It’s the End of the Year as We Know It; Do You Feel Fine?

Southeastern Actuaries Conference, Fall 2019

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Caveats and Limitations

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The attesting health actuaries have a duty to:

- the company or client
- the regulator (public)
- themselves
- their profession

There WILL be a time when…

- The “correct” decision isn’t obvious

- Your company or a client will prefer that you don’t rigorously fulfill your responsibilities

There WILL be a time when…

- All of the information that you need to express an informed opinion isn't readily provided to you

- You are afraid that your pushing or pushing back will jeopardize your job or needlessly drive away a good client

There WILL be a time when…

- Red flags emerge and you need to determine what they mean in the context of the situation and what you should do about it

- You are at least partly blinded by your trust in your company/client and your desire to serve them

There WILL be a time when…

- You will be too close to your company's/client's operations to see how outsiders will view the situation

- Your work will be scrutinized by regulators that have the luxury of information or later developments that you did not have or did not use when you issued your opinion

There WILL be a time when…

- Your work will be subpoenaed
- You will be deposed regarding your work

There WILL be a time when…

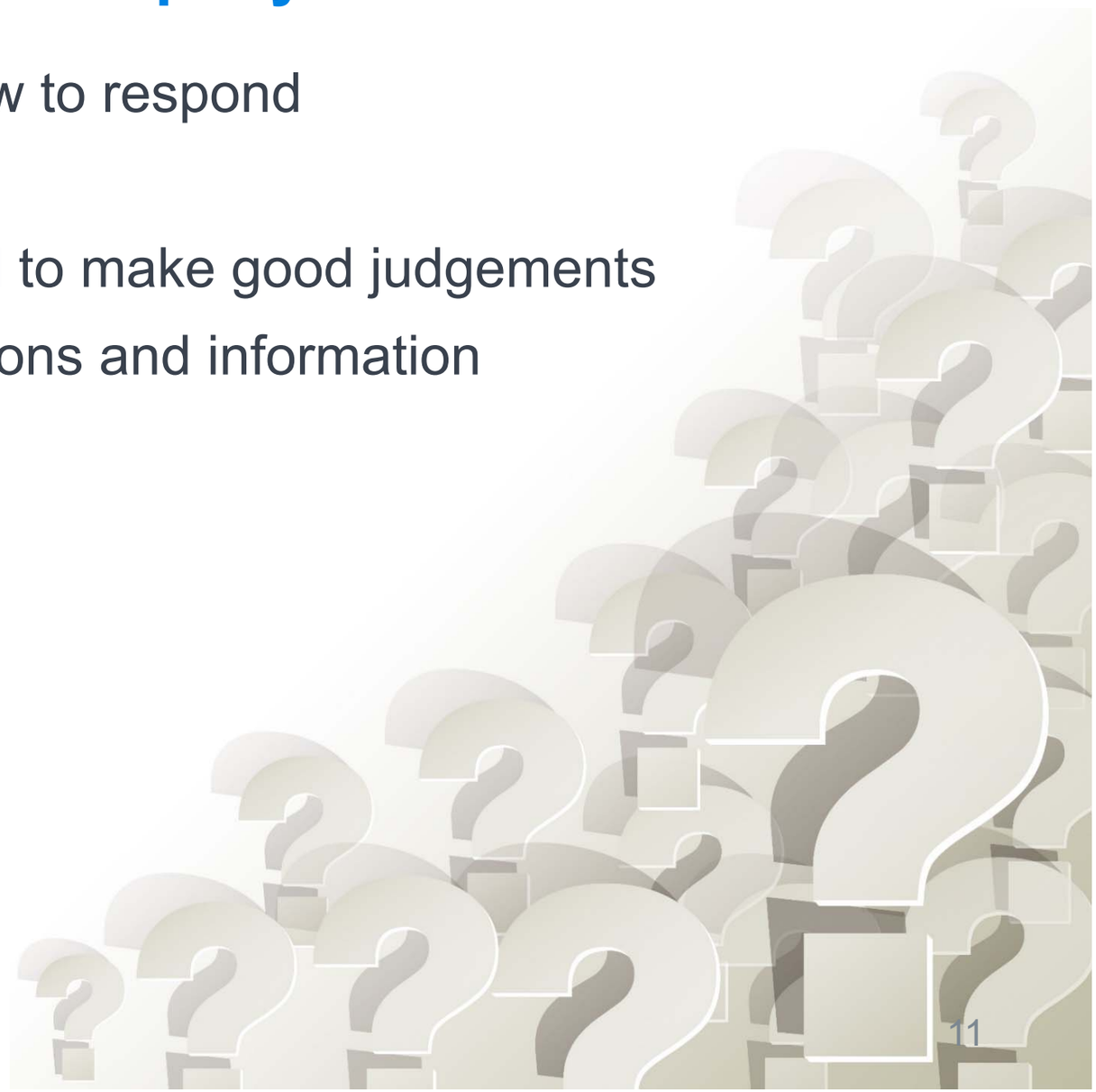
- A regulator will try to use you as a CYA (perhaps without you knowing)

Why in Summary

- Numerous ways that SAOs can be risky to you and to your company
- Even “good” companies/clients can become risky
- Risks that are spotted early facilitate avoidance or management

How to protect yourself and your company

- Looking for risk factors and knowing how to respond
- Robust understanding of responsibility
- Consistent interpretations that you need to make good judgements
- Rigorous documentation of representations and information
- Clear scope and disclosures



WHAT TO EXPECT TODAY

I. Are you Qualified?
II. The Appointed Actuary
III. The Scope of the Opinion
    a. Medicare Assets/Liabilities
IV. The Statement of Opinion
V. Other Considerations

Open discussions

Guidance you can use

Are you qualified?

Have you got what it takes?

- Professional Code of Conduct
- AAA Qualification Standards
- Actuarial Standards of Practice
- Company specific qualifications

Professional Code of Conduct

- Precept 2:
- *An Actuary shall perform Actuarial Services only when the Actuary is qualified to do so on the basis of basic and continuing education and experience, and only when the Actuary satisfies applicable qualification standards.*

- Annotation 2.1:
- *It is the professional responsibility of an Actuary to observe applicable qualification standards that have been promulgated by a Recognized Actuarial Organization for the jurisdictions in which the Actuary renders Actuarial Services and to keep current regarding changes in these standards.*

- Annotation 2.2:
- *The absence of applicable qualification standards for a particular type of assignment or for the jurisdictions in which an Actuary renders Actuarial Services does not relieve the Actuary of the responsibility to perform such Actuarial Services only when qualified to do so in accordance with this Precept.*

Mirror Test

- Letter of the law vs spirit of the law
- Can you look yourself in the mirror and honestly say “Yes, I am qualified”?

Qualification Standards for Actuaries Issuing Statements of Actuarial Opinions in the United States

- 42 page document promulgated by the American Academy of Actuaries
- Outlines in considerable detail what it means to be ‘qualified’
- **You should read it**
- General Qualification Standard
  - Basic Education and Experience Requirement
    - MAAA, FSA, FCAS, etc
    - Three years **responsible** actuarial experience
    - Be knowledgeable of relevant law
    - “Specialty track” requirement (applies to Health)
  - Continuing Education
    - 30 hours a year, 3 hours on professionalism, 6 hours “organized”

Qualification Standards for Actuaries Issuing Statements of Actuarial Opinions in the United States

- Specific Qualification Standards
  - Basic Education Requirement
    - Exams (different for blue blank vs. orange blank!)
    - Or, self-study, with attestation from qualified actuary
  - Experience requirement
    - 3 years of responsible experience **relevant to the subject** of the SAO
    - Under the review of a qualified actuary
  - Continuing education
    - 15 hours that is “directly relevant”
    - At least 6 of which needs to involve outside experts
- Other stuff (changes in actuarial practice, etc.)

ASOPs

- It is the actuary's responsibility to know which ASOPs apply
- Applicability Guidelines for Actuarial Standards of Practice – published by AAA (excel workbook) – very useful
- ASOPs 1, 23, 41 apply to everything
- ASOP 28: Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets
- Also consider, for example:
  - ASOP 5: Incurred Health and Disability Claims
  - ASOP 22: Statements of Opinion Based on Asset Adequacy Analysis for Actuaries for Life and Health Insurers
  - ASOP 42: Determining Health and Disability Liabilities other than Liabilities for Incurred Claims

The Appointed Actuary

What does it mean to be an Appointed Actuary?

- NAIC definition (orange blank)—Appointed Actuary

  "The appointed actuary must be a qualified health actuary appointed by the board of directors, or its equivalent, or by a committee of the board, by December 31 of the calendar year for which the opinion is rendered. Within five business days of the appointment, the company shall notify the domiciliary commissioner of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements of a qualified health actuary."

What does it mean to be an Appointed Actuary?

- NAIC definition (blue blank)—Appointed Actuary

  "An appointed actuary is a qualified actuary who is appointed by the board of directors, or its equivalent, or by a committee of the board, by Dec. 31 of the calendar year for which the opinion is rendered."

  - "Familiar with the valuation requirement applicable to life and health insurance"
  - Not in trouble, no track record of screwing up

What does it mean to be Qualified Health Actuary?

- Orange Blank: "'Qualified health actuary', as used herein means a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation."
- Blue Blank: "The term 'qualified actuary' means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the Academy qualification standards for actuaries signing such statement and who meets the requirements specified in the *Valuation Manual*"
  - Must also comply with Standard Valuation Law requirements (Model #820):
    - Be qualified to sign by meeting the AAA Specific Qualification Standards applicable to statutory requirements
    - Be familiar with life and health valuation requirements, and
    - Not have been found guilty of fraud

What does this mean?

- Be qualified— discussed this (Code of Conduct, Precept #2)
  - Basic education
  - Continuing education
  - Experience
- Be appointed—REMIND your company/client that this needs to happen
  - Needs to be done only once, when first appointed
  - Best practice—Board or Senior Officer re-affirms the appointment annually
    - Remind your company/client to make that happen—before December Board meeting
- Report to the Commissioner of appointment—REMIND your company/client about that as well
  - For Blue Blank, need to notify commissioner in ALL states, not just state of domicile

What does this mean?

- Report to the Board or Audit Committee
  - “The Appointed Actuary must report to the Board of Directors or the Audit Committee each year on the items within the scope of the Actuarial Opinion” (NAIC instructions to orange blank)
    - Covers both the opinion and actuarial memorandum
    - Similar requirement exists for blue blank
  - Could be in person or by report
    - If by report, have documentation that the Board discussed it and they had a chance to pose questions
    - DOCUMENT that it happened

Replacing another Appointed Actuary

- NAIC Requirements (Orange and Blue Blank)
  - Insurer must notify insurance department of state of domicile within 5 business days of the appointment
  - Insurer must also notify department within 10 business days stating whether there were disagreements with the former actuary in the last 24 months related to the contents of the opinion, whether resolved or not
  - Insurer should request, in writing, that the former actuary respond to the comments in the insurer's letter, stating whether the actuary agrees or not. If not, why not.
    - Insurer shall furnish that letter to the commissioner
- State Requirements: some states have additional requirements; learn them
- Other Potential Issues (prior to accepting assignment)
  - Discuss with company/client whether there were any disagreements with former actuary
  - Request copy of letter sent to DOI
  - Follow up with former actuary
    - If were disagreements, follow up prior to accepting appointment
    - If no disagreements, follow up at any time

Replacing another Appointed Actuary

- Actuarial Code of Conduct, Precept 10 and annotations
  - ANNOTATION 10–2.
  - A Principal has an indisputable right to choose a professional advisor.

  - ANNOTATION 10–5.
  - When a Principal has given consent for a new or additional actuary to consult with an Actuary with respect to a matter for which the Actuary is providing or has provided Actuarial Services, the Actuary shall cooperate in furnishing relevant information, subject to receiving reasonable compensation for the work required to assemble and transmit pertinent data and documents. The Actuary shall not refuse to consult or cooperate with the prospective new or additional actuary based upon unresolved compensation issues with the Principal unless such refusal is in accordance with a pre–existing agreement with the Principal. The Actuary need not provide any items of a proprietary nature, such as internal communications or computer programs.

Replacing another Appointed Actuary

- Review Insurer's letter to Insurance Department about replacement and disagreements
- Review former actuary's response to the insurer's letter
- Obtain permission to talk with prior actuary
  - Not getting permission—RED FLAG
  - Contact prior actuary after reviewing prior opinion, memorandum, and any available work products
    - Request copies of pertinent work products and analyses if needed
  - DOCUMENT that you had the conversations, including topics covered and any noteworthy elements of the conversation

References

- Instructions to NAIC Annual Statements
- Valuation Manual, January 1, 2019 Edition
- AAA Practice Note on Revised Actuarial Statement of Opinion (January 2011)
- AAA Financial Reporting Implications under the Affordable Care Act
- Relevant ASOPs
- Code of Professional Conduct
- State laws and regulations
- Statements of Statutory Accounting Principals (SSAPs), especially 54, 55, and 84

Scope of the Opinion

The Opinion – It's Not Just the Obvious Items

- Liabilities
  - Specified Line Items - Incentives/Bonus/Withholds, CAE, Aggregate Reserves
  - Blue Blanks – IBNR may be less important than pre-funded active life reserves
  - Unspecified – Review for items "actuarial in nature"
    - e.g., Liability for amounts held under uninsured plans (Line 22)

- Assets
  - Blue Blanks – Assets a critical component of scope
  - Orange Blank – Unspecified, review for items "actuarial in nature"
    - E.g. Accrued retrospective premiums (Line 15.3), Health care and other amounts receivable (Line 24)

- ASOP 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims

- Understanding the company/client's operations

Big Picture View

- Read the annual statement instructions
- Rules vary somewhat between orange blanks and blue blanks
- Not directly included in the Opinion – Does not mean it should be ignored
- Item on the balance sheet - Does not mean it should be included in the Opinion
- When is an item “Actuarial in Nature”?
  - Some matter of uncertainty
  - New guidance from ASOP 42 that specifies certain items

Rationale for Defining the Scope
Orange Blank Example

- NAIC requires specific line items within the scope of the opinion (e.g., Page 3 Line 1-7)
- These lines include non-actuarial items (e.g., invoice accrual recorded on Page 3 Line 1)
- Actuarial items may exist outside the prescribed line items. Examples:
  - Page 2, Line 23 (receivable from parent, subsidiary and affiliates) – risk sharing accruals
  - Page 2, Line 24 (health care and other amounts receivable) – includes pharmacy rebates
  - Page 2, Line 15.3 (accrued retrospective premiums) – includes Part D risk corridors, when receivables
  - Page 3, Line 22 & Page 2, Line 17 (liability for amounts held under /receivable relating to uninsured plans) - LICS
  - Page 3 Line 23 (aggregate write-ins for other liabilities) – may include risk adjustment, mixed in with taxes, etc.
- Mixed practice. One is to include just the actuarial amount in the Scope section and then explain in Relevant Comments section
- Some items are only actuarial because their key inputs are actuarial (e.g., MLR rebates, % revenue capitation)
- Can and should still review items that are not included in Scope (e.g., RBC levels, assignment of surplus for ACA tax). Use judgement.

Interview or Discuss Company Staff

- CFO or Designated Finance Department Contact
- Actuary
- Claim Department Manager
- Underwriters (particularly in relation to premium deficiency reserve)
- Auditor
- Controller

Minimum Data to Review

- Policy Contracts
- Provider Contracts (representative sample)
- Reinsurance Contracts and Transactions
- Definition of Data Provided (e.g. GAAP vs Stat, Incurral Date)
- Large Claim Reports
- Reconciliation of Lag Triangle Data to Company Financials
- Reconciliation of Policy Records for Pre-Funded Reserves
- Work Papers for Provided Values – Understand what was done
- Audit Reports
- Consistency of Statement Page Entries (e.g., page 3 liabilities with detailed schedules)
- Management Notes

Provider Liabilities and Receivables

- Growing in importance
- Continued evolution and complexity of arrangements
- With greater risk sharing, provider liabilities/receivables become more intertwined with “regular” health plan actuarial liabilities and assets
- Limited expertise by providers and insurers in many instances, so variance could be large
- Potential litigation between providers and insurers if things do not work well
- Providers that bear substantial portion of risk – can they meet obligations to company?
- See ASOP 42 Section 3.7 Considerations When Estimating Provider-Related Assets and Liabilities

Premium Deficiency Reserves

- Requires an understanding of future revenues and expenses
  - Administrative expenses are just as important (historical vs projected)
- What should be included or not included – guidance available, but not always clear
- Estimates should be realistic and achievable, typically booked without margin
- Provider risk sharing arrangements – do have any impact and collectability
- Particular challenges for startups and newer companies
- ASOP 42 Section 3.5 provides list of considerations for PDRs

ACA Risk Adjustment

- Multiple components
  - Baseline risk adjustment calculation
  - Risk adjustment data validation (RADV) adjustments
  - High-cost risk pool (HCRP) assessment, less receivables
- Complex considerations
  - Multiple parameters, including company-specific and state-specific
  - Varying approaches to estimating parameters at year-end, with varying degrees of uncertainty
  - Interaction with MLR, PDR, and other actuarial items
  - Key parameters heavily influenced by external unknown factors – competitors' coding, market morbidity
  - Different treatment of exiting vs. continuing health plans
  - Collectability
- Complex timing
  - Results not fully known until following August
  - RADV has a long settlement lag

ACA Risk Adjustment – thinking through scope

- RADV will begin to stack up on the year-end financial statements

2020 Year-End ACA Risk Adjustment Items	Settlement
2020 benefit year high-cost risk pool (HCRP)	late 2021 (8 mo)
2020 benefit year RA w/o RADV	late 2021 (8 mo)
2019 RADV impact on 2020 RA	mid 2023 (2.5 yrs)
2018 RADV impact on 2019 RA	mid 2022 (1.5 yrs)
2017 RADV impact on 2018 RA	mid 2021 (0.5 yrs)
2020 RADV adjustment to 2020 RA	mid 2023 (2.5 yrs)
If leaving market in 2021 and over-coding outlier	

- 2018 RADV will impact 2019 RA Accrual, 2019 YE PDR (via 2019 RA), 2022 MLR, and 2021 YE PDR (via 2022 MLR and potential rating treatment)

MLR and Risk Corridors

- Various programs applicable to ACA, Medicare and Medicaid
- If company wants to book it, be sure the opinion is on the amount, not the admissibility of the item.
- Opining on the MLR / risk corridor value requires your review of each contributing component. Understand how the inputs compare to your best estimates and whether they include margin.
- Interact with other key actuarial items, such as risk adjustment and IBNP. Should be considered and discussed when evaluating margin levels.

Medicare Part D Settlement Items

- Risk sharing with CMS
- Federal reinsurance
- Low income cost sharing subsidies (LICS)
- Coverage gap discount program (CGDP)

Medicare Risk Adjustment

- Typically a revenue settlement for the current benefit year, settled the upcoming October
- Can be either a receivable or liability, usually a receivable
- Long tail, since Medicare has risk adjustment data validation (RADV) audits of prior years
- Company calculations are often opaque, developed by a risk adjustment vendor, with exhibits and documentation not tailor made for actuaries
- Companies are often very conservative
- Retrospective reviews are an important way to establish the credibility of the methods
- Some companies hold RADV reserves even if an audit has not been announced

Capital and Surplus Levels

- Risk Based Capital Ratios
  - Review historical, current, and projected
  - Consider regulatory actions as well as corporate requirements (e.g. Blues plans)
  - Consider state specific surplus requirements, if any
  - Consider impact of ACA Fee

- Is company close to any of the regulator trigger points, either current or projected?
  - Company Action Level (< 200% or 200%-300% with >105% loss ratio) – Triggers High Risk and External Peer Review. Requires health plan to prepare and submit a Company Action Plan

- Review company Enterprise Risk Management (ERM) documents (e.g., ORSA) – Philosophy on RBC levels

- RBC is not necessarily in Scope of Opinion, but good practice to separately communicate concerns to the health plan and discuss in the Actuarial Memorandum. Courtesy email on Company Action Level and offer to help with Plan.

- Not opining on RBC - should something be noted in the opinion?

Consideration of Assets

- Even if opinion is not based on asset adequacy (e.g. most Orange Blanks)

- Review mix and duration of assets
  - Be wary if heavy in asset types other than bonds and short-term investments
  - Particularly if commodity and ownership of non-regulated types of assets
  - Do the assets have embedded options

- Review short term assets (e.g. cash and admitted assets) relative to liabilities. Do they cover IBNP?

- Collectability of assets that are in scope per ASOP 42.

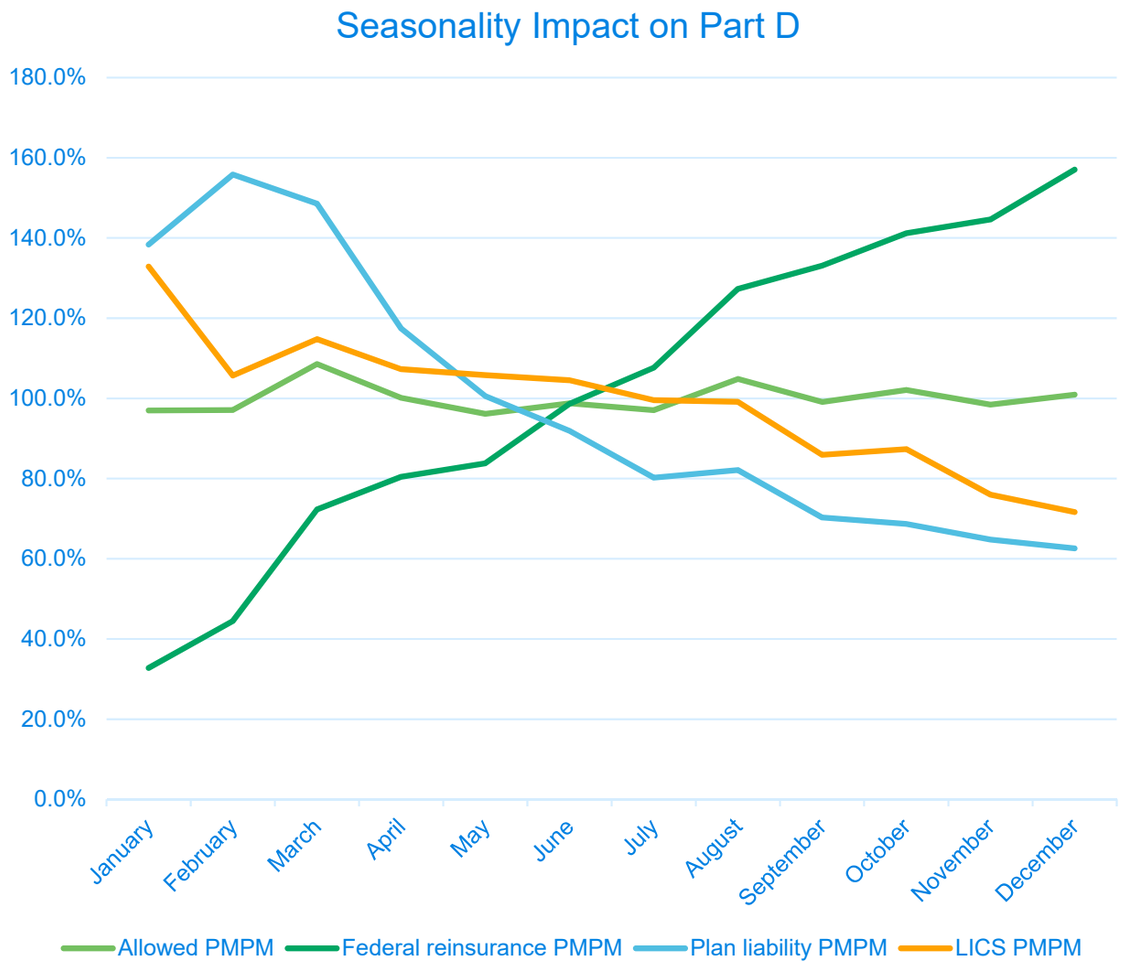
Break (10 min)

Medicare Part D vs Commercial Rx

- Standard Part D has a unique benefit design
  - Deductible
  - Coinsurance up to an Initial Coverage Limit
  - Coverage Gap (with coverage for non-low income members which reduces gap over time)
  - Federal reinsurance after member reaches an out-of-pocket limit
- Commercial plans
  - May have deductibles (either standalone for Rx or integrated with medical)
  - Typically don’t have a coverage gap
  - May have out-of-pocket limit with cost shifting to plan

Impact of Part D benefit design on monthly results

- Example is for a basic alternative plan with a deductible that applies only to brand and specialty drugs for a dual population
- Plan liability (orange) peaks in February at 156% of the annual amount, then drops to 63% in December
- Allowed (black) is relatively flat, with some seasonality for months with more working days
- Low income cost sharing (green) declines over time, similar to plan liability
- Federal reinsurance (blue) increases throughout the year



Part D settlement items – Risk Corridors

- Based on seasonality pattern from prior slide, first quarter loss ratios can be significantly higher than fourth quarter loss ratios
- Risk corridors / risk sharing provided by CMS can help “level out” the loss ratios
- If financial experience / loss ratio for Part D varies by more than 5% from the projected loss ratio, risk sharing occurs between MA plan and CMS

CMS Part D Risk Corridors

Actual Compared to Target	PD	CMS
< 90%	20%	80%
90% to 95%	50%	50%
95% to 105%	100%	0%
105% to 110%	50%	50%
> 110%	20%	80%

Target = risk adjusted basic Part D claim costs in the bids

Impact of risk corridors on monthly results

- Plan liability (net of DIR) average from example for Q1 is 148%, average for Q4 is 65%
- Assuming these averages are relative to the bid, Q1 would result in a risk sharing receivable, as follows
  - 0% of first 5%
  - 50% of next 5% = 2.5%
  - 80% of remaining amount (38%) = 30.4%
  - Total = 32.9%
  - This additional amount would be added to revenue to mitigate the negative impact of the Part D benefit design on plan liability
- The actual calculation compares the Part D basic revenue multiplied by the target loss ratio to the plan liability after DIR

Calculation of risk corridors and financial impact by quarter – Example 1

- Assumptions
  - Revenue PMPM (bid * risk score): $100 (all months)
  - Target loss ratio: 80%
  - Plan liability (after DIR)
    - Q1: $120
    - Q2: $85
    - Q3: $65
    - Q4: $50
  - Risk corridor settlement is cumulative
  - Membership is the same in each quarter

Calculation of risk corridors and financial impact by quarter – Example 1 (continued)

- Results
  - Target PMPM is $80.00 for all quarters
  - Actual /Target
    - Q1: $120.00 PMPM / $80.00 PMPM = 150%
    - Q1 - Q2: $102.50 PMPM / $80.00 PMPM = 128.125%
    - Q1 - Q3: $90.00 PMPM / $80.00 PMPM = 112.5%
    - Q1 - Q4: $80.00 PMPM / $80.00 PMPM = 100%
  - Risk Sharing
    - Q1: 150% - 110% = 40% * 80% * $80 + 5% * 50% * $80 = $27.60 PMPM, cumulative loss ratio 94.0%
    - Q1 - Q2: 128.125% - 110% = 18.125% * 80% * $80 + 5% * 50% * $80 = $13.60 PMPM, Q2 accrual is a reduction of $14.00 PMPM to offset Q1 accrual, cumulative loss ratio 90.2%
    - Q1 - Q3: 112.5% - 110% = 2.5% * 80% * $80 + 5% * 50% * $80 = $3.60 PMPM, Q3 accrual is a reduction of $10 PMPM to offset Q2 accrual, cumulative loss ratio 86.9%
    - Q1 - Q4: 100% = No risk corridor, Q4 accrual is a reduction of $3.60 PMPM to offset Q3 accrual, cumulative loss ratio 80.0%

Calculation of risk corridors and financial impact by quarter – Example 2 – your turn!

- Assumptions
  - Revenue PMPM (bid * risk score): $100 (all months)
  - Target loss ratio: 80%
  - Plan liability (after DIR)
    - Q1: $140
    - Q2: $110
    - Q3: $50
    - Q4: $40
  - Risk corridor settlement is cumulative
  - Membership is the same in each quarter

Calculation of risk corridors and financial impact by quarter – Example 2 - Answer

- Results
  - Target PMPM is $80.00 for all quarters
  - Actual /Target
    - Q1: $140.00 PMPM / $80.00 PMPM = 175%
    - Q1 - Q2: $125.00 PMPM / $80.00 PMPM = 156.25%
    - Q1 - Q3: $100.00 PMPM / $80.00 PMPM = 125%
    - Q1 - Q4: $85.00 PMPM / $80.00 PMPM = 106.25%

Calculation of risk corridors and financial impact by quarter – Example 2 - Answer

- Results
  - Risk Sharing
    - Q1: 175% - 110% = 75% * 80% * $80 + 5% * 50% * $80 = $43.60 PMPM, cumulative loss ratio 97.5%
    - Q1 - Q2: 156.25% - 110% = 56.25% * 80% * $80 + 5% * 50% * $80 = $31.60 PMPM, Q2 accrual is a reduction of $12.00 PMPM to offset Q1 accrual, cumulative loss ratio 95.0%
    - Q1 - Q3: 125% - 110% = 25% * 80% * $80 + 5% * 50% * $80 = $11.60 PMPM, Q3 accrual is a reduction of $20 PMPM to offset Q2 accrual, cumulative loss ratio 89.6%
    - Q1 - Q4: 106.25% - 105% = 1.25% * 50% * $80 = $0.50 PMPM, Q4 accrual is a reduction of $11.10 PMPM to offset Q3 accrual, cumulative loss ratio 84.6%

Part D settlement items – Federal reinsurance

- Federal reinsurance payments to pharmacies
  - All members have 80% of the cost of drugs paid by the Federal government after reaching an out-of-pocket limit (TrOOP)
  - TrOOP limit is $5,100 in 2019 and $5,350 in 2020
  - Both LICS and CGDP payments made by the plan on behalf of the Federal government count toward the out-of-pocket limit (as well as payments by other entities such as State Pharmaceutical Assistance Programs)
  - PMPM amount generally increases each month as more members have cost sharing that reaches TrOOP
- Federal reinsurance pre-payment
  - CMS pays a fixed PMPM to the MA plan based on the bid for all members

Part D settlement items – Federal reinsurance (continued)

- Federal reinsurance financial impact
  - CMS ultimately reimburses MA plans in full for actual Federal reinsurance payments (generally in October or November following the plan year) LESS a percentage of DIR
  - Percentage of DIR allocated to Federal reinsurance is based on total amount of Federal reinsurance from Prescription Drug Event (PDE) data / total drug cost
  - Since Federal reinsurance PMPM claim amounts are lower in the early months and higher in later months, while the CMS pre-payment amount is the same throughout the year, MA plans will generally have a payable for Federal reinsurance until the end of the third quarter or fourth quarter
  - MA plans should accrue for the difference between the payments from CMS and the value of the reimbursement to pharmacies on behalf of the member, net the reduction for DIR, on a monthly basis
  - The accrual only impacts the balance sheet and not the income statement since the net impact is ultimately $0

Part D settlement items – Federal reinsurance (example)

- Example 1
  - Total drug cost PMPM: $250 (GDCA = $80)
  - Prospective reinsurance payment from CMS PMPM: $50
  - DIR PMPM: $40
  - Actual federal reinsurance = [($80 * 80%) – ($80 * 80%) / $250 * $40] = $53.76
  - Since actual > bid, then Net Federal reinsurance receivable to MA plan = $53.76 - $50 = $3.76 PMPM
- Example 2 (your turn)
  - Total drug cost PMPM: $300 (GDCA = $100)
  - Prospective reinsurance payment from CMS PMPM: $80
  - DIR PMPM: $30
  - Net Federal reinsurance (receivable/payable) to MA plan = ?

Part D settlement items – Federal reinsurance (example)

- Example 2 (answer)
  - Total drug cost PMPM: $300 (GDCA = $100)
  - Prospective reinsurance payment from CMS PMPM: $80
  - DIR PMPM: $30
  - Actual federal reinsurance = [($100 * 80%) – ($100 * 80%) / $300 * $30] = $72
  - Since actual < bid, then Net Federal reinsurance payable from MA plan = $72 - $80 = $8 PMPM

Part D settlement items – Low Income Cost Sharing

- Low income cost sharing (LICS) payments to pharmacies
  - All members who are classified as “low income” by CMS are eligible to have most or all of the cost sharing reimbursed by the government
  - Actual member cost sharing varies by the low income category
    - Institutional members: no cost sharing
    - Full benefit dual members: either $1.25 or $3.40 for generics and $3.80 or $8.50 for brands in 2019 and $1.30 or $3.60 for generics and $3.90 or $8.95 for brands in 2020
    - Partial duals pay $3.40 for generics and $8.50 for brands and can have up to a $85 deductible in 2019 and $3.60 for generics and $8.95 for brands and can have up to a $89 deductible in 2020
  - Difference between actual cost sharing for the drug and amounts paid by member are considered LICS
  - As with plan liability, decreases over time as more members reach the catastrophic phase and member cost sharing declines

Part D settlement items – Low Income Cost Sharing (continued)

- LICS pre-payment
  - CMS pays a fixed PMPM to the MA plan based on the bid for all LI members, regardless of category
- LICS financial impact
  - CMS ultimately reimburses MA plans in full for actual LICS payments (generally in October or November following the plan year)
  - Since LICS PMPM claim amounts are higher in the early months and lower in later months, while the pre-payment amount is the same throughout the year, MA plans will generally have a receivable for LICS throughout the year
  - MA plans should accrue for the difference between the payments from CMS and the value of the reimbursement to pharmacies on behalf of the member on a monthly basis
  - The accrual only impacts the balance sheet and not the income statement since the net impact is ultimately $0

Part D settlement items – Coverage Gap Discount Program

- Coverage Gap Discount Program (CGDP) payments to pharmacies
  - Also called “brand gap coverage”
  - All members who are NOT classified as “low income” by CMS are eligible to have 70% of the ingredient cost of brand drugs covered in the coverage gap in 2019 and 2020
    - Assuming “standard” gap coverage, plan would pay 5% of the ingredient cost and 75% of dispensing fee in 2019 and 2020
    - Member would pay 25% of total in 2019 and 2020
  - As with federal reinsurance, total amount from the PDEs increases during the year as more members reach the coverage gap
- CGDP prepayment
  - CMS pays a fixed PMPM to the MA plan based on the bid for all non-LI members, regardless of category

Part D settlement items – Coverage Gap Discount Program (continued)

- Example
  - Claim with $198 in ingredient cost and $2 in dispensing fees
    - CGDP would pay 70% of $198 = $138.60
    - Assuming “standard” gap coverage, plan would pay 5% of the ingredient cost and 75% of dispensing fee in 2019 and 2020 ($9.90 + $1.50 = $11.40)
    - Member would pay 25% of total in 2019 and 2020 ($50)

Part D settlement items – Coverage Gap Discount Program (continued)

- CGDP financial impact
  - As CGDP amounts are submitted through PDEs, CMS notifies the pharmaceutical manufacturers of the amounts
  - Manufacturers are responsible for paying the MA plans for the amounts indicated by CMS and notifying CMS when they pay those amounts
  - As manufacturers pay MA plans, CMS reduces the pre-payment amounts to offset the payments to the MA plans
  - Since CGDP PMPM amounts are lower in the early months and higher in later months, while revenue is the same throughout the year, MA plans will generally have a payable for CGDP throughout the year
  - MA plans need to track the pre-payments and offsets from CMS, the actual amounts paid on behalf of their members, and the amounts received from manufacturers to determine the net payable or receivable amount
  - The accrual should only impact the balance sheet and not the income statement since the net impact after all settlements is $0

So you can’t fall asleep at the switch!

Risk scores and Revenue

Part C and Part D revenue

- Part C revenue
  - Part C “risk revenue” (Part C bid x risk score)
  - Rebates from Part C savings for Medicare advantage
  - Part C member premium
- Part D revenue
  - Part D direct subsidy (Part D bid x risk score - rounded basic premium)
  - Part D basic premium (including low income premium subsidy)
  - Part D supplemental premium

Sequestration

- Sequestration
  - 2% reduction in revenue which impacts
    - Part C “risk revenue” (Part C bid x risk score)
    - Rebates from Part C savings for Medicare advantage
    - Part D direct subsidy (Part D bid x risk score - rounded basic premium)
    - Part D basic premium from Part C rebates
    - Part D supplemental premium from Part C rebates

PMPM revenue changes every month – why?

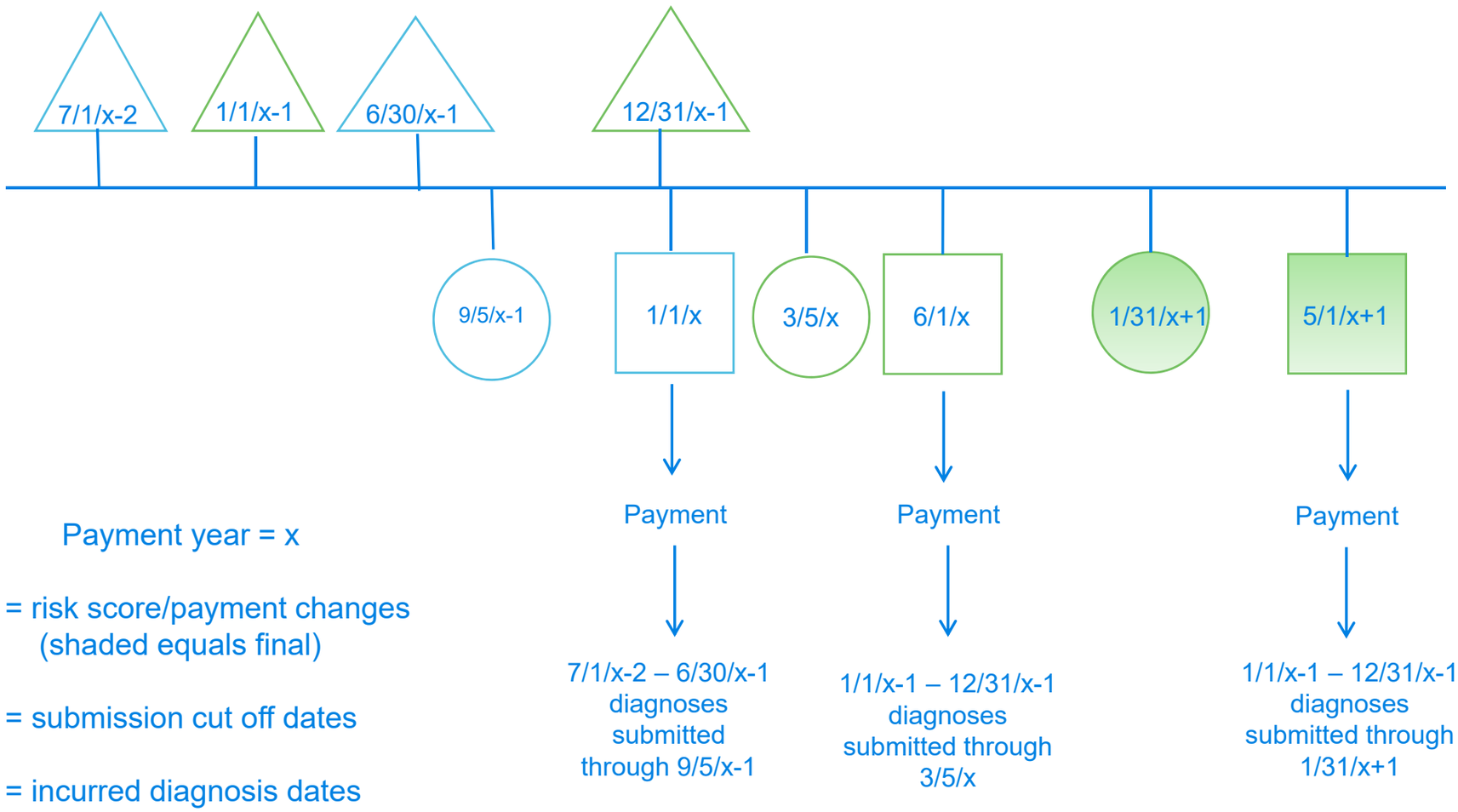
- Premium and rebate revenue PMPM are the same for every member in a Plan Benefit Package (PBP)
- However, risk scores and revenue based on risk scores change monthly
  - Seasonality
    - Members with higher risk scores have higher mortality than members with lower risk scores
    - New to Medicare members enroll and have lower than average risk scores
  - Updates to risk scores
    - For each payment year, an MA member can have 3 risk scores
      - Initial risk score in January of payment year
      - Updated risk score in August of payment year
      - Final risk score, typically in July following payment year
  - Members can change to ESRD or hospice status, generally retroactively

Seasonality pattern of risk scores

Updates to risk scores – timing and reasons

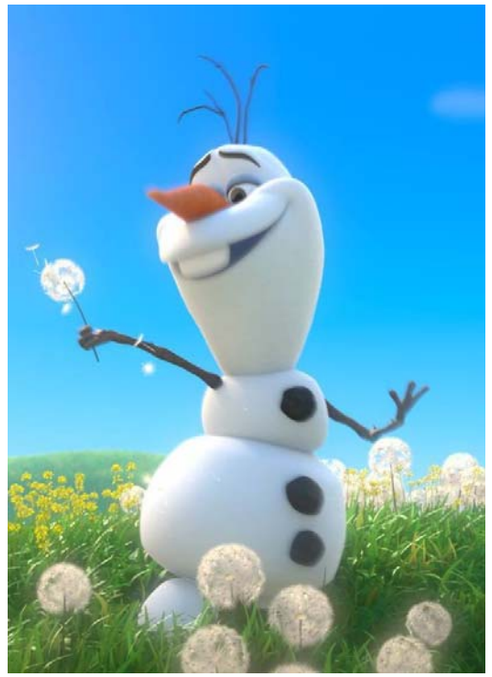
- January of payment year
  - New model, if applicable
  - New FFS normalization factor and coding improvement factor (Part C only)
  - Diagnoses from July from two years prior to payment year to June of one year prior to payment year, submitted through September prior to payment year
- August of payment year
  - Updates diagnoses to calendar year prior to payment year, submitted through March of payment year
  - Risk scores can increase or decrease for each member
- July following payment year (or later if issues arise, such as EDS for payment year 2016)
  - Additional diagnoses from calendar year prior to payment year, submitted through end of January in year following payment year
  - Risk scores only increase unless diagnoses are deleted

Timeline of risk score updates



Risk revenue accruals

- January through May of payment year (based on 2019)
  - Two future updates – one “in summer” (June in 2019) of payment year and one in following year
- Many plans accrue for the “mid-year” update payable “in summer” (occurred in June 2019)
  - Can calculate revenue impact using actual calendar year diagnoses submitted through March – most accurate
  - Can review prior year changes, but need to ensure diagnosis submission pattern is similar to prior years. If pattern is different, actual change in revenue could be impacted.
- Some plans accrue for the “final” update for January through May membership as well as the “mid-year”
  - Can include actual diagnosis submissions after the March cutoff
  - Can estimate a flat percent for the “final” update based on prior year’s. (Again, need to ensure submission patterns will be similar.)



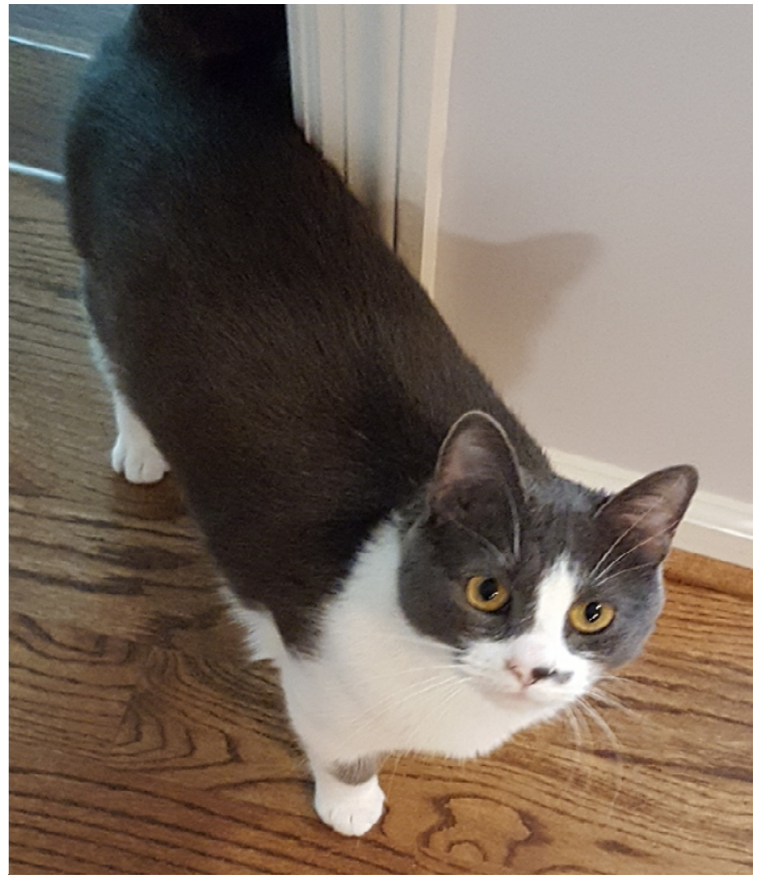
Risk revenue accruals (continued)

- After mid-year update for “final” update
  - Most plans develop accruals based on actual diagnoses submitted after March of payment year
  - Can also look at diagnoses which may have been captured but not submitted yet
  - If chart reviews are in process or planned, can develop an estimate based on the expected number of chart reviews and prior history

Ensuring accurate and complete risk scores

What's the big deal anyway?

- Missing diagnoses = loss of revenue
  - May result in loss of competitive advantage
- Miscoding = RADV audits, negative press



Oh no – what can we do??

- Calculating risk scores
  - Ongoing monitoring
  - Reconciliation of CMS results
- Measuring plan profitability
  - MLR analysis net of risk adjustment
  - Evaluating profitability of specific members or conditions
- Identification of “chart-chasing” opportunities
  - Potentially missed diagnoses
- Retrospective review
  - Use historical medical diagnosis and drug data to identify “suspects”
  - Review prior year diagnoses to identify “dropped” diagnoses (more than half of HCCs are “chronic” conditions)
  - Identify “biggest bang for the buck” by identifying members with a combination of prescription drug use or claims during diagnosis year AND dropped diagnoses
- Concurrent / Prospective Review
  - Identify members in “real time” to ensure diagnosis is coded in current year
- Diagnosis comparison
  - Identify differences in RAPS and EDS submissions

Methods for collecting diagnoses

- Chart reviews
  - Ensure diagnoses submitted in claim records are supported by medical records
  - Pro: can identify diagnoses to add or delete from prior year
  - Con: can't submit diagnoses if not in chart
- Home visits
  - Real time interaction with members done in current year
  - Pro: can identify diagnoses not in physician chart
  - Con: cost; member may not enroll in same MA plan the following year
- Rx data
  - Many prescription drugs are associated with certain diseases / HCCs
  - Pro: can create "target" list
  - Con: not all HCCs have associated drugs (amputations)

Break (10 min)

Statement of Opinion

The Actuarial Opinion

- Two primary types of opinions signed by health actuaries:
  - Orange Blank opinions (Health Company)
  - Blue Blank opinions (Life & Health Company)
- Concepts also apply to other types of financial statements
  - California Department of Managed Health Care (DMHC) statement

What is the Opinion?

- That the amounts set aside for future payments on liabilities:
  - Comply with ASOPs;
  - Are consistent with contract provisions and purpose;
  - Comply with state laws;
  - Make good and sufficient provision for all actuarial liabilities;
  - Are computed consistently with prior year end; and
  - Are complete

What is the Opinion?

- Orange Blanks Only
  - U&I 2B reasonable; and
  - Prepared consistently with ASOPs
  - Under certain conditions asset adequacy analysis

What is the Opinion?

- Blue Blanks Only
  - Specified language per the valuation manual
  - Generally based upon asset adequacy analysis, but may not be in certain situations
  - Regulatory Asset Adequacy Issues Summary, or RAAIS
  - “The reserves and related actuarial items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted ASOPs, for the anticipated cash flows required by the contractual obligations and related expenses of the company.”
  - Special Considerations
    - New York Special Considerations letter (Halloween Letter)
    - California Holiday letter
    - PBR exclusion

Comply with ASOPs

- Which ASOPS?
  - Your responsibility to identify them
  - Note that the AAA provides applicability guide: https://www.actuary.org/content/applicability-guidelines-actuarial-standards-practice-0

Comply with ASOPs

Applicability Guidelines for Actuarial Standards of Practice – Health

Please note that the following ASOPs apply to all assignments in all practice areas:

1. Introductory Actuarial Standard of Practice
23. Data Quality
41. Actuarial Communications

Description of Assignment			Actuarial Standard of Practice (ASOP)																						
			3	4	5	6	7	8	11	12	17	18	19	21	22	25	26	28	32	42	45	46	47	49	50
2.0	Cash Flow Testing																								
	2.1	Perform cash flow testing in determining reserve adequacy, performing pricing studies, evaluating investment strategies, developing financial projections or forecasts, developing actuarial appraisals, testing future charges of benefits that may vary at the discretion of the company			5		7						19	21	22	25				42	45				
5.0	Financial Analysis, Projections, Reserving, and Reporting																								
	5.1	Develop financial and other projections	3		5		7	8	11	12		18	19	21	22	25				42	45				
	5.2	Estimate incurred health claim liabilities			5				11					21		25		28							
	5.3	Estimate value of insurance company, insurance marketing organization, or other entity or block of health contracts, for acquisition/sale or for tax purposes			5		7		11	12		18	19	21		25		28		42	45				
	5.4	Perform analysis of health insurance risk-based capital and similar measures			5		7		11											42	45				
	5.5	Perform asset adequacy analysis			5		7		11	12				21	22					42	45				
	5.6	Perform cash flow testing in determining reserve adequacy, performing pricing studies, evaluating investment strategies, developing financial projections or forecasts, developing actuarial appraisals, testing future charges of benefits that may vary at the discretion of the company			5		7						19	21	22	25				42	45				
	5.7	Perform trend analysis			5											25				42	45				
	5.8	Recognize actuary's responsibility to the auditor in connection with preparation or review of audited financial statements												21						42	45				
	5.9	Perform valuation of incurred liabilities and other items for actuarial opinions and financial statements (for life/health/HMOs/health service corporations/CCRCs)	3		5	6	7	8	11	12		18	19	21	22			28		42	45				

Comply with ASOPs

- Usual Suspects
  - ASOP 1 – Introductory Actuarial Standard of Practice
  - ASOP 5 – Incurred Health and Disability Claims
  - ASOP 7 – Analysis of Life, Health, or Property/Casualty Insurer Cash Flows
  - ASOP 18 – Long-Term Care Insurance
  - ASOP 21 – Responding to or Assisting Auditors or Examiners in Connection with Financial Audits, Financial Reviews, and Financial Examinations
  - ASOP 22 – Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers
  - ASOP 23 – Data Quality
  - ASOP 25 – Credibility Procedures
  - ASOP 28 – Statements of Opinion Regarding Health Insurance Liabilities and Assets
  - ASOP 41 – Actuarial Communications
  - ASOP 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
  - ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies

Comply with ASOPs

- Actuarial Memorandum should document steps you took to ensure compliance
- CE log should document review of appropriate ASOPs in recent past

Consistent with contract provisions and purpose

- What is the purpose?
- Which contract provisions must be considered?
  - Those that affect amount of claim, duration of claim, or timing of claim payments
  - Additionally must consider premium levels and any future guarantees
- Examples
  - Episode of Care/Bundles
    - Maternity payments
  - Provider incentives/penalties
  - Risk sharing agreements with providers (e.g., bonus based on experience compared to a benchmark)
  - What else?

Comply with state laws

- Actuarial Memorandum should document steps you took to ensure compliance
- Any state-specific requirements: e.g., Florida: reserve may need to be held for subcapitated providers that are not insurers
- Note that Orange Blank and Blue Blank requirements are slightly different
  - Blue blank certification is ideally “Meet the requirements of the insurance laws and regulations of the state of [domicile] and are at least as great as the minimum aggregate amounts required by any state in which this company is licensed.

Good and Sufficient Provision (Orange Blank)

- Statutory requirement: good and sufficient under moderately adverse conditions
- How much margin is required to meet that goal?
  - What studies have you done?
  - Where are these documented?
- How did you arrive at that decision?

Make Adequate Provision (Blue Blank)

- Statutory requirement: Reserves make adequate provision, according to presently accepted ASOPs, for anticipated cash flows required by the contractual obligations and related expenses of the company.
- Is your asset adequacy testing adequate?
  - Is your projection period sufficient?
  - Do your assumptions reconcile well to past results?
  - Have you reflected all guarantees in place?
- How did you arrive at that decision?

Computed consistently with prior year end

- If there has been a significant change in methodology, this prescribed language statement must be edited or deleted, and discussed in relevant comments section and actuarial memorandum
- Probably should be deleted in first year as appointed actuary, unless your predecessor was a colleague, or unless predecessor provides complete documentation
- This should be deleted if the company is new, since there was no prior year end
- Trivial changes may be considered as consistent

Completeness
“Includes appropriate provision for all actuarial items …”

- Should include all lines required to be within scope by instructions
  - Lines 1-7 must be included, even if zero (Orange Blank)
  - Zero is an opinion
  - Should have documentation for zero amounts
- Should review all other held liabilities shown on Page 3 to determine whether they are actuarial and hence should be reviewed
- Should also review assets for those “actuarial in nature”
- If not “actuarial in nature”, do not include in scope

Completeness (Orange Blank)

- Claims unpaid (Page 3, Line 1);
- Accrued medical incentive pool and bonus payments (Page 3, Line 2);
- Unpaid claims adjustment expenses (Page 3, Line 3);
- Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves, premium deficiency reserves and additional policy reserves from the Underwriting and Investment Exhibit, Part 2D;
- Aggregate life policy reserves (Page 3, Line 5);
- Property/casualty unearned premium reserves (Page 3, Line 6);
- Aggregate health claim reserves (Page 3, Line 7);
- Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement:
  - E.g., risk adjustment – ACA risk adjustment liabilities (Page 3, Line 2301);
- Specified actuarial items presented as assets in the annual statement:
  - E.g., Part D risk corridor (subset of Page 2, Line 15.2)

Underwriting and Investment Exhibit, Part 2B

- Requirement:
  - Confirm that it was reviewed for reasonableness and consistency with applicable ASOPs
  - Confirm that the data were reconciled to Underwriting & Investment Exhibit, Part 2B
- What does this mean?

Underwriting and Investment Exhibit, Part 2B Reasonableness

- Frequently devolves to reconciliation to audited financial statement
- Are cash claims reasonably close to amount shown on Cash Flow exhibit?
- Do liabilities match Page 3?

Underwriting and Investment Exhibit, Part 2B Consistency with ASOPs

- ASOP No. 5: Retroactive studies
- ASOP No. 23: Data quality
- Implication is that you will use the results of this exhibit (and any other retrospective studies you conduct) to inform current estimates

Completeness (Blue Blank)

- Should include at least the following:
  - Page 3, Line 1 – Aggregate Reserve for Life Contracts (Exhibit 5)
  - Page 3, Line 2 – Aggregate Reserve for Accident and Health Contracts (Exhibit 6)
  - Page 3, Line 3 – Liability for Deposit-Type Contracts (Exhibit 7)
  - Page 3, Line 4.2 – Contract Claims: Accident and Health (Exhibit 8)
  - Page 3, Line 5 – Policyholders' Dividends
  - Page 3 – Any write-ins that are actuarial
  - Page 3, Line 9.4 – IMR
  - Page 3, Line 24.01 – AVR
  - Page 2, Assets – For asset adequacy analysis
- Review should include "reserves and related actuarial items": Exhibits 5, 6, 7, 8 (Part 1), Separate Accounts (if required for asset adequacy analysis)
- Anything else required by client/company circumstances, laws/regulations, professional judgement

Reserves (Blue Blank)

- Unlike orange blank work, for many blue blank carriers IBNR is not the largest actuarial liability in the opinion
  - For carriers that issue life insurance, annuities, SCWLCs, etc., Exhibit 5 will contain these reserves
  - Exhibit 6a reserves must be calculated in accordance with the Health Reserves Model Regulation
  - Exhibit 6b reserves may contain material disability and/or long-term care liabilities. The health reserve model regulation also provides guidance with respect to these reserves
  - Exhibit 6 – additional actuarial reserves as a result of asset adequacy analysis, aka PDR
  - Exhibit 7 includes non-life contingent benefits – SCNILCs, GICs, dividend and premium accumulations, etc.
  - Exhibit 8 contains ICOS and IBNR

Data reliance

- Required to be attached to statement of actuarial opinion, more than just a list of data received
- Include information received from others that has a significant impact on your estimate of any liability
- Examples:
  - Claims system disruption during year
  - Changes in data vendors during the year (e.g. TPA, PBM)
  - Provider reimbursement changes, including changes to provider incentives (movement from FFS to case rates, capitation of some services, etc.)

Relevant Comments

- This is your opportunity to give regulators a one or two sentence explanation of an important issue, your evaluation, and your conclusion. The actuarial memorandum can have a complete discussion.
- What is not within the scope of the opinion?
  - Be sure the opinion and the actuarial memorandum are clear as to items outside of the scope of the opinion
- If the opinion is anything other than unqualified
  - Clearly state in the opinion which items cause the opinion to be qualified
  - Consider if the opinion should be adverse or if there should be no opinion (inconclusive). Uncommon but may be necessary.

Relevant Comments
What should be included?

- Reasons for not following prescribed language, including:
  - Not appointed by board
  - Not consistent with prior year (first year of appointment)
- Language required by state law or regulation
- Description of any material changes in methodology
- Description of major uncertainties (e.g., risk adjustment)
- Factors that had a significant impact on your opinion
  - Client/company representations
  - Adjustments to data
- Significant data issues, if any
- What else?

Documentation

- Clearly indicate what you did, why you did it, and how you did it
  - “Do what you document, and document what you do”
  - The absence of documentation could be construed as the absence of consideration of a key point
- The actuarial memorandum should include commentary about items considered but held at $0
- Include commentary in the actuarial memorandum about items considered to be out of scope and why
- Document in a file (project memo) any reviews that were done, discussions with others about data, etc.
- Document in the actuarial memorandum any discussions that had a significant impact on your work
- If the opinion is anything other than unqualified because data are not clean or there are any other major uncertainties such as risk adjustment, include clear documentation in the actuarial memorandum

Other Considerations

Know Your Company/Client

Examples of Risky Companies/Clients

- Under investigation or subject to regulatory oversight
- In bad financial shape
- Inexperienced/incompetent/understaffed
- Significant turnover in leadership
- In disputes with their previous professionals
- Experiencing rapid growth change in their business
- Appearance that a particular results are needed – applying pressure

Things to do

- Review
  - Most recent Triennial Report of the Insurance Department (generally publicly available)
  - Most recent annual report of the company's auditors
  - Insurance Department website - investigations or notices about the client/company
  - Emerging financials (prior to year-end)

- Direct conversations regarding any recent changes (esp. adverse)
  - List of potential changes (e.g., markets, provider networks, provider contracts)

Considerations and issues

- Leadership changes in the organization (esp. C-suite)
- Ownership/organizational changes
  - Financial re-structuring
  - New stakeholders
- Actuarial, finance staff
  - Understanding flow of information
  - Team composition (size, experience, expertise)
  - Any limitations on having access to staff and their analyses?

Considerations and issues

- Annual Report to the Board on the Actuarial Opinion
  - Any resistance from management from making such report?
  - Any issues from the Board that could signal a problem?

- Regulatory problems or oversight
  - Routine reporting to the regulator?
  - If so, review the reports and analyses

Considerations and issues – Pressure (Current/Prior)

- What was the situation? Is it likely to repeat?
- What sort of pressure?
- What as the source of the pressure?
  - Internal stakeholders, regulatory considerations, etc.
- How material was the pressure?
  - Looking for results outside of reasonable range?
- How was it resolved (or was it)?

Questions/Comments