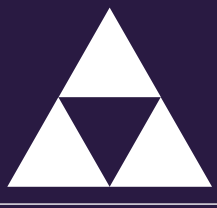
A PUBLIC POLICY PRACTICE NOTE

Practice Note on the Revised Actuarial Statement of Opinion Instructions for the NAIC Health Annual Statement Effective December 31, 2009

September 2009

American Academy of Actuaries
Health Practice Financial Reporting Committee



American Academy *of* Actuaries

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Practice Note on the Revised Actuarial Statement of Opinion Instructions for the NAIC Health Annual Statement Effective December 31, 2009

Developed by the Health Practice
Financial Reporting Committee

AMERICAN ACADEMY *of* ACTUARIES

This practice note is a product of the Academy's Health Practice Financial Reporting Committee, and was prepared by Darrell Knapp, chair, and Shari Westerfield. Practice notes are intended to provide actuaries with information on industry practices rather than authoritative guidance. This practice note is not a promulgation of the Actuarial Standards Board, is not an actuarial standard of practice, is not binding upon any actuary and is not a definitive statement as to what constitutes generally accepted practice in the area under discussion. Events occurring subsequent to this publication of the practice note may make the practices described in this practice note irrelevant or obsolete. This practice note does not necessarily represent the views of the Academy as a whole, nor does it represent a statement or view of the National Association of Insurance Commissioners (NAIC).

Comments are welcome as to the appropriateness of the practice notes, desirability of annual updates, substantive disagreements, etc. Comments should be sent to the Academy's State Health Policy Analyst, Melissa Stevens, at stevens@actuary.org.

TABLE OF CONTENTS

Introduction and Purpose

For the 2009 health annual statement filing, the NAIC adopted significant modifications to the actuarial opinion requirements that all practicing health actuaries need to be aware of in advance of the filing. This paper was prepared to assist actuaries to both understand and comply with these new requirements promulgated by the NAIC.

All types of insurance companies are subject to financial reporting requirements developed by the NAIC in the form of an annual statement blank. An actuarial statement of opinion relating to reserves and other actuarial items must accompany each annual statement filing, pursuant to the NAIC instructions. The type of annual statement filed depends on the insurer's lines of business inforce. Companies that pass the health test contained in the annual statement instructions can file the health annual statement blank, also known as the orange blank. The instructions for the health actuarial opinion are contained within the instructions for the health annual statement blank.

A company licensed as a life insurance company that files the orange blank may also be subject to the Standard Valuation Law and the Actuarial Opinion and Memorandum Regulation in addition to the health annual statement instructions. Similarly, a company licensed as a property/casualty insurance company that files the orange blank may also be subject to additional requirements. Be sure to check your state's specific requirements.

Effective with the 2009 health annual statement, the NAIC adopted revised actuarial opinion instructions. These revised instructions include some significant modifications that practicing health actuaries need to recognize. (See Appendix A for the instructions proposal as adopted.) This practice note focuses on these modifications and therefore does not cover all issues surrounding the health actuarial statement of opinion. It also provides the actuary with some practical information for compliance with the revised instructions.

Background Information

The NAIC Accident & Health Working Group developed the revised health actuarial opinion instructions effective for the 2009 annual statement filing with considerable input from both the NAIC Life & Health Actuarial Task Force and the Casualty Actuarial & Statistical Task Force. In developing the instructions, these regulators stated their intent was to bolster the regulatory value of the opinion and to bring more consistency between the life/accident and health, property/casualty, and health blank opinions. Other goals of their revisions were to make it easier for non-actuaries to review the opinions and to improve the clarity of the instructions.

In addition to some minor changes, the resulting health actuarial opinion instructions included the following major changes:

1.) A qualified health actuary must be appointed by the company's Board of Directors and must report annually to the Board of Directors or the Audit Committee;

2.) The use of a "checkbox" section to indicate whether the opinion is unqualified, qualified, adverse or inconclusive;

3.) The definition of prescribed language (as opposed to suggested language in the prior instructions) with any modifications or deviations noted within the "checkbox" section;

4.) The requirement to reconcile the underlying claim lag data to Part 2B of the Underwriting and Investment Exhibit; and

5.) A supporting Actuarial Memorandum.

Role of an Appointed Actuary

The 2009 NAIC health actuarial opinion instructions require that the opinion be that of an appointed actuary, which is defined as, "a qualified health actuary appointed by the Board of Directors, its equivalent, or a committee of the board." The instructions further define a qualified health actuary as, "a member of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuations."

All members of the Academy must comply with the current Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States. They must also follow all relevant and applicable Actuarial Standards of Practice as promulgated by the Actuarial Standards Board. Actuaries who want to be qualified to opine, but do not have sufficient valuation knowledge or experience, are encouraged to attend the Academy's Life and Health Qualifications Seminar held in November of each year.

According to the NAIC health actuarial opinion instructions, the actuary must be appointed by December 31 of the calendar year for which the opinion is rendered. The company must notify the domiciliary insurance commissioner within five business days of the appointment. The notification should include the name, title (and firm, if a consulting actuary), manner of appointment, and a statement that the person meets the requirements of a qualified health actuary. The appointment remains in effect unless the actuary ceases to be appointed or ceases to meet the requirements of a qualified health actuary.

Therefore, if an actuary who rendered a 2008 opinion was previously appointed in accordance with the 2009 instructions, then an actuary does not need to be re-appointed. However, if the actuary was not formally appointed as outlined in the 2009 instructions, or was appointed by management rather than the Board, then that actuary needs to be properly appointed in order to render the 2009 opinion.

The instructions require that the appointed actuary report to the company's Board of Directors or the Audit Committee each year on the items within the scope of the health actuarial opinion. As a practical matter, this reporting does not necessarily need to be made in person, but may be via a written report as long as the appointed actuary receives and responds to any questions of the Board. The Board minutes should reflect receiving the report of the appointed actuary.

The appointed actuary is also responsible for preparing a supporting actuarial memorandum to document and convey the actuary's work and conclusions. Once completed, the actuarial opinion and memorandum must be made available to the Board of Directors.

If the appointed actuary is replaced, the company is to notify the domiciliary commissioner of the change within five (5) business days. The company must also provide the commissioner with a separate letter within ten (10) business days of the notification stating whether there were any disagreements with the former appointed actuary regarding the content of the opinion on matters of

the risk of material adverse deviation, required disclosures, scopes, procedure, or data quality in the previous 24 months. Disagreements are to be reported regardless of whether they were resolved to the former appointed actuary's satisfaction. The company is required to request of the prior appointed actuary that he/she furnish a letter stating whether the actuary agrees with the statements in the company's letter. Since the Code of Professional Conduct indicates that the prior appointed actuary is required to cooperate regardless of whether he/she has disagreements with the company or if he/she has not been compensated, the prior appointed actuary should prepare a response to the company's letter in a timely manner.

Classification of an Actuarial Opinion

In developing an opinion relating to claim reserves and other actuarial items, the appointed actuary is to use professional judgment in determining whether it is unqualified, qualified, adverse or inconclusive. The instructions include definitions of qualified, adverse and inconclusive. If, under the definitions none of these applies, then by default the opinion may be unqualified.

A qualified opinion results from a situation where the actuary can determine that all liabilities, except for specifically defined components, make a good and sufficient provision. In this scenario, the actuary should state that the liabilities make a good and sufficient provision except for the amounts for which the opinion is qualified. It is not necessary to issue a qualified opinion if the amounts in question are believed by the actuary to be immaterial. For example, if the actuary has not performed asset adequacy analysis and does not believe that performing such analysis would result in a material additional liability, it is not necessary to qualify the opinion.

An adverse opinion arises when the actuary determines that the reserves and liabilities are not good and sufficient. Adverse opinions may have significant regulatory repercussions for the company and, as such, the actuary should thoroughly communicate the findings and the bases of the findings to the company and the Board of Directors prior to issuing such an opinion.

An inconclusive opinion is when the actuary is unable to form an opinion due to deficiencies in data, analysis, assumptions or related information. An inconclusive opinion should include a description as to what deficiencies caused this conclusion. If the company has limited historical experience data or a material new line of business, it may not be necessary to issue an inconclusive opinion; actuarial educational literature provides several alternative methods of establishing appropriate liabilities in these situations.

Body of the Actuarial Opinion

According to the health actuarial opinion instructions, the opinion must consist of the following six clearly designated sections:

1.) Table of Key Indicators - alerts the reader to the classification of the opinion, any modifications to the prescribed wording, and any deviations from actuarial standards;

2.) Identification Section - identifies the appointed actuary;

3.) Scope Section - identifies the subjects on which an opinion is to be expressed and describes the scope of the appointed actuary's work. All line items are to be displayed even if the

recorded amounts are zero. Note that the premium deficiency reserve is included in the aggregate health policy reserves. The scope of the opinion should include the methods and assumptions used to determine the premium deficiency reserve, even if that value is zero. In addition to the actuarial reserves and liabilities specified in the instructions, the appointed actuary is to include any other actuarial reserve or liability not listed. State insurance commissioners may request additional items be included; for example, some regulators have requested the opinion include any retrospective premium assets;

4.) Reliance Section - identifies anyone that the appointed actuary relied upon for the underlying data records and/or summaries. If relying on another party for the accuracy and completeness of the data, a reliance letter from that party should be attached;

5.) Opinion Section - expresses the appointed actuary's opinion with respect to the subjects identified in the Scope section. The statement in the opinion section related to compliance with state laws has changed to include not only the state of domicile but be at least as great as the minimum aggregate amounts required by the state in which the statement is filed. This requires the appointed actuary to understand what states the financial statements and actuarial opinion are to be filed in and to review any minimum reserve requirements in those states. The basis of the opinion should be documented in the actuarial memorandum described below; and

6.) Relevant Comments Section – allows the appointed actuary to further comment or explain any circumstances, concerns, or issues.

For each of these sections, the instructions contain defined requirements plus prescribed wording, with the exception of the Relevant Comments section. The instructions strongly recommend that the actuary use the prescribed wording for each section, if appropriate. The prescribed wording is intended to allow the regulatory analysts, who may not be actuaries, to focus on the overall content of the opinion without parsing the language for what may be an immaterial wording deviation. No prescribed wording is provided for the Relevant Comments section, because the purpose of that section is to allow the actuary to include additional comments or explanations that are not addressed by the other sections. Therefore, any Relevant Comments are automatically "revised wording."

The actuary may modify the prescribed wording or add to it for clarification as long as the appropriate box is checked in the newly required Table of Key Indicators. The use of alternative wording or additional wording does not imply an unacceptable opinion, but may be a trigger for closer reading from the regulator reviewing the opinion. The actuary should, in any case, use language that clearly expresses his or her professional judgment.

The Table of Key Indicators, positioned at the top of the opinion, contains a series of checkboxes intended to direct the attention of the reader, especially regulators, to the classification of the opinion, any modifications to the prescribed wording, and any deviations from the applicable Actuarial Standards of Practice. The actuary is to indicate whether the opinion is unqualified, qualified, adverse, or inconclusive. For each section of the body of the opinion, the actuary is to indicate whether the actual language used is the prescribed wording only, contains additional wording, or is revised wording altogether. If the actuary deviated from any Actuarial Standard of Practice, the actuarial memorandum must contain a disclosure, and the statement at the end of the Table of Key Indicators must be checked. If a disclosure stated that the actuary had not deviated, then the statement should be left unchecked.

Following is a sample table with completed checkboxes:

This Opinion is	☒ Unqualified	☐ Qualified	☐ Adverse	☐ Inconclusive
Identification Section	☒ Prescribed Wording Only	☐ Prescribed Wording with Additional Wording		☐ Revised Wording
Scope Section	☒ Prescribed Wording Only	☐ Prescribed Wording with Additional Wording		☐ Revised Wording
Reliance Section	☐ Prescribed Wording Only	☒ Prescribed Wording with Additional Wording		☐ Revised Wording
Opinion Section	☒ Prescribed Wording Only	☐ Prescribed Wording with Additional Wording		☐ Revised Wording
Relevant Comments				☒ Revised Wording
☐ The Actuarial Memorandum includes "Deviation from Standard" wording regarding conformity with an Actuarial Standard of Practice				

The opinion should always conclude with the signature and contact information of the appointed actuary and the date when the opinion was rendered. The date the opinion was rendered imply that the opining actuary considered any known significant events that occurred after the financial statement date, but prior to the date the opinion was rendered. This does not imply that the opining actuary should request subsequent claims development up to the rendering date and recalculate liabilities using more current information. However, if the actuary becomes aware of any significant events occurring after the financial statement date, he/she should reflect them to the extent that such events may materially impact the conclusions reached regarding the financial condition of the company as of the financial statement date.

Supporting Actuarial Memorandum

As previously mentioned, the appointed actuary is responsible for preparing an actuarial memorandum in support of the actuarial opinion. According to the health actuarial opinion instructions, an actuarial memorandum is defined as "a document or other presentation, prepared as a formal means of conveying the appointed actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the appointed actuary's opinion or findings, and of documenting the analysis underlying the opinion."

This definition entails the inclusion of proprietary information. As such, the memorandum is considered a confidential document by the insurance regulators, state laws permitting, and is not intended for public inspection. The memorandum is not actually filed with the state insurance department, but must be available upon request or during a statutory financial examination. The memorandum must be available by May 1 following the submission of the opinion or within two weeks after a request from a state insurance commissioner. Internal and external auditors may also request to review the memorandum as part of their audits. The memorandum must also be made available to the Board of Directors.

Given that the memorandum is to document and convey the appointed actuary's opinion, it is to contain both narrative and technical components. The narrative components should clearly explain to the Board of Directors, company management, regulators, auditors, or other authority the actuary's findings, recommendations and conclusions, while the technical components should document and disclose the analyses from the basic data to the conclusions. The intended audience of the narrative component is generally non-actuaries, while the intended audience of the technical component is other health actuaries. The memorandum must also conform to the documentation and disclosure requirements of applicable Actuarial Standards of Practice.

In order to achieve the objectives of the memorandum, the actuary needs to include enough detail to demonstrate sufficient steps in the analyses such that another health actuary could understand how the conclusions were reached, but not necessarily all the detailed work papers. Items to consider for inclusion within the memorandum are data reconciliations, claim lags/triangles, trend analyses, development of assumptions, and any other actuarial studies performed.

According to the instructions, the memorandum must also include:

- An exhibit that ties to the Annual Statement and compares the actuary's conclusions to the carried amounts;
- Documentation of the required reconciliation from the data used for analysis to the Underwriting and Investment Exhibit Part 2B of the health annual statement (the reconciliation should include comparison of the data and the exhibit with explanations of the causes driving any difference);
- Any other follow-up studies documenting the prior years' claim liability and claim reserve run-off as considered necessary by the actuary; and
- Documentation of the assumptions used for contract reserves and any material changes to the assumptions from those used in the previous valuation. Such documentation should address any studies which support the adequacy of any margin in the reserves.

Summary

For the 2009 health annual statement filing, the NAIC adopted significant modifications to the actuarial opinion requirements that all practicing health actuaries need to be aware of in advance of the filing. These modifications include the appointment of the actuary, the inclusion of checkboxes, the use of prescribed language, and a supporting actuarial memorandum. State insurance laws may alter the NAIC's actuarial opinion requirements. Actuaries are highly encouraged to review state laws prior to developing the actuarial opinion.

The Accident & Health Working Group and the Life & Health Actuarial Task Force of the NAIC each have several projects in progress that may alter the actuarial opinion requirements for 2010 and beyond. Actuaries are reminded keep abreast of the changes in the requirements.

All members of the Academy must comply with the current Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States and all relevant Actuarial Standards of Practice as promulgated by the Actuarial Standards Board. A list of relevant standards, as of the date of this publication, is included in Appendix B.

APPENDIX A – Excerpt from the 2009 Health Annual Statement Instructions

ACTUARIAL OPINION

1. There is to be included on or attached to Page 1 of the annual statement, the statement of the appointed actuary setting forth his or her opinion relating to claim reserves and any other actuarial items. 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 (5) 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. Once these notices are furnished, no further notice is required with respect to this person unless the actuary ceases to be appointed or retained or ceases to meet the requirements of a qualified health actuary. "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.

If an actuary who was the appointed actuary is replaced, the insurer shall within five (5) business days notify the insurance department of the state of domicile of this event. The insurer shall also furnish the domiciliary commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former appointed actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scopes, procedure, or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former actuary's satisfaction and those not resolved to the former actuary's satisfaction. The insurer shall also in writing request such former actuary to furnish a letter addressed to the insurer stating whether the actuary agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he does not agree; and the insurer shall furnish such responsive letter from the former actuary to the domiciliary commissioner together with its own.

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. The Actuarial Opinion and the Actuarial Memorandum must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors or the Audit Committee and that the Actuarial Opinion and the Actuarial Memorandum were made available. A separate Actuarial Opinion is required for each company filing an Annual Statement.

The Actuarial Opinion and the supporting Actuarial Memorandum and work papers must conform to the appropriate Actuarial Standards of Practice (ASOPs), as promulgated by the Actuarial Standards Board.

1A. Definitions

"Insurer" means an entity authorized to write accident and health contracts under the laws of any state and which files on the Health Blank.

"Actuarial Memorandum" means a document or other presentation, prepared as a formal means of conveying the appointed actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the appointed actuary's opinion or findings and that documents the analysis underlying the opinion. The expected content of the memorandum is further described in Section 1B.

APPENDIX A – Excerpt from the 2009 Health Annual Statement Instructions

1B. The Actuarial Memorandum and underlying actuarial work papers supporting the Actuarial Opinion will be available for regulatory examination for seven (7) years.

The Actuarial Memorandum contains significant proprietary information. It is expected that the Memorandum will be held confidential and is not intended for public inspection. The Memorandum must be available by May 1 of the year following the year-end for which the opinion was rendered or within two weeks after a request from an individual state commissioner.

The Actuarial Memorandum should conform to the documentation and disclosure requirements of the Standards of Practice as promulgated from time to time by the Actuarial Standards Board. The Actuarial Memorandum should contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to company management, the regulator, or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data, e.g., claim lags, to the conclusions.

The Memorandum must also include:

- An exhibit which ties to the Annual Statement and compares the actuary's conclusions to the carried amounts;

- Documentation of the required reconciliation from the data used for analysis to the Underwriting and Investment Exhibit Part 2B;

- Any other follow-up studies documenting the prior year's claim liability and claim reserve run-off as considered necessary by the actuary; and

- Documentation of the assumptions used for contract reserves and any material changes to those assumptions from the assumptions used in the previous memorandum. Such documentation should address any studies which support the adequacy of any margin in such reserves.

2. The Actuarial Opinion must consist of the following sections:

- A TABLE of KEY INDICATORS to alert the reader to the type of opinion and any changes from the prescribed language;

- IDENTIFICATION section - identifies the appointed actuary;

- SCOPE section - identifies the subjects on which an opinion is to be expressed and describes the scope of the appointed actuary's work;

- RELIANCE section – identifies anyone that the actuary has relied upon to for the underlying records and/or summaries;

- OPINION section – expresses the appointed actuary's opinion with respect to the subjects identified in the Scope section; and

- RELEVANT COMMENTS section.

APPENDIX A – Excerpt from the 2009 Health Annual Statement Instructions

Each section must be clearly designated. For each section there is prescribed wording for that section. If the appointed actuary changes this wording or adds additional wording to clarify the prescribed wording, the appropriate box in the TABLE of KEY INDICATORS must be appropriately checked. The prescribed wording should be modified only if needed to meet the circumstances of a particular case, and the actuary should in any case, use language that clearly expresses his or her professional judgment.

3. The TABLE of KEY INDICATORS is to be at the top of the Opinion and the appropriate boxes are to be checked consistent with the remainder of the opinion. The only options are those presented below:

This Opinion is: ☐ Unqualified ☐ Qualified ☐ Adverse ☐ Inconclusive

IDENTIFICATION SECTION
☐ Prescribed Wording Only ☐ Prescribed Wording with Additional Wording ☐ Revised Wording

SCOPE SECTION
☐ Prescribed Wording Only ☐ Prescribed Wording with Additional Wording ☐ Revised Wording

RELIANCE SECTION
☐ Prescribed Wording Only ☐ Prescribed Wording with Additional Wording ☐ Revised Wording

OPINION SECTION
☐ Prescribed Wording Only ☐ Prescribed Wording with Additional Wording ☐ Revised Wording

RELEVANT COMMENTS
☐ Revised Wording

☐ The Actuarial Memorandum includes "Deviation from Standard" wording regarding conformity with an Actuarial Standard of Practice

4. The IDENTIFICATION section should specifically indicate the appointed actuary's relationship to the company, qualifications for acting as appointed actuary, date of appointment, and specify that the appointment was made by the Board of Directors, or its equivalent, or by a committee of the Board.

A person who is not a Member of the American Academy of Actuaries but is recognized by the Academy as qualified must attach, each year, a copy of the approval letter from the Academy.

This section should contain only one of the following:

For a Member of the American Academy of Actuaries who is an employee of the organization the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

"I, (name and title of actuary), am an employee of (named organization) and a member of the American Academy of Actuaries. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion."

For a consultant who is a Member of the American Academy of Actuaries, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

APPENDIX A – Excerpt from the 2009 Health Annual Statement Instructions

"I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) with regard to loss reserves, actuarial liabilities and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion."

For an employee other than a member of the American Academy of Actuaries, the opening paragraph of the opinion should contain both the following sentences if the appointed actuary is using the prescribed wording:

"I, (name and title), am an employee of (name of organization) and am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions."

For a consultant other than a member of the American Academy of Actuaries, the opening paragraph of the opinion should contain both the following sentences if the appointed actuary is using the prescribed wording:

"I, (name and title of consultant), am associated with the firm of (name of firm). I am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind and have been retained by the (name of organization) with regard to such valuation. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions."

5. The SCOPE section should contain only the following statement (including all specified lines even if the value is zero) if the appointed actuary is using the prescribed wording:

"I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 20__.

A. Claims unpaid (Page 3, Line 1);

B. Accrued medical incentive pool and bonus payments (Page 3, Line 2);

C. Unpaid claims adjustment expenses (Page 3, Line 3);

D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves and additional policy reserves from the Underwriting and Investment Exhibit – Part 2D;

E. Aggregate life policy reserves (Page 3, Line 5);

F. Property/casualty unearned premium reserves (Page 3, Line 6);

G. Aggregate health claim reserves (Page 3, Line 7); and

H. Any actuarial reserves or liabilities not included in the items above."

6. The RELIANCE section should contain only one of the following if the appointed actuary is using the prescribed wording:

APPENDIX A – Excerpt from the 2009 Health Annual Statement Instructions

If the appointed actuary has examined the liability records, the reliance section should include only the following statement:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic liability records to the Underwriting and Investment Exhibit Part - 2B of the company's current annual statement."

If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., asset or liability records) prepared by the company, the reliance section should include only the following statement:

"In forming my opinion on [specify types of reserves] I relied upon data prepared by [name and title of company officer certifying liability records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to the Underwriting and Investment Exhibit - Part 2B of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary."

Attached to the appointed actuary's opinion should be a statement by each person relied upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall each provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

7. The OPINION section should include only the following statement if the appointed actuary is using the prescribed wording:

"In my opinion, the amounts carried in the balance sheet on account of the items identified above:

A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared,

C. Meet the requirements of the laws of (state of domicile) and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed,

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements,

E. Are computed on the basis of assumptions and methods consistent with those used in computing the corresponding items in the annual statement of the preceding year-end,

F. Include appropriate provision for all actuarial items that ought to be established.

The Underwriting and Investment Exhibit – Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion."

8. The opinion may include a RELEVANT COMMENTS section if the actuary so desires. For example, if there has been any material change in the assumptions and/or methods from those previously employed, a portion of this section can describe that change in the statement of opinion by including a description of the changes such as:

"A material change in assumptions (and/or methods) was made during the past year but such change accords with accepted actuarial standards." A brief description of the change should follow. A more detailed analysis should be contained in the Actuarial Memorandum.

The adoption of new coverages requiring underlying assumptions that differ from assumptions used for prior coverages is not a change in assumption within the meaning of this paragraph.

One or more additional paragraphs may be needed in individual cases to:

- Address topics of regulatory importance, or
- State a qualification of his or her opinion, if the actuary considers it necessary, or
- Explain some aspect of the annual statement that is not already sufficiently explained in the annual statement.

9. If the appointed actuary is able form an opinion that is not qualified, adverse or inconclusive as those terms are defined below, he or she should issue a statement of unqualified opinion. If the opinion is adverse, qualified or inconclusive, the appointed actuary should issue an adverse, qualified or inconclusive opinion explicitly stating the reason(s) for such opinion. In all circumstances the category of opinion should be explicitly identified in the TABLE of KEY INDICATORS section of the Actuarial Opinion.

An adverse opinion is an actuarial opinion in which the appointed actuary determines that the reserves and liabilities are not good and sufficient. (An adverse opinion does not meet item D of Section 7).

When in the actuary's opinion the reserves for a certain item or items are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items, the actuary should issue a qualified opinion. Such a qualified opinion should state whether the stated reserve amount makes a good and sufficient provision for the liabilities associated with the specified reserves, except for the item or items to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item or items in question are not likely to be material. (A qualified opinion does not meet one or more of the items A, B, C or F of Section 7).

The actuary's ability to give an opinion is dependent upon data, analyses, assumptions and related information that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions or related information, then the actuary should issue an inconclusive opinion. An inconclusive opinion shall include a description of the reasons why a conclusion could not be reached.

10. The Actuarial Opinion should conclude with the signature of the appointed actuary responsible for providing the Actuarial Opinion and the date when the opinion was rendered. The signature and date should appear in the following format:

_____

Signature of Actuary

_____

Printed Name of Actuary

_____

Address of Actuary

_____

Telephone number of Actuary

_____

Date Opinion was Rendered

APPENDIX B – Actuarial Standards of Practice Relevant to the Health Actuarial Opinion

ASOP No 5, *Incurred Health and Disability Claims*
This standard gives guidance to actuaries preparing or reviewing financial reports, claims studies, rates, or other actuarial communications involving incurred claims under a health benefit plan.

ASOP No 7, *Analysis of Life, Health, or Property/Casualty Insurer Cash Flows*
This standard provides guidance to actuaries performing the analysis of asset, policy, or other liability cash flows for life, health, or property/casualty insurers. This standard applies to actuaries when performing the analysis of part or all of an insurer's asset, policy, or other liability cash flows for life or health insurers (including health benefit plans).

ASOP No. 11, *Financial Statement Treatment of Reinsurance Transactions Involving Life or Health Insurance*
This standard provides guidance to actuaries when performing professional services relating to financial statements that contain material reinsurance transactions involving life or health insurance. This standard applies to actuaries when preparing, reviewing, or analyzing financial statement items that reflect reinsurance ceded or reinsurance assumed on health insurance.

ASOP No. 22, *Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers*
This standard provides guidance to actuaries when serving as an appointed actuary or a qualified actuary in providing a statement of actuarial opinion relating to asset adequacy analysis of a life or health insurer. This standard applies to actuaries when providing statements of opinion and supporting memoranda for life or health insurers, including health benefit plans. This standard does not require the actuary to perform asset adequacy analysis in situations where an actuarial opinion relating to asset adequacy analysis is not required by applicable law.

ASOP No. 23, *Data Quality*
This standard provides guidance to actuaries regarding selecting the underlying data, relying on data supplied by others, reviewing and using data, making appropriate disclosures with regard to data quality. This standard applies to actuaries in all practice areas.

ASOP No. 28, *Compliance with Statutory Statement of Actuarial Opinion Requirements for Hospital, Medical, and Dental Service or Indemnity Corporations, and for Health Maintenance Organizations*
This standard delineates the responsibility of the actuary in signing the statement of actuarial opinion. This standard applies to actuaries providing statements of actuarial opinion on reserves and related actuarial items contained in the statutory statements of health service corporations, as specified in the instructions to the NAIC blanks. This standard also applies to actuaries providing statements as required by individual state regulations to the extent that such regulations are consistent with the NAIC blanks. It does not apply to state laws and regulations that differ substantively from the NAIC blanks.

ASOP No. 41, *Actuarial Communications*
This standard provides guidance to actuaries regarding written, electronic, or oral actuarial communications. The actuarial opinion and memorandum can be considered written communications, while reporting to Board of Directors may be written, oral, or both.

ASOP No. 42, *Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims*
This standard provides guidance to actuaries in determining health and disability liabilities other than liabilities for incurred claims. Such liabilities are include contract reserves, premium deficiency reserves, provider-related liabilities, claim adjustment expense liabilities, and other liabilities of insurance entities, insured or noninsured risk-assuming entities, managed care entities, health care providers, government-sponsored health benefit plans, or risk contracts. Liabilities may be determined for purposes of financial reports, claims studies, ratemaking, or other actuarial communications.