



AMERICAN ACADEMY *of* ACTUARIES

September 3, 2003

Ms. Leslie Jones, Chair, HMO/HMDI Reserve Subteam of the NAIC Accident and Health Working Group
NAIC
2301 McGee Street
Kansas City, MO 64108

Dear Ms. Jones:

This letter is a reply to your letter of August 29, 2002 where you requested that the Health Practice Financial Reporting Committee (HPRFC) of the American Academy of Actuaries¹ provide some additional clarification regarding our January 2002 report. In your letter you requested further discussion on several items, including:

- General principles that should be considered in the development of and addressed by premium deficiency reserves and gross premium valuations;
- The role of the actuary in certifying the extent of downstream risks and their impact on reserves;
- The best contents for the actuarial opinion of a health entity;
- The degree to which reserves should reflect conservatism; and
- If there should be disclosure and/or limits on certain types of reserve assumptions

We formed a workgroup to address the last four bullets as well as other questions regarding actuarial opinions regarding health business as written by various legal entities, and we expect that workgroup to issue its report by the end of this year. We address the first bullet in this letter.

Actuaries have used the phrase “gross premium valuation” to refer to either (a) an actuarial methodology for assessing the adequacy of a set of actuarial liabilities by making a realistic projection of the future cash flows associated with a block of insurance contracts, or (b) the additional actuarial liability established as a result of the application of such a methodology. In the discussion that follows, we use the phrase “gross premium valuation” in the latter sense, i.e., as the additional reserve required by the Health Insurance Reserves Model Regulation (HIRMR).

¹ The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the actuarial profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

Principles for Premium Deficiency Reserves and Gross Premium Valuations

In our discussions regarding principles for premium deficiency reserves (PDR) and gross premium valuation (GPV), we took as given two basic principles:

- The primary regulatory goals of reserves for health insurance, as stated in your aforementioned letter, are twofold: a) assuring the long-term financial solvency of the health entity; and b) addressing the short-term deficiencies in revenues. We will refer to these goals as “long-term solvency” and “short-term sufficiency” respectively.
- Statutory accounting requires a reasonable degree of conservatism, since the regulator’s primary interest is that the reporting entity be able to satisfy policyholder obligations. This provides justification for establishing a loss contingency liability (i.e., a PDR) with respect to a situation where the underlying revenue has not yet been recognized and the associated expenses not yet incurred.

In light of the above we offer the following observations:

- In general, the establishment of a PDR is an attempt to address short-term sufficiency, whereas the establishment of a GPV is an attempt to address long-term solvency.
- The consideration of whether or not a PDR is required presupposes that the required contract reserves, which may or may not include a GPV, have already been established.
- Applicability of the PDR and GPV concepts will vary based on the contract type:
 - For annually renewable medical benefits where no prefunding is contemplated in rating, it is unlikely that there would be a contract reserve.² As such, the GPV concept is not relevant, but there may well be short-term revenue deficiencies meriting recognition in the reporting entity’s current financial statement via the establishment of a PDR.
 - For products involving prefunding (such as disability income and long-term care), a GPV will generally recognize any difference between experience and the original or required valuation assumptions. In most cases, contract reserves will be sufficient (through either GPV analysis or modification of other valuation assumptions) to result in no need for a PDR. However, conditions may be present where both a GPV and a PDR would be required. An example would be an issue–age rated Medicare Supplement product where a given year’s premium (after any increase) proved insufficient but would be anticipated to be rectified in subsequent

² A possible exception to this would be conversion policies, which are specifically mentioned as needing to be considered for contract reserves in SSAP 54. We believe that in this case prefunding implicitly occurs either through a conversion charge or a load on the commercial business from which the conversion occurs.

periods. In this case, a GPV may or may not be required in order to bring the contract reserve to the appropriate level, but in either case a PDR may be necessary to assure short-term sufficiency, due to the fact the actuarial analysis underlying the GPV projects near-term losses but later gains.

- With respect to both the PDR and the GPV requirements, it is important that the actuarial analysis be performed at the appropriate level of “granularity”, by which we mean a segregation of products within a reporting entity. Current regulatory requirements for the GPV (as found in the HIRMR) involve partitioning the reporting entity’s business into “major blocks of contracts”, while current regulatory requirements for the PDR (as found in SSAP 54) involve groupings based on how policies are “marketed, measured and serviced”.³ Our sense is that regulators’ concerns about long-term solvency are generally focused on the entire reporting entity, whereas regulators’ concerns about short-term sufficiency often relate more to distinct blocks of business within the entity. Therefore, different levels of granularity for the two concepts may be necessary to address those different concerns.
- With respect to the short-term sufficiency objective, there is significant disagreement among the members of our committee as to the appropriate level of granularity needed in order to assert that the PDR requirement accomplishes the objective. However, there was general agreement that if the analysis is too granular (i.e., is based on very narrow segments of the business), then excessive reserves would need to be established that go well beyond the stated objective of short-term sufficiency.

-

We appreciate this opportunity to provide input and we would welcome any additional questions that might be raised as a result of our input. Unfortunately, due to scheduling conflicts, neither I nor Rowen Bell (the Vice-Chair of HPFRC) will be in attendance at the Accident & Health Working Group’s September 11th meeting.

Sincerely yours,

Darrell D. Knapp
Chair, AAA Health Practice Financial Reporting Committee

³ The “marketed, measured and serviced” concept found in SSAP 54 was heavily influenced by the GAAP guidance in FAS 60 on PDRs for short-duration insurance contracts, which refers to the entity’s “manner of acquiring, servicing, and measuring the profitability of its insurance contracts.” We observe that GAAP financial reporting is, in general, significantly less granular than statutory financial reporting and allows for consolidation of business issued by multiple legal entities. Consequently, since the contract groupings for statutory financial reporting purposes are typically much smaller than those used in GAAP reporting, the SSAP 54 PDR standard appears to be more stringent than the FAS 60 PDR standard in most cases.