Republic of the Philippines
Department of Finance
INSURANCE COMMISSION
1071 United Nations Avenue
Manila

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TRANQUILINO E. ESPEJON
IC Supervising Administrative Officer
Administrative Division
Insurance Commission

Date: _____

Circular Letter (CL) No.:	2020-22
Date:	24 March 2020

CIRCULAR LETTER

TO : **ALL HEALTH MAINTENANCE ORGANIZATIONS (HMOs) DOING BUSINESS IN THE PHILIPPINES**

SUBJECT : **VALUATION STANDARDS FOR HEALTH MAINTENANCE ORGANIZATION (HMO) AGREEMENT LIABILITIES**

WHEREAS, Section 1, Executive Order (EO) No. 192, s. 2015, mandates that jurisdiction over Health Maintenance Organizations (HMOs) shall be transferred from the Department of Health (DOH) to the Insurance Commission (IC) in order to regulate and supervise the establishment, operations and financial activities of HMOs;

WHEREAS, the IC shall have the authority to exercise the following functions, among others:

a. Issue rules and guidelines, with respect to the establishment of HMO minimum capitalization, net worth, reserve funds and security deposit requirements, as well as the criteria for qualification and disqualification of directors, officers and marketing personnel, and the procedure for the submission of reportorial and/or examination requirements, registration of contracts and plans, adjudication of claims, and other relevant matters, as necessary;
b. Regulate, supervise, and monitor the operations and management of HMOs to ensure compliance with EO No. 192, s. 2015, existing laws, rules, regulations and such other directives and circulars issued by the Insurance Commissioner;
c. Prepare, approve or amend, rules, regulations, orders, and circulars, and issue opinions, provide guidance on and supervise compliance with such rules, regulations, orders, and circulars;
d. Exercise such other powers as may be provided by law as well as those which may be implied from, or which are necessary or incidental to carry out the express powers granted to the IC to achieve the objectives and purposes of EO No. 192; and
e. Pursuant to existing laws, rules, and regulations, impose sanctions, and/or appropriate penalties.

NOW, THEREFORE, pursuant to the power granted to the Insurance Commissioner to "issue rules and guidelines with respect to x x x reserve funds x x x" under Section 4 (a) of EO No. 192, s. 2015 dated 12 November 2015, the undersigned hereby issues the attached valuation standards for HMO Agreement liabilities.

This Circular shall take effect immediately.

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TRANQUILINO E. ESPEJON
IC Supervising Administrative Officer
Administrative Division
Insurance Commission

Date: _____

DENNIS B. FUNA
Insurance Commissioner

VALUATION STANDARDS FOR HEALTH MAINTENANCE ORGANIZATION AGREEMENT LIABILITIES

1. Introduction

1.1. Every Health Maintenance Organization (HMO) supervised by the Insurance Commission (IC) shall value their HMO Agreement Liabilities in accordance with this Valuation Standards.

2. Scope and Application

2.1. This Valuation Standards shall apply to all HMO Agreements issued by HMOs for HMO products defined under IC Circular Letter No. 2017-19.

3. Key Definitions

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

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

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

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

3.1.4. "Health Maintenance Organization (HMO) Agreement or HMO Agreement" 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 regardless of the payment option chosen by the Client.

3.1.5. "Administrative Services Only (ASO) Endorsement or ASO Endorsement" refers to the document affixed to the HMO Agreement whenever all or a portion of the fixed pre-paid fee is in the form of an enrolment fee, administrative fee and a fund. The ASO Endorsement is the document that states which of the benefits in the HMO Agreement are fund-based; and that all of the risk related to benefit payments drawn from the fund is borne by the Client.

3.1.6. "Membership Fee" refers to the fees arising for the period being reported from HMO Agreements where the HMO assumes the risk of funding the member's health care services and related administrative costs.

3.1.7. "Enrolment Fee" refers to the amount of fee arising for the period being reported for each member to be covered under an ASO Endorsement to be able to access the network. This is sometimes referred to as the network access fee.

3.1.8. "Administrative Fee" refers to the amount of fee arising for the period being reported for the administration of the fund and handling of claims payment under an ASO Endorsement.

3.1.9. "In-force Agreement" refers to a contract for which the Company has liabilities for promised or contracted benefits, or for the delivery of services. An in-force contract is a contract wherein (a) the Membership Fee is up-to-date or within the grace period; or (b) the coverage may still be reactivated, as provided for in the contract.

3.1.10. "ASO Fund" refers to the amount of fund owned by the Client which the Company will use to provide for benefits covered under an ASO Endorsement.

3.1.11. "HMO Agreement Liabilities" refers to the measure of the liabilities of the HMO for its In-force Agreements as of valuation date which is composed of the "HMO Agreement Reserves", "ASO Fund Liabilities" and "Unearned Administrative Fee Reserves" as applicable.

3.1.12. "HMO Agreement Reserves" refers to all benefit liabilities for membership fee-based benefits or where the fixed pre-paid fee is in the form of a membership fee where the risks are borne by the Company, which is the aggregate of the Claim Reserves and Membership Fee Reserves as defined below.

3.1.13. "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.

3.1.13.1. "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.

3.1.13.2. "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.

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

3.1.13.4. "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.

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

3.1.14. "Membership Fee Reserves" refers to all future claim payments and related expenses for policy maintenance and claims settlement, to be made after the valuation date, arising from future events for which the Company is liable under its HMO Agreements, and is computed as the higher of the Unearned Membership Fee Reserves and Unexpired Risk Reserves at a designated level of confidence.

3.1.14.1. "Unearned Membership Fee Reserves" or "UMFR" refers to the amount of reserve for that portion of the membership fee, net of taxes and commissions paid or due to the Company which is applicable to the period of coverage extending beyond the valuation date.

3.1.14.2. "Unexpired Risk Reserves" or "URR", refers to the amount of reserve required to cover future claims and expenses, at a designated level of confidence, that are expected to emerge from an unexpired period of cover.

3.1.15. "ASO Fund Liabilities" refers to all liabilities for fund-based benefits where the risks are borne by the Client, which is set-up equal to the Previous Period ASO Fund plus additional contributions to the fund less Fund Withdrawals (FW) as defined below.

3.1.16. "Fund Withdrawals" refers to the amount withdrawn from the ASO Fund to pay the cost of benefits availed by the members and its related expenses under an ASO Endorsement.

3.1.17. "Projected Fund Withdrawals" refers to the estimated amount to be withdrawn from the ASO Fund to pay the cost of benefits for claims (a)

that have been reported, adjudicated and processed, but for which final payment has not been recorded as of valuation date; (b) already known and identified but not yet adjudicated, settled and paid by the Company as of valuation date; (c) that are in dispute such as those for which a known litigation situation exists; (d) that have occurred but have not been reported to the Company as of the valuation date; and (e) its related expenses under an ASO Endorsement .

3.1.18. "Unearned Administrative Fee Reserves" or "UAFR" refers to the amount of reserve for that portion of the Administrative fee, net of taxes and commissions paid or due to the Company which is applicable to the period of coverage extending beyond the valuation date.

4. Data and Systems

4.1. 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 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.

4.2. The Actuary shall apply reasonable tests to satisfy himself that the membership fees 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.

4.3. 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.

4.4. 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

4.5. 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 HMO Agreement reserves.

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

5. Basis of Assumptions

5.1. As much as practicable, the valuation of HMO Agreement reserves shall be based on the Company's actual historical experience and/or industry data. Any deviations and the use of professional judgment must be supported by a strong rationale and must be documented in Section C of the Actuarial Valuation Report, as described in Annex A.

5.2. Membership Fee used in the calculation of the HMO Membership Fee Reserves shall be net of taxes and commissions.

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.

6. Valuation Methodology

6.1. Where the fixed pre-paid fee is in the form of a pre-agreed membership fee, the liability shall be the HMO Agreement Reserves which is composed of the Membership Fee and Claim Reserves both determined using best estimate assumptions, with an appropriate Margin for Adverse Deviation (MfAD) for expected future experience.

6.2. The Actuary shall be responsible in determining the level of HMO Agreement reserves using basis no less stringent than that prescribed in Sections 7 to 10 below.

6.3. Where the fixed pre-paid fee is a combination of the enrolment fee, administrative fee and a fund under an ASO Endorsement, the liability shall be the ASO Fund Liabilities and the Unearned Administrative Fee Reserves (UAFR).

7. Membership Fee Reserves

7.1. Membership Fee Reserves shall be determined as the higher of UMFR and URR.

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7.2. The UMFR shall be calculated using 1/365th method.

7.3. URR shall be calculated as the best estimate of future claims and expenses, with MfAD as computed in Section 9. This best estimate relates to expected future claim payments and related expenses to be incurred after the valuation date, arising from future events.

7.3.1. Expected future claims shall include all claims which might occur during the unexpired period.

7.3.2. Expected future expenses shall include Agreement maintenance expenses and claims management expenses (i.e., direct and indirect claims settlement costs).

7.4. A computation should be performed to determine whether the URR required is greater or smaller than the UMFR. If the URR is greater, then the difference should be booked as an additional reserve on top of the UMFR.

8. Claim Reserves

8.1. 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 9.

8.2. 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 4.2.

8.3. 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.

8.4. 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.

8.5. 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.

8.6. 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.

8.7. 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.

9. Margin for Adverse Deviation

9.1. 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.

9.2. 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.

10. Reserves under an ASO Endorsement

10.1. ASO Fund Liabilities is the aggregate of the Previous period ASO Fund less Fund Withdrawals (FW) plus additional contributions to the ASO Fund.

10.2. Unearned Administrative Fee Reserves (UAFR) shall be calculated using 1/365th method.

10.3. The ASO Fund for the given period must at least be equal to the ASO Fund Liabilities.

10.4. The minimum ASO Fund Liabilities for each ASO Account must be zero (0). If the ASO Fund Liabilities for an ASO Account is negative it should be transferred to Due from ASO Account. The negative ASO Fund Liabilities of an Account should not be used to reduce the Aggregate ASO Fund Liabilities.

10.5. The Projected Fund Withdrawals shall be calculated using the same principles in the calculation of the Claims Reserves (refer to Sections 8 and 9) and a schedule shall be provided for in the Actuarial Valuation Report.

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11. Actuarial Valuation Report

11.1. 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
H. Certification by the Chief Executive Officer (CEO) or Responsible Officer

11.2. 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.

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IC Supervising Administrative Officer
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Insurance Commission

Date: _____

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;

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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

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Administrative Division
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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.

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TRANQUILINO E. ESPEJON
IC Supervising Administrative Officer
Administrative Division
Insurance Commission

Date: _____

Annex A

Report on Actuarial Valuation of HMO Agreement Liabilities
Name of Company: _____
For the period ended dd/mm/yyyy

Section A: Scope of Review

1. Purpose of report

2. Name of Actuary (whether the Actuary is an employee of the HMO or an external consultant), professional qualifications, and the capacity in which he/she is carrying out the valuation of HMO Agreement Reserves, Projected Fund Withdrawals, UAFR, Aggregate Reserves for Long-Term Contracts, Insurance Premium Reserve, and Expense Reserve

3. Confirmation from the Actuary of compliance with requirements with this Valuation Standards, and reasons, if any, for not complying fully with any requirements

Section B: Data Requirements

1. The basis on which the analysis has been carried out

2. The source of the data and how it was extracted

    a. Description of the company's current underwriting policies: specific market segments targeted, risk selection process, any major recent changes in membership fees and agreement conditions, any recent changes in levels of underwriting authorities, any recent changes in key personnel and delegation of authority, and any changes in level of deductibles or agreement limits

    b. Description of the company's claims management policies: guidelines for case reserving, policies on opening and closing of claims, operational changes in claims function, large loss concerns and uncertainties

3. Documentation of any adjustments made to the data to allow for abnormal items such as large losses, etc. including the nature, amount and rationale for the adjustment

a. Description of significant events during the year affecting the claim experience and how these were taken into account in the valuation of the liabilities

b. Description of other effects considered including economic, technological, medical, legislative environment, social trends, competition, court decisions, consumerism, etc.

4. Documentation of quantitative information which may have an impact on valuation, if applicable

Section C: Valuation Methodologies and Assumptions

1. Detailed discussion on the valuation methods, assumptions, and professional judgment used in the estimation of the following:
   a. Membership Fee Reserves (Unearned Membership Fee Reserves and Unexpired Risk Reserves)
   b. Claim Reserves (Due and Unpaid Claims, In Course of Settlement, Resisted Claims, and Incurred But Not Reported)
   c. Claims Handling Expense Reserve and other related expenses
   d. Margin for adverse deviation
   e. Unearned Administrative Fee Reserves, if applicable
   f. Projected Fund Withdrawals, if applicable
   g. Aggregate Reserves for Long-Term Contracts, if applicable
   h. Insurance Premium Reserves, if applicable
   i. Expense Reserves, if applicable
   j. Discounting, if applicable

2. When more than one method is used, the basis for choice of results

3. Justification for key differences in assumptions between valuations of membership fee and claim reserves

4. Any material deviations from this Valuation Standards in terms of valuation methodologies and assumptions, and basis for these deviations

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TRANQUILINO E. ESPEJON
IC Supervising Administrative Officer
Administrative Division
Insurance Commission

Date: _____

Section D: Analysis of Experience

1. For year-end valuation, detailed analysis of the company's actual experience of both URR and claim reserves versus expected experience in previous year-end valuations, including justifications for any material change observed. The experience analysis should cover claims payments and incurred cost movement.

2. Detailed analysis of the company's actual versus projected fund withdrawals in previous valuations, including justifications for any material change observed.

3. Comparative analysis between current and previous valuation such as discussion of reserve movements.

Section E: Valuation Results and Discussion

This shall include a summary of the valuation results. Companies shall provide a short narrative discussing their valuation results for each class of business.

Section F: Certification by the Actuary

The Actuary shall provide a certification as set out below:

I have undertaken the actuarial valuation of *(Name of HMO)* as of *(date of valuation)*.

I have conducted tests necessary to verify the reasonableness and integrity of the data submitted by *(Name and Position of CEO or Responsible Person)*.

I hereby certify that:

1. The actuarial assumptions and formulations used in this actuarial valuation are in accordance with generally accepted actuarial principles and practices;

2. The reserves for all benefits are valued in accordance with the assumptions,

3. [The insurance benefits included in the HMO Agreement are covered under a separate insurance contract – to be included if applicable];

4. The information contained in this Report are accurate to the best of my knowledge and that I have calculated the (*HMO Agreement Reserves, Projected Fund Withdrawals from ASO Fund, UAFR, Aggregate Reserves for Long-Term Contracts, Insurance Premium Reserve, and Expense Reserve*) in

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TRANQUILINO E. ESPEJON
IC Supervising Administrative Officer
Administrative Division
Insurance Commission

Date: _____

accordance with the Valuation Standards prescribed by the Insurance Commission.

_____
Name & Signature of HMO Actuary
Date: _____
IC Accreditation No: _____
PTR No.: _____

Section G: Certification by the Chief Finance Officer (CFO)

The CFO shall provide a certification as set out below:

"I hereby certify that the ASO Fund Liabilities as reflected in the Financial Statements are accurate to the best of my knowledge and are in accordance with the Valuation Standards prescribed by the Insurance Commission. I further certify that a negative ASO Fund Liability of an ASO Account was not used to reduce the Aggregate ASO Fund Liabilities but was transferred to Due from ASO Account."

_____
Signature over Printed Name of CFO
Date: _____
PTR No.: _____

Section H: Certification by the CEO or Responsible Officer

The CEO/Responsible Officer shall provide the following certification:

"I hereby certify that the database is properly maintained and I have satisfied myself that the data provided to the certifying Actuary are accurate and complete."

_____
Signature over Printed Name of
Chief Executive Officer/Responsible Officer

Date: _____