



# AMERICAN ACADEMY *of* ACTUARIES

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## **Report of the American Academy of Actuaries Health Practice Financial Reporting Committee Presented to the National Association of Insurance Commissioners Accident and Health Working Group**

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Health Practice Financial Reporting Committee

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## **Introduction**

The Health Practice Financial Reporting Committee composed this report in response to a request from the HMO/HMDI subteam of the National Association of Insurance Commissioners' Accident and Health Working Group. In attempting to address areas where there appear to be inconsistencies between the various sources of accounting guidance and industry practice or variation by legal entity, the Health Practice Financial Reporting Committee identified three primary areas of focus: premium deficiency reserves and gross premium valuations; items to be included in or excluded from unpaid claim liabilities; and inconsistencies between with Appendix A-010, the Health Insurance Reserves Model Regulation and Actuarial Standards of Practice. The following discusses our primary findings in each area.

## **Premium Deficiency Reserves and Gross Premium Valuations**

We have reviewed the various Statements of Statutory Accounting Principles (SSAPs) and other relevant documents related to the requirement for, the determination of, and the actuarial certification regarding premium deficiency reserves and gross premium valuations. We have also looked at the NAIC Health Insurance Reserves Model Regulation (HIRMR), the NAIC Health Reserves Guidance Manual (HRGM), and Actuarial Standards of Practice (ASOP) to determine if there are areas of inconsistency or ambiguity that exist between these various documents.

We have identified several apparent inconsistencies, which to a large extent arise because the language of the SSAPs addresses premium deficiency reserves and gross premium valuations as though they were two independent requirements. However, both should be viewed as embodying the same underlying financial principles, and serving the same regulatory purpose. The first step in reconciling the inconsistent language should be to clearly and explicitly state the regulatory goal or goals that are addressed by these requirements, and then to state the general principles that must be considered in meeting these requirements. Without that fundamental groundwork, it will be difficult to achieve a satisfactory resolution of the issues outlined below.

## **Background**

Paragraph 18 of SSAP 54 addresses the potential need for establishing premium deficiency reserves. This relatively short section raises several key points. The language of SSAP No. 54 presents several inconsistencies and ambiguities with that of some of the other documents or with prevailing practice. It states that:

- a deficiency reserve shall be established “when the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period.”

Paragraph 10 of SSAP 54 points out that a “prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date.” The subject is touched on again in

paragraph 23 of SSAP 54; however SSAP 54 does not appear to explicitly require an insurer to hold additional reserves as a result of a gross premium valuation that indicates a reserve deficiency.

### **Observations**

- As noted in the HRGM, investment income and other investment cash flows can also be included in the calculation of the deficiency reserve test.
- ASOP No. 11 (The Treatment of Reinsurance Transactions in Life and Health Insurance Company Financial Statements) requires the actuary to consider the impact of reinsurance in preparing and reviewing financial statements. Neither SSAP 54 nor the HRGM make reference to the appropriateness of performing the premium deficiency test on a basis net or gross of reinsurance. Clearly the impact of a reinsurance arrangement can impact the need and/or size of a deficiency reserve, depending upon the agreement terms. For example, the ability or inability of the reinsurer to terminate the agreement may dictate the appropriateness of performing the calculation on a net or gross basis. The documents offer no guidance in this regard.
- The phrase “for the remainder of the contract period” is ambiguous. It is not clear from SSAP 54 whether a contract period is based upon the length of the premium rate guarantee (explicitly or implicitly) or the renewability provisions of the contract. The HRGM provides helpful guidance in this regard, but refers to the need of “a substantial amount of judgment in many cases.”

The definition of the contract period becomes subject of debate on blocks of business either because the contract period is one year for small group and individual policies even though they are guaranteed renewable or because each policy in the block has a different contract end date. Some individuals take the contract period literally even for policies that must be renewed and may have restrictions on the amount of premium increase that can be charged. In the case of blocks of policies with different contract periods, there is confusion about the period to use.

Which losses are to be recognized through the establishment of deficiency reserves and which through the support of company surplus? For example, many individual health insurance plans are priced with the expectation of losses (surplus strain) for several initial years, while over the lifetime of the policy healthy profits are expected. The rate guarantee period and often the period expected before the need for a rate increase for these plans usually do not exceed a one or two year period. Should the contract period be considered the rate guarantee period or the lifetime of these policies? In practice, the latter is typically used. Large group insurance, which is typically priced on an annual renewable term basis, is often subject to underwriting cycles in which deficiencies may be expected for a few years and then be more than offset by the remaining years in the cycle. Can the cycle be considered a “contract period” if the carrier sets its rates based upon cycle pricing?

What rate increases, if any, can be recognized during the “contract period”?

The ambiguities and need for judgment of the actuary are quite evident. However, consideration to clarify some of the ambiguity, as attempted in the HRGM, may be appropriate by means of codification.

- Contracts are to be grouped consistent with how policies are marketed, serviced and measured and the deficiency reserve, if any, determined by grouping.

There is concern with various potential interpretations of what this clause may require in terms of determining which and how many groups need to be examined. The HRGM again provides reasonable guidance, but still leaves considerable room for disagreement as to what business should be grouped. From a practicable perspective, it is important that groupings be held to a reasonable and manageable number such as major product lines.

What constitutes a contract?

For states that have rate restrictions and mandated benefits, should that state be separated out for premium deficiency reserve calculation? The state regulations may dictate how the policies are marketed, serviced and measured.

In situations where some blocks of business that by design are priced at a loss and subsidized by profitable policies, such as individual substandard policies offered by “carriers of last resort”, should the deficient block be combined with the subsidizing policies for the calculation of premium deficiency reserve calculation? Another example is a block of conversion policies that may be subsidized by the block of group insurance from which they converted.

- For companies filing either the Life/A&H statement or the Health statement, it appears to indicate that the appointed actuary’s statement of opinion must include any premium deficiency reserves since they are reported in the “aggregate policy reserves” line. By contrast, a Practice Note issued recently by the American Academy of Actuaries Committee on Property/Liability Financial Reporting indicates that the scope of the P&C actuarial certification does not necessarily include the need to comment on deficiency reserves since the relevant NAIC Annual Statement Instructions do not include such a requirement.
- When the results of a gross premium valuation indicate an ultimate deficiency on a present value basis over the entire testing period, this essentially becomes a premium deficiency situation. Presumably, the rules for premium deficiency reserves discussed above then apply.

However, the HIRMR allows for the recognition of reasonable future rate increases over the period being tested in a gross premium valuation. The discussion above on

the premium deficiency reserve testing contract period to be used leans toward measuring deficiency in segments of successive periods of new rate levels. Does this imply that a finding of deficiency in a gross premium valuation over the entire lifetime of the business would require the actuary to then regenerate the analysis based upon successive premium deficiency reserve calculations for each rating period?

- If a prospective gross premium valuation projection results in various years in which losses occur, when does a separate deficiency reserve calculation need to occur for the specific periods of loss?
- The interplay between prospective gross premium valuations and deficiency reserve contract periods can be confusing. It may be appropriate to include more guidance in the documents regarding this interplay.
- Paragraph 23 of SSAP 54 does not explicitly require an insurer to hold additional reserves as a result of a gross premium valuation that indicates a reserve deficiency. Appendix A-010 Paragraph 23 and the HIRMR Section 1.A. both clearly indicate “In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy.”

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Although the above comments identify areas where guidance is not clearly prescriptive, we would caution against a stance that makes the guidance entirely prescriptive. The universe of situations where a premium deficiency reserve may be necessary is widely dispersed. As such, the optimal result may be achieved under guidance that allows the actuary to apply professional judgment to the facts and circumstances of a particular situation. Guidance that is overly prescriptive may result in either the establishment of a liability where one is unnecessary or the failure to establish a necessary liability.

## **Items Included In and Excluded From Unpaid Claims Liabilities**

### **Background**

Various SSAPs assert that certain items relating to accident and health contracts either must, or cannot, be included in the claims liability:

- Certain “health related assessments”— include in UCL (SSAP 35 paragraph 4)
- Salvage & subrogation — deduct from UCL (SSAP 55 paragraph 12)
- Coordination of benefits — deduct from UCL (INT 00-31, an interpretation of SSAP 55)
- Pharmaceutical rebates; claim overpayment receivables; loans & advances to providers; risk sharing receivables — do not deduct from UCL, instead establish separate asset (SSAP 84)

## Observations

Paragraph 4 of SSAP 35 specifies that certain “health related assessments” are to be reported as a part of claims and an accrual of liability is required. These health related assessments are different from insolvency assessments in that the funds collected via the assessment are redistributed back to the participating entities based upon the cost of specific claims, enrollment demographics, or other criteria affecting health care expenses. Depending on how the assessments are determined, the liability might or might not be susceptible to traditional methods of actuarial analysis and may be better represented elsewhere on the balance sheet. This may create an inconsistency between statutory accounting and existing actuarial practice. We believe that under the current practice, the actuary’s opinion on the unpaid claim liability does not always include consideration of adequacy of assessment liabilities.

Concerns arise about subrogation and coordination of benefits because the language of SSAP 55 and INT 00-31 fails to make clear the necessary distinction between, on one hand, the actuarial estimation of incurred claims liabilities based on historical levels of costs and the development patterns of such costs; and, on the other hand, the recording of certain items that have been separately identified as being receivable. In the development of the SSAPs, there was no express intent to significantly alter the accepted actuarial practices for reserving, and in fact there are multiple references to existing standards of practice. However, the actual language of the SSAPs can in many instances be read as being in conflict with existing actuarial practices. We think it is more appropriate to interpret such language in a way that avoids any conflict, as that seems to provide a more reasonable result, and is more in keeping with the general idea that the SSAPs were not intended to modify existing actuarial practices except where that intent is explicitly stated.

SSAP 55 paragraph 12 deals with the treatment of salvage and subrogation. It states that if an entity chooses to anticipate salvage and subrogation receivables (including amounts recoverable from second injury funds), the recoverable amounts shall be estimated in accordance with the guidelines and deducted from the liability for unpaid claims or losses. Coordination of benefit amounts also should be deducted from unpaid claims liability (UCL). However, ASOP 5 section 3.3.5 asks the actuary to take into consideration organizational practices and regulatory requirements related to COB and subrogation when determining claim liabilities. Current practice generally has been to let these amounts flow through the paid claims used in reserving studies and, therefore, be implicitly reflected in the estimation of liabilities. It is easy to read SSAP 55 paragraph 12 as requiring the separate estimation of a contra-liability for COB and subrogation, which could require significant changes in the way data are recorded and processed, and significant changes in established reserving processes. However, a reasonable interpretation of the SSAP would recognize that the claims liability should be based on net costs, as has traditionally been the case, and that the requirement with respect to separate reporting applies only to COB and subrogation amounts that have been separately and explicitly identified. It would be helpful if it were clarified that the requirement for separate reporting applies only to such explicitly identified amounts, and does not require separate identification of the effects of COB and subrogation on the estimation of claims liabilities according to generally accepted methods.

SSAP 84 Exhibit C (the Implementation Guide) has detailed instructions on determining receivables for pharmaceutical rebates, loans and advances to providers, and risk sharing receivables. Determination of receivables using billed amounts and estimated amounts, use of invoiced amounts, rules for reconciliation, etc. are explained in great detail to assist regulators and reporting entities. Relevant actuarial guidance appears in Section 3.3.6 of ASOP 5 which asks the actuary to take into account the relevant contractual arrangements with providers and any changes in the arrangements. The actuary needs to consider the overall ability of the provider to meet its obligations, statutory limitations on the credits for transfer of risk, and the impact of unpaid medical costs resulting from failed contractors under capitation. In some instances, there is no apparent conflict between the requirements of SSAP 84 and historical actuarial practice as guided by ASOP 5. Some of these items would generally not have been includable in the claims used for reserving, either because they were required to be reported separately (generally the case with risk sharing), or because they were distinct events (such as loans) that would not have been projectible based on historical claim run-out. However, there may be an impact on reserving practices, for example if the claim data used in reserving have historically included (i.e., been net to) pharmaceutical rebates. While such inclusions have not been universal in practice, where they have been made historically there may need to be significant adjustments to companies' data capture procedures, data processing systems, and reserving methods.

SSAP 84 also prescribes the treatment of claim overpayment receivables. As in the case of SSAP 55 paragraph 12, it is important to distinguish between the estimation of liabilities for unpaid claims and the recovery of specifically identified past overpayments. When negative claims are included in the lags used to establish unpaid claim liabilities, a certain level of overpayment recoveries may be implicit in the completion factors developed. If SSAP 84 is interpreted to require that unpaid claims liabilities be estimated without recognizing a historical level of recoveries from overpayments, then some of these assumed reductions may not meet admissibility standards and significant reprogramming of the construction of the claim lags may be required. Alternatively, SSAP 84 could be interpreted to only govern the reporting of receivables with respect to specifically identified past overpayments, and not to address the estimation of the cost of unpaid claims. A clarification of this interpretation would be helpful.

The requirement in SSAP 55 paragraph 10 is that "management shall record its best estimate" of the unpaid claims liability. The "best estimate" language is occasionally interpreted to exclude any margin for adverse deviation. Requiring implicit margin for adverse deviation instead of explicit provision makes the hindsight review of the efficacy of the estimate more difficult. This hindsight review is one of the primary mechanisms a health actuary utilizes in order to assure that the liability estimation methodology is working properly. Section 3.3c of ASOP #5 states that "what margin for uncertainty if any might be appropriately included {in the unpaid claim liability}". Actuaries use margin for adverse deviation in calculating their best estimate per actuarial standards while codification "allows but doesn't require" according to SSAP 55 INT 01-28. This guidance expands variation in practice by allowing for either interpretation.

## Appendix A-010 vs. the HIRMR vs. the ASOPs

### **Background**

The Health Insurance Reserves Model Regulation (“HIRMR”) applies only to entities that are subject to the Standard Valuation Law, i.e. life/A&H companies but not HMOs, HMDIs, or P&C companies, whereas the Accounting Practices and Procedures Manual (“APPM”) applies to all entities. The regulation’s scope includes premium reserves, contract reserves, and claim reserves. In referring to “claim reserves”, the regulation includes both “claims unaccrued” (which are called “claim reserves” in SSAP 54) and “claims accrued” (which are called “claim liabilities” in SSAP 55).

Appendix A-010 (“Minimum Reserve Standards for Individual and Group Health Insurance Contracts”) of the APPM is a direct mirror of the HIRMR. A regular process exists whereby whenever the Accident & Health Working Group adopts changes to the HIRMR, those changes are also made shortly thereafter to Appendix A-010 by the Statutory Accounting Principles Working Group.

Appendix A-010 is referenced in SSAP 54 in three separate places:

“11. The reserving methodologies and assumptions used in calculating individual and group accident and health reserves shall meet the provisions of Appendices A-010, A-641, A-820, and A-822 (if applicable) and the actuarial guidelines found in Appendix C of this Manual. Further, policy reserves shall be in compliance with those Actuarial Standards of Practice promulgated by the Actuarial Standards Board.”

“23. As discussed in Appendix A-010, a prospective gross premium valuation is the ultimate test of the adequacy of a reporting entity’s accident and health reserves as of a given valuation date and shall be determined on the basis of unearned premium reserves, contract or additional reserves, claim reserves (including claim liabilities), and miscellaneous reserves combined; however, each component shall be computed separately.”

“37. This statement incorporates the requirements of Appendices A-010, A-225, A-641, A-820, A-822, and the Actuarial Standards Board *Actuarial Standards of Practice*.”

Appendix A-010 is not referenced in SSAP 55 (nor are the Actuarial Standards of Practice).

### **Observations**

Since Appendix A-010 is not referenced in SSAP 55, the portions of the HIRMR that pertain to SSAP 55 claim liabilities (as opposed to SSAP 54 claim reserves) are not part of codification, and thus they apply only to life/A&H companies and not to HMOs, HMDIs, or P&C companies that write accident & health contracts.



Paragraph 28 of Appendix A-010 discusses minimum standards for “claim reserves”, which as noted above encompasses both SSAP 54 claim reserves and SSAP 55 claim liabilities. Subparagraph 28.b.ii asserts, for coverages other than disability income, that “the reserve shall be based on the insurer’s experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities”. For disability income, subparagraph 28.a.ii.c asserts that “for claim reserves to reflect ‘sound values’ and/or reasonable margins, reserve tables based on credible experience should be adjusted regularly to maintain reasonable margins.

Thus, entities subject to the HIRMR are currently subject to the paragraph 28 requirement that statutory claim liabilities (in the sense of SSAP 55) for accident & health contracts need to “reflect sound values”, whereas other entities are not subject to that requirement due to the absence from SSAP 55 of any reference to Appendix A-010.

The recently revised ASOP 5 governs actuarial practice regarding estimates for incurred health and disability claims in a broad array of contexts. It states in subparagraph 3.3.1.c that “...the actuary should consider what margin for uncertainty, if any, might be appropriately included. If a margin is included, the unpaid claim liability should be appropriate, in the actuary’s judgement, under moderately adverse conditions.” There are certain actuarial activities in which the inclusion of margin in an unpaid claim liability estimate is not appropriate; however, it is generally believed by practicing health actuaries that margin is appropriate when estimating the unpaid claim liability for statutory reporting purposes.

We believe that this sentence was carried over from SSAP 51, where the same sentence appears in paragraph 15, and that the limitation of its applicability to policy reserves is inappropriate in SSAP 54. A literal construal of paragraph 37 of SSAP 54, which references the Actuarial Standards of Practice, would suggest that ASOP 5 applies to statutory claim reserves. On the other hand, paragraph 11 of SSAP 54, which only references the Actuarial Standards of Practice in connection with policy reserves, would suggest that SSAP 54 does not require compliance with ASOP 5 with respect to statutory claim reserves. Since at present there are no Actuarial Standards of Practice that exclusively apply to policy reserves for health coverages, the last sentence of SSAP 54 paragraph 11 requires compliance only with some very general principles, which ought not to apply only to policy reserves. We believe that this sentence was carried over from SSAP 51, where the same sentence appears in paragraph 15 and that the limitation of its applicability to policy reserves was inadvertent.

Paragraph 19 of SSAP 54 covers much the same ground as, but creates possible conflicts with, the language in subparagraph 28.a.ii.b of Appendix A-010. Where Appendix A-010 makes explicit provision for an insurer to use its own experience for claims in durations 3 through 5 if it is credible (as defined) and “for which the insurer maintains underwriting and claim administration control”, SSAP 54 does not specifically mention this possibility in paragraph 19, but may allow for it through use of the word “generally” in paragraph 19 and the requirement in paragraph 11 that reserving methodologies and assumptions need to meet the provisions of Appendix A-010. What is ambiguous is that use of company experience for durations 3 through 5 is an option to the insurer, but paragraph 19 of SSAP does not directly make allowance for this being an option rather than a requirement.

Furthermore, with respect to this issue, Appendix A-010 does not exactly replicate the requirements of the HIRMR, thus creating potential differences between entities that are subject to the HIRMR versus those that are subject only to Appendix A-010. The HIRMR requires the approval of the state insurance commissioner in order for an insurer to use its own experience for durations 3 through 5 and lists specific items that must be included in the request for such approval. Only the requirements for credibility and administration control are included in Appendix A-010. (No reference to commissioner approval appears in SSAP 54 paragraph 19.)

Another significant deviation between Appendix A-010 and the HIRMR occurs in paragraph 33.b, where Appendix A-010 effectively requires that contract reserves be considered for all policies irrespective of their issue dates. The corresponding passage in the HIRMR, Section 4.A.(2)(b), contains an exemption from the need to establish contract reserves for contracts already in force on the effective date of the standard if none had been required under the immediately preceding standards.

Similarly, where Sections 4.B.(1)(c)(ii) and 4.B.(2)(b) of the HIRMR apply only to long-term care policies issued after the effective date of the regulation, subparagraphs 34.a.iii.b and 34.b.ii. of Appendix A-010 apply to all policies in force. This would effectively require insurers to recalculate all their past contract reserve factors for LTC policies if they had used a different, less conservative termination rate assumption or a different reserving method (e.g., 2-year FPT) which may have been allowed at the time of the policy's issue date.

The minimum morbidity standards listed in Exhibit 1 of Appendix A-010 differ from those in the Appendix A of the HIRMR, primarily for older disability income policies. As such, SSAP 54 apparently does not allow reserves for older policies to be determined on tables in effect at the time of policy issue (e.g. 1964 CDT). Exhibit 1 also excludes a table found in Appendix A of specified adjustment factors to be applied to the 1985 CIDA termination rates for claim reserve calculations.

### **Contact Information**

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