ADDENDUM TO VALUATION STANDARDS
FOR HEALTH MAINTENANCE ORGANIZATION
AGREEMENT LIABILITIES

1. Introduction

1.1. The Insurance Commission (IC) recognizes that there are Health Maintenance Organizations (HMO) that have issued products that are not in accordance with the products defined under IC Circular Letter No. 2017-19 for which the HMOs have outstanding liabilities.

1.2. In view of this, HMOs shall value their reserve liabilities for these types of products in accordance with the Valuation Standards set forth below.

2. Key Definitions

2.1. In this Valuation Standards, unless the context otherwise requires:

2.1.1. "Company" refers to an HMO supervised by the IC.

2.1.2. "Client" refers to the Principal Member/Payor, in the case of Individual/Family or the Client Company/Association in the case of Corporate/Group.

2.1.3. "Actuary" refers to an in-house actuary of the Company or an external consulting actuary accredited by IC as an HMO actuary.

2.1.4. "HMO Agreement" or "Contract" refers to the contract between the Company and the Client for the delivery of a pre-agreed or designated health care benefits and services by the Company to the member for a fixed pre-paid fee.

2.1.5. "Membership Fee" or "Consideration" refers to the price for the purchase of the HMO product, paid either in one lump sum or in instalment payments.

2.1.6. "In-force HMO Agreement" or "In-force Contract" is a contract for which the Company has liabilities for promised or contracted benefits, or for the delivery of services. An in-force contract may be anyone of the following:

2.1.6.1. A contract wherein considerations are still payable and which payments are either up-to-date or within the grace period provided for in the contract;
2.1.6.2. A contract wherein all considerations have been fully paid but benefits are not yet being paid or services are not yet being utilized;

2.1.6.3. A contract wherein considerations have been fully paid and benefits are already being paid or services are being utilized, but have not been completely paid or delivered.

2.1.7. "Claim Reserves" refers to claims incurred but not yet paid as of the end of the valuation date. It includes claims due and unpaid, claims in the course of settlement, resisted claims and those which are incurred but not reported at a designated level of confidence, as well as direct and indirect expenses related to settling all outstanding claims, whether reported and unreported, as of valuation date.

2.1.7.1. "Due & Unpaid (D&U) Claims" refers to the liabilities for claims that have been reported, adjudicated and processed, but for which final payment has not been recorded as of valuation date.

2.1.7.2. "In Course of Settlement (ICOS)" refers to the liabilities for claim already known and identified but not yet adjudicated, settled and paid by the Company as of valuation date.

2.1.7.3. "Resisted Claims" refers to amount of claims that are in dispute such as those for which a known litigation situation exists.

2.1.7.4. "Incurred but not Reported (IBNR)" refers to the amount to be provided for claims in respect of claim events that have occurred but have not been reported to the Company as of the valuation date.

2.1.7.5. "Claims Handling Expense Reserve" refers to the estimated amount of expenses for settling all claims, whether reported or unreported, outstanding as of valuation date.

2.1.8. "Aggregate Reserves for Long-Term Contracts" refers to the actuarial reserves for HMO products that have period of coverage and payment period of more than 1 year. It consists of the liabilities for all benefits stipulated in the HMO Agreement or Contract which are provided directly by the Company for all in-force contracts.

3. Data and Systems
3.1. The Company's Chief Executive Officer (CEO) or a Responsible Officer with a comparable rank shall ensure that the Company's database is properly maintained so that the membership fees/considerations and claims data provided to the Actuary is accurate and complete. The CEO or the Responsible Officer must furnish the data to the Actuary and must allow his/her Actuary reasonable access to the Company's database.

3.2. The Actuary shall apply reasonable tests to satisfy himself that the membership fees/considerations and claims data is accurate and complete. A check for both integrity and completeness of data should precede the valuation work. Furthermore, the Company shall build, if it has not done yet in the past, and maintain a historical claims database of at least five (5) years.

3.3. The Company shall create loss development triangles on both paid and incurred claims. The length of historical data needed in creating the loss development triangles must be based on the Company's underlying business.

3.4. Companies which have insufficient data shall be required to use as much data as they currently have until they have accumulated the appropriate length of historical claims data for valuation purposes.

3.5. The Company shall also maintain records on historical earned and unearned membership fees as well as commissions and other expense information in relation to policy maintenance and claims settlement, for the purpose of estimating future expenses for valuation of its HMO Agreement reserves.

3.6. The Company shall determine the granularity of data for the valuation of HMO Agreement reserves.

4. Valuation Methodology

4.1. The Actuary shall be responsible in determining the level of the actuarial reserve liabilities for all the benefits stipulated in the contract using basis no less stringent than that prescribed in the following paragraphs.

The benefits may be provided by the HMO directly or indirectly by transferring the responsibility for the delivery of such benefits to a third party (such as the insurance benefits which is transferred to an insurance company).

4.2. The actuarial reserves for benefits shall be determined on a prospective basis.
4.3. The Aggregate Reserves for Long-Term Contracts is the reserves for benefits provided **directly** by the HMO and must be equal to the present value of all future benefits directly provided by the Company less the present value of the future contribution to reserves for such benefits. The schedule of contribution to reserves for benefits directly provided by the Company must be provided in Annex A.

4.4. The actuarial reserves for benefits provided **indirectly** by the HMO must be equal to the present value of the cost of providing these benefits less the present value of the future contribution to reserves to provide for these benefits. The schedule of contribution of reserves for benefits indirectly provided by the HMO must be provided in Annex A. For insurance benefits provided indirectly by the HMO under the contract, the actuarial reserve is the Insurance Premium Reserves as indicated in Section 8.

4.5. The Aggregate Reserves for Long-Term Contracts should never be less than the corresponding termination/surrender values indicated in the contract.

4.6. The period within which contributions to reserves are assumed to be made should not exceed the period within which considerations are to be paid. For paid-up plans, future contributions to reserves are zero.

4.7. Contribution to Reserve for a particular period should not exceed the Gross Consideration for the same particular period.

4.8. Expense reserves shall be set up for expenses to be incurred on the plan after the plan is fully paid as indicated in Section 8.

5. **Basis of Assumptions**

5.1. Assumptions used in the valuation of actuarial reserves should reflect current experience of the Company with respect to those assumptions, adjusted only for expected future trends, which are reasonable and realizable, and appropriate margin for adverse deviation (MfAD) from the expected experience. Justification should be made for any assumptions used that do not reflect current experience and must be documented in Section C of the Actuarial Valuation Report, as described in Annex A.

5.2. When updating assumptions, the changes in the assumptions and the effect of such changes on the actuarial reserves should be disclosed in the actuarial valuation report.
5.3. The Actuary shall gather information from the Underwriting Department or its equivalent to provide information on the following areas: market outlook, changes in pricing levels, changes in the mix of business, renewal rates and changes in terms and conditions.

5.4. The Actuary shall also gather information from the Claims Department or its equivalent to provide information on the following areas: typical claims process from notification to settlement, claims expense inflation, operational changes in the claims function, delays in reporting of claims that may affect the projection of liabilities, and changes in initial estimates.

5.5. The discount rate assumption shall be based on the lower of the following (a) yield rate or series of yield rates that are expected to be earned from the assets of the funds that back-up the corresponding actuarial reserves over the remaining term of the contracts involved, or (b) the risk-free discount rates equivalent to the zero-coupon spot yield that match the remaining term of the contracts and the currency of the cash flows as prescribed by the IC.

5.6. The effects of inflation shall be recognized in actuarial assumptions. The inflation rate to be used shall be appropriate to the cash flow and applicable to the Philippine setting.

5.7. The expense assumptions shall be based on the expense studies of the Company and should reflect the medium or long-term trends that match the remaining duration of the contracts.

5.8. The morbidity/hospitalization/utilization assumptions shall be based on rates of morbidity/hospitalization claims/utilization rates that are appropriate to the nature of the risks covered based on the Company's actual experience. The utilization assumption must take into account the special features in the contract such as but not limited to the transferability benefit. If actual experience is not available or if the Company's actual experience is inappropriate to be used, the basis and justification for the assumptions used shall be provided.

5.9. The effects of surrenders and lapses must always be considered. The Company's own experience should serve as a guide in making assumptions, with due regard to changing practices and market conditions. If lapse and/or surrender experience is not yet available, the basis and justification for the assumption used shall be provided.

5.10. The level of non-guaranteed benefits to be valued, including the dividends under the contract/HMO Agreement, shall be determined with due regard to the Company's duty to treat its members/Clients fairly and meet the members'/clients' reasonable expectations.

The Actuary must disclose the basis for the dividend scale.
6. Claim Reserves

6.1. Claim Reserves shall be calculated as the sum of D&U Claims, ICOS, Resisted Claims, Claims Handling Expense Reserve and IBNR, with MfAD as computed in Section 7.

6.2. D&U Claims, ICOS, and Resisted Claims shall be based on actual claims reported but have not yet been settled as of valuation date. The Company shall ensure integrity of the data inputs as well as minimize uncertainties in the claims processing, subject to paragraph 3.2.

6.3. The Claims Reserves shall be calculated based on standard actuarial projection techniques or combination of such techniques, such as but not limited to the following methods: Development Method, Tabular Method, Exposure Method, and Loss Ratio Method.

The Actuary shall determine the appropriateness of the methodology considering the characteristics of the data and the maturity of the business.

6.4. Claim Reserves shall also include a provision for Claims Handling Expense Reserves, which covers the estimated expenses of settling all claims, both reported and unreported, outstanding as of valuation date.

6.5. The Actuary shall ensure the reliability of the expected loss ratios by obtaining estimates from various sources, such as underwriters, the business plan, pricing actuaries, market statistics, or from a historic view of profitability and loss ratios.

6.6. In valuing the Claim Reserves, the Actuary should consider other factors such as but not limited to: varying expense structure, operational changes in claims management, underwriting changes such as business mix and membership fee changes, changes in claims handling process, and external conditions.

6.7. To ensure sufficiency of reserves, the Actuary shall conduct a back-testing exercise of the Claims Reserves by comparing the previous year's Claims Reserves of expected current year claim developments, with actual current year claim developments. The results of such shall be documented in Section D of the Actuarial Valuation Report, as outlined in Annex A. In cases where the Claims Reserves was proven insufficient to cover actual claims development, the Actuary shall revisit the assumptions for Claims Reserves valuation and document the rationale for this deterioration.

7. Margin for Adverse Deviation

7.1. The actuary shall estimate the MfAD based on applicable statistical methodologies such as but not limited to Bootstrapping Method, Mack Method or
combination of such methodologies to bring the actuarial best estimate of HMO Agreement Reserves at the 75th percentile level of sufficiency. The data, basis and analysis in the determination of the MfAD shall be included in Annex A.

7.2. The purpose of the MfAD is to allow for inherent uncertainty of the best estimate of the HMO Agreement Reserves and to consider the variability of claims experience in the best estimate.

8. Other Reserves

8.1. Where deemed appropriate, the actuary shall include other reserves, such as but not limited to the following:

8.1.1. “Insurance Premium Reserve” refers to the reserve set up for the insurance premiums to be paid by the Company to the Insurance Company for the insurance benefits provided for in the contract. The insurance benefit is one of the benefits stipulated in the HMO Agreement or Contract which is provided indirectly by the Company.

8.1.2. “Expense Reserve” refers to the reserve set up for expenses that will be incurred after the paying period for HMO Agreements or Contracts where the payment period is shorter than the period of coverage.

8.2. The actuary shall estimate the Other Reserves based on generally accepted actuarial principles. The data, basis and analysis in the determination of the Other Reserves shall be included in Annex A.

9. Actuarial Valuation Report

9.1. The Actuary shall prepare an actuarial valuation report to be submitted to the IC. The actuarial valuation report, at a minimum, shall contain the following information (see Annex A for details):
   A. Scope of Review
   B. Data Requirements
   C. Valuation Methodologies and Assumptions
   D. Analysis of Experience
   E. Valuation Results & Discussion
   F. Certification by the Actuary
   G. Certification by the Chief Finance Officer (CFO)
   H. Certification by the Chief Executive Officer (CEO) or Responsible Officer

9.2. The Certifications to be provided by the Actuary, the Chief Finance Officer (CFO) and the Chief Executive Officer (CEO) or Responsible Officer shall be duly notarized.