ACTUARIAL STANDARDS BOARD

Actuarial Standard
of Practice
No. 42

Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

Developed by the
Health Committee of the
Actuarial Standards Board

Adopted by the
Actuarial Standards Board
March 2004

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March 2004

TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice (ASOP) No. 42

This booklet contains the final version of ASOP No. 42, *Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims*.

Background

ASOP No. 5, *Incurred Health and Disability Claims*, specifically excluded liability items other than incurred claims, such as contract reserves, premium deficiency reserves, claim settlement expense reserves, and various reserves related to provider contracts.

This ASOP has been developed to provide guidance to actuaries regarding determination of these other liabilities. The Health Committee and the ASB determined that it is more appropriate to address these items in this standard, rather than in ASOP No. 5, because they are more diverse than claim liabilities.

The Health Committee believes that the practice of actuaries varies widely and that there may be significant differences of opinion regarding generally accepted actuarial practice for actuaries involved in determining liabilities other than incurred health and disability claims. The committee believes that this actuarial standard of practice is necessary to provide guidance on the areas of analysis that actuaries should consider. The standard is not meant to be prescriptive of specific methods or procedures, nor is it intended to require in and of itself that specific liabilities be established.

First Exposure Draft

The first exposure draft of this ASOP, then titled *Determining Health and Disability Liabilities Other Than for Incurred Claims*, was issued in June 2002 with a comment deadline of December 15, 2002. Twenty-five comment letters were received and considered in developing modifications that were reflected in the second exposure draft.

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Second Exposure Draft

The second exposure draft of this ASOP was approved for exposure in October 2003 with a comment deadline of January 31, 2004. Seventeen comment letters were received and considered in developing the final standard. These letters showed thoughtful insight of the issues and were considered in developing the final standard of practice. A summary of the substantive issues contained in the second exposure draft comment letters and the Health Committee's responses are provided in appendix 2.

The most significant changes from the second exposure draft were as follows:

1. Several commentators pointed out that the standard might be considered to apply to the work of actuaries on health benefits provided under pension plans and other retiree benefit plans and to certain self-insured plans. The Health Committee does not intend that this standard apply when such work is covered by another standard of practice, and added language to section 1.2, Scope, to address the issue. The Health Committee does not intend for this standard to apply to actuarial work on medical or disability benefits provided under pension plans, or to calculations for SFAS No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*, or SFAS No. 112, *Employers' Accounting for Postemployment Benefits*, where the determination of a liability is subject to another ASOP. The committee does intend that this standard apply to self-insured health benefit plans in the same manner as ASOP No. 5, *Incurred Health and Disability Claims,* with respect to the determination of liabilities. For these plans, the standard applies only to the determination of the liabilities and not to the funding of the plans.

2. The Health Committee made some modifications to clarify further that this standard is not intended to require that certain liabilities be established, but rather provides guidance to the actuary if those liabilities are established. Similarly, language related to follow-up studies was modified to clarify that such studies are not required by this standard.

The Health Committee would like to thank all those who commented on both exposure drafts.

The Health Committee would also like to thank Steven J. Abood, Michael S. Abroe, Janet M. Carstens, Robert B. Cumming, and David F. Ogden for their contribution to the development of this ASOP.

The ASB voted in March 2004 to adopt this standard.

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ACTUARIAL STANDARD OF PRACTICE NO. 42

DETERMINING HEALTH AND DISABILITY LIABILITIES OTHER THAN LIABILITIES FOR INCURRED CLAIMS

STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries determining health and disability liabilities other than liabilities for incurred claims. This ASOP complements ASOP No. 5, *Incurred Health and Disability Claims*.

1.2 Scope—This standard applies to actuaries when performing professional services in connection with determining health and disability liabilities, other than liabilities for incurred claims, associated with a health benefit plan, as defined in section 2.7 of this standard, or a risk-sharing arrangement, as defined in section 2.13 of this standard. Such liabilities are described in sections 3.3–3.7, and 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. This standard also applies to actuaries determining liabilities for self-insured plans (including voluntary employees' beneficiary association (VEBA) plans) that are not subject to other standards such as those referenced below.

This standard does not apply when such liabilities are determined in accordance with other ASOPs, such as ASOP No. 4, *Measuring Pension Obligations*, and ASOP No. 6, *Measuring Retiree Group Benefit Obligations*. Furthermore, this standard does not apply in situations where a benefit is included within a plan subject to another standard, such as a disability benefit under a life plan or a 401(h) account that is part of a pension plan.

Liabilities may be determined for purposes of financial reports, claims studies, ratemaking, or other actuarial communications. This standard does not interpret statutory or generally accepted accounting principles.

Throughout this standard, any reference to determining liability includes establishing or reviewing the liability.

When applicable law, regulation, or other binding authority conflicts with this standard, compliance with such law, regulation, or other binding authority shall not be deemed a deviation from this standard, provided the actuary discloses that the actuarial work was performed in accordance with the requirements of such law, regulation, or other binding authority.

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard will be effective for all actuarial work involving health and disability liabilities, other than liabilities for incurred claims, performed on or after September 30, 2004.

Section 2. Definitions

The terms below are defined for use in this actuarial standard of practice.

2.1 Block of Business—All contracts of a common coverage type, demographic grouping, contract type, or other segmentation useful for estimating liabilities for actuarial purposes, or useful to a risk-assuming entity for evaluating its business.

2.2 Capitation Arrangement—An arrangement that calls for periodic payments to a provider to cover specified services to certain members of a health benefit plan regardless of the number or types of such services provided.

2.3 Carve-Outs—Carve-outs are designated services provided by specified providers, such as prescription drugs or dental, or condition-specific services such as cancer, mental health, or substance abuse treatment. Carve-outs are often provided by a separate entity specializing in that type of designated service.

2.4 Contract Period—The time period for which a contract is effective.

2.5 Contract Reserve—A liability established when a portion of the premium due prior to the valuation date is designed to pay all or a part of the claims expected to be incurred after the valuation date (sometimes referred to as an *active life reserve* or *policy reserve*). A contract reserve may or may not include a provision for the reserve for unearned premiums.

2.6 Exposure Unit—A unit by which the cost for a health benefit plan is measured. For example, an exposure unit may be a contract, an individual covered, $100 of weekly salary, or $100 of monthly benefit.

2.7 Health Benefit Plan—A contract or other financial arrangement providing medical, prescription drug, dental, vision, disability income, accidental death and dismemberment, long-term care, or other health-related benefits, whether on a reimbursement, indemnity, or service benefit basis, regardless of the form of the risk-assuming entity, including health benefit plans provided by self-insured or governmental plan sponsors.

2.8 Incentive Payment—A bonus payment to a provider, typically used to motivate efficiency or quality in patient care management, or to encourage retention of providers in a network.

2.9 Premium Deficiency Reserve—A liability established when, for a period of time, the value of future premiums, current reserves, and unpaid claims liability are less than the value of future claim payments and expenses plus the anticipated liabilities at the end of the period.

2.10 Providers—Individuals, groups, or organizations providing health care services, including doctors, hospitals, physical therapists, medical equipment suppliers, etc.

2.11 Provider-Related Liability—A liability established to cover expected future incentive or non-claim payments or to cover the possibility of a change in the relationship between the risk-assuming entity and a provider.

2.12 Risk-Assuming Entity—The entity with respect to which the actuary is determining liabilities associated with health benefit plans or risk-sharing arrangements.

2.13 Risk-Sharing Arrangement—An arrangement involving a provider, calling for payments to or from the provider where the payment is not related to a specific service performed by that provider, and the payment is contingent upon certain financial or operational goals being achieved. Examples of risk-sharing arrangements include provider incentives, bonuses, and withholds.

2.14 Trends—Measures of rates of change, over time, of the elements affecting the determination of certain liabilities.

2.15 Unpaid Claims Liability—The value of the unpaid portion of incurred claims includes (a) unreported claims; (b) reported but unprocessed claims; and (c) processed but unpaid claims. For a risk-assuming entity's balance sheet, the unpaid claims liability includes provision for all unpaid claims incurred during the contract period as of the current valuation date.

2.16 Valuation Date—The date as of which the liabilities are determined.

Section 3. Analysis of Issues and Recommended Practices

3.1 Introduction—The determination of liabilities is fundamental to the practice of health actuaries. It is necessary for the completion of financial statements; for the analysis and projection of claim trends; for the analysis or development of premium rates; and for the development of various management reports, regardless of the type of risk-assuming entity.

3.2 General Considerations—When determining liabilities under this standard, the actuary should consider relevant provisions of the health benefit plans or risk-sharing arrangements, business practices, and environmental factors that, in the actuary's professional judgment, are likely to materially affect liabilities or claim trends, including those highlighted in the sections below.

When, in the actuary's professional judgment, a representation from management is reasonable and management is an appropriate source of information about a specific item, the actuary may rely on the representation of management with respect to such item. The actuary should disclose such reliance in an appropriate actuarial communication.

3.2.1 Health Benefit Plan Provisions and Business Practices—The actuary should consider the health benefit plan provisions, including any special practices known to the actuary that are imposed by group requirements and provider arrangements and which, in the actuary's professional judgment, materially affect the cost and frequency of claims; the level and schedule of premium rates; the ability to change premium rates; and renewability provisions. These include, for example, elimination periods, deductibles, pre-existing condition limitations, maximum service payment allowances, and managed-care restrictions.

The actuary should compare internal business practices, as described by an appropriate source, to plan provisions to determine whether there are material differences between the plan provisions and actual operation of the plan, such as differences in definitions of payment allowances, incurral dating methods, and benefit interpretations, and consider how such differences are likely to affect the determination of claim costs and claim liabilities.

3.2.2 Risk-Sharing Arrangement Provisions—The actuary should consider the risk-sharing arrangement provisions, including any special requirements for networks or providers, which are known to the actuary and, in the actuary's professional judgment, are likely to materially affect the financial results of the arrangement. These include, for example, allowances for number of enrolled lives included, the results of membership satisfaction surveys, and actual usage of certain facilities. The actual payments may be defined by internal business practices, contracts, and plan provisions.

3.2.3 Economic Influences—Economic conditions may affect the frequency and cost of claims. The actuary should consider such factors as changes in expected trends, managed-care contracts, provider networks, provider fee schedules, and medical practices to the extent such changes, in the actuary's professional judgment, are material individually or in the aggregate. In addition, economic conditions may influence such factors as continuation of disability, cost shifting, and frequency of elective procedures performed in recessionary periods or prior to plan termination.

3.2.4 Risk Characteristics and Organizational Practices by Block of Business—The actuary should consider how marketing, underwriting, and other business practices can influence the types of risks accepted. Furthermore, the pattern of growth or contraction and relative maturity of a block of business can influence liabilities. Claims administration practices can influence claim rates and trends and in turn influence liabilities.

3.2.5 Legislative Requirements—Governmental mandates can influence the provision of new benefits, risk characteristics, care management practices, rating and underwriting practices, or claims processing practices. The actuary should consider relevant legislative and regulatory changes as they pertain to determination of liabilities.

3.2.6 Carve-Outs—The actuary should consider the pertinent benefits, payment arrangements, and separate reporting of those benefits subject to carve-outs in trend analysis and determination of a risk-assuming entity's liabilities.

3.2.7 Special Considerations for Long-Term Products—Certain health benefit plans provide for long-term medical or disability benefits. Some examples are cancer, long-term care, and long-term disability policies. The actuary should consider the benefits available in these health benefit plans, such as lump-sum, fixed, or variable payments for services; provisions such as cost of living adjustments and inflation protections; payment differences based on institutional or home-based care; social insurance integration; and the criteria for benefit eligibility.

3.2.8 Reinsurance Arrangements—The actuary should appropriately reflect the effect of reinsurance arrangements in determining liabilities. In particular, the actuary should take into account the extended reporting or recovery periods and delayed collectibility often associated with certain types of reinsurance.

3.2.9 Expenses—The actuary should consider whether an explicit liability for expenses should be established, or whether a particular liability implicitly provides for future expenses.

3.2.10 Consistency of Bases—The actuary should use consistent bases for determining related liabilities and reserves, including those not covered by this standard, such as incurred health and disability claims, unless it would be inappropriate to do so.

3.3 Considerations for Determining Contract Reserves—The actuary should establish a contract reserve when such a reserve is required. For example, contract reserves are typically established for entry-age-rated health benefit plans (where premium rates are based on entry age and may be level over the lifetime of the contract), or where flat premium rate guarantees or premium rate change limitations apply for multiple-year periods. The actuary may perform the valuation on a seriatim basis, using grouping techniques, or a combination of both. When determining contract reserves, the actuary should consider the following:

3.3.1 Assumptions—The actuary should use assumptions that are reasonable in the aggregate. The actuary should take into account the following assumptions and any other assumptions that the actuary deems appropriate:

a. Interest Rates—The actuary should use interest rates in the present value calculation that are reasonable and consistent with the purpose for which the reserve is being calculated.

b. Morbidity—The actuary should use morbidity assumptions that reflect the underlying risk. These assumptions may reflect factors such as age, gender, and marital status of the insured as well as the elimination period and dependent status. In addition, the actuary should take into account the wearing away of durational effects such as risk selection and pre-existing condition limitations, changes in health benefit plans, changes in provider agreements, adverse selection due to premium rate increases and plan design, and other factors that, in the actuary's professional judgment, materially affect future claim payments. The impact of these items may be recognized by a set of assumptions that varies over time.

c. Persistency—The actuary should consider using persistency or termination assumptions that include both involuntary terminations, such as deaths and disablements and voluntary terminations, as appropriate. Voluntary termination assumptions, if any, should reflect the expected impact of future premium rate increases.

d. Expenses—The actuary should consider whether an assumption is appropriate for expenses such as maintenance, acquisition, and claim settlement, depending on the purpose for which the reserve is being calculated.

e. Trend—The actuary should consider trend assumptions for inflation, utilization, morbidity, and expense rates that are consistent with the purpose for which the reserve is being calculated.

3.3.2 Premium Rate Changes—The actuary should consider whether an assumption may be appropriate to reflect premium rate changes in the reserve calculation. The actuary should use a premium rate change assumption that is reasonable in relation to the projected claims costs and the manner in which the rate change will be implemented (for example, on a given date for an entire block of business or on the next policy anniversary). This assumption should take into account factors such as market conditions, regulatory restrictions, and rate guarantees.

3.3.3 Previously Established Assumptions for Contract Reserves—The actuary may determine that previously established assumptions are not appropriate and may change them in accordance with the standards of the financial statements in which the reserves are reported. The actuary should follow the process set forth in section 3.3.1 when establishing new contract reserve assumptions for future valuation dates.

3.3.4 Valuation Method—For a new policy form, in addition to the assumptions discussed above, the actuary may need to determine the valuation method. The most common valuation methods are the gross premium method, the net level premium method and the full preliminary term (one- or two-year) method. Except where the valuation method is prescribed, the actuary should choose an appropriate method for the intended use of the reserve, such as in statutory financial statements or analysis of operating income. When not using a net level premium method, the actuary should consider the expense structure, such as higher first-year costs, in selecting the valuation method.

3.4 Considerations for Determining Premium Deficiency Reserves—The actuary should establish a premium deficiency reserve when such a reserve is required. Premium deficiency reserves are typically established for financial reporting purposes. They may also be established for other purposes such as management reporting. The actuary commonly performs a gross premium valuation in order to determine whether or not a deficiency exists.

3.4.1 General Considerations—When determining deficiency reserves, the actuary should take into account the following:

a. Assumptions in the Aggregate—The actuary should use assumptions that are reasonable in the aggregate.

b. Exposure—The actuary should consider reasonable increases and decreases in exposure units over the time period of the calculation in the premium

deficiency reserve calculation. This parameter should reflect changes due to such factors as mortality, lapses, and the impact of expected premium rate changes.

c. Premium Rate Changes—The actuary should use a premium rate change assumption that is reasonable in relation to the projected claims costs and the risk-assuming entity's expectations. This assumption should take into account factors such as market conditions, regulatory restrictions, and rate guarantees.

d. Claim Trend—The actuary should take into account the wearing away of durational effects such as risk selection and pre-existing condition limitations, changes in provider agreements, adverse selection due to premium rate increases and plan design, and other factors that affect future claim payments.

e. Risk-Sharing Arrangements—The actuary should take into account risk-sharing arrangements. If the actuary anticipates there will be a payout for risk-sharing arrangements associated with a block of business that is being tested for premium deficiency, the actuary should treat the amount of the payout as an expense. Some of these arrangements require providers to share in losses as well as gains. If such an agreement is in effect and the actuary anticipates there will be losses associated with the block of business being tested, the actuary should include the amount due from the providers to offset the losses only to the extent that the actuary reasonably expects the amount due to be collectible.

f. Interest Rates—The actuary should use interest rates in the present value calculation that are reasonable and consistent with the purpose for which the reserve is being calculated.

g. Reinsurance—The actuary should consider the expected effects of reinsurance and changes in reinsurance premiums in determining the premium deficiency reserve.

h. Taxes—The actuary should consider the effect of losses assumed in the calculation of the premium deficiency reserve on the risk-assuming entity's taxes and may include a tax credit in the calculations where appropriate.

i. Expenses—The actuary should consider total expenses of the risk-assuming entity in establishing a premium deficiency reserve and should consider whether the expenses allocated to the block of business are reasonable for the purpose of determining premium deficiency reserves.

3.4.2 Additional Considerations for Financial Reporting—When determining premium deficiency reserves for financial reporting, the actuary should consider the following:

a. Blocks of Business—In order to determine whether or not a premium deficiency exists, the actuary should consider blocks of business in a manner consistent with applicable financial reporting requirements. The characteristics of a block of business may include, but are not limited to, benefit type (for example, major medical, preferred provider organization, or capitated managed care), contract type (for example, group or individual policies), demographic grouping (for example, group size or geographical area), and length of rate guarantee period. Whatever criteria are used, a block of business should be large enough so that its financial results are material relative to the risk-assuming entity as a whole. The actuary may need to establish a premium deficiency reserve for a block of business where a premium deficiency exists even if the contract period has not started.

b. Time Period—The actuary should take into account any applicable law, regulation, or other binding authority in establishing the time period of the calculation. The valuation date is the beginning of the time period used to project losses from a block of business. The end of the time period is generally the earlier of the end of the contract period or the point at which the block no longer requires a premium deficiency reserve.

3.5 Considerations When Determining Provider-Related Liabilities—Provider-related liabilities may arise for a risk-assuming entity as a provider or a non-provider. Risk-sharing arrangements create potential liabilities for both parties while provider incentive payments create potential liability to the risk-assuming entity offering such provisions to their providers. Finally, capitation arrangements may create a provider-related liability for either party. When determining provider-related liabilities, the actuary should consider the following:

3.5.1 Non-Provider Risk-Assuming Entities—The actuary should consider the relevant contractual arrangements with providers to determine whether the contractual arrangements require a liability to be held by the risk-assuming entity.

The actuary should consider whether a provider-related liability for contracts in effect or not fully settled as of the valuation date should be determined. In determining the liability, the actuary should consider any amounts due from the provider, the overall financial condition of the provider, and the likelihood of collecting amounts due.

Similarly, the actuary should consider whether the risk of a provider failing or leaving a network creates a need to determine a liability for the contingency of the

payment by the risk-assuming entity of higher capitations or fees for services while a replacement provider is identified and suitable arrangements are concluded.

3.5.2 Provider Risk-Assuming Entities—The actuary should consider relevant contractual arrangements with other providers as well as non-provider risk-assuming entities to determine whether the contractual arrangements require a liability to be held. One primary source of potential liability between providers is the receipt of capitation by one provider with payments due to other providers using fee-for-service.

3.5.3 Risk-Sharing and Capitation Arrangements—The actuary should consider the nature of any risk-sharing and capitation arrangements in determining whether to establish a provider-related liability. The actuary should consider stop-loss provisions, if any, included in the risk sharing or capitation arrangements when establishing a provider-related liability.

3.5.4 Provider Financial Condition—When a risk-assuming entity shares risk with a provider under a risk-sharing or capitation arrangement, the actuary should determine, to the extent practical, whether the provider's overall financial condition will allow it to meet its obligations, and, if not, adjust the liability accordingly. To the extent that these liabilities are not otherwise included in the claim liabilities of the risk-assuming entity, such liabilities should be included in the provider-related liabilities.

3.5.5 Provider Incentive Payments—If a provider agreement calls for incentive payments to be made to a provider if certain conditions are met, such as quality of care standards or claim targets, the actuary should consider whether the risk-assuming entity should hold a liability for those payments.

3.6 Claim Adjustment Expense Liabilities—The actuary should determine a liability for claim adjustment expenses associated with unpaid claims, unless such liabilities are included in the liability for unpaid claims or otherwise provided for appropriately.

3.7 Other Liabilities—The actuary may not always be responsible for determining certain other liabilities. However, the actuary may be asked to assist in the determination of or opine on the adequacy of certain of these other liabilities. The following are examples of such liabilities:

3.7.1 Liabilities for Payments to State Pools—When involved in determining liabilities for payments to state pools, the actuary should consider whether adequate provision has been made for payments due under state assessment pools, such as insolvency pools, risk-sharing pools, or other arrangements.

3.7.2 Reserves for Unearned Premiums—When involved in determining reserves for unearned premiums, the actuary should consider whether adequate provision has been made for liabilities associated with coverage during the period when the premium will be earned.

3.7.3 Liabilities for Dividends and Experience Refunds—When involved in determining liabilities for dividends and experience refunds, the actuary should consider whether adequate provision has been made for dividends or experience refunds payable under the provisions of a health benefit plan.

3.8 Follow-Up Studies—The actuary may be called upon to conduct follow-up studies that involve performing tests of reasonableness of the prior period liability estimates and the methods used over time. When conducting such follow-up studies, the actuary should, to the extent practical, do the following:

a. collect sufficient data to perform such studies;

b. perform studies in the aggregate or for appropriate blocks of business; and

c. utilize the results, if appropriate, in preparing current liability estimates.

3.9 Margin for Uncertainty—Recognizing the fact that liabilities are an estimate of the true liabilities that will emerge, the actuary should consider what margin for uncertainty, if any, might be appropriately included.

3.10 Data Requirements—The expansion of health benefit coverages and the variety of organizations offering health benefit coverages have increased the volume, type, detail, and the frequency of data needs by the actuary. The actuary should refer to ASOP No. 23, *Data Quality*, when dealing with data requirements.

3.11 Documentation—The actuary should document the methods, assumptions, procedures, and the sources of the data used. The documentation should be in a form such that another actuary qualified in the same practice area could assess the reasonableness of the actuary's work.

Section 4. Communications and Disclosures

4.1 Communications and Disclosures—When issuing actuarial communications under this standard, the actuary should refer to ASOP No. 41, *Actuarial Communications*. In particular, such actuarial communications should disclose the following items:

a. the sources of information;

b. the extent of reliance on information supplied by others;

c. limitations on the use of the actuarial work product;

d. the need for any follow-up studies;

e. any unresolved concerns the actuary may have about the information that could have a material effect on the actuarial work product; and

f. any conflicts arising from the application of law, regulation, or other binding authority.

4.2 Reliance on Others—The actuary may rely on information, including data, supplied by others. In doing so, the actuary should disclose both the fact and the extent of such reliance in an appropriate actuarial communication. The accuracy and comprehensiveness of the information are the responsibility of those who supply it.

4.3 Prescribed Statement of Actuarial Opinion—This ASOP does not require a prescribed statement of actuarial opinion as described in the *Qualification Standards for Prescribed Statements of Actuarial Opinion* promulgated by the American Academy of Actuaries. However, law, regulation, or accounting requirements may also apply to an actuarial communication prepared under this standard, and as a result, such actuarial communication may be a prescribed statement of actuarial opinion.

4.4 Deviation from Standard—An actuary must be prepared to justify the use of any procedures that depart materially from those set forth in this standard and must include, in any actuarial communication disclosing the results of the procedures, an appropriate statement with respect to the nature, rationale, and effect of such departures.

Appendix 1

Background and Current Practices

Note: This appendix is provided for informational purposes, but is not part of the standard of practice.

Background

Health and disability liabilities other than incurred claims are important to many lines of health and disability business. New forms of these liabilities arose during the 1980s and especially the 1990s with the rapid increase in managed care provider risk arrangements. The increasing attention to financial statements has enhanced the importance of other liabilities such as contract reserves and premium deficiency reserves.

Current Practices

Actuaries have been able to obtain guidance on when statutory reserves are required, how to reserve for health coverages and how to document those reserves from various publications of the National Association of Insurance Commissioners. The primary publications are the Accounting Practices and Procedures Manual, the Health Insurance Reserves Model Regulation and the Health Reserves Guidance Manual. Similar guidance on when liabilities are required by generally accepted accounting principles is available in Statements of Financial Accounting Standards. Determining liabilities may be necessary or useful in situations other than financial statement reporting, such as the acquisition of a block of a business or in experience analysis.

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Appendix 2

Comments on the Second Exposure Draft and Committee Responses

The second exposure draft of this standard, *Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims*, was exposed for review in October 2003, with a comment deadline of January 31, 2004. Seventeen comment letters were received. The Health Committee of the ASB carefully considered all comments received. Many helpful ideas and suggestions were offered in the comment letters and are reflected in the standard as appropriate. Summarized below are the significant issues and questions contained in the comment letters, and the committee's responses to these issues and questions. Unless otherwise noted, the section numbers and titles used below refer to those in the second exposure draft.

GENERAL COMMENTS	
Comment	One commentator observed that the term "liability" appeared to be used synonymously with the term "reserve." The commentator suggested a number of changes throughout the standard to reflect this comment.
Response	The committee believes that the use of the term "liability" is appropriate and is reflective of common usage. Where the term "reserve" is used, it applies to a specific terminology recognized in regulation and practice, such as "premium deficiency reserve," "contract reserve," or "unearned premium reserve."
Comment	Several commentators questioned whether this standard was intended to cover situations such as disability and medical benefits provided through pension plans, benefits provided through voluntary employees' beneficiary association's (VEBAs), calculations under SFAS No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions,* and SFAS No. 112, *Employers' Accounting for Postemployment Benefits,* 401(h) accounts, and incidental health benefits provided under other plans.
Response	The committee considered these questions and added clarifying language to section 1.2, Scope, which states that this standard does not apply to actuaries determining liabilities in accordance with other standards of practice. This standard does not apply for liabilities determined in accordance with standards of practice such as ASOP No. 4, *Measuring Pension Obligations*, and ASOP No. 6, *Measuring Retiree Group Benefit Obligations*. Furthermore, this standard does not apply in situations where a benefit is included within a plan subject to another standard, which may include a disability benefit under a life plan, or to a 401(h) account that is part of a pension plan. The committee believes that this standard does apply to self-insured plans (including VEBA plans) that are not subject to other standards such as those referenced above. This is specifically noted in the definition of health benefit plan, and is identical to the treatment of ASOP No. 5, *Incurred Health and Disability Claims*.
Comment	One commentator observed that the standard uses the term "premium" frequently, and also uses the term "policy form," and asked whether the standard was to apply to non-insured arrangements.
Response	The standard does apply to certain self-insured health plans, and the committee believes that the terms noted by the commentator are appropriate.
Comment	One commentator observed that contract reserves are merely a special case reserve that is defined at issue and cannot be subsequently recalculated unless shown to be inadequate. The commentator suggested a number of changes to the definition of contract reserve and the assumptions to be used.
Response	The committee believes that the standard provides appropriate flexibility to the actuary, and that any further descriptive definition would be prescriptive and limiting.

SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.1, Purpose	
Comment	One commentator suggested that adding, "This ASOP is not intended to be prescriptive of specific methods or procedures, nor is it intended to require that specific liabilities can be established," would clarify the intent of the section.
Response	The committee believed the existing language was appropriate and made no change.
Section 1.2, Scope	
Comment	One commentator suggested changing, "This standard applies to actuaries when they…"to "This standard applies when actuaries.…"
Response	The committee believed the existing language was appropriate and made no change.
Comment	One commentator suggested deleting everything starting with "provided the actuary discloses.…"
Response	The committee disagreed, and believed the existing language was appropriate.
Comment	One commentator suggested that this section could be taken to mean this standard does not apply to work performed for statutory or GAAP reporting.
Response	The committee confirms that the standard does apply to work performed for statutory or GAAP reports, and believed the language was sufficiently clear.
Comment	One commentator suggested that the language detailing the meaning of "determining" may more logically fit in section 2, Definitions.
Response	The committee believed this sentence was appropriately included in section 1.2, Scope.
SECTION 2. DEFINITIONS	
Comment	One commentator suggested that the ASOP define "incurred claims."
Response	The committee believed this term was of common usage and did not need further definition for purposes of this standard.
Section 2.4, Contract Period	
Comment	One commentator suggested the phrase "contract is effective" should be replaced with "coverage is effective."
Response	The committee believed the existing definition was appropriate and made no change.
Section 2.5, Contract Reserve	
Comment	One commentator suggested that the definition of contract reserve and section 3.3, Considerations for Contract Reserves, were either wrong or poorly worded. Specifically, the commentator believed that the statement did not adequately address the difference between a contract reserve and a premium deficiency reserve. The commentator believed that contract reserves are a special case of premium deficiency reserve, even though the actuarial language has not evolved in this way. Contract reserves are created by the difference in slope in premiums over time relative to the slope of the claims. Only in the NAIC statutory reserve model laws is the term actually defined. The ASOP as drafted, unfortunately, gave so much more latitude to the actuary in calculating the reserve, and even defining what the liability is, as not to make it very valuable in practice. In summary, a contract reserve is nothing more than a special case reserve that is defined at time of issue, and cannot be recalculated for changes in future periods, unless a gross premium reserve calculation shows an inadequacy. Even in that case, one can argue the contract reserve stays the same, and an additional reserve is put up as a deficiency reserve. The definitions should reflect this, as should the entire standard.

Response	The committee notes that this ASOP does not supersede existing GAAP or statutory requirements, and that the actuary should comply with these requirements. The committee believed that contract reserves are not unique in that their determination is based solely on benefit and does not consider expenses. This ASOP is not intended to prescribe how the actuary should so comply, and is intended to provide guidance on what the actuary should consider in determining liabilities. Further, the committee believed these aspects of the definitions of contract reserves and premium deficiency reserves in the ASOP were sufficiently clear for the purpose of providing such general guidance. The committee did clarify that a contract reserve may or may not include a provision for an unearned premium reserve in response to a comment on section 3.7.2.
Section 2.9, Premium Deficiency Reserve	
Comment	One commentator suggested that the definition should be changed to "when, for the remainder of the contract, the value of future premiums…."
Response	The committee believed the existing language was appropriate and made no change.
Section 2.12, Risk-Assuming Entity	
Comment	One commentator suggested that this definition should be more specific. There are situations in which the entity for which the actuary's work is being performed is not the risk-assuming entity (for example, when the work is an analysis of a potential acquisition or an analysis performed for a regulatory agency). This would be especially true when the actuary is evaluating the adequacy of the reserves of a risk-assuming entity.
Response	The committee modified the language for clarification.
Section 2.13, Risk-Sharing Arrangement	
Comment	One commentator suggested that the words "related to a specific service" be replaced by "directly for a specific service" or "associated with a specific service" because risk sharing arrangements are "related to" (the aggregate of) all specific services.
Response	The committee believed the existing language was appropriate and made no change.
Section 2.14, Trends	
Comment	One commentator suggested changing "of the elements affecting the determination of certain liabilities" to "of certain elements affecting the determination of liabilities."
Response	The committee believed the existing language was appropriate and made no change.
Section 2.15, Unpaid Claims Liability	
Comment	One commentator suggested that many of the ASOPs are inconsistent in the use of the term claim liability. In the definition of "unpaid claims liability," the phrase "unpaid portion of incurred claims" could be construed to mean future benefits on incurred claims. It might help to clarify the language by referring to the "due and unpaid" portion of incurred claims.
Response	The committee believed the existing language was appropriate and made no change.
SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Section 3.2, General Considerations	
Comment	One commentator suggested removing "or claim trends" as they are one of several environmental factors that can affect liabilities.
Response	The committee did not make a change, as claim trends may be a significant source of the need to establish a liability.

Comment	One commentator suggested deleting wording that suggests a need to determine if "management is an appropriate source of information about a specific item," as well as disclosure of reliance in this section.
Response	The committee believed that there may be situations where management may not be the best source (for example, where certain types of health benefit plans are handled by a separate TPA), and it is appropriate for the actuary to consider the appropriateness of each source. While disclosure requirements are consolidated in section 4, ASOPs may note them in other sections as well.
Section 3.2.1, Health Benefit Plan Provisions and Business Practices	
Comment	One commentator suggested revising the third sentence to clarify that the actuary is to consider "material differences between the plan provisions and actual operation of the plan," and noted that the remainder of the sentence contains examples, such as differences in definitions of payment allowances, etc.
Response	The committee agreed and made the proposed change.
Comment	Another commentator suggested removing the last sentence, as it is included in ASOP No. 5.
Response	The committee believed the sentence was appropriate for this ASOP.
Section 3.2.3, Economic Influences	
Comment	One commentator suggested wording to clarify that "to the extent changes are material" should be a view of the future by changing to "to the extent such changes, in the actuary's judgment, are likely to be material."
Response	The committee agreed and made the proposed change.
Section 3.2.10, Consistency of Bases	
Comment	One commentator was concerned with a blanket requirement for consistency, and that immaterial differences may be interpreted as violating the standard.
Response	The committee believed that the language did not dictate that the assumptions be identical, and allowed for some differences.
Section 3.3.1, Assumptions	
Comment	One commentator expressed concern that contract reserve assumptions, which are changed at the time of acquisition of a block, might not reflect experience prior to the acquisition, and proposed adding a new second sentence to say that "assumptions used must be reasonable relative to the entire block or blocks of business from issue."
Response	The committee believed that the existing first sentence requiring the use of "assumptions that are reasonable in the aggregate" would include the use of reasonable assumptions for prior periods and no change.
Comment	One commentator suggested adding additional examples of factors specific to disability plans in section 3.3.1(b).
Response	The committee did not feel additional examples were necessary.
Section 3.4, Considerations for Determining Premium Deficiency Reserves	
Comment	Several commentators suggested that the first sentence was not clear as to the basis for "when necessary."
Response	The committee revised the wording in sections 3.4 and 3.3 to clarify the basis as an outside requirement. The next two sentences in 3.4 remain as the principal sources of an "outside requirement" on the actuary.
Section 3.4.1, General Considerations	
Comment	Regarding section 3.4.1(e), one commentator suggested that amounts due from providers would normally be considered a receivable from a non-insurance entity and, therefore, problematic.
Response	The committee made no change. It does understand that some receivables may have special rules applied to them under some financial reporting rules. The ASOP, being more general, recognizes the potential for value.

Comment	Regarding section 3.4.1(h), one commentator expressed concern that the ASOP would not be consistent with the NAIC Health Reserves Guidance Manual.
Response	The committee believed that the existing language was appropriately broad and recognized that "applicable law, regulation or other binding authority" may be more restrictive.
Comment	Regarding section 3.4.1(i), one commentator noted that the treatment of expense allocation in calculating deficiency reserves is frequently different than for financial reporting in general and asked if the ASOP should address this.
Response	The committee agreed with the comment and added "for the purpose of determining premium deficiency reserves" at the end of this section.
Section 3.4.2, Additional Considerations for Financial Reporting	
Comment	Regarding section 3.4.2(a), one commentator suggested that certain blocks of business (for example, group conversions) are never intended (or allowed by law) to be profitable and that this would then require a premium deficiency reserve.
Response	The committee believed that defining a block of business will vary. If there are no other sources than the premiums, the policy form may need contract or additional reserves at issue. In some situations, other sources of revenue (for example, conversion charges) may be a source of funding such reserves. In some situations it may be appropriate to combine these forms into a larger block that is intended to support the unprofitable forms. The ASOP allows for reasonable approaches subject to applicable financial reporting requirements.
Comment	Regarding section 3.4.2(b), several commentators expressed concern that the time period language was not clear, especially with respect to the end of the period. Of particular concern were examples like conversion policies, blocks that "wander in and out of year-by-year profitability" and situations involving contracts committed to (new or renewal) by the risk-assuming entity that will result in a loss.
Response	The committee removed the wording requiring some level of profitability as the basis for the end of the period and revised the wording to clarify that the end of the period would normally be the date in the future, under the assumptions used to determine the reserve currently, when no premium deficiency reserve would then be required, including new business written at a loss. This will generally result from premium changes, increasing contract reserves or adding additional reserves or a combination. During such a period some portion of the block may be expected to produce profits before the entire block reaches the "end." Expected profits during this period, but not later periods, are a reasonable offset to the reserve.
Section 3.5.1, Non-Provider Risk-Assuming Entities	
Comment	Several commentators expressed concern that the actuary may not have sufficient information to determine a liability relating to added costs following a provider failing or leaving a network. One suggested that the ASOP make it clear that "it is not the actuary's responsibility to review the financial soundness" of providers. Others requested examples.
Response	The committee did not believe examples were appropriate for the ASOP but could be a part of a practice note. The committee did revise the language to require the actuary to "consider whether" there is a material risk relating to providers failing or leaving the network so that a liability should be determined. Such considerations would not normally involve the financial review of providers just for this purpose. Financial analyses of providers, if completed for other reasons, should be reviewed. The committee revised the prior paragraph to be consistent with this approach.

Section 3.6, Claim Adjustment Expense Liabilities	
Comment	One commentator suggested that, in practice, the actuary may not determine this liability, and that in such situations this liability is similar to those in section 3.7 and should be moved there.
Response	The committee made no change but notes that the ASOP uses the word "determines" to encompass both determining and reviewing liabilities, and within this concept, the actuary is required to determine a value of the liability. The committee believed that the ASOP provided flexibility for the actuary, even if not the one to calculate the liability, to be satisfied that the liability is covered in accordance with the financial reporting rules applicable.
Comment	Another commentator questioned whether implicit approaches should be allowed.
Response	The committee believed that so long as the liability is determined, the manner of reporting should not be defined by the ASOP. No change was made.
Section 3.7, Other Liabilities	
Comment	Several commentators noted that certain of these liabilities may be included in the liabilities subject to an actuarial opinion. They were concerned that the language seemed to suggest that actuaries are not responsible.
Response	The committee agreed with this concern and revised the second sentence to provide for two reasons for the actuary to be involved—a request to assist or where the liability is subject to the actuary's opinion.
Section 3.7.2, Reserves for Unearned Premiums	
Comment	One commentator noted that the definition of contract reserve would normally include the unearned premium reserve.
Response	The committee did not intend to include premiums for the balance of the contract year, as of the valuation date, in the basis for contract reserves. The committee intended to allow flexibility in the methodology of calculating contract reserves, such that the contract reserve can be calculated with or without the provision for unearned premiums. Section 2.5 was changed to reflect this. The committee believed that section 3.7.2 allowed the actuary to take this into account when determining reserves for unearned premiums.
Comment	One commentator asked how one could match future liabilities with unearned premium.
Response	The committee believed that the description of the unearned premium reserve was appropriate.
Section 3.7.3, Liabilities for Dividends and Experience Refunds	
Comment	One commentator asked if premium stabilization reserves were to be considered under this section.
Response	The standard would cover premium stabilization reserves in this section, as stabilization reserves are usually established for dividends or experience refunds.
Section 3.8, Follow-Up Studies	
Comment	Several commentators raised concerns about whether follow-up studies by the actuary were necessary. Some provided alternative wording to clarify positions.
Response	The committee believed that follow-up studies, while of great value, are the responsibility of the risk-assuming entity. An actuary is frequently involved but may not be the same actuary as the one determining the liability. The committee revised the wording to note that the responsibility of the actuary, under this ASOP, begins when the actuary is required or is asked to conduct (or assist) in completing a follow-up study. A disclosure statement was also added to section 4.1, Communications and Disclosures.
Section 4.2, Reliance on Others	
Comment	One commentator suggested that the sentence concerning disclosure be deleted from this section.
Response	The committee disagreed and made no changes.