ACTUARIAL STANDARDS BOARD

• EXPOSURE DRAFT •

Proposed Revision of
Actuarial Standard of Practice No. 5

Incurred Health and Disability Claims

Comment Deadline:
April 30, 2016

Developed by the
Task Force to Revise ASOP No. 5 of the
Health Committee of the
Actuarial Standards Board

Approved for Exposure by the
Actuarial Standards Board
December 2015

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APPENDIX

December 2015

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: Proposed Revision of Actuarial Standard of Practice (ASOP) No. 5

This document contains an exposure draft of a proposed revision of actuarial standard of practice No. 5, *Incurred Health and Disability Claims*. Please review this exposure draft and give the ASB the benefit of your comments and suggestions. Each response will be acknowledged, and all responses will receive appropriate consideration by the drafting committee in preparing the final document for approval by the ASB.

The ASB accepts comments by either electronic or conventional mail. The preferred form is e-mail, as it eases the task of grouping comments by section. However, please feel free to use either form. If you wish to use e-mail, please send a message to **comments@actuary.org**. You may include your comments either in the body of the message or as an attachment prepared in any commonly used word processing format. **Please do not password protect any attachments**. **If the attachment is in the form of a PDF, please do not "copy protect" the PDF**. Include the phrase "ASB COMMENTS" in the subject line of your message, as any message not containing this exact phrase in the subject line will be deleted by our system's spam filter. Also please indicate in the body of the e-mail if your comments are being submitted on your own behalf or on behalf of a company or organization.

If you wish to use conventional mail, please send comments to the following address:

ASOP No. 5 Revision
Actuarial Standards Board
1850 M Street, NW, Suite 300
Washington, DC 20036

The ASB posts all signed comments received to its website to encourage transparency and dialogue. Unsigned or anonymous comments will not be considered by the ASB nor posted to the website. The comments will not be edited, amended, or truncated in any way. Comments will be posted in the order that they are received. Comments will be removed when final action on a proposed standard is taken. The ASB website is a public website, and all comments will be available to the general public. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

Deadline for receipt of responses in the ASB office: **April 30, 2016**

Background

ASOP No. 5, then titled *Incurred Health Claim Liabilities*, was adopted in 1991. Under direction from the ASB and its Health Committee, a task force revised ASOP No. 5, retitled *Incurred Health and Disability Claims*, which was adopted in 2000 and updated for deviation language in 2011.

This proposed revision of ASOP No. 5 reflects a number of changes to other standards that have been made since the 2000 revision, including updating the ASOP, where appropriate, to incorporate reference to new standards that have been issued since the 2000 revision, eliminate guidance that does not conform to current ASOP practices regarding references to other standards of practice, and make consistent the definitions used in the standard with those of other standards of practice. In addition, this proposed revision of ASOP No. 5 has been updated to reflect the legal and regulatory changes imposed by the Affordable Care Act.

Key Changes

The most significant changes from the existing ASOP No. 5 are as follows:

1. revising certain definitions, and adding others for clarity and for consistency with other standards;

2. explicitly addressing certain considerations in estimating and analyzing incurred claims, including behavior of claimants, claim seasonality, credibility, payments and recoveries under government programs, and the purpose and intended use of the unpaid claim estimate;

3. expanding the guidance regarding provider contractual arrangements;

4. including, in section 3.4 regarding methods for estimating incurred claims, explicit discussion of projection methods as well as an updated discussion of other methods commonly in use; and

5. making the standard consistent with the revised guidance in ASOP No.1, *Introductory Actuarial Standard of Practice*, regarding use of the language “should consider.”

Request for Comments

The Task Force to Revise ASOP No. 5 appreciates comments on all sections of this proposed ASOP and would like to draw readers’ attention to the following issues in particular:

1. Is it appropriate to change the language in the first sentence of section 3.2 from "should consider" to "should include"?

2. Is the guidance in section 3.3.6 on "provider contractual arrangements" too detailed?

3. Is the required disclosure on "provider insolvency risk," as discussed in section 3.3.6, appropriate?

4. Which common methods, if any, are appropriate to include in section 3.4?

5. Are the methods included in section 3.4 described in appropriate detail?

6. Is the requirement to disclose explicit provision for adverse deviation (PAD), as discussed in section 4.1, appropriate?

The ASB voted in December 2015 to approve this exposure draft.

Task Force to Revise ASOP No. 5

Richard Lassow, Chairperson
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The ASB establishes and improves standards of actuarial practice. These ASOPs identify what the actuary should consider, document, and disclose when performing an actuarial assignment. The ASB's goal is to set standards for appropriate practice for the U.S.

EXPOSURE DRAFT—December 2015

PROPOSED REVISION OF
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** as of a **valuation date** under a **health benefit plan**, as defined in section 2.7 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 **risk-bearing entities**, such as 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.

This standard applies to the actuary only with respect to **incurred claim** estimates that are communicated as an actuarial finding (as described in ASOP No. 41, *Actuarial Communications*). Actions taken by the actuary's principal regarding such estimates are beyond the scope of this standard.

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 will be effective for any actuarial work product covered by this standard's scope issued on or after four months after adoption by the Actuarial Standards Board (ASB).

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), contract type, or other segmentation used in estimating **incurred claims**, or used by a **risk-bearing entity** for evaluating its business.

2.2 Capitation—The amount of money paid to a provider, usually per covered member, to provide specific health care services under a **health benefit plan** regardless of the number or types of services actually rendered. A capitated plan is one that includes such an arrangement.

2.3 Carve-Outs—Designated services provided by specific **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 Development (or Lag) Method—An estimation technique 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 **development method** uses these groupings to create a claims processing or development pattern, which is used to help estimate the unprocessed portion of **incurred claims**.

2.6 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, 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 entity**, including self-insured or governmental plan sponsors.

2.8 Incurred Claims—For use in this ASOP, the value of all amounts paid or payable under a **health benefit plan**, determined to be a liability with an **incurral date** within the contract period or other appropriate period, as of the **valuation date**. It includes payments on all claims as of the **valuation date** plus a reasonable estimate of **unpaid claims liabilities**. This definition is different than the alternate definition for a **risk bearing entity**'s income statements, for which **incurred claims** include payments on all

claims plus the estimate of **unpaid claims liabilities** as of the current **valuation date** less the estimate of **unpaid claims liabilities** at the end of the prior **valuation date**.

2.9 Incurral Date—The date a claim became a liability of the **risk-bearing entity** in accordance with the terms of the **health benefit plan**. For **health benefit plan**s 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.

2.10 Projection Method—The application of an adjusted historical claim metric to an appropriate exposure base, in order to estimate **incurred claims**.

2.11 Providers—Individuals, groups, or organizations providing health care services or supplies, including doctors, hospitals, physical therapists, medical equipment suppliers, and pharmaceutical suppliers..

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

2.13 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).

2.14 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.

2.15 Trends—Measures of rates of change, over time, of the elements affecting **incurred claims**.

2.16 Unpaid Claims Liability—The value of the unpaid portion of **incurred claims**, including (1) unreported claims; (2) reported but unprocessed claims; and (3) processed but unpaid claims. For a **risk-bearing entity**'s balance sheet, the **unpaid claims liability** includes provision for all unpaid claims incurred during the appropriate period as of the current **valuation date**.

2.17 Valuation Date—The date as of which the liabilities are estimated.

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 **risk-bearing entity**.

3.2 Considerations for Estimating Incurred Claims—The actuary should include factors associated with the **incurred claim** estimate analysis that, in the actuary's professional judgment, are applicable, material, and are reasonably foreseeable to the actuary at the time of estimation.

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 and business practices, including special group contract holder requirements and provider arrangements, which in the actuary's judgment may materially affect the cost, frequency, and severity of claims. These include, for example, elimination periods, deductibles, preexisting conditions limitations, maximum allowances, and managed-care restrictions.

The actuary should make a reasonable effort to understand internal business practices relative 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. The actuary should also be familiar with any changes in internal business practices made since the last estimate of incurred claims was determined. The actuary should consider how such differences or changes are likely to affect the determination of claim costs and claim liabilities.

3.2.2 Economic and Other External Influences—The actuary should consider items such as changes in price levels, unemployment levels, medical practice, 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 Behavior of Claimants—The actuary should consider reasonably available information regarding claimant behavior, such as pent-up demand for new benefits, or impending benefit changes, which may impact incurred claims.

3.2.4 Organizational Claims Administration—The actuary should consider factors that may affect claims administration practices, such as staffing levels, variable claim processing and investigation time (for example, for complicated claims or claims submitted on paper), computer system changes or downtime, seasonal backlogs of claims submitted, increased electronic submission of claims by **providers**, governmental influences, and cash flow considerations. The actuary should also be aware that the administration practices of external contracted parties (for example, pharmacy benefit managers and third party administrators) can affect the **unpaid claims liability**. The actuary should make reasonable efforts to obtain information from appropriate personnel and evaluate whether there have been

material changes in operational practices that impact the incurred claim estimate and, if so, make appropriate adjustments.

3.2.5 Claim Seasonality—The actuary should understand how seasonality may impact the estimation of **incurred claims** and make appropriate adjustments. Claim seasonality may be exhibited in the pattern of claims incurral and submission, or in the manner that costs actually emerge within the **health benefit plan** provisions, such as plans with high deductibles.

3.2.6 Credibility—The actuary should consider how the credibility of the data affects the development of **incurred claim** estimates and refer to ASOP No. 25, *Credibility Procedures*, for further guidance.

3.2.7 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, and how the pattern of growth or contraction and relative maturity of a **block of business** can influence **incurred claims**.

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

3.2.9 Carve-Outs—The actuary should consider the pertinent benefits, payment arrangements, and separate reporting of those benefits subject to **carve-outs** in **incurred claims** estimates.

3.2.10 Special Considerations for Long-Term Products—The actuary should consider the variety of 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 protection; payment differences based on institutional or home-based care; social insurance integration; and the criteria for benefit eligibility. 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 and claims usually extend beyond the valuation date.

3.3 Analysis of Incurred Claims—After reviewing the considerations in sections 3.2.1–3.2.10 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 should determine **unpaid claims liabilities** for claims incurred as of the **valuation date**.

a. Purpose or Use of the Unpaid Claim Estimate—The actuary should identify the intended purpose or use of the unpaid claim estimate. Potential purposes or uses of unpaid claim estimates include, but are not limited to, establishing liability estimates for external financial reporting, internal management reporting, and various special purpose uses such as appraisal work and scenario analyses. Where multiple purposes or uses are intended, the actuary should consider the potential conflicts arising from those multiple purposes and uses and should consider adjustments to accommodate the multiple purposes to the extent that, in the actuary's professional judgment, it is appropriate and practical to make such adjustments.

b. Plan Provisions—The actuary should review the relevant plan provisions to determine if they create obligations for services or payments after the **valuation date** (for example, medical benefits that extend beyond the **contract period**, or long-term disabilities). The actuary should determine if these obligations are part of the current or future period's liability, or if these obligations make up a separate reserve.

c. Data and Reporting—The actuary should consider 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.

d. Provision for Adverse Deviation—Recognizing that the determination of liabilities for incurred but unpaid health and disability claims involves an estimate of the true obligations that will emerge, the actuary should consider what explicit provision for adverse deviation, if any, might be appropriately included. If a provision for adverse deviation is included, the **unpaid claims liability** should be appropriate, in the actuary's judgment, for the intended use. A greater provision for adverse deviation may be appropriate when, for example, credibility of the data is lower or payment patterns are unstable.

e. Time Value of Money—The actuary should consider if the **time value of money** 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 any applicable accounting standards.

f. Consistency of Bases—The actuary should use a basis consistent with that used for determining related liabilities and reserves, unless it would be inappropriate to do so.

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. If separate development is performed, 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, type of service, geographic area, premium rating method, demographic factors, distribution method, and provider risk-sharing arrangements.

3.3.3 Reinsurance Arrangements—The actuary should consider the effect of reinsurance arrangements in estimating the **incurred claims**. In particular, the actuary should consider the effect of different lag patterns due to the extended reporting or recovery periods often associated with certain types of reinsurance.

3.3.4 Large Claims—The actuary should consider the effect of large claims on incurred claims. Specifically, large claims can distort claim payment patterns or historical per-unit claim levels that the actuary considers when estimating **incurred claims**. The actuary should understand how large claims, if any, 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), Subrogation, and Government Programs—The actuary should understand the relevant organizational practices and regulatory requirements related to COB, subrogation, and government programs (state or federal). 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, and payments or recoveries resulting from government programs.

3.3.6 Provider Contractual Arrangements—The actuary should consider 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. Some examples of these latter arrangements include the following:

a. **capitation**;

b. amounts initially withheld from provider payments, which may later become payable based upon contractually defined experience outcomes;

c. reimbursement of services based on the expected cost for an episode of care, in which more services are at risk than would normally be the case for a given fee-for-service event;

d. bonuses or other contractual incentive payments based on financial results or achievement of contractually defined quality metrics; and

e. stop-loss contracts which limit the provider's risk for certain high cost, infrequent services.

The arrangements will typically specify what portion of the risk, if any, has been shifted to the **providers**. Under provider risk-bearing contracts, provider insolvency may result in reimbursement of claims on a fee-for-service basis. If provider insolvency may have a material effect on the risk-bearing entity's ultimate liability, the actuary should disclose this risk. Depending on the purpose of the analysis, the actuary should consider any statutory limitations on the credits for such transfers of risk.

Certain contractual arrangements may also result in amounts due from **providers** (for example, risk sharing receivables, pharmacy rebates) based on financial results or other experience metrics. The actuary should consider the impact of unpaid medical costs resulting from failed **providers** bearing a material portion of the risk or losses incurred by **providers** deemed to be related parties.

3.4 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 purpose, constraints, and scope of the assignment. The actuary should consider the reasonableness of the assumptions underlying each method used, and should consider the sensitivity of the **incurred claim** estimates to the use of reasonable alternative assumptions. 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 3.4.1–3.4.4 below discuss some of the more common methods for estimating **incurred claims**.

3.4.1 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. When using the development method, the actuary should consider processing fluctuations due to seasonality, claims processing practices, inflation, or significant changes in medical practices.

When using the development method, the actuary should, when appropriate, evaluate the ratio of estimated **incurred claims** to earned premiums or **exposure units** for reasonableness.

3.4.2 Tabular Method—The **tabular method** is generally used for known long-term claims for which a claim event triggers a series of payments. 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.

When using the tabular method, the actuary should take into account specified benefit changes throughout the lifetime of the claim and the assumptions used to develop the factors, and should select the appropriate factors 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**.

3.4.3 Projection Methods—**Projection methods** may be used to estimate **incurred claims** when the incidence of claims or volume of available data is limited or not sufficiently credible for other estimation methods, to supplement the **development method** for the most recent incurral months, or as a reasonableness check for other estimation methods. This method starts with the development of a historical claim metric (for example, cost per claim, cost per member per month, loss ratio) and then multiplies this value times the appropriate base for the period being estimated (for example, claim volume, member **exposure units**, earned premium, respectively.) Adjustments to the historical claim metric may be appropriate, for example as a result of trend. Utilization metrics (for example, authorized days per thousand members) may be used to improve the projected cost levels for recent months, and to adjust for the impact of catastrophic claims. The actuary may also consider using risk adjustment techniques or pharmacy claims to help project shifts in the morbidity of the block.

3.4.4 Other Methods—Greater availability of data and advances in computing power

have resulted in alternative approaches that the actuary may consider to estimate **incurred claims**. These include (but are not necessarily limited to) regression, time series and other statistical and econometric models, as well as different approaches to categorizing and aggregating data (for example, summarizing by weekly data cells or estimating the cost of reported claims separately from incurred but not reported claims.)

3.5 Follow-Up Studies—The actuary may 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 practicable, acquire the data to perform such studies; perform studies in the aggregate and for pertinent blocks of business; and utilize the results, if appropriate, in preparing current **incurred claims** estimates.

3.6 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.

Section 4. Communications and Disclosures

4.1 Actuarial Communication—When issuing an actuarial communication subject to this standard, the actuary should consider the intended purpose or use of the **incurred claim** estimate and refer to ASOP No. 41 for further guidance.

The actuary should include the following items, as applicable, in an actuarial communication. This list includes certain pertinent items from ASOP No. 41 as well as additional items.

a. important dates used in the analysis such as the incurral, processing, and **valuation dates**;

b. significant limitations, if any, which constrained the actuary's **incurred claim** estimate analysis such that, in the actuary's professional judgment, there is a significant risk that a more in-depth analysis would produce a materially different result;

c. specific significant risks and uncertainties, if any, with respect to whether actual results may vary from the **incurred claim** estimate;

d. the need for any follow-up studies, as described in section 3.5;

e. any explicit provision for adverse deviation, as described in section 3.3.1;

f. the risk that provider insolvency may have a material effect on the risk-bearing entity's ultimate liability (see section 3.3.6);

g. the disclosure in ASOP No. 41, section 4.2, if any material assumption or method was prescribed by applicable law;

h. 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

i. 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.

4.2 Changes in Assumptions, Procedures, Methods, or Models—In addition to those in section 4.1 and in certain cases, consistent with the intended purpose or use, the actuary may need to disclose changes in assumptions, procedures, methods, or models that the actuary believes to have a material impact on the **incurred claim** estimate and the reasons for such changes to the extent known by the actuary. This should be disclosed when the **incurred claim** estimate is an update of a previous estimate. This standard does not require the actuary to measure or quantify the impact of such changes.

Appendix

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 are estimated as part of the determination of unpaid claim liabilities for financial reporting purposes. Incurred claims are often the starting point for premium rate development. The incurred claims from a period are adjusted to project the incurred claims for a future period.

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

Practices differ among actuaries and among types of coverage. The tabular, development, projection, and other approaches to evaluating incurred claims, as described in the standard, are representative of the range of current practices.