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 runout 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.**