Valuation Update – Life & Health

- *Regulatory Health Reform*
- ~~*Actuarial Opinion changes for Health*~~
- *LHATF and A&HWG Updates*

Steven L Ostlund, FSA, MAAA, Actuary
Alabama Department of Insurance

Regulatory Health Reform

PPACA, (ACA) Actuarial Sections

1. 2718 Medical Loss Ratio
2. 2794 Rate Review
3. 1341 Transitional Reinsurance
4. 1342 Risk Corridors
5. 1343 Risk Adjustment

SEC. 2718
BRINGING DOWN THE COST OF HEALTH CARE COVERAGE

(a) CLEAR ACCOUNTING FOR COSTS.—
A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—
(1) on reimbursement for clinical services provided to enrollees under such coverage;
(2) for activities that improve health care quality; and
(3) on all other non-claims costs, including an explanation of the nature of such costs, and excludingFederal and State taxes and licensing or regulatory fees.
The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.
(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—
(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—
(A) REQUIREMENT.—
Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—
(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or
(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.
(B) REBATE AMOUNT.—
(i) CALCULATION OF AMOUNT.—
The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—
(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and
(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.
(ii) CALCULATION BASED ON AVERAGE RATIO.—
Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.
(2) CONSIDERATION IN SETTING PERCENTAGES.—
In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.
(3) ENFORCEMENT.—
The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.
(c) DEFINITIONS.—
Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.
(d) ADJUSTMENTS.—
The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

SEC. 2794
ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS

(a) INITIAL PREMIUM REVIEW PROCESS.—
(1) IN GENERAL.—
The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.
(2) JUSTIFICATION AND DISCLOSURE.—
The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.
(b) CONTINUING PREMIUM REVIEW PROCESS.—
1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—
As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—
(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and (B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.
(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—
(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

PART V--REINSURANCE AND RISK ADJUSTMENT

SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL MARKET IN EACH STATE.

SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

SEC. 1343. RISK ADJUSTMENT.

PART V--REINSURANCE AND RISK ADJUSTMENT

SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL ~~AND SMALL GROUP~~ MARKET IN EACH STATE.

(a) In General- Each State shall, not later than January 1, 2014--

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subsection (b); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

PART V--REINSURANCE AND RISK ADJUSTMENT

SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

(b) Payment Methodology-

(1) PAYMENTS OUT- The Secretary shall provide under the program established under subsection (a) that if--

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN- The Secretary shall provide under the program established under subsection (a) that if--

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

PART V--REINSURANCE AND RISK ADJUSTMENT

SEC. 1343. RISK ADJUSTMENT.

(a) In General-

(1) LOW ACTUARIAL RISK PLANS- Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(2) HIGH ACTUARIAL RISK PLANS- Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

LIFE AND HEALTH ACTUARIAL TASK FORCE

ACCIDENT AND HEALTH WORKING GROUP

Charges for 2011

1. Work with the Society of Actuaries to develop a replacement for the 1985 NAIC Cancer Claim Cost Tables as the basis for the valuation of individual cancer policies. Provide periodic status reports on this project.
2. Revise model rules for appropriate long-term care rates, rating practices, and rate changes.
3. Study the minimum standards applicable to statutory reserves for long-term care insurance. Begin developing a principles-based framework for a set of minimum standards.
4. Review the Medicare supplement refund formula.
5. Provide support in developing provisions that enable States to establish and maintain a transitional reinsurance program, and to assist in developing the permissible age bands for rating purposes, as legislated in the Affordable Care Act
6. Review and update the Guidelines for Filing of Rates for Individual Health Insurance Forms (#134).
7. Work with the Society of Actuaries and the American Academy of Actuaries to develop a replacement for the 1987 Commissioners Group Disability Income Table.

LIFE AND HEALTH ACTUARIAL TASK FORCE

Charges for 2011

1. Study the feasibility of a new non-forfeiture law for life insurance and annuities to replace the existing non-forfeiture standards. Provide periodic status reports on this project.
2. Work with the American Academy of Actuaries and the Society of Actuaries to develop new mortality tables for the valuation of pay out annuities, for preneed, simplified issue and guaranteed issue forms of life insurance and minimum non-forfeiture requirements for life insurance. Provide periodic status reports on this project.
3. Work with the Society of Actuaries to develop the reporting of channels of distribution information needed to better establish GRET factors.
4. Review Actuarial Guideline XLIII, CARVM for Variable Annuities, and recommend changes to the requirements.

New Objectives and Goals

1. Develop and submit proposals to facilitate the implementation of a principles-based approach to valuation. Monitor international developments regarding life and health insurance reserving. Provide periodic reports on this Project.

Future Regulatory Environment for Insurers and Reinsurers

- PBA
- Valuation Manual
- NAIC SMI Initiative
- Reinsurance Task Force

Leslie M. Jones, ASA, MAAA
South Carolina Department of Insurance

PBA/Valuation Manual Update

- The “Good”
- The “Bad”
- The “Ugly”
- The “Details”

The "Good"

- Standard Valuation Law (SVL) - Revisions
  - Adopted by NAIC in 2009
  - Establish the statutory framework for a principles based reserve valuation
- The Valuation Manual
  - Sets forth detailed valuation requirements
  - VM 20 – Life Insurance
    - "final" version exposed in August 2010 at the Summer National Meeting
    - two amendments adopted since then
      - » Reinsurance - Needs to include the Net Premium calculation - Technical
      - » Equity return assumption for Deterministic Scenario - Test

The "Bad"

- PBR adoption may still take some time
  - PBR Testing Project (VM-20 Impact Study)
    - Towers Watson has been selected as consulting actuary
    - Strategy on confidentiality is being developed
    - 60 life insurers have been asked to participate
    - Training session for participants & web address for questions from participating companies under development
  - Effective Date of VM
    - 1/1 following the 7/1 that at least 42 states/jurisdictions representing more than 75% of premium volume have adopted the amended SVL

The "Ugly"

Exposed Version of VM-20 is 72 pages long

Visit:

http://www.naic.org/committees_lhatf.htm

And has many complexities…..

d. For a policy issued at age *x,* on any valuation date *t*, the net premium reserve shall equal (m_{x+t}) multiplied by (r_{x+t}) where:

i. m_{x+t} = the actuarial present value of future benefits less the actuarial present value of future valuation net premiums and less the unamortized expense allowance for the policy,

E_{x+t}, determined as:

$E_{x+t} = (a_{x+t:s-t})\ [(x_1+z)/\ a_{x:s} + y_{2\text{-}5} \cdot C_{x+t}]$ for $t < s$

$= 0$ $t \geq s$

Where:

$C_{x+t} = 0$ when $t = 1$

$= \sum (1/\ \ddot{a}_{x+w:s-w})$ when $2 \leq t \leq 5$, w varying from 1…(t-1)

$= \sum (1/\ \ddot{a}_{x+w:s-w})$ when $t > 5$, w varying from 1…4

ii. r_{x+t} = equals the ratio $(e_{x+t})/(f_{x+t})$, but not greater than 1, with (e_{x+t}) and (f_{x+t}) defined as below:

e_{x+t} = the actual policy fund value on the valuation date *t*

f_{x+t} = The policy fund value on the valuation date *t* is that amount which, together with the payment of the future level gross premiums determined in subsection 9.a above, keeps the policy in force for the entire period coverage is to be provided, based on the policy guarantees of mortality, interest and expenses.

The "Details"

- Modifications to the SVL Add the Following Sections to Enable a Principle-Based Reserving System
  - Section 1: Definitions
  - Section 11: Valuation Manual for Policies Issued on or After the Operative Date
  - Section 12: Requirements of a Principle-Based Valuation
  - Section 13: Experience Reporting Requirements for Policies In Force On or After the Operative Date of the Valuation Manual
  - Section 14: Confidentiality
  - Section 15: Single State Exemption
- The Valuation Manual sets for the Detailed Valuation Requirements

The "Details"

- The Valuation Manual
  - Process and Coordination (VM 00, VM-01)
    - Scope
    - Consistency of Definitions & Principles
    - Annual and Quarterly Statement Reporting Issues
  - PBR Life (VM-20)
    - Reserving Standards for Individual Life Insurance
    - Net Premium Reserve
  - PBR VACARVM (VM-21)

The "Details"

- The Valuation Manual
  - PBR for Health Products (VM – 25 & 26)
    - Health Insurance Reserves
    - Credit Life & Disability Reserve Requirements
  - PBR Reporting & Review (VM-30 & VM-31)
    - Actuarial Opinion and Memorandum
    - Principle-Based Valuation Report Requirements
  - PBR Experience Reporting (VM-50 & VM 51)
    - Experience Reporting Format
    - Process for Selecting a Statistical Agent
    - Treatment of Small Companies
  - Amendments to the VM
- Most recent exposure draft: www.**naic**.org/documents/committees_lhatf_VM-00.doc

Solvency Modernization Initiative (SMI)

- Mission - to coordinate all NAIC efforts to successfully monitor/make recommendations with respect to implementing solvency-related work products of the International Association of Insurance Supervisors (IAIS).
- The Task Force will utilize the technical expertise of other NAIC groups, particularly for the five focus areas of the Solvency Modernization Initiative:
  - Capital Requirements, which will be coordinated with the Capital Adequacy (E) Task Force;
  - International Accounting, which will be coordinated with the Statutory Accounting Principles (E) Working Group as well as the International Accounting Standards (EX) Working Group;
  - Group Supervision, which will be addressed by the Group Solvency Issues (EX) Working Group;
  - Valuation Issues in Insurance, which will be coordinated with the Principles-Based Reserving (EX) Working Group; and
  - Reinsurance, which will be coordinated with the Reinsurance (E) Task Force.

SMI – 2010 Charges

- Monitor solvency-related work products of the International Association of Insurance Supervisors (IAIS). Assign papers to working groups to submit comments to the IAIS. Additionally, the Working Groups should review the papers and recommend whether and/or how the ideas in those papers should be implemented in the U.S. regulatory solvency system.
- Communicate and coordinate with the International Insurance Relations (G) Committee and provide technical support to the Committee as needed.
- Report the status of its work to the Executive Committee no less frequently than on a quarterly basis.

NAIC Reinsurance Task Force

- Wall Street Reform
  - Signed into law on July 21st
  - Nonadmitted and Reinsurance Reform Act (NRRA)
    - effective 1-year after enactment
    - prohibits a state from denying credit for reinsurance if the domiciliary state of the ceding insurer recognizes such credit and is either (1) an NAIC-accredited state; or (2) has financial solvency requirements substantially similar to NAIC accreditation requirements.
- NAIC Reinsurance Task Force Response

The End

Questions?