



# AMERICAN ACADEMY *of* ACTUARIES

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Date: February 19, 2008

To: Larry Bruning, Chair, National Association of Insurance Commissioners (NAIC)  
Accident and Health Working Group, Life and Health Actuarial Task Force

From: Darrell Knapp, Chair, American Academy of Actuaries<sup>1</sup> (Academy) Health Practice  
Financial Reporting Committee

Re: January 2008 Exposure Draft of the Actuarial Opinion Section of the Health Annual  
Statement Instructions

Dear Mr. Bruning:

On behalf of the Health Practice Financial Reporting Committee of the American Academy of Actuaries, I am pleased to have this opportunity to provide input to the NAIC on the January 14, 2008 draft of proposed changes to the Actuarial Opinion instructions for companies filing the NAIC Health Annual Statement.

We commend the NAIC for taking on a project to achieve greater consistency, where appropriate, between the Health Actuarial Opinion requirements and the equivalent requirements for life/A&H and property/casualty insurers. We hope that our comments below will be of assistance to the NAIC and we stand ready to provide additional assistance, as requested. This letter will begin with some general comments surrounding this project, followed by detailed section-by-section comments on the exposed draft.

## General Comments

It appears to us that the main intent of the changes exposed in the January 14, 2008 draft is to make the Health Actuarial Opinion more consistent with the revised version of the Property/Casualty Actuarial Opinion, which was adopted by the NAIC earlier this decade. In light of the similarities that exist between many of a health insurer's short-term actuarial liabilities and a property/casualty insurer's actuarial liabilities, we can see why the promotion of such consistency might be a desirable regulatory objective. However, we do see two potential pitfalls that should be highlighted.

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<sup>1</sup> The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.

The first potential pitfall involves potential inconsistencies between the changes being proposed to the Health Actuarial Opinion instructions and other changes currently being proposed by the NAIC to the regulatory framework applicable to insurers issuing health coverage. In particular, the January 7, 2008 exposure draft of the Standard Valuation Law (SVL) would include all health insurers within the scope of the SVL for the first time. This raises the possibility that all health insurers would be expected to eventually comply with the Actuarial Opinion and Memorandum requirements in Section VM-30 of the proposed Valuation Manual, at least with respect to portions thereof, which set forth the requirements for actuarial appointment. The current exposure draft of Section VM-30 is largely based on the existing Actuarial Opinion & Memorandum Regulation (AOMR) applicable to Life and A&H insurers.

We recognize the NAIC's preference for changing the Health Actuarial Opinion instructions in the very near term, rather than waiting for the Valuation Manual to become effective. However, we believe that it is also highly desirable to minimize any additional changes that will be needed in the future. Thus, it would be prudent to ensure that current changes are as consistent as possible with the current draft versions of the Standard Valuation Law and the Valuation Manual. Some of our detailed comments below are directed at achieving this consistency.

The second potential pitfall, which we believe has the potential to be very significant, is the replacement in the Health Actuarial Opinion language of the phrase "good and sufficient provision" with "adequate provision."

Some health actuaries believe that the "good and sufficient provision" language, historically used in the NAIC Health Actuarial Opinion, represents a higher standard than the term "adequate provision," used in the NAIC Life/A&H Actuarial Opinion. Actuarial Standard of Practice (ASOP) 28, which applies to practice relating to the NAIC Health Actuarial Opinion, indicates that, in order to opine that the recorded balances make a "good and sufficient provision" for a company's liabilities, the actuary "**should be satisfied that** the reserves and related items opined on are adequate to cover obligations under moderately adverse conditions" (emphasis added).<sup>2</sup> On the other hand, the corresponding language in ASOP 22, which applies to practice relating to the NAIC Life/A&H Actuarial Opinion, is that the actuary "**should consider whether** the reserves and other liabilities being tested are adequate under moderately adverse conditions" (emphasis added).<sup>3</sup> The key here is the potential semantic difference between the Health standard of "should be satisfied that" versus the Life standard of "should consider whether."

If the phrase "good and sufficient provision" were replaced by "adequate provision," many health actuaries could draw an inference that the NAIC standard has been intentionally weakened. Whether or not such weakening was intentional and/or appropriate, we offer the following observations:

- If the NAIC does not intend to weaken the standard, then leaving the "good and sufficient provision" language intact would create the least confusion among practitioners.

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<sup>2</sup> ASOP 28: *Compliance with Statutory Statement of Actuarial Opinion Requirements for Hospital, Medical, and Dental Service or Indemnity Corporations, and for Health Maintenance Organizations*. Section 3.3.1, pg 3. [http://www.actuarialstandardsboard.org/pdf/asops/asop028\\_054.pdf](http://www.actuarialstandardsboard.org/pdf/asops/asop028_054.pdf).

<sup>3</sup> ASOP 22: *Statement of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers*. Section 3.4.2, pg. 7. [http://www.actuarialstandardsboard.org/pdf/asops/asop022\\_083.pdf](http://www.actuarialstandardsboard.org/pdf/asops/asop022_083.pdf).

- If the NAIC does not intend to weaken the standard, but nevertheless wants to replace the words “good and sufficient” with “adequate,” we suggest the NAIC clearly communicate to all interested parties that the language change was not intended to create a change in actuarial practice. Another alternative would be to use the phrase “adequate provision under moderately adverse conditions” in the opinion language, in lieu of “adequate provision.”
- If the NAIC does intend to weaken the standard applicable to health insurers’ actuarial liabilities, there are three items that would need to be addressed before such a change could be implemented:
  1. The NAIC Health Insurance Reserves Model Regulation (HIRMR) includes a statement that the morbidity basis used for health claim reserves should be based on “assumptions designed to place a sound value on the liabilities.” Similarly, the discussion within the HIRMR on contract reserve valuation methods makes reference to the insurer’s underlying objective of “determining a sound value of its liabilities.” Thus, it may not be possible to effect a change in the level of prudence included in health insurers’ claim reserves solely by changing the opinion standard; it may also be necessary to modify the HIRMR’s “sound value” language.
  2. To the extent that the NAIC no longer wanted the opining actuary’s assurance that the insurer’s recorded balances would be adequate under moderately adverse conditions, conforming changes to ASOP 28 would need to be made by the Actuarial Standards Board.
  3. The NAIC Health Risk-Based Capital (RBC) formula does not currently contain any provision for Reserving Risk for lines of business other than long-term care, unlike the NAIC Property/Casualty RBC formula. Some HPFRC members, who participated in discussions leading to the adoption of the Health RBC formula, believe that the absence of reserving risk from the Health RBC formula reflects the fact that health claim reserves are subject to a “good and sufficient provision” standard, mitigating the risk that the insurer’s surplus would be impaired because of a claim reserve deficiency. Consequently, if the opinion standard for a health insurer’s actuarial liabilities were weakened, it would likely be actuarially appropriate to modify the Health RBC formula in order to introduce a Reserving Risk provision for all lines of business.

## Section 1

In the first sentence of this section (lines 11-12), we suggest that the phrase “loss reserves, provision for experience rating refunds, and any other actuarial items” be replaced with “claim reserves and liabilities, and any other actuarial items.” According to the current NAIC Accounting Practices & Procedures Manual, “loss reserves” is a concept that applies only to property & casualty insurance contracts, and “claim reserves and liabilities” is the corresponding concept for health insurance contracts. There is also no need to emphasize experience rating refunds in the first sentence, as they represent only one of many types of other actuarial liabilities that may need to be included in the opinion scope. Furthermore, we suggest that all subsequent references to “loss reserves” in the document be replaced (e.g., line 95, line 117, et al.).

The main function of the proposed changes to Section 1 is to introduce a formal “appointed actuary” concept. While we support this concept, we do have three primary concerns regarding the precise manner in which it has been implemented in the current exposure draft.

First, we suggest that the term “qualified health actuary” be changed to “qualified actuary” and be made consistent with the definition of “qualified actuary” in the Standard Valuation Law (i.e., Section 1.B.(7) of the January 7, 2008 SVL exposure draft, together with any modifications made thereto as a result of the SVL exposure process). This could be done by removing the definition of “qualified health actuary” from the first paragraph of Section 1, and adding to Section 1A a definition of “qualified health actuary” that is based on the SVL definition of “qualified actuary.” Any references to “life and health” in the SVL definition could then be replaced with “health.”

Second, we are concerned about the lack of consistency between the actuary appointment process and the requirements for replacement outlined in this document, and the corresponding language in the AOMR and in Section B.2 of the January 30, 2008 exposure draft of Section VM-30 of the Valuation Manual. The problems involved are not just theoretical, but practical and, for the actuary, professional. There are many insurance companies that are licensed as Life/A&H companies, and are thereby subject to the SVL and AOMR, but which file the Health Annual Statement instead of the Life/A&H Annual Statement. If the proposed changes to the Health Actuarial Opinion instructions are adopted, such a company may need to comply with two different sets of actuarial appointment requirements, which would be problematic if there were conflicts between the two. We suggest that the second paragraph of Section 1 be re-drafted to make it consistent with the current AOMR appointed actuary requirements, and that any desired changes to those requirements be made in tandem for both Life/A&H and Health insurers.

Should you decide to retain the current language in the second paragraph of Section 1, we suggest some modifications to the language. Line 24 contains a reference to “the risk of material adverse deviation.” Upon our first reading, we were unsure of the intended meaning of this phrase. It appears that it was carried over from the NAIC Property/Casualty Actuarial Opinion instructions and that Risk of Material Adverse Deviation is a concept that carries a specific meaning within the Property/Casualty Actuarial Opinion. We would propose editing the sentence, in order for it to end with the word “opinion”, as follows: “The insurer shall also furnish the domiciliary commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former appointed actuary regarding the content of the opinion ~~on matters of the risk of material adverse deviation, required disclosures, scopes, procedure, or data quality.~~”

Third, the proposed language creates a requirement (in lines 34-35) that the newly-required Actuarial Memorandum “be made available to the Board of Directors.” Section 11 indicates that the Actuarial Memorandum will consist of a narrative component and a technical component. As noted below in our comments to Section 11, the technical component of this memorandum will be voluminous, based on the requirements as currently drafted. In light of this and the likelihood that the technical aspects of the memorandum will not be of any significant interest to an insurer’s board members, we recommend modifying the language, requiring that only the narrative component be made available to the board.

## Section 1A

The phrase “Audit Committee” is used in Section 1 without being defined. If this phrase is going to be used throughout the document, we would recommend including a definition that is consistent with the definition found in Section 3 of the NAIC Annual Financial Reporting Model Regulation, as adopted in 2006.

## Section 3

The second, seventh, eighth, and ninth paragraphs of this section discuss the situation in which the appointed actuary is not a member of the Academy. We have previously recommended that the definition of “qualified actuary” should be changed to be consistent with the definition of a qualified actuary in the SVL exposure draft. Under that definition, a qualified actuary must be a member of the Academy. Therefore, these four paragraphs of Section 3 would not be needed and should be deleted.

For purposes of clarity, we suggest the following non-substantive changes to the third through sixth paragraphs of Section 3. Note that these changes reflect the possibility that the appointed actuary for an insurer may technically be an employee, not of that insurer, but of an affiliate of that insurer, such as a parent or sister company.

For an appointed actuary who is an employee of the ~~organization~~ insurer or an affiliate thereof, the opening paragraph of the opinion should contain a sentence such as:

“I, (name and title of actuary), am an officer (employee) of (named organization; if named organization is not the insurer, state the relationship of named organization to the insurer) and a member of the American Academy of Actuaries.”

For an appointed actuary who is a consulting actuary, the opening paragraph of the opinion should contain a sentence such as:

“I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by (name of ~~insurer organization~~) to render an opinion with regard to claimless reserves and liabilities, actuarial liabilities and related items.

## Section 4

We understand the apparent intent underlying the proposed changes to this section, namely that if the opining actuary uses language that significantly differs from the model language included in the instructions, then the non-standard language should be immediately apparent to the regulator reading the opinion. However, we are concerned that the proposed requirement that “any modifications should be described at the top of the first page of the actuarial opinion” is too broad. We suggest that alternatives be considered; for example, adding a word such as “material” or “significant” before “modifications.” We also note that if the language changes are a consequence of the fact that the opinion is adverse, qualified, or inconclusive, then the language proposed in Section 9 (specifically, lines 237-238) would require the actuary to make a disclosure at the top of the first page of the opinion.

## Section 5

We have several comments regarding the list of items to be included in the scope paragraph of the opinion.

1. Further clarity would be helpful on the opining actuary's obligations in the situation where one of the line items that would normally be included in the opinion scope has a zero balance. If such a line item has a zero balance, we would anticipate that the line item will still be included in the scope paragraph and that the scope of the actuary's review has included an analysis of whether or not zero is an appropriate balance for that line item. If that is consistent with your intent, additional guidance to that effect would help to avoid any confusion on this point.

In our experience, this issue is most germane with respect to line item D, aggregate health policy reserves. There are many health insurers whose insurance contracts do not lead to any unearned premium reserves, contract reserves, or experience rating refund liabilities. For such an insurer, the only item that the insurer might report on page 3, line 4, of the Health Annual Statement would be a premium deficiency reserve (PDR). Thus, in years where the insurer does not hold a PDR, the line item would be zero. In this specific situation, is there an expectation that the scope of the actuary's opinion will include the assertion that the insurer does not need to record a PDR?

2. Technically speaking, the language that has been added to item D, "aggregate health policy reserves," is correct but redundant. To the extent that the insurer records any unearned premium reserves or additional policy reserves, those items are reported on the Underwriting & Investment Exhibit - Part 2D, and will be automatically included in the insurer's aggregate health policy reserves balance on page 3, line 4. To make the situation clearer, particularly in light of the proposed deletion of previous item F ("experience rated refunds"), we would suggest a minor revision to the item D language as follows:

"D. Aggregate health policy reserves (Page 3, Line 4); (Drafting Note: This line item includes any unearned premium reserves, premium deficiency reserves, experience rating refund liabilities, and other types of additional policy reserves from that would be reported in the Underwriting and Investment Exhibit - Part 2D.)"

3. We have observed that some health insurance activities give rise to actuarial balances that may be included on either the Liabilities page or the Assets page of the annual statement, depending on whether the balance is a payable or a receivable, but where the balance is automatically included in the opinion scope if it is a payable. One example of this is risk-sharing settlement balances between the insurer and CMS relating to Medicare Part D products; risk-sharing payables are typically reported as experience rating refund liabilities in the Underwriting and Investment Exhibit - Part 2D, while risk-sharing receivables are typically reported as assets. Also, in light of the accounting guidance on health care receivables in SSAP 84, there are some claims-related balances that health insurers are required to report as assets rather than as reductions to unpaid claim liabilities, such as pharmaceutical rebate receivables.

In light of this, the NAIC may wish to determine if it would be appropriate for certain actuarial assets of this nature to be explicitly included within the desired opinion scope. In addition to delineating which types of assets should be included within the opinion scope, it would also be necessary for the NAIC to clarify whether the opinion covers only the admitted portion of the asset balance or the gross asset balance prior to admissibility restrictions.

4. In item H, the proposed phrase “any actuarial reserves or liabilities not included in the items above” may be overly broad. A health insurer’s balance sheet may include liabilities that are actuarial in nature but are not related to the insurer’s insurance contracts, such as pension liabilities. Such liabilities have not historically been in the scope of the actuarial opinion and the actuary engaged to opine on the insurer’s health insurance actuarial liabilities may not be professionally qualified to assess pension liabilities or other actuarial liabilities not related to the insurer’s insurance contracts. It may be desirable to use more restrictive wording, such as “any actuarial reserves or liabilities arising from policies or contracts issued by the insurer that are not included in the items above.”

## Section 6

The phrases “liability records” or “underlying basic liability records” are used throughout this section (see lines 159, 163, 164), which is a change from the previous language of “underlying records and/or summaries.” It seems that the phrase “liability records” is more appropriate in a life insurance context, where most of the insurer’s actuarial reserves come from seriatim reserve calculations, than in a health insurance context, where most of the insurer’s actuarial reserves are calculated using claims lag data. In particular, the phrase “liability records” could be interpreted as excluding the underlying claims lag data. We suggest returning to “underlying records,” in order to avoid this ambiguity.

Similarly, in lines 168-169, the examples cited of data prepared by the company are “listings and summaries of policies in force or asset records,” which are examples more appropriate to life insurance rather than health insurance. It would seem appropriate to replace this language with something like “claims lag data.”

We also suggest a non-substantive change to the sentence in lines 171-172 as follows:

“In forming my opinion on [specify types of reserves] I relied upon data ~~prepared~~provided by or at the direction of [name and title of company officer certifying in force records or other data] as certified in the attached statements.”

This suggestion reflects the fact that the officer signing the data certification is unlikely to have personally prepared the data used by the opining actuary, but instead was responsible for the staff who prepared the data. Furthermore, the appointed actuary knows who provided the data, but not necessarily who originally prepared it. The person who provided it may have reviewed data obtained from another source. As long as that person is prepared to attest to the accuracy and completeness of the data, that should be sufficient.

## Section 7

As discussed above in our general comments, the proposal to change “good and sufficient provision” to “adequate provision” in item D of the opinion statement raises a number of issues.

With respect to the second-to-last paragraph of Section 7 (lines 218-220), at a minimum it should be placed within quotation marks, consistent with the other language that is to be included in the opinion.

Our understanding is that this paragraph has historically been intended as a certification that the Underwriting and Investment Exhibit - Part 2B constitutes a reasonably meaningful test of the adequacy of prior-year health reserves and liabilities, net of the corresponding healthcare receivables and reinsurance receivables. We have noted, though, that in light of changes made to ASOP 5 (*Incurred Health and Disability Claims*) over the years, the intent of this paragraph is no longer as clearly stated as it was originally.

We also note that, in recent years, the use of the Health Blank has been extended to some companies that hold reserves subject to discounting at interest, and Part 2B is not designed to properly reflect the “unwinding” of the interest discount. Although this discrepancy will rarely, if ever, be material, the actuary may feel uncomfortable certifying to the validity of Part 2B as a follow-up study when there is a fundamental technical flaw in the presentation.

Considering all this, we offer the following suggestions.

To start, the NAIC should consider whether this certification still provides value to regulators. If not, the entire paragraph should be deleted. It is important to note that this would not affect the reconciliation of data to Part 2B, as discussed in Sections 7 and 11. There are two considerations that should be kept in mind. First, to our knowledge, a property/casualty insurer’s appointed actuary is not asked to provide a similar certification of Schedule P – Part 1 within the actuarial opinion, nor is a Life/A&H insurer’s appointed actuary asked to provide a similar certification of Schedule H – Part 3 within the actuarial opinion. Second, the certification requirement is the successor to a requirement that existed in the old HMO Annual Statement, at a point in the evolution of the health insurance industry where the level of regulatory concern over potential inadequacies in a health insurer’s actuarial liabilities was much higher than it is in the current environment.

If this certification is to be retained, we think the intent could be clarified by rewording the paragraph as follows.

“It is also my opinion that, with respect to health reserves and liabilities net of the applicable healthcare receivables, the Underwriting and Investment Exhibit - Part 2B represents a valid follow-up study as described by ~~was prepared consistent with Section 3.6, ‘Follow-Up Studies,’ of contained in~~ Actuarial Standard of Practice No. 5, ‘Incurred Health and Disability Claims,’ as adopted by the Actuarial Standards Board of the American Academy of Actuaries in December 2000.”

It should be noted that the Actuarial Standards Board is an independent entity as implied by the current wording.

It would also be prudent to develop an additional section of instructions, a new Section 9, which would read as follows:

“9. Section 7 of these instructions requires the appointed actuary to make a certification regarding the Underwriting and Investment Exhibit - Part 2B. If the actuary believes that the follow-up study is technically incorrect (e.g., because of the presence of reserves that have been discounted for interest), but that the degree of adequacy as presented in the exhibit is not materially distorted by those technical flaws, the actuary should use certification wording such as the following in lieu of the wording shown in Section 7:

‘Other than as noted below, it is also my opinion that, with respect to health reserves and liabilities net of the applicable healthcare receivables, the Underwriting and Investment Exhibit - Part 2B represents a valid follow-up study as described by Section 3.6, ‘Follow-Up Studies,’ of Actuarial Standard of Practice No. 5, ‘Incurred Health and Disability Claims,’ as adopted by the Actuarial Standards Board in December 2000. In my opinion, the exceptions noted below do not materially impact the overall adequacy or inadequacy as portrayed in that exhibit.’

The exceptional items should then be explained in a RELEVANT COMMENT section as described in Section 11 of these instructions.

If the actuary believes that the follow-up study is not valid because of material errors in the data or the presentation, or if the actuary is unable to reach a conclusion regarding validity, the actuary should use certification wording such as the following in lieu of the wording shown in Section 7:

‘I am unable to certify that, with respect to health reserves and liabilities net of the applicable healthcare receivables, the Underwriting and Investment Exhibit - Part 2B represents a valid follow-up study as described by Section 3.6, ‘Follow-Up Studies,’ of Actuarial Standard of Practice No. 5, ‘Incurred Health and Disability Claims,’ as adopted by the Actuarial Standards Board in December 2000.’

The reasons for the actuary’s inability to certify should be stated in a RELEVANT COMMENT section as described in Section 11 of these instructions.”

Note that the references to “Section 11” above are actually to the current Section 10, which would need to be renumbered upon the addition of the new Section 9.

Finally, should the certification requirement be retained, the NAIC should consider whether the failure to certify Part 2B is sufficient to make the actuarial opinion an adverse, qualified, or inconclusive opinion within the meaning of the current Section 9.

## Section 9

We seek clarification as to the circumstances in which the NAIC anticipates an actuary would refuse to issue a statement of actuarial opinion, as opposed to issuing an inconclusive opinion. The inconclusive opinion is ordinarily issued when “the appointed actuary cannot reach a conclusion.” However, line 235 states that “if the appointed actuary is unable to form an opinion, he or she should refuse to issue a statement of opinion.”

In the definition of “adverse opinion,” the reference in lines 240-241 to “one or more of the points in Section 6” seemingly should refer to the six opinion section items in Section 7.

## Section 10

The reference to a “no opinion” in line 252 should be to an “inconclusive opinion,” as defined in Section 9. Otherwise, the inconclusive opinion would not be addressed within Section 10. Also, the reference cannot be to the actual non-issuance of an opinion, because the topic of this section is additional material to be included within the opinion.

## Section 11

We wish to make a cautionary observation regarding the practical implications of the new requirement in lines 267-268 that “the technical component [of the Actuarial Memorandum] must show the analysis from the basic data, e.g., claim lags, to the conclusions.” For many health insurers, the recorded claim liability is a sum of dozens of separate lag-based liability calculations, where the lag triangles are month-by-month, rather than year-by-year, as they might be for property/casualty insurers. The act of pulling together all of these lag-based calculations into a formal document may be unnecessarily duplicative of the insurer’s current financial reporting records, and it may lead to a large and unwieldy Actuarial Memorandum. An alternative approach would be to specify that the lag data itself does not need to be included within the technical component of the Actuarial Memorandum, but that it does need to be included as part of the “underlying actuarial work papers supporting the actuarial opinion [that] will be maintained at the company and available for regulatory examination for seven years.”

We are concerned about the references to “explicit margins” in the definition of the materials that are required to be included in the Actuarial Memorandum. There is currently no requirement that explicit margins be included in health claim liabilities. While many health actuaries might use explicit margins in order to arrive at liability balances that satisfy the “moderately adverse conditions” standard of ASOP 28, others may arrive at sufficiently prudent liability balances via implicit margins embedded within the assumptions used in the liability estimation process. Under the current proposal, as drafted, particularly the bullet point on line 283, an insurer that used explicit margins would need to make disclosures within the Actuarial Memorandum that would not need to be made by an insurer that used implicit margins. Such a state of affairs would likely discourage the use of explicit margins and encourage the use of implicit margins.

It would be unfortunate if disclosure requirements were to create an incentive favoring one form of actuarial practice over another. Therefore, we propose the following changes to the Actuarial Memorandum requirements in Section 11:

- Change the bullet point on line 283 to: “Support for the appropriateness, in light of Actuarial Standards of Practice, of the reserves inclusive adequacy of any explicit or implicit reserve margins included therein.”
- Delete the bullet point on lines 274-276, as it appears to be duplicative of the proposed modifications to the bullet point on line 283.

Lines 255-257 state that “the Actuarial Opinion must include assurance that an Actuarial Memorandum and underlying actuarial work papers supporting the actuarial opinion will be maintained at the company and available for regulatory examination for seven years.” The appointed actuary cannot legitimately give such assurance, because the company’s future

actions are not within his or her control. This is especially true if the appointed actuary is a consultant, but is equally true of an employee whose employment terminates before the end of the seven-year period. This “assurance” could cause the appointed actuary to be held liable if the company does not comply. If, however, it is clear that the actuary would not be held liable, then the “assurance” seems of no value.

As an alternative, we propose the following changes to the language: “The Actuarial Opinion must include an assurance that an Actuarial Memorandum and underlying actuarial work papers supporting the ~~a~~Actuarial ~~o~~Opinion will be provided to ~~maintained at~~ the company with instructions that they be maintained and available for regulatory examination for seven years.” That language properly describes the extent of the appointed actuary’s ability to influence the company’s behavior.

In addition to the comments made regarding the phrase “explicit margins,” we have questions regarding two additional aspects of the Actuarial Memorandum requirements articulated in lines 270-283.

First, the bullet point in lines 271-272 contemplates an exhibit that “compares the appointed actuary’s conclusions to the carried amounts.” Further clarification of what this is intended to mean would be helpful. For example, it might refer to an exhibit reconciling the line item totals in the financial statement back to specific reserve items, together with the appointed actuary’s assessment of each such component going into the line item.

Second, we are uncertain as to why the bullet point on line 281 has been included, concerning “follow-up studies documenting the prior year’s reserve run-off,” where that is the underlying function served by the Underwriting & Investment Exhibit – Part 2B.

Again, we appreciate your efforts to bring consistency to the Actuarial Opinions and stand ready to assist you as this project progresses. If you have any questions, I invite you to contact Geralyn Trujillo, the Academy’s staff liaison to the Health Practice Financial Reporting Committee, at (202) 785-6924 or [trujillo@actuary.org](mailto:trujillo@actuary.org). Thank you for your time and consideration.

Sincerely Yours,

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Chair, Health Practice Financial Reporting Committee  
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cc: Shari Westerfield, Chair, Committee on State Health Issues  
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