reserve levels and the timing of liability outflows to changes in economic conditions and changes in interest rates. The results of these analyses are used to assess the availability and appropriateness of assets to meet the liability obligations under moderately adverse conditions.

Assets purchased or assigned to a segment of business typically would reflect the nature of the risk (i.e., as to duration, quality, liquidity and cash flows). If assets are already segmented for management purposes, then this would be a good starting point. If assets are not segmented, some division of assets among lines of business usually would be made, taking into account the nature of the risks. A conversation with the company's investment or treasury department may be appropriate to validate asset assumptions.

Another approach would be to discuss the results of the reserve sensitivity analysis with the company's investment or treasury department obtaining their active participation, including an evaluation of the current asset portfolio and whether it is appropriately balanced, flexible, and marketable to mature liabilities without significant risk of asset diminution.

Q13. Is reserve adequacy typically examined on a closed block basis or a going concern basis?

LGM reserves for the purposes of asset adequacy analysis typically are examined on the existing block of business, as of the valuation date, without regard to new business. This is because LGM contracts are generally short duration without provisions for guaranteed renewability, with the most significant reserves being attributable to claim reserves and claim liabilities that are the result of events that have already occurred.

Premium deficiency reserves may be an exception to this general view. See the discussion below regarding premium deficiency reserves.

Q14. How might an actuary demonstrate that reserves for a block of business are relatively insensitive to changes in economic conditions or interest rate scenarios?

The approach discussed in response to Q13 applies here as well. Sensitivity analysis could be performed in a manner to provide information regarding a block's sensitivity to changes in economic conditions or interest rates. The LGM contract might need to be examined for the existence or absence of policyholder guarantees or options that may be more (or no more) susceptible to being exercised under various scenarios. However, even if the liabilities for that block are demonstrated to be relatively insensitive to changes in economic conditions or interest rates, the assets supporting those liabilities might need to be evaluated for appropriateness, as described above.

Additional Suggested Resources:

[ASOP No. 22 – Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life and Health Insurers](#)

[ASOP No. 42 – Determining Health and Disability Liabilities Other Than for Incurred Claims](#)

[American Academy of Actuaries' Premium Deficiency Reserves Discussion Paper](#)

NAIC Health Reserve Guidance Manual

Q15. Is it advisable to perform a gross premium valuation to demonstrate reserve adequacy?

LGM generally provides coverage over a 12-month contract period, while a gross premium valuation is more likely to be used to assess premium adequacy over a period of 12 months or longer. In terms of health insurance, and LGM in particular, a gross premium valuation is more likely to provide insights into the sensitivity of assumptions

used in pricing and the development of estimates and emergence of associated claim costs. In this context, a gross premium valuation is used to test the adequacy or expected profitability of prospective gross premiums against expected future incurred claim costs, claim adjustment expenses and administrative expenses, and less likely to be used to provide a specific demonstration of reserve adequacy.

Q16. What obligation risks might be considered? How may assumptions be set?

A gross premium valuation includes all contractual obligations and guarantees, using best estimate assumptions, generally with little or no conservatism. These obligations and assumptions include premium or other contractual guarantees, claim trends, anticipated rate increases, member lapses, conversions, experience rating refunds and deficits, and administrative expense levels. The assumptions may be different from those used in pricing; however, they are intended to represent the best, readily available information, including the actuary's judgment regarding their appropriateness and applicability. The results of a gross premium valuation could lead to recognizing the need for premium deficiency reserves. See premium deficiency reserve discussion below.

Q17. How are claim cycles and underwriting cycles reflected in projection assumptions?

Claim cycles and underwriting cycles may be reflected in pricing, gross premium valuations, and other actuarial projections to the extent those claim cycles or underwriting cycles can be demonstrated to exist or be expected to exist based on benefit design, company or industry experience, historical data, etc. However, many actuaries do not attempt to specifically project such cycles because of the uncertainty in the timing or magnitude of future cycles.

Benefit seasonality observed on high deductible medical plans is one example of a claim cycle that might be reflected in an actuarial projection. This is particularly important for a projection that starts several months after the beginning of the contract year, or calendar year, as the results for the remaining portion of the year may look very different from the beginning portion of the year, while the year as a whole may be developing as expected. The existence of a particular cycle might be tested with available data, if possible, or projected based on product design and plausible assumptions and scenarios. One possible solution to addressing benefit seasonality would be to normalize benefits over the projection period to allow the analysis to focus on the emergence of profits or losses for other causes.

Q18. How long are projection periods for large group medical business when performing cash flow testing or gross premium valuations ?

Projection periods for gross premium valuations may vary depending on the intended purpose; in most cases, the projection period extends to at least the end of the current contract period.

The projection period for a gross premium valuation may be extended beyond the current contract period to gain insights into expected future gains or losses under various scenarios; test changes in benefit design, persistency, rate increases, or trend; model proposed changes for rate negotiations; model the impact of changes in administrative cost structures or allocations, etc. This would be in addition to testing premium sufficiency.

If a gross premium valuation reveals the possible need for premium deficiency reserves, the projection period may need to be longer. See below for further discussion regarding premium deficiency reserves.

The projection period for asset adequacy analysis or cash flow testing should be long enough to run out all liabilities and to determine that sufficient reserves and assets supporting them are not likely to change. Given that most LGM liabilities are substantially run out during the first 12 months (or less), a 12-month projection horizon may be sufficient. The length of the projection period may be longer or shorter, but may provide a sufficient length of time to judge the sensitivities of both the liabilities and the supporting assets.

Additional Suggested Resources:

[ASOP No. 22 – Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life and Health Insurers](#)

[ASOP No. 42 – Determining Health and Disability Liabilities Other Than for Incurred Claims](#)

[American Academy of Actuaries’ Premium Deficiency Reserves Discussion Paper](#)

NAIC Health Reserves Guidance Manual

NAIC Accounting Practices and Procedures Manual – SSAP 54, “Individual and Group Accident and Health Contracts”

NAIC Accounting Practices and Procedures Manual – SSAP 5, “Liabilities, Contingencies and Impairments of Assets.”

Q19. When are premium deficiency reserves required for large group medical?

In general, a premium deficiency reserve is established when there is the likelihood that a segment of business will not be able to fund through reserves and prospective premiums future contractual obligations and guarantees, putting a strain on surplus.

Statutory guidance (see SSAP 54) requires premium deficiency reserves when expected incurred claims, claim adjustment expenses, and administrative expenses exceed expected gross premiums over the remainder of the contract period. Additionally, SSAP 54 says that deficiencies in one policy grouping may not be offset by anticipated profits in other groupings. However, there are many questions that arise regarding how to interpret this guidance.

Typically, these questions include:

How finely to group the business? The finer the groupings, the more likely particular groupings will demonstrate deficiencies. If combined in a larger grouping, the larger grouping may show no deficiency. To determine the appropriate groupings to use, the actuary may consider how the business is priced, marketed, and managed. For example, a company may choose to group in to these categories: individual, small group, large group, Medicare supplement, and possibly further segmented by geography. It is important that the groupings, once chosen, remain consistent from year-to-year, with the expectation that changes in grouping will have to be justified.

What administrative expenses are required? It is not entirely clear or obvious whether fully allocated expenses are required, particularly regarding the allocation of indirect expenses when a company's business is generally profitable. It is clear that direct expenses, both fixed and variable, must be included in the calculation of premium deficiency reserves. Further most, if not all, allocated indirect variable expenses and any other expenses (indirect fixed and possibly some portion of indirect variable) not specifically included in the premium deficiency reserves must be supported by other segments of business.

The NAIC Health Reserves Guidance Manual discusses situations in which overhead may or may not be required.

How long is the projection period? The projection period extends at least to the end of the current contract period. If the company's practice has been, or its intention is, to continue to price a particular segment of business such that it is expected to generate losses, which it may do for strategic reasons, then the actuary might consider using a longer projection period, as deemed appropriate and where assumptions are reasonably credible.

Due to a product's design, results may not be evenly distributed over the year. For example, a product line may be expected to be profitable over the entire contract period but may demonstrate a deficiency toward the latter part of the contract year when expected incurred claims are proportionately higher. Consideration may be given to evaluating such a block over a 12-month period of time to test if an apparent deficiency is simply the result of benefit design within the contract period or due to another issue.

Although uncertainty may exist regarding expected incurred claims, claims adjustment expenses or administrative expense allocations, or which assumptions to use, a premium

deficiency reserve calculation generally is performed using best estimates with little or no conservatism.

Q20. What does the actuary generally consider regarding business not yet issued as of the valuation date?

See SSAP 54 for statutory guidance, which states that premium deficiency “accruals shall be made for any loss contracts, even if the contract period has not yet started.” Therefore, consistent with SSAP 54, if the company’s intention is to price a particular segment of business such that it is expected to generate losses, which it may do for strategic reasons, then the actuary takes these expected losses into consideration for premium deficiency reserve calculations, using a projection period that is deemed appropriate and in which assumptions are reasonably credible. Otherwise, the appointed actuary does not usually consider business not yet issued when establishing reserve liabilities or for asset adequacy testing purposes.

Q21. How are self-funded plans contemplated in developing premium deficiency reserves?

Premium deficiency reserves apply to insured business only. However, complications may exist in the interplay between insured products that are priced, marketed, and managed alongside self-insured plans. Stop loss, for example, is often sold to self-insured customers as a package, in which the expected profitability of that customer’s business is measured in total and not by individual components alone.

The actuary may need to consider how to appropriately and fairly group and measure the true performance of these insured products that are sold to self-insured customers for the purpose of calculating potential premium deficiency reserves.

If the administrative fee charged on a self-insured contract is not sufficient to cover direct fixed and variable expenses, including a defensibly consistent allocated share of indirect expenses, then some believe that a liability similar in concept to a premium deficiency reserve is appropriate, under the guidance in ASOP No. 5, [*Incurred Health and Disability Claims*](#) regarding contingent liabilities. However, others believe that such a liability is not necessarily appropriate. Opinions differ within the accounting profession regarding the appropriateness of recording a liability for expected future losses under a contract in situations in which, unlike the case for premium deficiencies under insurance contracts, there is no clear guidance in the literature mandating recognition of the liability.

While acting as the administrator, the insurance company does not share in the responsibility for meeting the self-insured customer’s cash flow or deficits emerging from actual claims experience outpacing expected. However, it is expected that periodic reporting to the customer will surface findings of potential deficient funding, which may need to be highlighted to the self-insured customer.

Q22. What liabilities or assets might arise out of provider incentive arrangements?

Incentives that reward a provider with a cash settlement or payment of withheld amounts based on achievement of certain goals within an experience period require a reserve to be established during the experience period for the expected amount of payment. More recently, such incentives may be built into prospective contractual provider rates, in which case no reserve is required. Risk-sharing arrangements also may reward providers for achievement of certain financial targets, for example, if the MLR or claim costs per-member per-month (PMPM) are below target. The variance to target may be shared with providers on either a one-sided (only surplus is shared) or two-sided (surplus and deficits are shared) basis. If one-sided, only a liability is present. If two-sided, the arrangement could result in the company having either a liability or a receivable, if the arrangement is in a surplus or deficit position, respectively. The size of the receivable might require more information on the financial ability of the provider to fulfill its obligation. The admissibility of the receivable would be subject to additional constraints listed in SSAP 84.

Q23. What does an actuary investigate regarding the financial condition of capitated providers?

Guidance on this issue is included in ASOP No. 5, [*Incurred Health and Disability Claims*](#). If a provider accepts a substantial portion of risk via a capitation or other prepaid arrangement, the actuary may consider the ability of that provider to fulfill its obligations. Typically, the provider contracting area would be aware of any providers having cash flow difficulties, but other resources also may be used to assess credit worthiness. In the event of provider insolvency, the health plan's contractual language may not fully protect it, and the health plan may be required to reimburse policyholder claims on a fee-for-service basis. If such an insolvency is anticipated, the actuary may consider the need to establish a reserve.

Q24. How are liabilities with respect to stop-loss coverages established?

Stop-loss coverage is a form of reinsurance provided to self-insured employers. Stop-loss coverage can be written by an insurance entity that also provides the underlying ASO or ASC contract for the employer group or by a separate insurance organization. Stop-loss coverage can be either on a "specific" or individual basis by providing catastrophic protection on a member-by-member basis or on an "aggregate" or group basis by providing protection against catastrophic losses on the aggregate of the group's claims. Typically, both coverages will be offered in cases in which the level of stop-loss protection (i.e., attachment points) will vary, depending on the size of employer group, with larger groups having more capacity for risk and less need for stop-loss insurance coverage.

Stop-loss carriers that also provide the underlying administrative services have an advantage since pricing and reserving decisions can be based on their own records, rather

than depend on timely reporting from the employer group or third party administrator. A stop-loss carrier that is not also administering the underlying benefit plan will include periodic reporting requirements by the employer group that will allow the carrier to establish appropriate liabilities as well as enable more accurate renewal pricing.

Specific stop loss involves establishing an attachment point above which the insurance company will cover losses—e.g., an attachment point of \$75,000 per year per employee. Aggregate stop-loss coverage has an attachment point above which the insurance company will cover losses in aggregate for the entire group for the plan year—e.g., 100 percent coverage of losses beyond 115 percent of estimated total group benefit costs of \$X. Aggregate stop loss often includes a second attachment point above which coverage amount changes (or is eliminated)—e.g., 90 percent of costs beyond 110 percent of estimated costs, up to 115 percent above estimated costs, with 100 percent thereafter (or 0 percent after).

Other terms to consider within a stop-loss contract include the basis of payment on an incurred basis, paid basis or some other basis. For example, a 12/15 contract provides for payment based on claims incurred within the 12-month contract period, completed through 15 months. Some coverages may include run-in liability, such as a 15/12 contract that includes payment on some claims incurred prior to the policy effective date that were paid by the prior carrier during the first active policy year with a new carrier. So a 15/12 contract would cover claims incurred up to three months prior to the effective date.

The actuary may consider contract provisions when establishing contract liabilities. Liabilities include establishing IBNR reserves, claim reserves for known claim costs, and potentially, premium deficiency reserves. Claim reserves can be established based on reporting of existing claims per person or in aggregate. IBNR data may be difficult to obtain, particularly with frequent turnover of stop loss contract coverages and assigning incurral dates is unclear as a claim is often the accumulation of claims with a number of different service dates. Instead of relying solely on traditional claim triangles, the actuary may rely at least partly on anticipated loss ratios. IBNR reserves typically will be set in aggregate for all contracts, with a split between specific stop loss and aggregate stop loss coverage reserves. While reserving for single employer accounts may not be practical for any but the larger employer groups, part of the stop loss coverage insurer's responsibility may be to either provide actual experience to the employer group for analysis or to calculate liabilities on behalf of the employer group.

Premium deficiency reserves may be appropriate under certain circumstances. Stop-loss coverage typically is underwritten with premiums established based on underwriting. Base rates will be adjusted to reflect group experience and certain underwriting characteristics including industry and population demographics. In a competitive market, aggressive underwriting may lead to mispriced coverage. Also, if stop-loss attachment points do not increase as underlying medical trend increases, and stop-loss rates do not adequately account for the increased leveraging, premiums may quickly become insufficient to cover increasing claims. Current experience studies may show that the

underlying base rates, adjustments factors, or attachment points may be out of date, inappropriately applied, or inadequate. These could lead to premium deficiency reserves for coverages currently written.

Q25. How are experience rated refund liabilities or contingent premium receivables established?

Experience rating provisions in an insurance or reinsurance contract may result in payment of premium refunds to the insured employer group. These provisions may exist in large group insurance policies, stop-loss coverage contracts, or within a reinsurance contract between two insurance companies. Experience refund provisions in large group health insurance coverage are not as common today as in times past. These provisions are more common in multi-year agreements. Including an experience refund for large group contracts allows for a sharing of favorable loss experience. Although less frequent, the provision also may allow for cost sharing with the employer group sharing in unfavorable experience in addition to, or instead of, experience refund provisions.

When present in any contract, the actuary may consider the potential for refunds when establishing reserve liabilities. The estimated liability for a refund may need to include a discount factor that reflects a contractual interest requirement on accumulated surpluses, and may incorporate a probability factor expressing the likelihood of payment. As a plan year's experience unfolds, the potential of a refund payment will become more or less likely, which is then reflected in the current liability. The amount of refund payment will be spelled out in the insurance contract, based on a schedule of values, a percentage of difference between the actual experience loss ratio and a target loss ratio, or other formulas.

An insurance or reinsurance contract that shares unfavorable experience likely will include a contingent premium provision. In this case, the insurer may initially charge premiums that are lower than what a fully insured case may warrant, with provisions for an additional, contingent premium to be paid if claims exceed a target loss ratio. When settled at the end of the contract year, unfavorable experience will result in the additional premium being paid by the employer group.

Instead of relying on the insured group to pay the contingent premium, the funds may be collected in advance as a premium stabilization reserve. A premium stabilization reserve may be accumulated over time through higher premium charges until it reaches a predetermined level, or the amount necessary for the premium stabilization reserve otherwise may be guaranteed by the insured group. The purpose of the premium stabilization reserve is to offset potential deficits during temporary periods of unfavorable claims experience. Still, a group's premium stabilization reserve could be insufficient to cover a period of unfavorable experience, leaving that group in a deficit position. The actuary may consider the collectability of any employer groups' deficits before using them to offset positive surpluses of the remaining employer groups.

If these funds are held by the insurance company, an unearned liability would be set up to reflect the contingent nature of the funds. Any funds remaining after the end (or cancellation) of the contract may be owed back to the employer group. If funds are not held by the insurance company, the company will recognize the contingent premium as income when claims experience indicates that the contingent premium will be earned by the company.

Q26. What liabilities are established for risk pool assessments and guarantee fund assessments?

Provisions may be made for program assessments if such assessments are likely to be made. These provisions are reported as claim reserves by some carriers and as accrued expenses by others. The nature of the assessment is often the determinant as to whether these provisions are reported as claims reserves or as accrued expenses. It is prudent for the actuary to determine whether the assumptions used in generating this accrual or reserve are reasonable and to take into account changing circumstances in the legislative environment determined to be material. In most instances, individual company decisions will affect the establishment of this accrual directly.

Q27. How does an actuary reflect obligations under extension of benefits provisions?

A company's extension of benefits provision defines how long payments continue after termination of a contract or membership. Provisions can vary by state, but generally are defined for members that are hospital confined or otherwise disabled on termination of the group contract. Most policies will extend benefits until the earlier of 1) the member being discharged from the facility or no longer being disabled; 2) other coverage being attained; or 3) a set period of time that can vary from 30, 60, or 90 days to as much as a year after termination. The benefit extension may be for inpatient hospital services only, for inpatient and outpatient claims, for hospital and professional services, or for hospital, professional, and pharmacy services. The actuary may consider the specific contractual provisions and consideration should be given to adjusting claim reserves to the extent normal claim coding of the incurred date does not accurately reflect the extension of benefits in the group contract.

Many actuaries do not establish a separate liability for extension of benefits but implicitly recognize that conservatism included in other liability estimates is sufficient to cover this liability.

Q28. How are estimates of MLR based rebate requirements addressed?

The ACA requires companies to give rebates to members and groups if the loss ratio on their category is not above a MLR based rebate requirements defined in the statute. The MLR rebate categories are individual, small group, and large group insured business as defined in the statute. The calculation of the loss ratio differs from the usual statutory and GAAP loss ratios. The rebate is calculated annually for a calendar year reporting period,

beginning with 2011. The actuary should consider reviewing recent applicable guidance regarding these issues.

The actuary might consider making at least quarterly estimates of the rebate payable at year end for each of the categories. Two potential accounting policies are conceivable with respect to how the projected rebate is to be accounted for at interim periods. Under the more common policy, a pro-rata portion of the full-year projected rebate would be reflected in the interim financials, generally as part of the reserve for experience rating refunds. Under the less common policy, the amount recorded at an interim period would be based on a mechanical application of the rebate formula against year-to-date experience only, without regard to projected future experience. For large group medical, the two accounting policies often would produce similar results; this statement is less true for lines of business exhibiting greater benefit seasonality, such as individual medical.

Practice is still evolving with respect to the question of whether and how the actuary incorporates a contingency margin into the financial statement estimate of rebate liabilities.

Q29. How does an actuary reflect obligations under conversion provisions?

Most group contracts allow the subscriber to convert to an individual policy on termination from the group contract. Some companies make a conversion charge to the group lines for the individual line of business to cover those new subscribers who are given coverage without any underwriting. The net gain for the company is not changed. Historically, the conversion charge would be amortized by the individual line of business over the expected period of the adverse morbidity. The intent is that the amortized conversion charge would offset the extra morbidity.

Q30. How is reinsurance ceded and assumed for large group medical reflected in financial statements?

Broadly speaking, reinsurance on large group medical insurance can be divided into two categories: proportional, also known as quota share, or non-proportional, also known as stop loss (not to be confused with stop-loss insurance issued by the insurer to plan sponsors) or excess loss reinsurance. Most reinsurance on large group medical is non-proportional. Stop-loss reinsurance can be written on either a specific (excess loss coverage per insured) or aggregate (coverage group-wide or block-wide) basis.

For the ceding company, a ceded reserve is held for the unearned premium and claim liability. For the assuming company, an assumed reserve is held for the unearned premium and claim liability. The reinsurance reserves are summarized in Schedule S. Note that the reserve and liability of the ceding company and assuming company could be different due to timing of data and simplified approaches. The concept of mirror reserves is that the ceding company cannot take reserve credit for any reserves in excess of the amount of reserves held by the assuming company. This is a complicated area, subject to debate. Only a few states have regulations in this area.

Guidance for reinsurance ceded and assumed in statutory financial statements is provided by the following:

- NAIC Life and Health Reinsurance Agreements Model Regulation
- SSAP No. 61 Life, Deposit-Type and Accident and Health Reinsurance
- APPM Appendix A-785 Credit for Reinsurance
- APPM Appendix A-791 Life and Health Reinsurance Agreements
- ASOP No. 11 [*Financial Statement Treatment of Reinsurance Transactions Involving Life or Health Insurance*](#)
- [*Reinsurance Reserve Credit*](#) Practice Note
- Instructions for Schedule S
- [*Life, Health & Annuity Reinsurance*](#) by John E. Tiller, Jr. and Denise Fagerberg Tiller

Reinsurance Ceded

The actuary typically considers risk transfer of the reinsurance treaty and the credit worthiness of the reinsurance company before taking reserve credit for reinsurance ceded. Under the NAIC Life and Health Reinsurance Agreements Model Regulation, reserve credit may not be taken for treaties that meet certain conditions, including the establishment of the treaty primarily for surplus relief while not transferring all of the significant risks. Also, in certain states, the reinsurer must be an authorized reinsurer to take a reserve credit. If the reinsurer is an unauthorized reinsurer, the ceding company will need a letter of credit or other form of security in order to take a reserve credit. Additional guidance on reserve credit is given in SSAP No. 61, A-785, A-791 and the Academy's [*Reinsurance Reserve Credit*](#) Practice Note. The direct writing company has ultimate liability for its policies and contracts in the event of default of the reinsurer; hence, the health actuary may want to evaluate whether the assuming company has the financial strength to meet its obligations.

Reinsurance Assumed

Guidance on reinsurance assumed in financial statements is given by SSAP No. 61 and ASOP No. 11 [*Financial Statement Treatment of Reinsurance Transactions Involving Life or Health Insurance*](#).

In the case of reinsurance assumed, limited data may be available, especially for those treaties that are handled on a bulk basis (i.e., without detailed records of policies ceded). The appointed actuary may need to place reliance on other actuaries' work or may need to perform checks of reasonableness in addition to the usual work. The actuary may need to become familiar with the requirements of ASOP No. 23 [*Data Quality*](#), and ASOP No. 11 [*Financial Statement Treatment of Reinsurance Transactions Involving Life or Health Insurance*](#), as applied to this area.

Q31. What other considerations might the appointed actuary be aware of?

Some other considerations that might be considered are federal income taxes (including DAC tax), tax reserves, state and local income taxes, surplus notes and liabilities related to pending or expected litigation.

The actuary may consider any impacts of reserves and liabilities on the NAIC RBC.

Q32. What are the considerations for tax reserves for large group medical?

The actuary may wish to work with tax counsel to determine the exact methodologies and calculations for tax reserves.

For large group medical tax reserves, guidance is provided by the Internal Revenue Code, revenue rulings, private letter rulings, technical advice memoranda and *U.S. Tax Reserves for Life Insurers* published by the Society of Actuaries and written by Edward L. Robbins and Richard N. Bush. Note that some issuers of large group medical may be taxable as property & casualty insurers, while others may be taxable as life insurers.

Unearned premium tax reserves are subject to a 20 percent reduction, pursuant to Section 807(e)(7) for life insurers and Section 832(b)(4) for property & casualty insurers, except for organizations qualifying under Section 833(c)(3) (typically, Blue Cross and Blue Shield plans). Per Section 846(f)(6), tax reserves for claim liabilities are unpaid losses and are determined by discounting the statutory claim liability for one-half year at the applicable federal interest rate (AFR) for the year of claim incurral. For “reasonable special contingency reserves” (e.g., premium stabilization reserves), per Section 807(c)(6), tax reserves are statutory reserves.