Comment #5 – 9/20/17 – 10:30 a.m.

To: the Actuarial Standards Board

Below are my comments regarding the exposure draft of the proposed revision of Actuarial Standard of Practice No. 42, "Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims," as approved for exposure by the Actuarial Standards Board in May 2017. These comments represent my opinions, and do not necessarily represent the opinions of my employer or any other organization with which I am associated.

The heading of each comment below indicates the specific section of the draft to which it relates. The comments are primarily aimed at clarifying certain aspects of the exposure draft.

Section 2.1.

The definition of "Block of Business" begins, "All policies …" The term "policy" in this context would usually be interpreted to mean an insurance policy. However, this standard also applies to estimates made with respect to self-insured arrangements. Perhaps the more general term "arrangement" should be used in place of "policy."

Section 2.2.

This definition has lost the concept in the current version of ASOP No. 42 that capitations are periodic payments. This is necessary to distinguish capitations from, e.g., DRG payments, which might also be deemed to be independent of the number and types of services provided, relying only on the fact that some services are provided with respect to a specific condition. I suggest beginning the definition, "A periodic amount of money …"

Section 2.7.

The current version of ASOP No. 42 includes accidental death and disability coverage within the scope of "health benefit plan." Is it the intention of the ASB to now exclude that coverage, as might be inferred from its deletion? Since such coverage is often considered to be a "health" benefit, and since it is not included within the specified coverage types, clarification of this point would be desirable.

Section 2.8.

This definition states, "The plan's benefits may not begin for several years after policy purchase …" Is it really the case that benefits do not begin, i.e., are not available for several years (comparable to a deferred annuity product)? Or is this intended to mean that benefits "may not become payable" for several years, depending on when (and whether) the covered event actually occurs? If the latter, "become payable" seems to be clearer wording than "begin."

Section 2.11.

Because there are two separate definitions for "Provider-Related Asset or Liability" and "Risk-Sharing Arrangement," it might be helpful to note explicitly that "Provider-Related Asset or Liability" includes the assets and liabilities that arise from provider risk-sharing arrangements.

In fact, since risk-sharing arrangement has been defined to include incentive and bonus programs, most of the provider-related assets and liabilities probably are associated with risk-sharing arrangements. Therefore, it might also be helpful to note at least examples of provider-related assets and liabilities that do not arise from risk-sharing

arrangements. For example, are liabilities related to settlements of claim disputes intended to be encompassed within this definition?

Section 2.13.

I believe that at the end of this definition, "government-sponsored" is intended to modify both "plans" and "risk contracts." If so, it would be more grammatically correct to say, "and government-sponsored plans or risk contracts," i.e., insert the word "and."

Section 3.3.3.

This section refers to "elective claims processed in recessionary periods or prior to contract termination." I see two problems with this phraseology.

First, I do not think the relevant consideration is when the claims are processed, especially in the case of them being processed before a contract termination. What is relevant is when the services were obtained.

Second, most claims are indeed processed, and are certainly incurred, prior to contract termination. The situation being addressed here is when insured persons seek elective services because of an impending known termination of the contract, being concerned that they may be without coverage (or coverage at the same level) for some period of time.

Therefore, I think this section should end, "… and elective services sought in recessionary periods or prior to an anticipated contract termination."

I am not certain whether "elective claims … in recessionary periods" was intended to refer to the uptick in disability income claims that often occurs in such situations. If so, another term than "elective" should be used, since by definition disability claims are not supposed to be "elective."

Section 3.3.6.

This section makes reference to "government programs" and "payments or recoveries resulting from government programs." It appears from the context that "government programs" is intended to mean "risk-sharing arrangements with the government." Since "risk-sharing arrangement" is a defined term, it should be used here. Medicaid managed care plans are "government programs," but the premium revenue received from such programs is not relevant to the purpose of this section, so "government programs" needs to be clarified.

Section 3.3.10.

This section ends with the sentence, "Reinsurance arrangements may also include risk-sharing provisions." It seems that the "risk-sharing provisions" discussed here fall within the definition of "risk-sharing arrangement," in which case that defined term should be used here for avoidance of doubt.

Section 3.3.11.

In this context, "expenses" means administrative expenses. Claim costs are also "expenses" from an income-statement standpoint. It would be helpful to specify the type of expenses that are addressed here, with language such as is used in Section 3.4.4: "expenses such as maintenance, acquisition, and claim settlement."

Section 3.5.1.

This section ends by noting that a premium deficiency reserve may be needed "even if the contract period has not started." That concept is often unclear, and perhaps should be clarified here. Before the contract period has started, a premium deficiency reserve will be needed if deficient premium rates have been offered by the risk-bearing entity and accepted by one or more customers as of the valuation date. The acceptance may be known or reasonably assumed (for example, if you have offered Medicare Advantage plans, it is probably reasonable to assume that someone will accept your rates prior to 1/1).

Section 3.5.2.

Perhaps the most important consideration in regard to the end of the time period is not directly addressed here. That is, "the time at which premium rates may be adjusted." That may or may not coincide with the end of the contract period; e.g., some Medicaid managed care contracts span multiple years, but the premium rates are adjusted annually or even more frequently. Perhaps this is what was intended by "the point at which the block no longer requires a premium deficiency," but that seems a bit circular as a consideration for estimating the premium deficiency.

Section 3.5.7.

The reference to "duration" here should be specifically to "asset duration." In earlier sections of the ASOP, "duration" has been used to mean "policy duration" or "claim duration," so the distinction of meaning should be made clear here.

Section 4.1.c.

This phrase should end, "whether actual results may vary materially from the asset or liability estimate"; i.e., include the word "materially." It is virtually certain that actual results will vary from the estimate; the issue of concern is whether the variation will be material. This is not addressed by the reference to "significant risks and uncertainties"; there may be a significant amount of uncertainty surrounding some underlying assumption, but that assumption may have only an immaterial influence on the amount of the estimate.

Thank you for your consideration of these comments.

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