HEALTH PRACTICE NOTE 1995–3
November 1995

Large Group Medical Business

Introduction

This practice note was prepared by a work group organized by the Committee on State Health of the American Academy of Actuaries. The work group was charged with developing a description of some of the current practices used by health actuaries in the United States. This work group was originally formed in 1993 and issued the first set of Health Practice Notes that year; changes have been made to this set of practice notes to reflect additional information on current practices.

The practice notes represent a description of practices believed by the work group to be commonly employed by health actuaries in the United States in 1995. The purpose of the practice notes is to assist actuaries who are faced with the requirement of preparing a statutory statement of opinion by providing examples of some of the common approaches to this work. However, no representation of completeness is made; other approaches may also be in common use. It should also be recognized that the information contained in the practice notes provides guidance, but is not a definitive statement as to what constitutes generally accepted practice in this area. Moreover, these practice notes are based upon the model Standard Valuation Law of the National Association of Insurance Commissioners (NAIC). To the extent that the laws of a particular state differ from the NAIC model, practices described in these practice notes may not be appropriate for actuarial practice in that state. This practice note has not been promulgated by the Actuarial Standards Board, nor is it binding on any actuary.

The members of the work group responsible for this practice note are Richard J. Nelson, chairperson; David A. Brodtrick; Paul M. Conlin; Stephen P. Meyers; and Mintu Pal.

Comments are welcome as to the appropriateness of the practice notes, desirability of annual updates, substantive disagreements, etc. Comments should be sent to Peter L. Perkins at his Directory address.

Q. For purposes of this practice note, what is *large group medical business?*

A. *Large group medical business* includes basic medical plans, basic plans with supplemental major medical, comprehensive major medical, and specific and aggregate stop loss plans of 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 may also be relevant to short-term ancillary products when sold independently of medical coverages.

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This practice note does not address group term life.

Q. For purposes of this practice note, what is considered to be a *large group?*

A. Generally, this practice note addresses issues related to groups not affected by small group reform and in excess of 50 lives where retrospective experience rating and self-funding are employed; at the time of initial underwriting, individual evidence of insurability is not collected. However, large claim information may be collected.

Q. What funding arrangements are currently used in large group medical business?

A. *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.

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.

Cost Plus—This is an insurance arrangement whereby the policyholder is charged the amount of the claim paid plus the insurer's retention.

Self-Funding—This refers to 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.

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.
Stop Loss Insurance—This is a method of protecting self-funded plans from individual high claims (specific stop loss) or aggregate claim levels (aggregate stop loss).

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Also refer to Health Practice Note 1995–1, *General Considerations*.

Standard Valuation Law Section 7 Opinions

Refer to the section below for discussion concerning gross premium valuation. Also refer to Health Practice Note 1995–1, *General Considerations.*

Standard Valuation Law Section 8 Opinions

Q. Is cash flow testing (CFT) necessary for large group medical business?

A. Refer to Actuarial Standard of Practice (ASOP) No. 14, *When to Do Cash Flow Testing for Life and Health Insurance Companies*, which states that it is not always necessary. No member of this committee is currently performing cash flow testing for his or her large group medical business. Since the premium is the main asset used to cover the liabilities, cash flow testing isn't seen as crucial for this type of business.

Q. Other than CFT, what methods can be used to demonstrate asset adequacy?

A. Refer to ASOP No. 5, *Incurred Health Claim Liabilities*. In addition, a gross premium valuation may be advisable for guarantees that affect the ability to adjust premiums. It may also be advisable to test results for sensitivity to assumptions used. Section 8 of the Standard Valuation Law (SVL) requires the liabilities to be adequate to cover the obligations under moderately adverse conditions.

Q. What testing should be done for asset (C-1) risk, and what type of assets should be assigned?

A. If cash flow is positive, then explicit testing may not be necessary. If cash flow is negative, the actuary can review assets allocated to the large group line for duration and reliable quality. It may be advisable for the asset segmentation to be detailed enough to permit a review of duration and quality.

In addition, some companies have guaranteed interest crediting formulas for claim reserves. This may create a need for CFT even if cash flow is positive.

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

A. Since cases are individually rated with no guarantees to cases that might be sold in the future, the need to extend consideration beyond in-force cases is typically not apparent. Also, it is often impractical in the large group market to subsidize current business with new business.

Q. Does the actuary generally consider the level of investment-rate-of-return risk?

A. Large group insurance products often are not highly interest sensitive, in the sense that lapse rates or claim costs are not dependent upon movements in interest rates. Therefore, investment-rate-of-return risk is rarely considered for short-term medical products.

Q. What claim reserve contingency margin generally is held for large group medical business, and how does this vary by funding arrangement?

A. For prospective- and retrospective-rated groups, a review of historical claim fluctuations for the line of business is usually appropriate. This is done by reviewing prior loss developments, trends in pure premium or claim cost per unit of exposure, and loss ratios. Also, explicit margins are often added (0–10%). In addition, for retrospective-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.

For cost-plus groups, the credit worthiness of each policyholder can be assessed to determine any necessary margin, or to set up a “default” reserve liability.

For stop loss insurance, the elements of such insurance, written in conjunction with minimum premium or self-funding, can be tracked to determine historical claim fluctuations.

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

A. For large group medical business, the ability to change premiums annually at renewal to prevent future losses typically makes this an issue only if claims can rise suddenly and subsequent renewal premiums would be deficient. The claim liability is the largest part of reserves, and we refer in the previous question to contingency margins that address this issue.
It may be prudent to test sufficiency of current year premiums. If they are insufficient, then a gross premium valuation may be warranted to check reserve adequacy.

Stop loss insurance experience develops more slowly than medical insurance. Experience for contracts written in the 12 months prior to the evaluation date typically cannot be assessed based on paid claims for these contracts (see below for reference on stop loss insurance reserve methodologies). Thus, projections based on a mixture of claim payments and loss ratios are often used. Given the greater uncertainty in results, a gross premium valuation may be advisable to properly assess reserve adequacy.

Also, multiyear rate guarantee arrangements may require a gross premium valuation.

Q. What obligation risks may be considered? How may assumptions be set for each risk if a gross premium valuation or CFT is to be performed?

A. Among these risks are the following:

1. premium rate guarantees and adequacy;
2. adequacy of claim liabilities;
3. claim trends;
4. conversions;
5. experience rating deficits (if the full deficit cannot be made up in the future); and
6. administrative costs, managed care costs, and operational standard guarantees (which is a major risk on ASO groups).

Premium—Assume that rate increases are consistent with claim and administrative cost trends and company re-rating procedures. The actuary is generally prudent to estimate realistically the ability to recoup past losses.

Claims—Recent company experience is generally used in setting loss ratios and claim cost assumptions. Assumptions for future claim trends typically are set based on experience and future expectations.

Administrative—Administrative costs generally are based on recent experience, and cost increases are based on experience and future expectations.

Q. Should claim cycles and underwriting cycles be reflected in projection assumptions?

A. That may be more appropriate for surplus adequacy analysis, although it would not necessarily be inappropriate to make such assumptions for reserve adequacy purposes.

Q. How long should projection periods be for large group medical business when performing either CFT or gross premium valuations?

A. For medical, given the 1-year term nature and annual re-rating of the business, a term of more than 1 year usually does not seem to be needed. However, some large accounts are now written with (up to) 3-year rate guarantees and, thus, a 3- to 5-year projection may be appropriate.

For stop loss insurance, given the longer delay in experience recognition, a longer period of up to 2 years may be appropriate.

For group medical conversions, a projection period of 20 to 30 years may be appropriate.

Also refer to Health Practice Note 1995–1, *General Considerations.*

Q. Are there any reference materials with regard to stop loss insurance?

A. There is a discussion of three methods included in the Society of Actuaries' publication *Proceedings of the Valuation Actuary Symposium—1992*.

Also refer to Health Practice Note 1995–1, *General Considerations*.