



ACTUARIAL STANDARDS BOARD

**Actuarial Standard
of Practice
No. 5**

Incurred Health and Disability Claims

Revised Edition

**Developed by the
Health Committee of the
Actuarial Standards Board**

**Adopted by the
Actuarial Standards Board
December 2000**

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December 2000

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

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice (ASOP) No. 5

This booklet contains the final version of the revision of ASOP No. 5, now titled *Incurred Health and Disability Claims*.

Background

Under direction from the ASB, the Health Committee began revising ASOP No. 5, which in its prior form (adopted 1991, Doc. No. 028) was titled *Incurred Health Claim Liabilities*. The revision of ASOP No. 5 has a number of changes from the 1991 version, including the following:

1. The standard has been reformatted to be consistent with the current ASOP format adopted by the ASB in May 1996 for all future actuarial standards of practice.
2. This standard discusses incurred health and disability claims in total, rather than just unpaid health claims liabilities. Thus, the standard addresses the paid portion of incurred health and disability claims.
3. This standard explicitly discusses long-term claim products, and the knowledge and considerations for estimating incurred health and disability claims. Such considerations include provider contracts, reinsurance, and testing of liabilities.
4. Claim settlement expenses are no longer included in this standard and will be addressed in a standard under development at this time. This standard deals only with incurred health and disability claims. In the interim, actuaries may look to the guidance in section 5.13 of the previous edition of this standard with respect to claim settlement expenses.
5. This standard explicitly excludes deficiency reserves and policy reserves, which will be addressed in a standard under development at this time.

Exposure Draft

This standard was exposed in September 1999 with a comment deadline of March 31, 2000. Thirty comment letters were received. All of the comments received were thoroughly reviewed. Many of the comment letters showed thoughtful perception of the issues involved, and many clarifying suggestions were incorporated into the final standard, including the following:

1. The committee clarified several definitions and added the definition of “Exposure Unit.”
2. The definition of “Development (or Lag) Method” was expanded to reflect received claims as well as paid claims.
3. Sections 2.10 and 3.3.1(d), Time Value of Money, were added.
4. Section 3.3.1(c), Margin for Uncertainty, was expanded to provide guidance on the size of the margin, if one is included.
5. A reference to provider contractual arrangements not reimbursed through claims processing was added to section 3.3.6.
6. Section 3.3.7 was added, indicating that the basis for related liabilities and reserves should generally be consistent.

Appendix 2 contains a detailed discussion of the committee’s responses to the comments.

The Health Committee thanks all those who commented on the exposure draft.

The ASB voted in December 2000 to adopt this standard.

Health Committee of the ASB

David F. Ogden, Chairperson

Janet M. Carstens	John M. Friesen
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ACTUARIAL STANDARD OF PRACTICE NO. 5

INCURRED HEALTH AND DISABILITY 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 preparing or reviewing financial reports, claims studies, rates, or other actuarial communications involving incurred claims within a valuation period under a health benefit plan as defined in section 2.5 of this standard.
- 1.2 Scope—This standard applies to actuaries who estimate or review incurred claims under health benefit plans on behalf of insured or noninsured entities, managed-care entities, health care providers, government-sponsored plans or risk contracts, or regulatory agencies. This standard does not provide guidance to actuaries regarding reserves such as policy reserves, premium reserves, or claim settlement expense reserves, although such reserves may be required for financial reporting. This standard does not address interpretations of statutory or generally accepted accounting practices.
- If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority), or for any other reason the actuary deems appropriate, the actuary should refer to section 4.
- 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 is effective for work performed on or after May 1, 2001.

Section 2. Definitions

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

- 2.1 Block of Business—All policies of a common coverage type (for example, major medical, preferred provider organization, or capitated managed care); demographic grouping (for

example, size, age, or area, group or individual policies); or other segmentation useful for estimating incurred claims for actuarial purposes.

- 2.2 Capitation—The amount of money paid to a provider by an exposure-based payment system to provide certain health care services to any Managed Care Health Provider members. The payment does not vary on the basis of the number or type of services actually rendered. The verb “to capitate” is used to indicate the act of entering into such an arrangement. Capitation is also sometimes used to mean the total medical cost or premium per enrollee, though it is not used in this manner in this document.
- 2.3 Development (or Lag) Method—A method under which historical claim data, such as the number and amount of claims for the subject block of business, are grouped into the time periods in which claims were incurred and the time periods in which they were processed. The processing date is typically the date the claim is received, adjudicated, or paid by the claim payer. The method uses these groupings to create a claims processing or development pattern, which is used to help estimate the unprocessed portion of incurred claims.
- 2.4 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.
- 2.5 Health Benefit Plan—A contract providing medical, prescription drug, dental, vision, disability income, long-term care, or other health-related benefits, whether on a reimbursement, indemnity, or service benefit basis, regardless of the form of the risk-bearing organization, including benefit plans provided by self-insured or governmental plan sponsors.
- 2.6 Incurral Date—The date a claim is determined to be a liability of the organization in accordance with the terms of the health benefit plan. For health benefit plans where the claim must exceed a minimum threshold, for example where there is a deductible or elimination period, the incurral date may be the date claims begin to accumulate toward the threshold.
- 2.7 Incurred Claims—The value of all amounts paid or payable under a health benefit plan, determined by contract to be a liability with an incurral date during the valuation period. It includes all payments during the valuation period plus a reasonable estimate of unpaid claims liabilities. For an organization’s income statement, incurred claims equal paid claims plus the estimate of unpaid claims liabilities at the end of the current valuation period less the estimate of unpaid claims liabilities at the end of the prior valuation period.
- 2.8 Material—Resulting in an impact, significant to the interested parties, on the affected actuarial incurred claim estimate.
- 2.9 Tabular Method—The application of a factor to a volume measure (for example, number of individual claims) based on prior experience, in order to estimate unpaid claims liabilities for reported claims (commonly used for long-term claims).

- 2.10 Time Value of Money—The principle that an amount of money available at an earlier point in time has different usefulness and value than the same amount of money has at a later point in time.
- 2.11 Trends—Measures of rates of change, over time, of the elements affecting incurred claims.
- 2.12 Unpaid Claims Liability—The value of the unpaid portion of incurred claims includes (1) unreported claims; (2) reported but unprocessed claims; and (3) processed but unpaid claims. For an organization’s balance sheet, the unpaid claims liability includes provision for all current and prior valuation periods.
- 2.13 Valuation Period—A defined period for which incurred claims are recorded.

Section 3. Analysis of Issues and Recommended Practices

- 3.1 Introduction—The estimation of incurred health and disability claims is fundamental to the practice of health actuaries. It is necessary for the completion of financial statements; for the analysis and projection of trends; for the analysis or development of rates; and for the development of various management reports, regardless of the type of insurance or managed-care contract.
- 3.2 Considerations for Estimating Incurred Claims—The actuary should consider how to appropriately reflect relevant plan provisions, business practices, and environmental factors that materially affect incurred claims or trends, such as those highlighted in sections 3.2.1–3.2.7 below.
 - 3.2.1 Health Benefit Plan Provisions and Business Practices—The actuary should consider the health benefit plan provisions and business practices, including special group contract holder requirements and provider payment arrangements, that materially affect the cost, frequency, and severity of claims. These include elimination periods, deductibles, preexisting conditions limitations, maximum allowances, and managed-care restrictions. Payment allowances, incurrual dating methods, or benefit interpretations may be defined by internal business practices, plan provisions, or both.
 - 3.2.2 Economic Influences—Economic conditions may affect incurred claims. For example, changes in price levels, unemployment levels, or medical practice will affect morbidity (including both the incidence and duration of disability). The actuary should consider items such as relevant changes in managed care contracts, cost shifting, provider fee schedule changes, medical procedures, epidemics, or catastrophic events, and elective claims processed in recessionary periods or prior to contract termination.

- 3.2.3 Organizational Claims Administration—Organizations have various practices for administering claims, which may cause fluctuations in the rates of completion or lag factors used by the actuary to determine unpaid claims liability. The actuary should consider how claims administration practices can be influenced by staffing levels, process and investigation time for complicated claims, computer system changes or downtime, seasonal backlogs of claims submitted, governmental influences, and cash flow considerations.
- 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 and relative maturity of a block of business can influence incurred claims.
- 3.2.5 Legislative Requirements—Governmental mandates can influence the provision of new benefits; risk characteristics; rating, reserving and underwriting practices; and claims processing practices. The actuary should consider relevant legislative and regulatory changes as they pertain to determination of incurred claims.
- 3.2.6 Carve-Outs—Carve-outs can represent services such as prescription drugs or dental; or condition-specific services such as cancer treatment, mental health, or substance abuse. Carve-outs are often provided by a separate entity specializing in that type of service. The actuary should consider the pertinent benefits, payment arrangements, and separate reporting of these benefits in incurred claims determination and trend analysis.
- 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 plan’s benefits may not begin for several years after policy purchase, while claims usually extend over many valuation periods. The actuary should consider the variety of benefits available in these policies, such as lump-sum, fixed, or variable payments for services; provisions such as cost of living adjustments and inflation protection; payment differences based on institutional or home-based care; social insurance integration; and the criteria for benefit eligibility.
- 3.3 Analysis of Incurred Claims—After reviewing the considerations in sections 3.2.1–3.2.7 above, the actuary should follow the relevant procedures highlighted in sections 3.3.1–3.3.7 below.
- 3.3.1 Unpaid Claims Liability—Using incurral and processing dates, the actuary determines unpaid claims liabilities for claims incurred during the valuation period.
- a. Plan Provisions—The actuary should review the relevant plan provisions to determine if they create liabilities for services or payments after the valuation period (for example, completion of medical treatments, deferred maternity

benefits, or long-term disabilities). The actuary should determine if these liabilities are part of the current or future period's liability, or if these liabilities make up a separate reserve.

- b. **Data and Reporting**—The actuary should take into account the relevant reporting systems for processed claims, exposure units, and premium rates, and the various dating methods the systems use (for example, loss recognition, service rendered, reporting, or payment status). The actuary should use professional judgment in estimating the extent to which an adjustment to the reported data is needed, based on the dating methodology.
- c. **Margin for Uncertainty**—Recognizing the fact that determination of liabilities for incurred but unpaid health and disability claims is an estimate of the true liabilities that will emerge, the actuary should consider what margin for uncertainty, if any, might be appropriately included. If a margin is included, the unpaid claims liability should be appropriate, in the actuary's judgment, under moderately adverse conditions.
- d. **Time Value of Money**—The actuary may consider the time value of money if doing so will have a material effect in the determination of incurred claims. The use of any interest discounts depends on the purpose for which incurred claims are being calculated, and should reflect applicable statutory and accounting standards.

3.3.2 **Categories of Incurred Claims**—The actuary should consider separate development of incurred claims for each category that may exhibit different lag patterns, costs per exposure unit, trends, or exposure unit growth rates. The actuary should define categories of incurred claims in a manner that is appropriate to the available data and to the task being performed. Categories may be defined broadly, such as fee-for-service claims paid to health care providers, capitation payments to providers, or disability income paid to insureds. Categories might be further refined to more accurately analyze or project costs and utilization data, for example, by method of payment (such as electronic vs. manual), type of contract, place of service, premium rating method, demographic factors, distribution method, and provider risk-sharing arrangements.

3.3.3 **Reinsurance Arrangement**—The actuary should recognize the impact of reinsurance arrangements on the data and should appropriately reflect the effect of such arrangements in estimating the incurred claims. In particular, the actuary should recognize the different lag patterns due to the extended reporting or recovery periods often associated with certain types of reinsurance.

3.3.4 **Large Claim Patterns**—The actuary should take into account any relevant change in the pattern of large claims. Specifically, large claims can distort claim payment patterns or historical per-unit claim levels that the actuary considers when estimating

incurred claim estimates. The actuary should consider how large claims impact the particular method being employed to determine incurred claim estimates and make appropriate adjustments. For example, incurred claim estimates may be overstated if completion factors are applied to processed claims levels that include an unusually high number or amount of large claims.

3.3.5 Coordination of Benefits (COB) or Subrogation—The actuary should take into account the relevant organizational practices and regulatory requirements related to COB or subrogation. In particular, the actuary should consider how these items are reflected in the data (for example, negative claims or income) and make appropriate adjustments for COB, subrogation, or other adjustments or recoveries.

3.3.6 Provider Contractual Arrangements—The actuary should take into account the relevant contractual arrangements with providers and any changes in such arrangements. These arrangements can affect trends, claim cost levels, and claims processing. The actuary should consider any relevant variation in these arrangements by region or product, and any provider contractual arrangements that do not provide for reimbursement through the claim payment process, for example, capitation.

The arrangements will also typically specify what portion of the risk (if any) has been shifted to the providers. If the providers bear a substantial portion of the risk, the actuary should consider the overall ability of the provider to meet its obligations. Depending on the purpose of the analysis, the actuary should take into account any statutory limitations on the credits for such transfers of risk.

Additional amounts may be owed to providers for supplemental payments for high-cost medical treatment beyond capitation, return of payment withholds, or incentive payments based on financial results. Certain contractual arrangements may also result in amounts due from providers based on financial results. The actuary should consider the impact of unpaid medical costs resulting from failed contractors under capitation or losses incurred by contractors deemed to be related parties.

3.3.7 Consistency of Basis—The actuary should consider the basis for determining related liabilities and reserves, including those not covered by this standard, such as claim settlement expense reserves. The basis for these items generally should be consistent.

3.4 Data Requirements and Assumptions—The expansion of health benefit coverages and the greater variety of organizations offering or administering health benefit coverages have increased the volume, type, precision, and the frequency of data needs by the actuary. Consistent with ASOP No. 23, *Data Quality*, the actuary should make appropriate efforts to obtain accurate data from claim processing reports, accounting systems, and other relevant internal organization sources in order to determine incurred claims. External sources may be needed to provide reasonableness checks on limited data.

- 3.5 Methods Used for Estimating Incurred Claims—Various methods may be used to estimate incurred claims. Some methods are based on statistical analysis and projection of the costs or rates at which claims were processed in recent periods. Such projection of the costs is usually done by category of incurred claims for greater accuracy. However, the adequacy of incurred claim estimates is determined in the aggregate for financial statements.

Because no single method is necessarily better in all cases, the actuary should consider the use of more than one method. The actuary should evaluate the method(s) chosen and the results obtained in light of the credibility of the data. The actuary should also consider the effect of trends both in previous periods and the current period for estimating incurred claims. The actuary should choose the outcome that, in the actuary's professional judgment, is the most reasonable provision for incurred claims, whether from a single method or a combination of several methods. Sections 3.5.1–3.5.3 below discuss some of the more common methods for estimating incurred claims.

- 3.5.1 Development Method—This method is appropriate and widely used for short-term benefits having processed claims (i.e., not capitation) and may also be appropriate for long-term claims. It typically requires monthly (or quarterly) claim summary reports split by period of incurral and period of processing. There should be similar reports of earned rates and exposure units for the same periods. With these data, the actuary estimates the percentage or amount of completion needed to project all future yet unrecorded claims accruable to the valuation period, for each block of business. The actuary should consider processing fluctuations due to seasonality, claims processing practices, inflation, or significant changes in medical practices. The summary of all the months' estimates of (1) unreported claims; (2) reported but unprocessed claims; and (3) processed but unpaid claims represents the unpaid claims liability.

When the estimates are completed and added to known payments for each time period, the total incurred claims should be matched and compared to earned rates and exposure units for reasonableness. The actuary should test alternatives to gain understanding of their use and reliability depending on the block of business or accuracy desired.

- 3.5.2 Tabular Method—The tabular method is generally used for known long-term claims and may be required by regulatory standards to estimate the unpaid claims liability using life annuity values, continuance probabilities, or commutation function tables. This method applies factors to items such as individual claims, waived rates, or other volume measures based on previous experience in order to estimate the unpaid claims liability for known claims. The factors are often based on the age and sex of the insured, elimination period, cause of claim, length of disablement on the valuation date, and remaining benefit period, as appropriate to the coverage.

The actuary should take into account specified benefit changes throughout the lifetime of the claim and the assumptions used to develop the table; and should select the appropriate table(s) to estimate the unpaid claims liability given the risk

characteristics of the policy.

For long-term disability, the actuary should recognize the specific impacts that recovery, mortality, and government offsets have on tabular factors.

The tabular method is not appropriate for estimating unknown claims. When the tabular method is used, the actuary should consider whether an additional adjustment is necessary to reflect unreported incurred claims.

- 3.5.3 Other Methods—Other methods the actuary may consider to estimate incurred claims include (but are not necessarily limited to) multiplying the number of reported claims by the average size of previously closed claims; multiplying projected cost per unit by exposure units; multiplying projected cost per service by service counts; and multiplying earned premium by an estimated loss ratio. Other methods may be necessary when organizational data are limited or not credible, particularly for new blocks of business.
- 3.6 Follow-Up Studies—Follow-up studies involve performing tests of reasonableness of the prior period incurred claims estimates and the methods used over time. The results are required in some financial statements and may be required in actuarial reports. The actuary should, to the extent practicable, acquire the data to perform such studies; perform studies in the aggregate and for pertinent blocks of business involving rating concerns; and utilize the results, if appropriate, in preparing current incurred claims estimates.

Section 4. Communications and Disclosures

- 4.1 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 field could assess the reasonableness of the work. For further guidance, the actuary is referred to ASOP No. 23, *Data Quality*; ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*; and ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*.
- 4.2 Disclosures—The actuary should include the following, as applicable, in an actuarial communication:
- a. the disclosure in ASOP No. 41, *Actuarial Communications*, section 4.2, if any material assumption or method was prescribed by applicable law (statutes, regulations, and other legally binding authority);
 - b. the disclosure in ASOP No. 41, section 4.3, if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and

- c. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

Appendix 1

Background and Current Practices

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

Background

The determination of incurred claims is an integral, fundamental part of the work of most health actuaries. It is necessary to set proper financial statements for ratemaking, planning, and projections.

Incurred claims determination has become more challenging with the proliferation of provider contracts that share risk in different ways. Having accurate data continues to be an issue.

Current Practices

A reformatted version of this standard has been in place since January 1991; the original standard since March 1988. The committee believes that current practices are generally in keeping with the current standard. While there is no reason to believe current practices are inappropriate, the revisions to this standard keep it consistent with the changing times.

Appendix 2

Comments on the Exposure Draft and Committee Responses

The proposed standard was exposed for review in September 1999, with a comment deadline of March 31, 2000. Thirty comment letters were received. The Health Committee of the ASB carefully considered all comments received. Summarized below are the significant issues and questions contained in the comment letters, printed in standard type. The Health Committee's responses to these issues and questions appear in **boldface**.

General Observations

Many helpful ideas and comments were offered in the comment letters and are reflected in this standard, as appropriate.

Several commentators believed that only unpaid claims liabilities should be addressed. **The committee continues to believe that broadening the definition to include all incurred claims results in a better overall approach.**

One commentator believed the standard was a ratemaking standard. **The standard applies to the estimation of incurred claims. Therefore, it applies to ratemaking only to the extent that incurred claim estimation is a part of the ratemaking process.**

One commentator was concerned that methods, approaches, or formulas should not be prescribed. **The committee believes the standard does not prescribe any of these items.**

Several commentators believe the standard should discuss the need for claim settlement expense liabilities, or the effective date of the standard should be delayed until another standard is written and approved that includes them. **Claim settlement expense liabilities will be covered in a separate standard, which is under development.**

Several commentators believed that the time value of money should be explicitly discussed. **The committee agreed and added sections 2.10 and 3.3.1(d) to discuss it.**

One commentator recommended that the standard should discuss using either paid or received claim data in the development method. **The committee agreed and changed several parts of the standard to refer to processed claims, rather than paid only.**

One commentator stated that the descriptions of the development method was too specific and should be generalized. **The committee disagrees, believing that only a broad outline of the development method is included.**

Transmittal Memorandum

The committee posed four questions in the transmittal memorandum of the exposure draft:

1. Is the proposed revision too specific or too general with its discussion of background issues (see section 3.2, Considerations for Estimating Incurred Claims) and specific methods and practices (see sections 3.3–3.6)? If too specific, what should be deleted? If too general, what should be added?
2. Is it clear that the proposed revision refers to the determination of incurred health and disability claims only and does not address practices concerning policy reserves, premium deficiency reserves, or claim settlement expense reserves—which may be necessary for statutory reporting? If the standard is not clear, what should be revised?
3. Is it clear that the proposed revision applies to government actuaries?
4. Is it appropriate that the proposed revision does not specifically address the time value of money, but instead leaves such decisions to the professional judgment of the actuary?

Comments on these four questions and the committee’s responses follow:

Question #1: Several commentators stated that the amount of specificity is about right. Two commentators believed parts were too general; these comments are discussed in the specific sections.

Question #2: Four commentators believed the standard was clear.

Question #3: Several commentators believed the standard was clear; one commentator suggested wording changes to the scope. **The committee retained the proposed wording, as it does not believe the suggestion was a material improvement.**

Question #4: **As discussed above, the standard has been changed to discuss the time value of money.**

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

Section 1.2, Scope—One commentator suggested the scope specifically include or exclude rate stabilization reserves. Another commentator believed that the scope could be improved by defining for what the standard does not provide guidance. **The committee revised the definition to be more general by removing specific reference to accidental death and dismemberment reserves and changing premium deficiency reserves to premium reserves. The committee**

does not believe rate stabilization reserves or other reserves need to be noted specifically.

One commentator suggested inclusion of a description of the three different categories of reserves from the NAIC minimum reserve standard model. **The committee believes such a description is not necessary in this standard.**

One commentator suggested that the scope be expanded to specifically include actuaries who estimate or review incurred claims on behalf of employers who sponsor self-insured health care and disability plans for employees. **The committee believes reference to actuaries performing this work for non-insured entities is sufficient to include actuaries working for employer-sponsored plans.**

Section 2. Definitions

Section 2.1, Block of Business—One commentator suggested that “expected claim runoff pattern” be added to the list of segmentation criteria. Another commentator suggested inclusion of “significant benefit variations” (for example, deductibles and coinsurance/copays and maximum limits) as a criterion for segmentation. **The committee believes the current definition is adequate and additional criteria do not need to be included.**

Section 2.3, Development (or Lag) Method—One commentator suggested the definition be revised for clarity as well as to recognize the use of received date. **The committee agreed and revised the definition based on the commentator’s suggestion.**

Another commentator suggested inclusion of the words “or health benefit plan” after “block of business” to recognize employers. **The committee believes the current definition is sufficient to recognize employers and does not believe this change is necessary.**

Section 2.4, Exposure Unit—One commentator suggested including a definition for exposure. **The committee agreed and included a definition for “exposure unit.”**

Section 2.5, Health Benefit Plan—Two commentators suggested specific clarification regarding whether workers’ compensation and auto insurance coverages are intended to be covered. Another commentator suggested clarification regarding whether associations, MEWAs, and Taft-Hartley plans are intended to be covered. **The committee believes the current definition is adequate and that these items do not need to be addressed specifically.**

One commentator suggested the inclusion of examples of self-insured plan sponsors. **The committee does not believe specific examples are necessary.**

Another commentator suggested distinguishing between a contract with an insured and a contract

with a provider. **The committee believes the current definition includes all these items and that additional information is not necessary.**

Section 2.6, Incurral Date—One commentator suggested the current definition for incurral date is not appropriate for stop-loss coverage. Another commentator did not believe the definition was appropriate for disability income. **The committee agreed and revised the definition for these types of accumulation claims.**

One commentator suggested that additional information as to how to determine the incurral date be included. Another commentator suggested providing examples of the documents to be used to determine the incurral date (including, but not limited to, individual or group insurance policies, plan documents, managed care contracts, etc.). **The committee does not believe that these types of examples should be included in the definition.**

Section 2.7, Incurred Claims—Several commentators noted that the current definition was confusing and some thought the definition did not include the change in estimated incurred claims for the current valuation period. **The committee agreed that the definition was confusing and has revised the definition.**

One commentator suggested including the words “as defined in [section 2.12] of this standard” after “unpaid claims liability.” **The committee believes the current definition is adequate and that the additional reference is not necessary.**

One commentator suggested changing “incurred claims” to “accounting claims,” “booked claims,” “reported claims,” or “accrual claims” to be more indicative of accounting terminology. **The committee does not believe this change should be made.**

One commentator was concerned with the definition in conjunction with the current definition for incurral date with respect to stop-loss or other accumulated benefits. **The committee believes this issue has been addressed by changing the definition of incurral date.**

Section 2.9, Tabular Method—One commentator suggested changing the definition from “estimate unpaid claims liability for” to “develop.” Another commentator indicated that the term “tabular method” is generally used to refer to a subset of the “exposure method,” and that the tabular method is more limiting since the exposures are claims data. The exposure method would allow use of exposures other than claims data. **The committee believes that the current definition is consistent with the term listed in the *Definitions from ASOPs and ACGs of the ASB*, and made no change to the definition.**

Section 2.10, Time Value of Money—Several commentators indicated that the ASOP should reflect the time value of money. **The committee agreed and added a definition of the “Time Value of Money.”**

Section 2.11, Trends—One commentator indicated the definition was too vague. **The committee believes the definition is consistent with ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*, and made no change to the definition.**

Section 2.12, Unpaid Claims Liability—One commentator suggested that the second sentence in the definition should read, “For an organization’s balance sheet, the unpaid claims liability includes provision for all current and prior valuation periods.” **The committee agreed with the suggestion and modified the definition.**

One commentator indicated that it might be useful to recognize the separation between claim liabilities (for amounts due prior to the end of the valuation date) and claim reserves (for amounts due after the end of the valuation date), given the importance of statutory accounting for health claims. **The committee believes it is clear in the current definition that the unpaid claims liability includes both and that separate definitions are not necessary.**

Section 2.13, Valuation Period—Two commentators indicated that the definition was not clear that a valuation period could represent a period other than a calendar year. **The committee agreed and modified the definition.** One commentator indicated that “accounting period” should be used instead of “valuation period” when the reference is to a time period rather than to a point in time. **The committee believes that the current definition is clear and made no change to the definition.**

Section 3. Analysis of Issues and Recommended Practices

Section 3.1, Introduction—One commentator indicated that the word “determination” should be changed to “estimation” since actuaries estimate incurred health and disability claims. **The committee agreed with the suggestion and changed the wording in section 3.1 and other sections.**

One commentator indicated that although section 3 covers “issues,” it does not appear to address directly the issue of conservatism. **The committee believes that the issue of conservatism is adequately addressed in section 3.3.1(c), *Margin for Uncertainty*.**

One commentator suggested that language be inserted to clarify that the section applies to both insurers and plan sponsors. **The committee believes this is adequately addressed in section 1.2, *Scope*.**

One commentator suggested removal of the parenthetical comment in the first paragraph since it was somewhat misleading. **The committee agreed and removed the parenthetical comment.**

Two commentators indicated that the paragraph suggesting that the actuary keep current regarding advances in generally accepted actuarial practice was either duplicative with current educational requirements, might be used in malpractice litigation, or could be difficult to ascertain compliance. **The committee agreed and removed the paragraph.**

Section 3.2, Considerations for Estimating Incurred Claims—One commentator indicated that the word “determining” should be changed to “estimating” in the title since incurred claims are estimated. **The committee agreed and changed the title.**

One commentator indicated that the actuary should not only consider relevant plan provisions, business practices, and environmental factors that materially affect incurred claims or trends, but should also reflect the item when it is material. **The committee agreed and changed the first sentence to read, “the actuary should consider how to appropriately reflect.”**

One commentator indicated that the list of considerations was not all-inclusive and that a reference should be made to phenomena on the operations side. **The committee agreed and added the phrase “such as” to refer to the list of considerations.**

Section 3.2.1, Health Benefit Plan Provisions and Business Practices—One commentator indicated that a statement should be included indicating that the actuary should consider how the claims administrator reports the incurral dates for a series of claims derived from a common condition or injury. **The committee believes that incurral dating methods are adequately covered in the last sentence but modified the first sentence in 3.2.1 to read, “the actuary should consider the health benefit plan provisions and business practices” for clarification purposes.**

One commentator indicated that although provider payment arrangements are considerations for determining incurred claims, they were not mentioned. **The committee agreed and inserted the words “and provider payment arrangements” in the first sentence.**

One commentator indicated that the potential for over-insurance, especially as it relates to disability income, should be covered. **The committee believes that the concept of over-insurance is adequately covered.**

Several commentators indicated that the section on benefit characteristics was vague or overlapping. **The committee agreed and removed the section.**

Section 3.2.2, Economic Influences—One commentator recommended changing the first sentence to refer directly to changes in medical practice methods, not just expense levels and morbidity, since average costs can change even if the overall sickness and price levels remain the same. The commentator also suggested changing the reference to inflation to a reference to price levels. **The committee agreed with these suggestions and incorporated the changes.**

One commentator did not like the reference to “claims done in recessionary periods.” **The committee agreed and eliminated the word “done.”**

Two commentators suggested adding references to disability incidence and termination rates and one commentator suggested adding a reference to elective claims. Another commentator indicated that specific reference to epidemics or catastrophic events should be included. **The committee added a specific reference.**

Section 3.2.3, Organizational Claims Administration (formerly titled, Organizational Claim Processing Methods and Reports)—Several commentators noted that description of claims processing was limited, and suggested that “internal” did not include third party payor methods. **The committee agreed and modified the wording to refer to administering claims rather than simply processing and to remove the reference to internal.**

One commentator stated that this list of influences did not include management reorganization as a factor. **The committee modified the language to make it clear that the list is not intended to be exhaustive.**

Section 3.2.4, Risk Characteristics and Organizational Practices by Block of Business (formerly titled, Risk Characteristics and Underwriting Practices by Block of Business)—Several commentators pointed out that there were other items in addition to marketing and underwriting, such as competition that could influence the types of risks accepted. **The committee agreed and modified the section to include “other business practices” in order to reflect items that would include the influence of competitive practices on risk characteristics of a block of business.**

One commentator suggested that the risk characteristics be enumerated, such as age, sex, and medical conditions. **The committee believes that this is common knowledge and that it is not necessary to include such an enumeration in the standard.**

Several commentators pointed out that the term “loss ratio” was introduced in this section and should either be explained or deleted. **The committee chose to replace the term with “incurred claims” in keeping with the rest of the standard.**

Section 3.2.5, Legislative Requirements—One commentator indicated that the statement that the actuary should consider relevant legislative and regulatory changes was redundant with language elsewhere in the document. **The committee believes that it is appropriate to retain the sentence in this section.**

Section 3.2.6, Carve-Outs—Several commentators noted that this section was not clear as to what was intended to be included as carve-outs. **The committee modified the language to**

clarify that carve-outs include services such as prescription drug, mental health treatment, or dental. The list is not intended to be exhaustive.

One commentator noted that capitation might be included here in the case of mixed (partially capitated) plans. **The committee believes that capitation could indeed be considered as a carve-out in certain circumstances. Capitation is also covered by section 3.3.6, Provider Contractual Arrangements.**

One commentator suggested that this section noted the need to review liability for coverage in the event of provider failure to perform. **The committee believes that this is covered under section 3.3.6.**

Section 3.2.7, Special Considerations for Long-Term Products—Two commentators noted that the term “factors” was used in two different ways in the section. The first usage was to reference items influencing incurred claims and the second reference was to reference tabular values. **The committee determined usage of the term was not pertinent to the meaning of the section and also determined that the reference in the second paragraph to the use of judgment was not needed in the standard.**

Two commentators suggested that additional influences be included in the list. **The committee agreed and added cost-of-living, inflation protection, social insurance integration, and benefit eligibility criteria to the section.**

One commentator suggested that a section on nonrecurring or catastrophic events such as weather, labor disputes, epidemics, terrorism, or earthquakes be added to the standard. **The committee believes this is not necessary, as these items could be considered economic influences and are covered by section 3.2. Modifications to this section described elsewhere broaden the scope of the section to include such factors.**

Section 3.3, Analysis of Incurred Claims—Several commentators noted that this “Procedures for Analyzing Incurred Claims” was not an appropriate title for this section. **The committee agreed and changed the title.**

Several comments suggested that a discussion of the time value of money should be included. **The committee agreed and added new section 3.3.1(a) to address the issue.**

One commentator noted that certain items such as case management, capitations, and other items associated with direct delivery of services should be included. **The committee agreed but determined that this should be addressed elsewhere, and modified section 3.3.6 to reference this.**

One commentator suggested that reference be made to the practice of commuting long-term claim payment liabilities with lump-sum settlements. **The committee agrees that this practice has an impact on incurred claims and assumptions used to determine them, but believes that this level of detail is not appropriate for this standard. Section 3.2.3 briefly addresses this issue.**

Section 3.3.1, Unpaid Claims Liability—One commentator suggested that the section be split into three parts for clarity. **The committee agreed, labeled each of the three sections in the document separately, and added a fourth section on the time value of money.**

One commentator noted that this section seemed to require the use of a lag method, and pointed out that data to determine an unpaid claims liability on this basis may not always be available. **The committee agreed and modified the draft to incorporate language recognizing that point.**

One commentator also noted that the term “payment date” was limiting and did not allow for the variety of definitions associated with payment and processing of claims, particularly with respect to disability claims and hospitalizations. **The committee agreed and modified the language to use the term “processing date” in section 3.3.1, and similar wording in new sections 3.3.1(b) and 3.3.1(c).**

Two commentators suggested that the last sentence in new section 3.3.1(a) be expanded to describe what to do under each situation. **The committee considered this point and concluded that adequate guidance was provided elsewhere and no modification was necessary.**

One commentator noted that the term “enrollment” was undefined. **The committee agreed and substituted the term “exposure units” in new section 3.3.1(b).**

One commentator noted that the term “rates” was unclear. **The committee agreed and added the word “premium” before “rates” in new section 3.3.1(b).**

Several commentators noted that the paragraph on margin should be expanded to provide more guidance. One suggested that language similar to ASOP No. 28 be included. **The committee agreed and added some language to the new section 3.3.1(c) for this purpose. It should be noted that the standard does not require that an actuary include a margin, but rather defines the level of margin that should be included if a margin is indeed determined.**

Section 3.3.2, Categories of Incurred Claims—Two commentators suggested that the categories of incurred claims should make reference to the different methods of payment, with pharmacy claims being the example used by both commentators. **The committee agreed with the suggestion and added the phrase “method of payment (for example, electronic vs. manual).”**

Section 3.3.3, Reinsurance Arrangements—One commentator expressed the concern that this section seemed to apply only to reinsurers and another commentator suggested adding the phrase “stop-loss claim” to the section. **The committee believes the original wording does apply to direct writers as well as reinsurers, including stop-loss coverage.**

One commentator suggested that the section was too restrictive with regard to varying actuarial techniques, if applied to rate making. **The committee believes the wording “reflect the effect of such arrangements in estimating the incurred claims” does not restrict actuarial rating techniques.**

Section 3.3.4, Large Claim Patterns—One commentator suggested that the example used in this section also should have addressed the possibility of understatement of incurred claims estimates. Another commentator suggested adding “unusually high” to the phrase “number or amount of large claims.” **The committee agreed and changed the wording to include “unusually high” to address both comments.**

Section 3.3.5, Coordination of Benefits (COB) or Subrogation—One commentator suggested adding a reference to adjustments or recoveries other than COB or subrogation. **The committee agreed and added the phrase “other adjustments or recoveries.”**

One commentator expressed concern about adjustments not overly reducing the level of conservation otherwise assumed. **The committee believes this is adequately addressed in the revised section 3.3.1(c).**

Section 3.3.6, Provider Contractual Arrangements—One commentator believed that a reference to provider arrangements not reimbursed through the claim payment process, for example, capitation, should be added. **The committee agreed and added a sentence to that effect.**

Section 3.3.7, Consistency of Basis—Several commentators believed that a reference to claim settlement expense reserves should be added to ensure consistency in determining all liabilities and reserves. **The committee agreed and added section 3.3.7.**

Section 3.4, Data Requirements and Assumptions—One commentator believed that the variety of organizations providing administrative services would affect the data needs of the actuary. **The committee agreed and added the phrase “or administering” to address these situations.**

Section 3.5, Methods Used for Estimating Incurred Claims—Several commentators expressed concern about the phrase “not an average of the methods” being too limiting in how to use alternative methods of estimating incurred claims. **The committee agreed and deleted the phrase.**

One commentator believed that the phrase “early part of the current valuation period” was confusing. **The committee agreed and deleted the phrase.**

One commentator expressed concern that the phrase “most reasonable provision” was not adequately defined with regard to various levels of conservatism that are appropriate. **The committee believes this is adequately addressed in the revised section 3.3.1(c).**

One commentator believed that the concept of credibility should be defined or discussed more fully as it relates to selection of an appropriate method of estimating incurred claims. **The committee believes that the current wording is adequate for guidance to the actuary.**

Section 3.5.1, Development Method—One commentator suggested the possibility of using the development method for long-term claims. **The committee agreed and added the wording “development methods may also be appropriate for long-term claims.”**

One commentator suggested removing the sentence redefining claims lag. **The committee agreed and deleted the sentence.**

One commentator suggested changing the wording from “the actuary should analyze” to “the actuary should consider” as it pertains to fluctuations. **The committee agreed and changed the wording.**

One commentator suggested making the wording more stringent about considering fluctuations by requiring that an adjustment be made if deemed to have a significant impact. **The committee believes the original wording is adequate to provide guidance to the actuary.**

One commentator believed that the use of paid loss ratios by incurred period should not be considered a development method. **The committee agreed and deleted the wording.**

One commentator expressed the opinion that the references to “paid dates” would be better referenced as “processed dates.” **The committee agreed and changed the wording throughout the standard of practice.**

Section 3.5.2, Tabular Method—Three commentators suggested that the tables might be dictated by regulations. **The committee believes that this is adequately covered under section 3.2.5, Legislative Requirements.**

One commentator suggested that the list of factors included in the last sentence of the first paragraph be broadened to include cause of claim. **The committee agreed with this and also generalized the list to apply to any type of contract, not just to long-term disability. Also, the committee added wording to section 3.2.7, Special Considerations for Long-Term Products, to incorporate these concepts.**

One commentator requested that wording be added regarding the impacts of recovery, mortality and government offsets on tabular factors for long-term disability. **The committee agreed with this request and added the suggested wording.**

Another commentator suggested expansion of the last sentence of this section to state that “the actuary should consider whether an additional adjustment is necessary to reflect unreported incurred claims.” **The committee agreed with this and added the wording.**

Section 3.5.3, Other Methods—Two commentators suggested that “Other Methods” be expanded to include methods frequently used by managed care plans, such as hospital logs and pre-authorization data. **The committee agreed with this and expanded the examples to include these. It should be noted that this list of examples is not intended to be exhaustive.**

Section 3.6, Follow-Up Studies—Several commentators suggested expanding the wording in this section to include other items to study, for example, lag patterns, seasonality patterns, trends, and duration of unpaid claims liability. **The committee believes that the wording used in this section sufficiently covers these.**

One commentator expressed concern that the measures of “reasonableness” seemed to focus on “accuracy” of prior estimates, which “leaves the actuary open to second-guessing by regulators and others when the estimates are less than 100% accurate.” **The committee disagrees with this interpretation and thus made no change in this section.**

Two commentators stated that the wording implied that “all” financial statements require follow-up studies. **The committee agreed and modified the statement to state “some financial statements.”**

One commentator suggested adding a new section 3.7, Other Considerations; section 3.7.1, Materiality; and section 3.7.2, Cost Effectiveness. **The committee agreed to expand on the definition and issue of “Materiality” elsewhere in the standard. The committee did not believe it necessary to add a separate section on “Cost Effectiveness,” since the committee believes these concepts are adequately addressed elsewhere in the standard.**

Section 4. Communications and Disclosures

Section 4.2, Prescribed Statement of Actuarial Opinion (PSAO)—One commentator suggested eliminating this section since the actuary is required to be familiar with all relevant standards, and thus this is redundant. **The committee believes this section should remain since this language is included in ASOPs that include a Communications and Disclosures section.**

Section 4.3, Deviation from Standard—One commentator suggested eliminating reference to “procedures set forth in this standard” since there are no references to “procedures” in the standard. **The committee made no change in the wording since this is standard wording for this section used in other ASOPs.**

Appendix 1. Background and Current Practices

One commentator stated that under current practice the term “changing times” in the last line might more appropriately be called “current or changed times.” **The committee believes the current wording is appropriate.**

Another commentator suggested adding reference to the NAIC Statutory Reserve Guidance Manual in the appendix. **The committee decided that such reference was not appropriate for this appendix.**