Draft date: 8/5/24

2024 Summer National Meeting
Chicago, Illinois

HEALTH ACTUARIAL (B) TASK FORCE
Monday, August 12, 2024
2:30 – 4:00 p.m.
Hyatt Regency McCormick Place—Regency Ballroom—Level 2

ROLL CALL

Anita G. Fox, Chair	Michigan	Joy Y. Hatchette	Maryland
Jon Pike, Vice Chair	Utah	Grace Arnold	Minnesota
Mark Fowler	Alabama	Chlora Lindley-Meyers	Missouri
Ricardo Lara	California	Eric Dunning	Nebraska
Michael Conway	Colorado	D.J. Bettencourt	New Hampshire
Andrew N. Mais	Connecticut	Justin Zimmerman	New Jersey
Michael Yaworsky	Florida	Judith L. French	Ohio
Gordon I. Ito	Hawaii	Glen Mulready	Oklahoma
Dean L. Cameron	Idaho	Michael Humphreys	Pennsylvania
Amy L. Beard	Indiana	Alexander S. Adams Vega	Puerto Rico
Doug Ommen	Iowa	Cassie Brown	Texas
Vicki Schmidt	Kansas	Scott A. White	Virginia
Robert L. Carey	Maine	Mike Kreidler	Washington

NAIC Support Staff: Eric King

AGENDA

1. Consider Adoption of its May 13 Minutes—*Kevin Dyke (MI)* — Attachment A
2. Hear a Presentation from the American Academy of Actuaries (Academy) on Drivers of 2025 federal Affordable Care Act (ACA) Health Insurance Premium Changes—*Cori Uccello (Academy)* — Attachment B
3. Hear an Update on Society of Actuaries (SOA) Research Institute Activities—*Achilles Natsis (SOA)* — Attachment C
4. Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO)—*Beth Karpiak (CCIIO)*
5. Hear an Update from the Academy Health Practice Council—*Matthew Williams (Academy)* — Attachment D

6. Hear an Academy Health Knowledge Statement Presentation— *Lisa Slotznick, Darrell Knapp, and Rhonda Ahrens (Academy)* — Attachment E, Attachment F

7. Hear an Academy Professionalism Update—*Maryellen Coggins, Shawna Ackerman, and Kevin Dyke (Academy)*

8. Discuss Any Other Matters Brought Before the Task Force —*Kevin Dyke (MI)*

9. Adjournment

Draft: 6/7/24

Health Actuarial (B) Task Force
Virtual Meeting
May 13, 2024

The Health Actuarial (B) Task Force met May 13, 2024. The following Task Force members participated: Anita G. Fox, Chair, represented by Kevin Dyke (MI); Jon Pike, Vice Chair, represented by Ryan Jubber (UT); Ricardo Lara represented by Ali Zaker-Shahrak (CA); Michael Conway represented by Eric Unger (CO); Michael Yaworsky represented by Kyle Collins (FL); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Scott Shover (IN); Robert L. Carey represented by Marti Hooper (ME); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom (NJ); Judith L. French represented by Craig Kalman (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Dave Yanick (PA); Cassie Brown represented by Aaron Hodges (TX); Scott A. White represented by Julie Fairbanks (VA); and Mike Kreidler represented by Lichiou Lee (WA).

1. Adopted its Spring National Meeting Minutes

Hodges made a motion, seconded by Trexler, to adopt the Task Force's March 15 minutes (*see NAIC Proceedings – Spring 2024, Health Actuarial (B) Task Force*). The motion passed unanimously.

2. Adopted a VM-26 Credit Disability Update Proposal

Dyke said that on Feb. 20, the Task Force exposed an amendment proposal form (APF) (Attachment XX) to revise Valuation Manual (VM)-26, Credit Life and Disability Reserve Requirements, Section 3.B. Contract Reserves for Credit Disability Insurance, for a public comment period ending March 22. No comments were received on the exposure.

Shover made a motion, seconded by Unger, to adopt the APF and forward it to the Life Actuarial (A) Task Force for consideration. The motion passed.

Having no further business, the Health Actuarial (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Committees/B CMTE/HATF/2024_Summer/HATF/5-13 HATF/HATF Minutes 05-13-24.docx

Drivers of 2025 Health Insurance Premium Changes

Presentation at the NAIC Summer National Meeting Health Actuarial Task Force (HATF) Session

August 12, 2024

Cori E. Uccello, MAAA, FSA, FCA, MPP
Senior Health Fellow
American Academy of Actuaries

Agenda

- Background on the rate development process
- Drivers of 2025 premium changes
- Overview of rate filing information

Premium Rate Development Process

- Analyze prior health spending
- Adjust data to reflect future trends
- Use data to project future costs

Insurers develop premium *rates*, not premium *increases*. The rate review process assesses whether premium *rates* are reasonable.

Premium Development Components

- Who is covered—the composition of the risk pool
- Projected medical costs
- Other premium components—administrative costs, taxes, profit/risk charge
- Laws and regulations

2025 Premium Rate Change Factors

- Medical trend factors
  - Major factors: inflation, increasing prescription drug spending
- Risk pool composition factors
  - Risk pools are likely to be relatively stable, with minimal effect on premiums
- Other factors
  - Local market dynamics and state-based policies

Medical Trend Factors

- Inflation
  - After years of significant increases, general inflation has returned to historical norms
  - Assumptions possibly higher for insurers with multiyear provider contracts recently or soon up for renewal

- Increased prescription drug spending
  - Higher price growth than for medical services
  - The high cost of GLP-1s and their long-term use, if covered

Medical Trend Factors (cont.)

- Gene therapy treatments
  - Treatment costs can be in the $millions
  - Not typically covered by individual and small group market plans
  - Small impact on premiums unless coverage expands

- Adult dental coverage
  - New rules that states can include adult dental coverage as an EHB starting in 2027
  - At that point, any related premium changes depend on state decisions and coverage specifics

Medical Trend Factors (cont.)

- COVID-19
  - Treatment and testing costs are better understood and are part of the underlying claims used to project 2025 claims
  - Unlikely to contribute to premium changes for 2025 and beyond

- No Surprises Act
  - Plan members can't be billed unexpectedly for certain out-of-network care, including at in-network facilities
  - Effects on provider network development and prices still unclear
  - Minimal effect on 2025 premiums

Risk Pool Composition Factors

- Medicaid eligibility redeterminations
  - Because of uncertainty, few adjustments made to 2024 premiums
  - Enrollment shifts from Medicaid = improved risk pool profile (but effects on premiums likely to be small)
  - Impact can vary widely by state
- Enhanced premium subsidies
  - Higher subsidies (especially when combined with CSR loads) = Low- and moderate-income individuals gained access to free or low premium plans
  - Risk pool improvements likely incorporated into 2024 premiums
  - Expiration of 2025 enhanced subsidies = likely 2026 premium increases

Risk Pool Composition Factors (cont.)

- Contraction of short-term limited duration (STLD) plans
  - STLDs more attractive to healthy individuals
  - Trump-era rules allowed individuals to remain in STLD plans for three years
  - New rules for 2025 will reduce maximum allowable duration to four months
  - If STLD enrollees enroll instead in individual market, could slightly lower premiums

- Extension of coverage to DACA recipients
  - 100,000 uninsured DACA recipients soon eligible for marketplace or basic health plans
  - Minimal premium effects, but impact could vary geographically

Risk Pool Composition Factors (cont.)

- ICHRAs and QSERHAs
  - Shift workers (and dependents) from group coverage to individual market coverage
  - If small employers with high-cost members take up this option, could improve small group risk pool and worsen individual market risk pool
  - Take-up likely to be higher where individual market premiums are less than group premiums
  - Effect on premiums small unless take-up among employers (especially large employers) increases

- Self-funding and level funding among small employers
  - Shifts among small employers from ACA-compliant coverage to alternative funding arrangements could worsen small group risk pool
  - Likely to have nominal effect on 2025 small group premiums

Other Factors

- State and local factors
  - Local market conditions
  - State-based policies, such as:
    - Medicaid expansion status
    - State reinsurance programs
    - State benefit requirements
    - Public option programs
    - Supplemental premium or cost-sharing subsidies

Other Factors (cont.)

- Change Healthcare cyberattack
  - Delays in claims information may have made it more difficult for issuers to incorporate info from early 2024 claims activity into initial 2025 rate filings
  - Federal regulators delayed certain rating and risk adjustment deadlines, which could reduce or eliminate effects of the cyberattack on pricing

- CSR load factor
  - Nationwide, the percentage of enrollees eligible for most generous silver plan CSR variant has increased
  - Insurers might increase load to reflect shift

Rate Filing Components and Where to Find Them

Rate filing components

- Part 1: Uniform Rate Review Template (URRT)
- Part 2: Written Explanation of the Rate Increase
- Part 3: Actuarial Memorandum

Where rate filing information is available

- State Department of Insurance (DOI) website
- CMS rate review website at http://ratereview.healthcare.gov
- NAIC Systems for Electronic Rates and Forms Filing (SERFF) database

Part 1: Uniform Rate Review Template (URRT)

- Summarizes data used to determine rate increases for entire single risk pool
  - States may release URRT via SERFF and/or DOI website
  - CMS releases data from the URRTs in a public use file

- A few states have state-specific templates that include more detailed information
  - States may release additional information via SERFF and/or DOI website
  - Proprietary information may be redacted

Part 2: Written Explanation of the Rate Increase

- Brief description of the data and assumptions used in the URRT and an explanation of the main factors causing the rate increase
- Federal government requires only if proposed increases exceed 15%
- Some states require for all proposed rate increases
- Available at the CMS rate review website and potentially SERFF

Part 3: Actuarial Memorandum

- More detailed and technical information documenting actuarial assumptions, justifications, and methods

- Possible federal and state versions
  - Federal—based on URRT instructions
  - State—any additional state requirements regarding required exhibits and rate development process information

- Available on SERFF, CMS rate review website, and possibly the state Department of Insurance website
  - Proprietary information may be redacted

Questions?

Thank You

For more information, please contact

Matthew J. Williams, JD, MA

Senior Policy Analyst, Health

American Academy of Actuaries

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SOCIETY OF ACTUARIES RESEARCH UPDATE TO HATF

August 12, 2024

Achilles Natsis, FSA, MAAA
Health Research Actuary

Presentation Disclaimer

The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.

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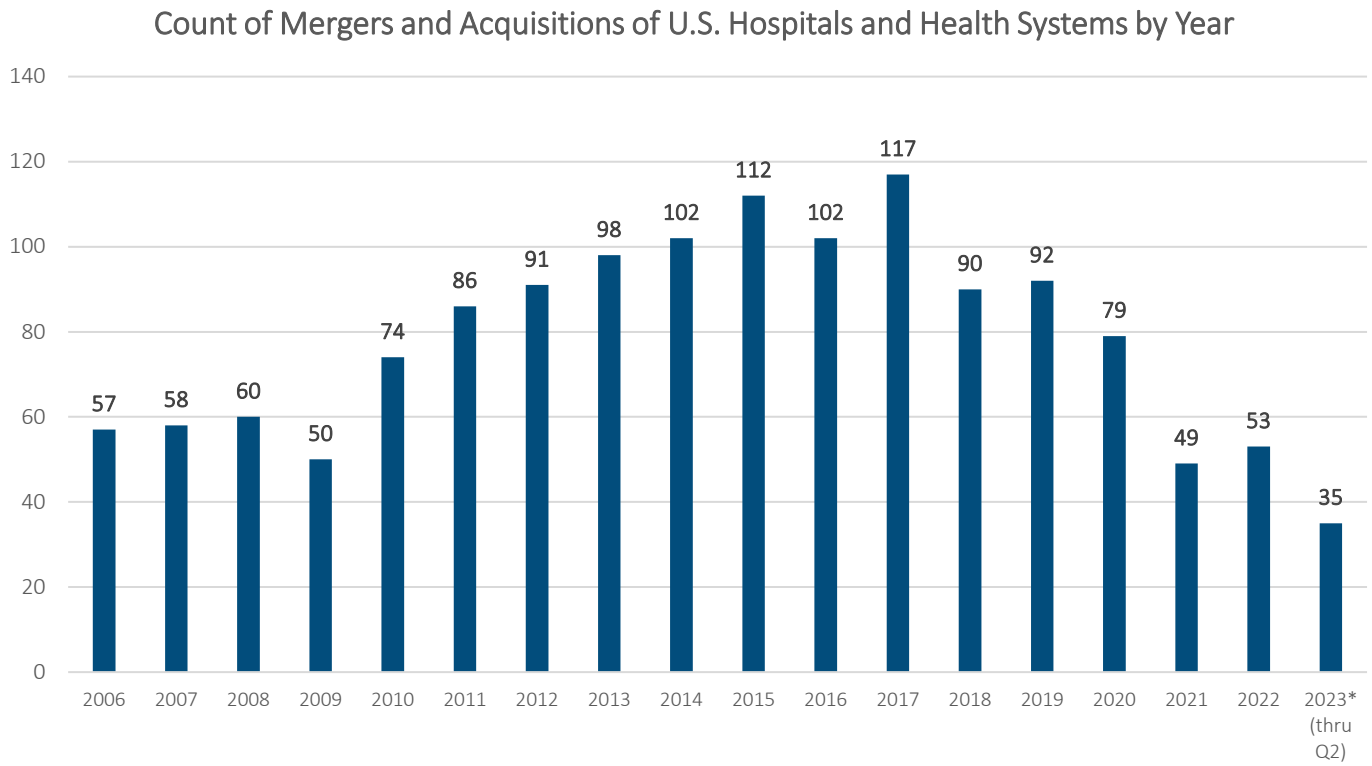
Healthcare Provider Consolidation and Shortage Impact to Morbidity



- 1,887 hospital mergers between 1998 and 2021
- 68% of community hospitals in 2023 are part of a larger system
- 61% of mergers are within the same state
- 77% of hospital markets are highly concentrated

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CONCENTRATION OF HOSPITAL MARKETS

Rank by Population	States	Metropolitan Area	Population (000s)	2021 Hospital HHI
1	NY-NJ-PA	New York-Newark-Jersey City	19,618	775
2	CA	Los Angeles-Long Beach-Anaheim	12,872	1,059
3	IL-IN-WI	Chicago-Naperville-Elgin	9,442	1,356
4	TX	Dallas-Fort Worth-Arlington	7,944	1,889
5	TX	Houston-The Woodlands-Sugar Land	7,340	2,550
6	DC-VA-MD-WV	Washington-Arlington-Alexandria	6,374	1,156
7	PA-NJ-DE-MD	Philadelphia-Camden-Wilmington	6,241	1,226
8	GA	Atlanta-Sandy Springs-Roswell	6,222	2,007
9	FL	Miami-Fort Lauderdale-West Palm Beach	6,139	1,359
10	AZ	Phoenix-Mesa-Scottsdale	5,016	3,161
11	MA-NH	Boston-Cambridge-Newton	4,901	2,123
12	CA	Riverside-San Bernardino-Ontario	4,668	657
13	CA	San Francisco-Oakland-Hayward	4,580	1,867
14	MI	Detroit-Warren-Dearborn	4,346	2,129
15	WA	Seattle-Tacoma-Bellevue	4,034	1,419
16	MN-WI	Minneapolis-St. Paul-Bloomington	3,694	2,281
17	FL	Tampa-St. Petersburg-Clearwater	3,291	1,966
18	CA	San Diego-Carlsbad	3,276	2,441
19	CO	Denver-Aurora-Lakewood	2,986	2,414
20	MD	Baltimore-Columbia-Towson	2,836	1,411
21	MO-IL	St. Louis	2,801	2,527
22	FL	Orlando-Kissimmee-Sanford	2,764	3,773
23	NC-SC	Charlotte-Concord-Gastonia	2,756	3,030
24	TX	San Antonio-New Braunfels	2,655	3,228
25	OR-WA	Portland-Vancouver-Hillsboro	2,509	2,580
1 to 25	**Weighted Average**		**139,304**	**1,716**
26 to 183	**Weighted Average**		**100,465**	**3,244**
64	FL	Cape Coral-Fort Myers	822	6,804
71	NC	Wilmington	746	7,719
117	IL	Peoria	396	5,648
129	SC	Spartanburg	346	5,910
130	NE	Lincoln	342	5,963
140	TN-VA	Kingsport-Bristol-Bristol	311	7,590
153	MI	Kalamazoo-Portage	261	5,626
158	WA	Bellingham	231	6,692
163	TN	Johnson City	210	8,246
180	MO-KS	St. Joseph	120	6,219
Total	**Weighted Average**		**239,769**	**2,356**

- Herfindahl-Hirschman Index (HHI) Concentration (Sum of squares of provider market share% 0 – 10K)
  - >2,500: **High**
  - 1,500 to 2,500: **Moderate**
  - 0 to 1,500: **Not Concentrated**
- 25 Largest metros are 47% less concentrated than all other metros
- Handful of large transactions in 2022-2023 among top 25 metros
  - Chicago, Charlotte, Denver, Minneapolis, Oakland, St Louis

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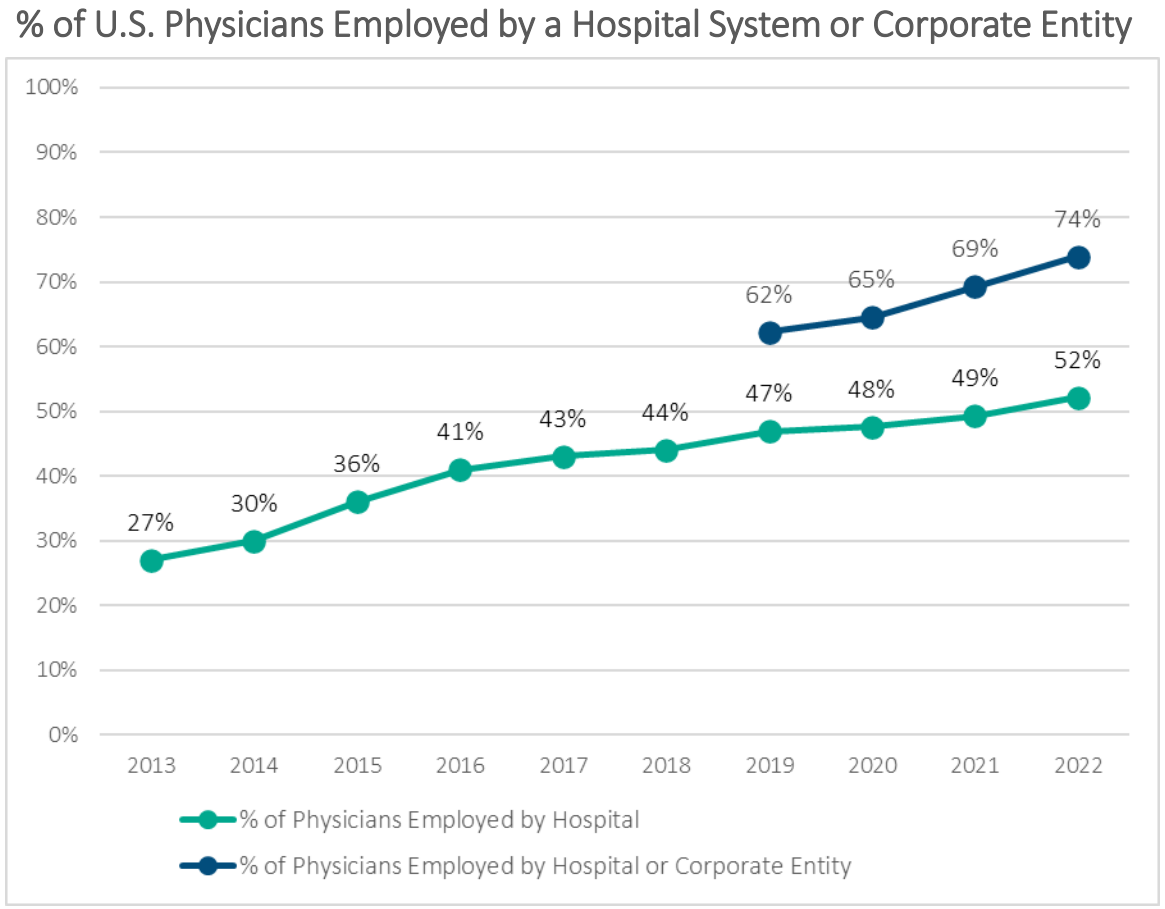
CONCENTRATION OF PHYSICIAN MARKETS



- 2008 – 66% of physicians worked in a solo or group practice
- 2016 – Concentration of Physicians:
  - PCPs – 39% of metro areas were highly concentrated
  - Specialists – 65% of metro areas were highly concentrated

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REASONS FOR CONSOLIDATIONS / ACQUISITIONS

- Legislative Changes – ACA; MACRA
  - Encouraged formation of ACOs allowing for increased risk taking
  - Most ACOs are vertically integrated organizations
- Financial Distress / Growing Operating Costs
  - 40% of transactions between 2015 and 2019 involved a hospital that was financially challenged or financially distressed
  - 50% of hospitals had a negative operating margin in 2021
- Potential for Economies of Scale / Increased Market Power
  - Ability to attain higher rates in negotiations with insurance companies
- Integration of Care / Capital Investments
  - Steerage of Referrals
  - IT and other capital upgrades (i.e., Electronic Health Records)
- Regulatory Constraints
  - Physician practices acquisitions below threshold for reporting to FTC
  - A small number of states require final merger approval from the state government

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CONSOLIDATIONS – COST & UTILIZATION IMPACTS

Cost Impacts

- ↑ Billed charges / negotiated prices with commercial payers - **8-17%** increases for Hospitals, up to **20%** for Physicians.
- ↑ Capital Expenses (e.g., IT, EMR Systems)
- ↑ Commercial insurance premiums – Increase in ownership of physician practices was associated with a **12% increase** in ACA marketplace premiums
- ↑ Site of service differentials (facility fees) – represent **25% of the price increase**
- ↓ Operating Costs due to efficiencies for duplication of administrative and clinical services – **Reductions of 3% to 7%** for an acquired hospital

Utilization Impacts

- ↑ Inpatient and outpatient referrals increase due to coordination of care – referrals to specialists employed by the acquiring system **increased by 52%** following an acquisition, while **referrals to other competing systems fell 7%** on average; overall market-wide **increase in specialist visits, 23%**
- ↑ Recently acquired Physician Practices saw increases in new patients and longer visits with existing patients **unique patients increased by 26%**, as **new patients increased by 38%** and **existing patients had a 9% increase in visits billed for longer visits**
- ↑ Inpatient and outpatient referrals increase due to coordination of care and steerage – **10% of cases** are shifted away from ASCs to hospitals;
- ↓ Closure of Services – **8.4% decrease in patient volume** following privatization of the hospital
- ↑↓ Varying Impacts across populations –following a merger there are drops in Medicare **(-5%)** and Medicaid **(-15%)** admissions. Also, lower physician acceptance rates in Medicaid **(60%)** and Medicare **(83%)**.

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PROVIDER SHORTAGES

% of U.S. Population in a County Designated as a Geographic Health Professional Shortage Area

Census Region	Primary Care	Dental Health	Mental Health
Northeast	10%	0%	5%
Midwest	25%	4%	40%
South	13%	5%	24%
West	58%	21%	68%
Nationwide	25%	8%	34%

- Physicians: Expected shortage by 2034 of 18k to 48k for PCPs and 21k to 77k non-PCPs
  - Offset by expected growth in NPs and PAs
- Nurses: Expected 100k shortage by 2026
- Nursing Aids and Medical Assistants: Expected 3.2m shortage by 2026

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PROVIDER SHORTAGES (continued)

% of U.S. Population in a County Designated as a Geographic Health Professional Shortage Area By State

REASONS FOR SHORTAGES

- Demographics – Aging of the Population – Increasing Demand
  - From 2019 to 2034, U.S. population expected to grow 11%, while 65+ expected to grow 42%
- Demographics – Aging of the Provider Base – Reducing Supply
  - 40% of currently active physicians will exceed the traditional retirement age of 65 within the next decade
- Burnout / Leaving the Profession Early – Reducing Supply
  - In 2022, 40% of physicians and 49% of nurses reported feeling burned out
- Educational and Training Slots Not Keeping Pace with Demand
  - From 2006 to 2016, Medical school openings increased 21% and residents and fellows increased 13%
  - In 2022, nursing schools turned away 90k+ applications due to insufficient staff and resources
- Closure of Services
  - Following a merger, studies show there are often decreases for inpatient pediatric services, maternity care, neonatal care, surgical care, intensive care, psychiatric care, and cardiac surgery
  - Rural areas are most impacted

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PROVIDER SHORTAGES – COST & UTILIZATION IMPACT

- Cost
  - Foregone care due to travel time and low access rates can exacerbate health conditions
  - Member costs due to longer distances to seek OB and specialty care
  - Use of more emergent services due to primary care shortages

- Utilization
  - Lower access rates for Medicaid population than Medicare and Commercial patients
  - Increasing wait times, which are larger in rural areas
  - Facility closures and reduction in service offerings (primarily in rural areas)
  - Telehealth and in-store clinics emerging to pick up the slack

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Available on SOA website

https://www.soa.org/resources/research-reports/2023/provider-consolidation-shortage/

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Reimagining Pharmacy Financing - Background

- Reimagining Pharmacy Workshop held on 3/25/23 in Chicago
  - Discussed how to attack the issue of pharmacy costs with different industry experts
  - Participant backgrounds included:
    - Health economics outcomes researchers
    - Clinical pharmacists
    - Medical doctors
    - Health actuaries
    - Benefits consultants
    - Brokers
  - Discussion focused on:
    - How to define and measure the value of prescription drugs
    - How the value of drugs should impact pharmacy financing
    - Developing new methodologies for pharmacy financing
  - Link to the conference report below:
  - https://www.soa.org/4904ae/globalassets/assets/files/resources/research-report/2023/reimagining-pharmacy-finance.pdf

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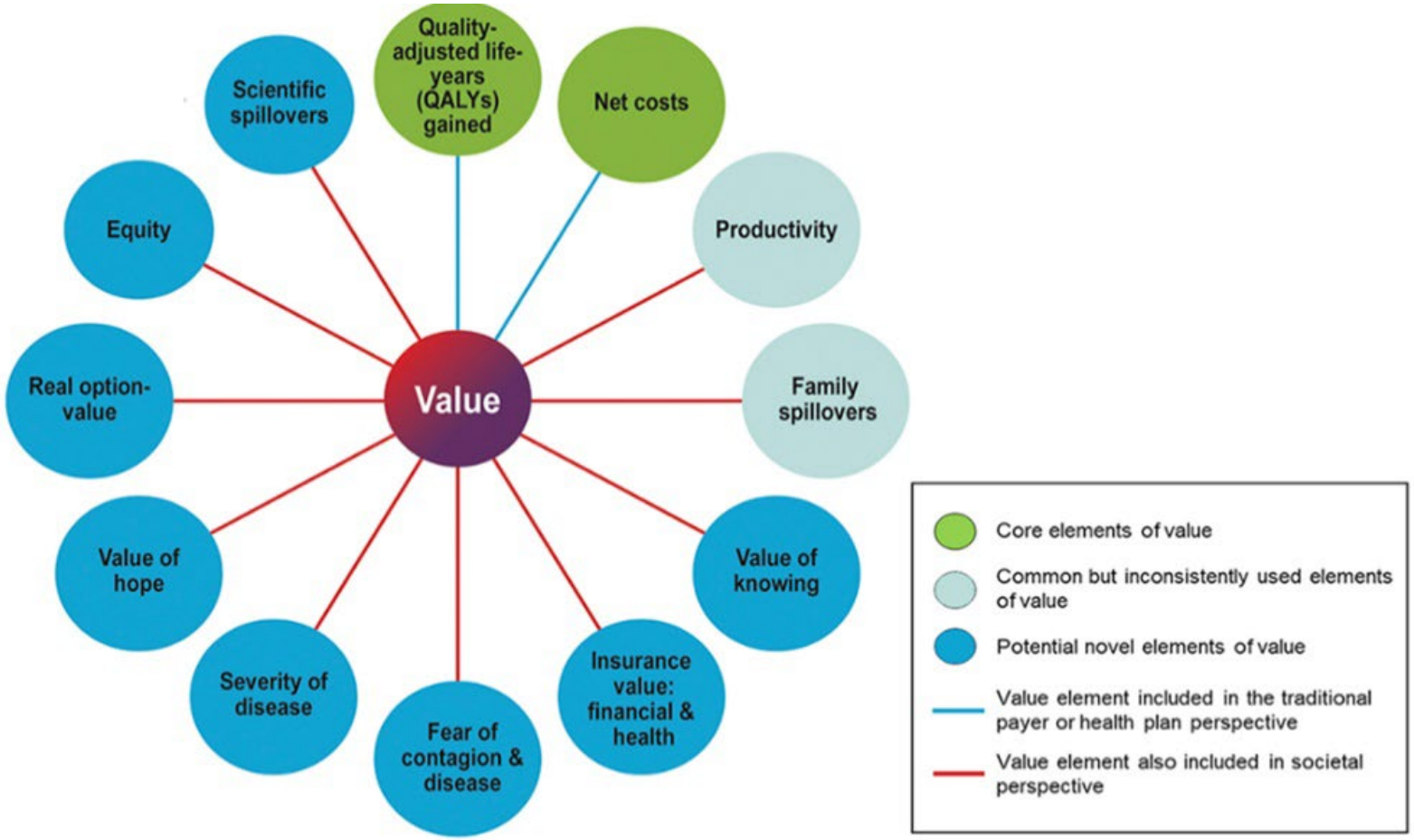
Reimagining Pharmacy Financing: Defining Value

The ISPOR* Value Flower



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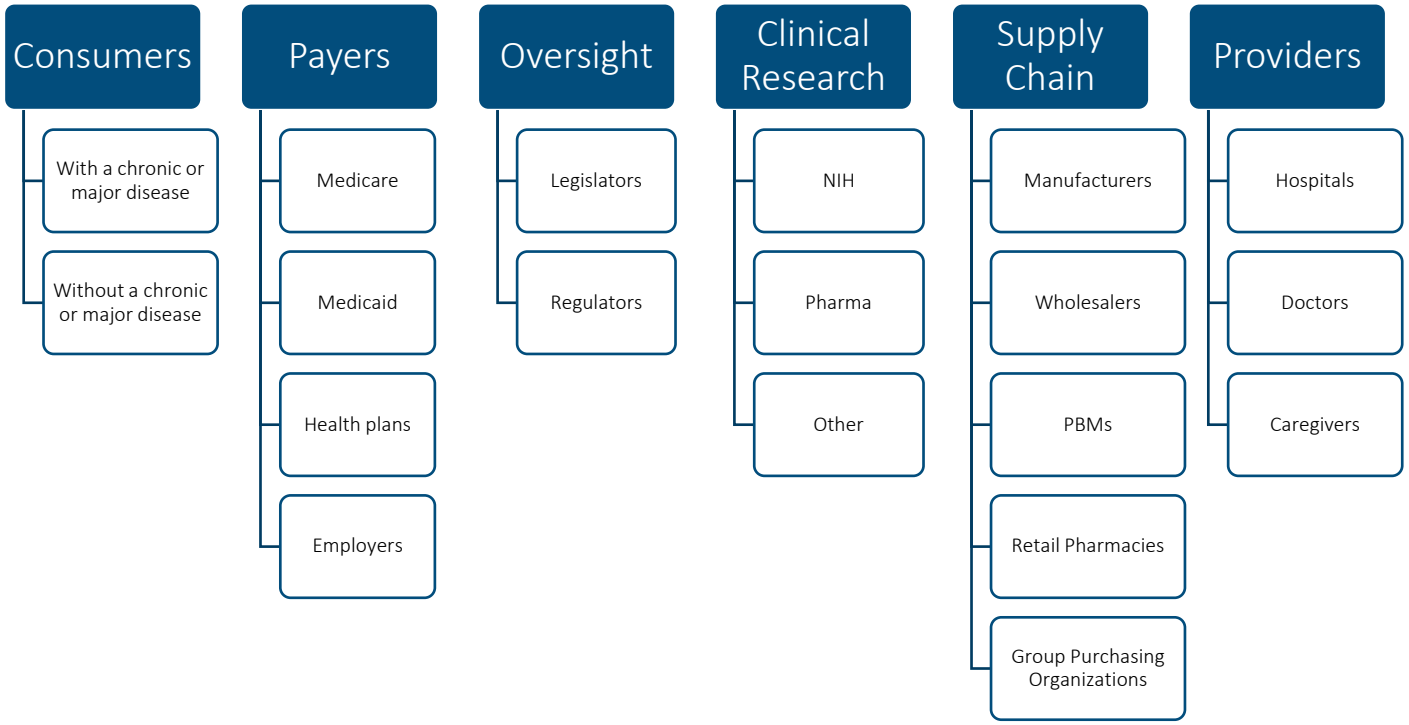
* International Society for Pharmacoeconomics and Outcomes Research

Reimagining Pharmacy Financing: Defining Value

- Definition of Value varies by Stakeholders



- Help create or determine value
- Impact supply and demand of drugs
- Influence cost and utilization of drugs

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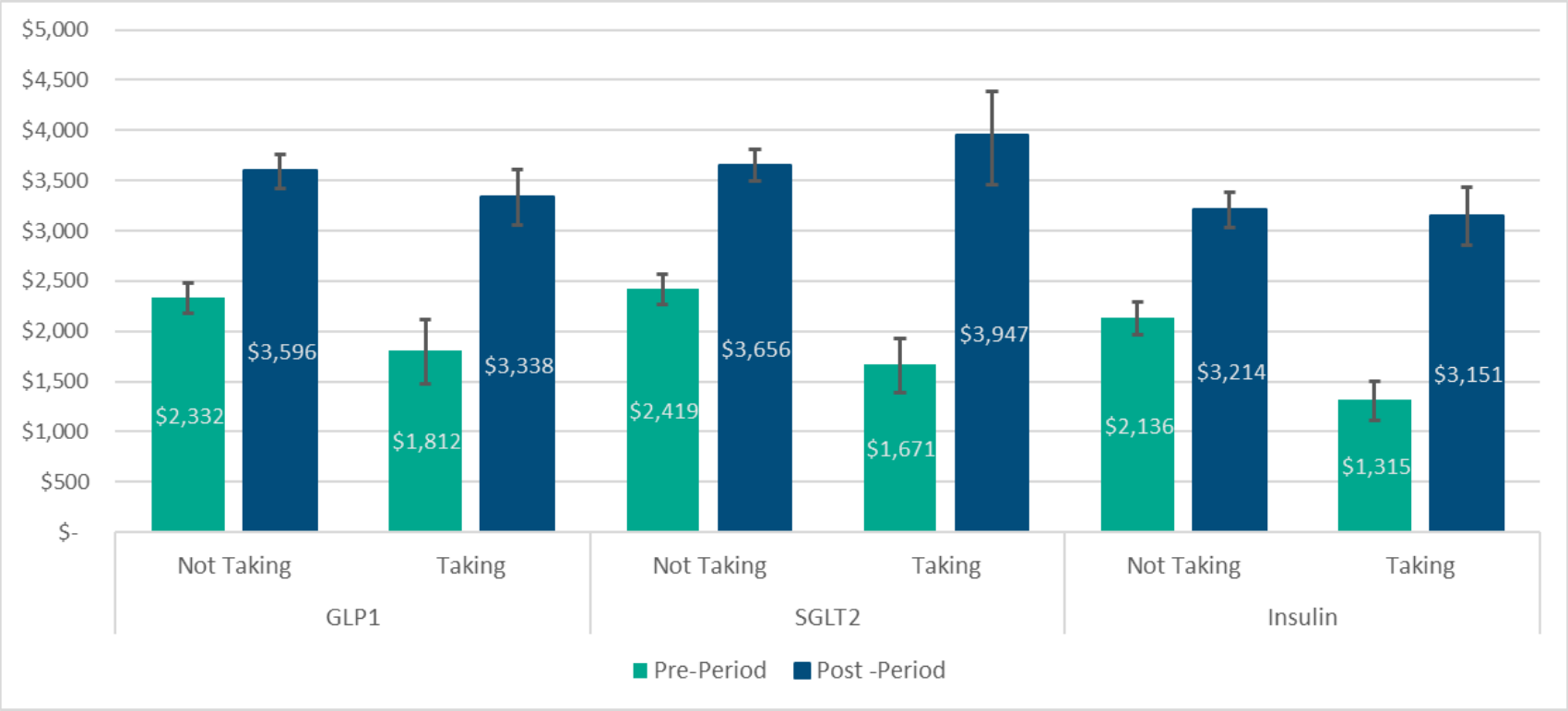
Measuring Value: Diabetes Drugs

2021 INDEX PERIOD ALLOWED COST PMPM COMPARISONS



- Compared PMPM Costs Pre- and Post Diagnosing Event
- Compared patients taking a drug to those not taking the drug with similar risk profiles post diagnosis
- GLP1's and Insulin most effective in reducing costs
- Taker Cost may be overstated due to absence of Drug Rebates

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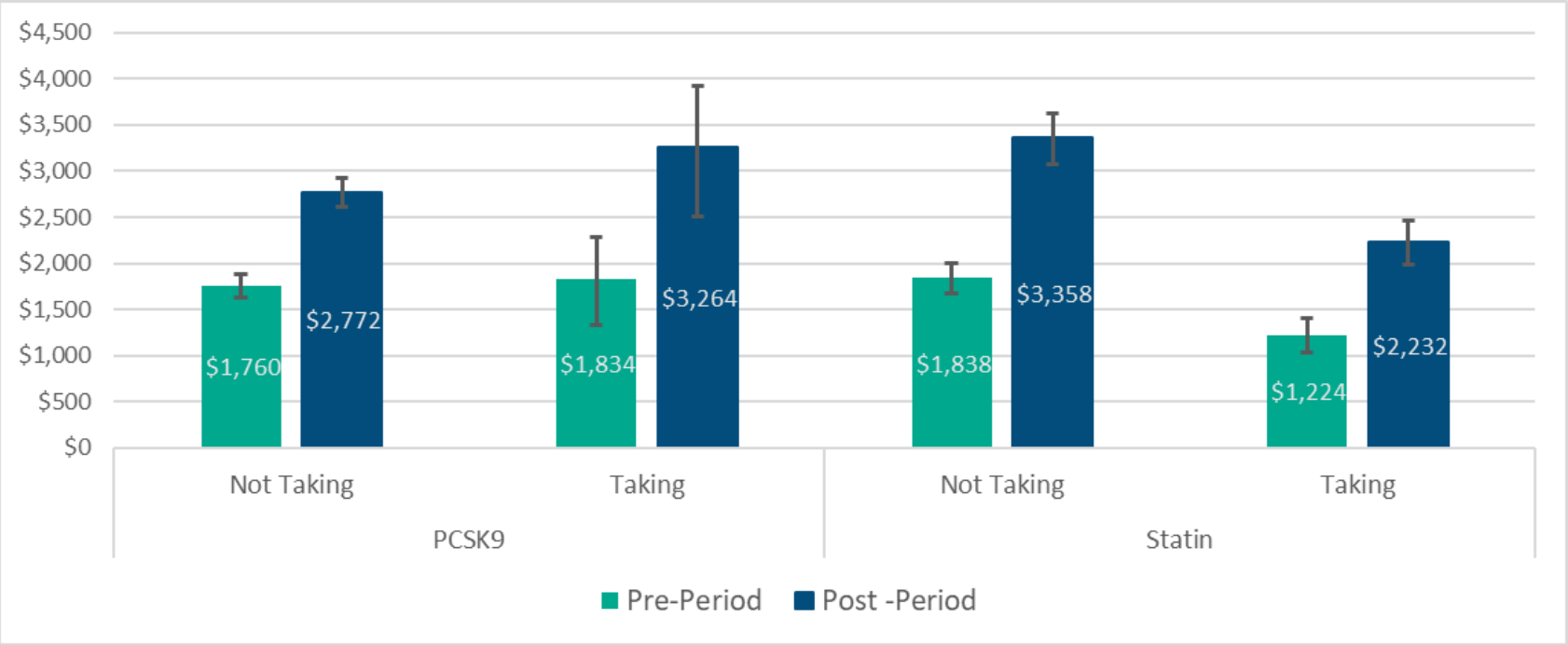
Measuring Value: Hypercholesterolemia Drugs

2021 INDEX PERIOD ALLOWED COST PMPM COMPARISONS



- Compared PMPM Costs Pre- and Post Diagnosing Event
- Compared patients taking a drug to those not taking the drug with similar risk profiles post diagnosis
- Statins most effective in reducing costs
- Taker Cost may be overstated due to absence of Drug Rebates

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Rewarding Value: Defining Success and Measuring Value

- Goal was to create Financing structures to reward values using current infrastructure
- Key components of a successful program include:
  - Increasing Transparency
  - Encouraging Competition
  - Mitigating total cost of care (TCOC) increases
  - Aligning stakeholder incentives
- Components of value to be measured:
  - Total Cost of Care
  - Incorporating QALYs and other ISPOR Value Flower Components
  - Components must be easily measurable
  - Proxy values can be developed to include additional value elements

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Rewarding Value: Considerations in Application

- Drug Prices are negotiated between payers and manufacturers
- Price Setting Considerations include:
  - Drug Portfolio vs. Single Drug
  - Fee for Service (FFS) vs. Shared Savings and Risk
  - Considerations of shared savings include:
    - How to split the savings
    - Bonuses vs. penalties
    - Use of Provider Incentives
- Risk Management needed for Payers to handle very expensive drugs
- Actuarial Health Technology Assessments
  - Needed to value drugs up front
- Technology Curve
  - Different stage of uptake can result in different utilization and pricing
- Value Stack
  - Compare incremental value vs. incremental cost of new drugs to determine ROI

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Available on SOA website

https://www.soa.org/resources/research-reports/2024/reimagining-pharmacy-financing/

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Additional Health Research

Experience Studies & Practice Research

Project Name	Objective	Expected Completion Date
Reimagining Pharmacy Financing	A follow-up to the Reimagining Pharmacy gathering in the Spring, this research will look to define and measure the value of different drugs for the same drug class and then also suggest methodologies for rewarding value.	https://www.soa.org/resources/research-reports/2024/reimagining-pharmacy-financing/
Statistical Approaches for Imputing Race and Ethnicity	Outline the various approaches for statistically imputing race and ethnicity in the U.S. along with their strengths and weaknesses to help familiarize actuaries with these techniques.	https://www.soa.org/resources/research-reports/2024/stat-methods-imputing-race-ethnicity/
Medicaid Underwriting Margin - COVID Update	Update the Medicaid Underwriting Margin Model with data through CY 2023 and incorporating data from the COVID PHE and the beginning of the PHE Unwinding.	https://www.soa.org/resources/research-reports/2024/medicaid-underwriting-margin-model/
Actuarial Weather Extremes - Drought Around the World in Early 2024	Highlight observations for extreme weather events across North America	https://www.soa.org/resources/research-reports/2019/weather-extremes/
Long Term Care Population Research Model	Assesses the impact of reform proposals for LTC system changes on stakeholders including consumers.	10/15/2024
HCCI Quick Hit - Specialty Pharmacy Trends	This research will examine some key specialty drugs to look at how increases in uptake in drugs worth between 10K and 200K are driving current pharmacy trend.	10/1/2024
HIV + Medicare	This research involves evaluating the impact of HIV positive individuals on Medicare Advantage.	9/15/2024
Assessing and Valuing the Impact of Technology in HealthCare	Examines the way actuaries value Technology within the Healthcare System	10/31/2024
The Impact of Social Determinants of Health on Risk Adjustment	Analyzes the potential impact of SDOH factors on Risk Adjustment	10/31/2024

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Attachment D

American Academy of Actuaries Health Practice Council (HPC) Updates Summer 2024

August 12, 2024
Health Actuarial (B) Task Force (HATF) Meeting

Matthew Williams, JD, MA
Senior Health Policy Analyst, Health
American Academy of Actuaries

American Academy of Actuaries

About the American Academy of Actuaries

The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues.

The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

For more information, please visit: www.actuary.org

American Academy of Actuaries

Activity Since Spring National Meeting

Webinars:

- April: Continuous Medicaid Unwinding: What's Next for the Health Care Markets in 2024?
- May: Medicare's Financial Outlook and the Effects of Growing Enrollment in Medicare Advantage
- June: 2025 Final Rules for Exchanges
- July: Drivers of 2025 Health Insurance Premium Changes

Key Takeaways from Federal Hill Visits

Federal Hill and Agency Visits in April

- How to improve affordability of care and coverage
- How to improve health care access and outcomes
- Market trends
- How will emerging treatments be covered and what will their costs be?
- Intersection of Artificial Intelligence and health

NAIC Engagement

Health Risk-Based Capital (HRBC) (E) Working Group Meetings

- June 6 meeting: Continued discussion on comments received on draft factors on the H3—Health Care Receivables project
- July 25 meeting: Verbal updates shared on the H2—Underwriting Review project, with final report still intended by year-end

NAIC Engagement

Long-Term Care Actuarial (B) Working Group

- Comments provided on “Minnesota Approach as a Candidate for a Single LTCI Multistate Rate Review (MSA) Approach”

Envision Tomorrow - 2024 Academy Annual Meeting

Oct. 15-16 at the Grand Hyatt in Washington, D.C.

Health-specific breakout sessions:

- Broadening the Focus: Incorporating Indirect Costs/Savings and Non-Financial Outcomes
- Integration of Care for Dual-Eligible Beneficiaries across Medicare and Medicaid
- Regulating the Affordable Care Act: What's New for 2025?

American Academy of Actuaries

Questions?

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American Academy of Actuaries

Policy Priorities for 2024

- Health equity
- Public health challenges
- Insurance coverage and benefit design
- Health care costs and quality
- Medicare sustainability
- Long-term services and supports
- Financial reporting and solvency
- Professionalism

August 1, 2024

Kevin Dyke, Chair
Ryan Jubber, Vice Chair
Health Actuarial (B) Task Force
National Association of Insurance Commissioners (NAIC)
1100 Walnut Street, Ste 1000
Kansas City, MO 64106

Re: Draft Knowledge Statements for Life and Health Actuaries

Dear Chair Dyke and Vice Chair Jubber,

On behalf of the American Academy of Actuaries (Academy),[1] I appreciate the opportunity to share an update regarding the Life Actuarial (A) Task Force's (LATF) request following the Fall National Meeting in Orlando.

In a November 30, 2023, letter, LATF requested that the Academy develop knowledge statements that outline the knowledge necessary for life actuaries signing certain statements of actuarial opinion, including the roles of appointed actuary, illustration actuary, and qualified actuary for principles-based reserves. After meeting with LATF leadership, along with several members of the Health (B) Actuarial Task Force (HATF) to better understand expectations, the Academy has drafted the attached materials. The draft reflects our initial effort to develop such knowledge statements for appointed actuary roles for orange blank filings (health).

The drafted knowledge statements are intended to reflect a baseline level of knowledge that the actuary should have for a designated role. Meeting this baseline level of knowledge does not imply that an actuary is qualified to issue the specified actuarial opinion. The *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States* (USQS) has many components of qualification beyond the baseline level of knowledge. In addition, there may be certain situations where the specified actuarial opinion is so limited in scope that some components of the baseline level of knowledge are not necessary.

The knowledge statements were developed by a group of Academy volunteers and have not been subject to a formal exposure process. As such, they should not be interpreted to be prescriptive or to be an interpretation of the USQS.

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

The Academy is pleased to be able to assist both actuarial task forces in this analysis. We appreciate your ongoing collaboration and feedback on this effort. Per the original request, we do expect that the final drafts will be submitted to HATF before the end of 2024. If you have any further questions, please feel free to contact Geralyn Trujillo, senior director of public policy (trujillo@actuary.org, 202-785-7875).

Sincerely,

Lisa Slotznick, President
American Academy of Actuaries

cc: Eric King, NAIC

Knowledge Statements for Appointed Actuary for Health Blank

These knowledge statements would apply to Appointed Actuary for Health and apply to the Health Annual Statement, also known as the Health Blank or Orange Blank.

As stated within the Health Blank instructions, the requirements for an actuary to qualify as the Appointed Actuary and be permitted to sign the Actuarial Opinion are that the actuary must be "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." Being a member in good standing implies, among other things, that an actuary adheres to the "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States" (USQS), effective January 1, 2022.

The USQS was revised from prior editions of the qualification standards and therefore specifically apply to actuaries issuing Statements of Actuarial Opinion (SAOs) starting on January 1, 2023. Furthermore, such actuaries need to meet the continuing education (CE) requirements before issuing any SAOs.

Section 2.1 of the USQS specifies the Basic Education and Experience Requirements, stating that an actuary should have achieved the following:

- Through education or mutual recognition, received a Fellow or Associate designation from either the Society of Actuaries (SOA) or the Casualty Actuarial Society (CAS). It is important to note that this would most likely be the SOA for an actuary issuing an opinion related to the Health/Orange Blank.
- Membership in the Academy.
- Three years of responsible actuarial experience, which is defined as work that requires knowledge and skill in solving actuarial problems.
- Be knowledgeable, through education or documented professional development, of
    1. U.S. Law, including statues, regulations, judicial decisions, and other statements having legally binding authority, applicable to the SAO, and
    2. U.S. actuarial practices and principles.
- Have either
    1. Obtained Fellowship in the CAS or SOA. In addition to obtaining this fellowship, the actuary must:
        i. Have completed education relevant to the subject of the SAO. Such education may have been obtained in attaining the fellowship designation or highest possible designation of a non-U.S. actuarial organization, or by completing additional education relevant to the subject of the SAO; or
        ii. Have a minimum of one year of responsible actuarial experience in the particular subject relevant to the SAO, under the review of an actuary who was qualified to issue the SAO at the time the review took place under the USQS in effect at the time.

OR

2. Have a minimum of three years of responsible actuarial experience in the particular subject relevant to the SAO, under the review of an actuary who was qualified to issue the SAO at the time the review took place under the USQS in effect at that time.

Section 3. of the USQS specifies the Specific Qualification Standards beyond those required to satisfy the General or Basic Education and Experience requirements. For issuing Health SAO, this includes examinations administered by either the Academy, CAS or SOA covering

a) Principles of insurance and underwriting;
b) Principles of ratemaking;
c) Statutory insurance accounting and expense analysis;
d) Premium, loss, expense and contingency reserves; and
e) Social insurance.

Alternatively, this education may be acquired through responsible work or self-study, if another qualified actuary familiar with the work is willing to attest to the knowledge of the opining actuary. To meet the experience requirement, an actuary is required to have at least three years of responsible experience relevant to the Opinion, under the review of another actuary who was qualified to issue the Opinion at the time the review took place.

DRAFTING NOTES: The regulators may allow caveats in the stem since not all statements filed on the Health Blank will include every item listed in the Knowledge Statement.

To address the regulatory concern of "not knowing what you don't know," a comprehensive listing is a good direction. These knowledge statements should also be seen as a flexible document that keeps old products relevant while being updated to allow for new product concepts along the way

It may be beneficial to include guidance in a cover page or introduction to the knowledge statements that suggests a "best practice" for the actuary, encouraging record keeping of the key items and an explanation of how the actuary met the requirement, such as when they achieved a credential or what their 1 or 3 years of experience looked like, which is kept updated. This record is particularly valuable when there are changes within their organization, to help an Appointed Actuary think about and know about when working with a new product.

Principles of Insurance and Underwriting

1. **Insurable Risk Concepts**: Understanding the dynamic between moral hazard and insurable risks; recognizing the increased risks associated with moral hazards as insurable risks diminish.

2. **Health Insurance Products**: In-depth knowledge of various health insurance products and their unique features, including:
    - **Medical Insurance**: Differentiating between individual, small group, large group, self-funded, Medicare Advantage, Medicare Part D, Medicare Supplement, Managed Medicaid, and short-term medical plans.
    - **Dental and Vision Insurance**: Characteristics and coverage details.
    - **Group Term Life and AD&D**: Key aspects and insurance parameters.
    - **Disability Insurance**: Nuances of short-term, individual, and long-term disability insurance.
    - **Long-Term Care**: Coverage scope and policy features.
    - **Specialized Health Insurance**: Understanding cancer/critical illness and hospital indemnity insurance.
3. **Distribution Methods**: Comprehensive knowledge of distribution channels for each type of coverage.
4. **Underwriting Processes**: Mastery of underwriting procedures for each coverage type and strategies to address selection risks.
5. **Behavioral Underwriting Factors**:
    - Effects of network and coverage limitations.
    - Impact of healthy lifestyle incentives on consumer choices.
    - The correlation between individual choices and funding sources.
6. **Seasonal Claim Patterns**: Recognizing and analyzing seasonal trends in claim incidences for different products.

Principles of Ratemaking

1. **Premium Rate Components**: Understanding the constituents of premium rates, including benefit costs, expenses, and risk charges.
2. **Medical Insurance Contract Elements**: Comprehensive knowledge of risk assumption, provider network access, care management/wellness programs, and claims management/adjudication.
3. **Risk Levels of Different Products**: Expertise in evaluating risk for diverse products, including self-funded plans, dental/vision, retrospective experience rated, fully insured plans, specific and aggregate stop loss, disability, and long-term care (LTC).
4. **Renewal Rate Change Rules**: Familiarity with renewal rate change regulations for each product.
5. **Rating Restrictions**: Understanding the rating limitations for products such as those under the 2010 federal statute, the Patient Protection and Affordable Care Act (ACA).
6. **Risk Adjustment in ACA and Medicare Advantage**: Proficiency in the impact of risk adjustment on premium amounts and payment timings, including risk adjustment data validation (RADV) issues.

Statutory Insurance Accounting and Expense Analysis

1. **Statutory Accounting Principles**: Deep understanding of statutory accounting principles and guidance sources.
2. **Statutory Accounting Blanks and SSAPs**: Familiarity with statutory accounting blanks and associated Statements of Statutory Accounting Principles (SSAPs).
3. **Conservatism in Financial Statements**: Knowledge of the treatment of conservatism in statutory financial statements.
4. **Reserves vs. Liabilities**: Distinguishing between reserves and liabilities.
5. **Covered and Uncovered Expenses/Liabilities**: Understanding the differences and implications.
6. **Reinsurance Treatment**: Mastery of reinsurance treatment in statutory accounting, including issues related to risk transfer.
7. **Expense Segmentation**: Skills in segmenting expenses between claim adjustment expenses and distinguishing between variable and overhead costs.
8. **Appointed Actuary Requirements**: Familiarity with the roles and responsibilities.
9. **Actuarial Opinion and Memorandum Components**: Understanding of the different types of opinions, prescribed language, and scope.
10. **Timing of Actuarial Opinions and Memorandums**: Knowledge of appropriate timing for these documents.
11. **Risk-Based Capital (RBC) Formula Elements**: Expertise in the components of the risk-based capital formula and its regulatory impacts.
12. **Testing of Prior Period Liabilities and Assets**: Skills in evaluating the accuracy and adequacy of prior period liabilities and actuarial assets.

Premium, Loss, Expense, and Contingency Reserves (and Actuarial Assets)

1. **Premium Reserves**: Understanding of assets and liabilities typically found in health products, calculation methods, and their documentation. Premium reserves include items such as:
    1. Due and uncollected premium
    2. Premium paid in advance
    3. Unearned premium
    4. Retrospective premium receivable or payable
    5. Risk adjustment receivable or payable
    6. Minimum loss ratio (MLR) refund liability
    7. Risk corridor assets and liabilities

2. **Loss Reserves**: Proficiency in calculating loss reserves, including segmentation and consideration for various factors. Loss reserves include items such as:
    1. Unpaid claim reserves and liabilities, including segmentation into not reported, in course of settlement, due and unpaid and present value of amounts not yet due.
    2. Contract reserves and gross premium reserves, including prescribed minimum assumptions.
    3. Provider assets and liabilities, including the types of contractual provisions that give rise to such assets/liabilities.

3. **Claim Adjustment Expense Liability**: Expertise in determining claim adjustment expense liabilities.

4. **Premium Deficiency Reserves**: Mastery in calculating premium deficiency reserves (PDR), including considerations for grouping, projection time periods, expense reallocation, treatment of investment income, and tax implications.

5. **Asset Adequacy Analysis**: Skills in conducting asset adequacy analysis and determining additional reserve requirements.

6. **Capitations and Provider Insolvency Risks**: Knowledge of capitations and the associated risks of provider insolvency.

7. **Other Actuarial Assets**: Expertise in estimating and documenting other actuarial assets specific to health insurance products. Other actuarial assets include items such as:
    1. Provider risk sharing receivables
    2. Loans and advances to providers
    3. Capitation arrangement receivables
    4. Pharmacy rebate receivables
    5. Claim overpayment receivables

Social Insurance

1. **Medicare Program**: Comprehensive understanding of the components, coverages, and funding mechanisms of the Medicare program.
2. **Medicaid and CHIP**: In-depth knowledge of Medicaid and the Children's Health Insurance Program (CHIP), including their components, coverages, and funding.
3. **Disability Insurance and Social Security**: Understanding the components and coverages of the Disability Insurance (DI) portion of Social Security and its interactions with other disability income coverages.

Professionalism and Business Skills

The Appointed Actuary must have professional and business skills to enable the Appointed Actuary to perform the required actuarial services in an ethical manner that upholds the reputation of the actuarial profession. The Appointed Actuary must know and adhere to the Code of Professional Conduct, as well as relevant ASOPs and must meet the USQS. The Appointed Actuary must have the professional and business skills to manage the tasks, make informed decisions, communicate effectively with users of the actuary's work products, resolve disagreements, and seek guidance as necessary.

1. **Code of Conduct**: Familiarity with the Code of Conduct and its application in professional scenarios.
2. **US Qualification Standards**: Profound understanding of the USQS.
3. **Actuarial Standards of Practice (ASOPs) and Applicability**: Mastery of applicable ASOPs and guidelines for their application. The actuary should refer to the Academy's Applicability Guidelines to determine applicable ASOPs.
4. **Documentation:** Understanding the importance of documentation of work as discussed in many ASOPs and as required by the Laws and Regulations applicable to the SAO.

In addition to these knowledge statements, Section 2.1.c of the USQS requires the actuary to be knowledgeable of the U.S. law applicable to the SAO. For a health blank actuarial opinion signed by the Appointed Actuary, this would include knowledge of:

- Health Insurance Reserves Model Regulation.
- NAIC Health Reserve Guidance Manual.
- NAIC Annual Statement Instructions, specifically as it relates to Health and the SAO.
- Applicable provisions of Health Insurance Portability and Accountability Act (HIPAA)
- Applicable SSAPs including:
    - SSAP 54
    - SSAP 55
    - SSAP 84
- Individual state laws and regulations applicable to the actuarial opinion and assets and liabilities within the scope of the opinion.
- Other applicable laws and regulations related to specific products referenced in the specific SAO.

Familiarity with the relevant Practice Notes from the Academy is also a valuable component of professionalism.

Attachment F

American Academy of Actuaries Response to Knowledge Statement Request

Lisa Slotznick
Darrell Knapp
Rhonda Ahrens

August 12, 2024

American Academy of Actuaries

About the Academy

- The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues.
- The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

For more information, please visit:

www.actuary.org

Agenda

- Background
- Process to date
- Review draft language
- Next steps

American Academy of Actuaries

Background

Request from LATF at 2023 Fall National Meeting

- LATF requested American Academy of Actuaries recommend knowledge statements for life actuaries signing certain Statements of Actuarial Opinion, including for actuaries serving as appointed actuaries, as illustration actuaries, and as qualified actuaries for principle-based reserves.
- HATF, although not making a formal request, raised a similar discussion in its meeting.

Process To Date

- Styled after the casualty knowledge statements that were developed by the NAIC's Casualty Actuarial Task Force
- Leveraged materials from the Academy's Life and Health Qualification Standards
- Focused on appointed actuaries first, both life and health
- Several regulator-only meetings to discuss preferences and strategy

Important Considerations

- The knowledge statements provided are recommendations in response to the LATF request and the HATF discussion.
- Knowledge statements are not a position of the Committee on Qualifications, and future use and modification of these recommendations are the responsibility of LATF and HATF.
- The knowledge statements focused on additional knowledge that an actuary should have to perform specifically identified tasks. This does not include basic knowledge of actuarial mathematics, accounting, economics, and risk theory that all actuaries should have (primarily knowledge demonstrated prior to the associateship level in either the Society of Actuaries or Casualty Actuarial Society).
- Fulfillment of the knowledge statements does not imply an actuary is qualified to provide a given opinion. There are additional qualification requirements, and there may be additional knowledge required dependent on the topics covered under the opinion.

Drafted Language for Appointed Actuary

- The knowledge statements are broken down into six groupings—Principles of Insurance and Underwriting; Principles of Ratemaking; Statutory Insurance Accounting and Expense Analysis; Premium, Loss, Expense, and Contingency Reserves (and Actuarial Assets); Social Insurance; and Professionalism and Business Skills.
- The first five groupings correspond to the specific topics mentioned in Section 3 of the U.S. Qualification Standards. Professionalism and Business Skills was added as an additional topic to highlight the importance of professionalism in the appointed actuary role.

Next Steps

Will continue to draft qualified actuary and illustration actuary knowledge statements (*drafts anticipated before Fall National Meeting)*. We anticipate the qualified actuary draft will be a subset of the appointed actuary statement.

In November, the completed drafts will be submitted to LATF.

Questions?

For more information, please contact

Geralyn Trujillo

Senior Director, Public Policy

trujillo@actuary.org

American Academy of Actuaries