



## **ACTUARIAL STANDARDS BOARD**

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### **Actuarial Standard of Practice No. 42**

### **Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims**

**Revised Edition**

**Developed by the  
Task Force to Revise ASOP No. 42 of the  
Health Committee of the  
Actuarial Standards Board**

**Adopted by the  
Actuarial Standards Board  
March 2018**

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**Doc. No. 191**

**TABLE OF CONTENTS**

Transmittal Memorandum	v
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**STANDARD OF PRACTICE**

Section 1. Purpose, Scope, Cross References, and Effective Date	1
1.1 Purpose	1
1.2 Scope	1
1.3 Cross References	1
1.4 Effective Date	2
Section 2. Definitions	2
2.1 Block of Business	2
2.2 Capitation	2
2.3 Carved-Out Services	2
2.4 Collectability	2
2.5 Contract Period	2
2.6 Contract Reserve	2
2.7 Exposure Unit	2
2.8 Health Benefit Plan	2
2.9 Long-Term Product	2
2.10 Premium Deficiency Reserve	3
2.11 Providers	3
2.12 Provider-Related Asset or Liability	3
2.13 Risk Adjustment Data Validation (RADV)	3
2.14 Risk-Bearing Entity	3
2.15 Risk-Sharing Arrangement	3
2.16 Time Value of Money	3
2.17 Trends	3
2.18 Unearned Premium Reserve	3
2.19 Valuation Date	3
Section 3. Analysis of Issues and Recommended Practices	3
3.1 Introduction	4
3.2 Purpose or Use of the Asset or Liability Estimate	4
3.3 Considerations for Estimating Assets and Liabilities	4
3.3.1 Health Benefit Plan Provisions and Business Practices	4
3.3.2 Risk-Sharing Arrangement Provisions	4
3.3.3 Economic and Other External Influences	5
3.3.4 Risk Characteristics and Organizational Practices by Block of Business	5
3.3.5 Legislative and Regulatory Requirements	5
3.3.6 Coordination of Benefits (COB), Subrogation, and Government Programs	5
3.3.7 Carved-Out Services	5

**ASOP No. 42—Doc. No. 191**

3.3.8	Time Value of Money	5
3.3.9	Special Considerations for Long-Term Products	6
3.3.10	Reinsurance Arrangements	6
3.3.11	Non-Claim Expenses	6
3.3.12	Consistency of Assumptions and Methodology	6
3.4	Considerations for Estimating Contract Reserves	6
3.4.1	Interest Rates	6
3.4.2	Morbidity	6
3.4.3	Persistency	7
3.4.4	Non-Claim Expenses	7
3.4.5	Trend	7
3.4.6	Premium Rate Changes	7
3.4.7	Previous Assumptions for Estimating Contract Reserves	7
3.4.8	Valuation Method	7
3.5	Considerations for Estimating Premium Deficiency Reserves	7
3.5.1	Blocks of Business	8
3.5.2	Time Period	8
3.5.3	Exposure	8
3.5.4	Premium Rate Changes	8
3.5.5	Claim Trend	8
3.5.6	Risk-Sharing Arrangements	8
3.5.7	Interest Rates	9
3.5.8	Reinsurance	9
3.5.9	Taxes	9
3.5.10	Non-Claim Expenses	9
3.5.11	Applicable Authority	9
3.6	Reserve for Insufficient Administrative Fee for Self-Insured Contracts	9
3.7	Considerations When Estimating Provider-Related Assets and Liabilities	9
3.7.1	Provider Risk-Sharing and Capitation Arrangements	9
3.7.2	Provider Financial Condition	10
3.7.3	Provider Incentive or Penalty Payments	10
3.7.4	Provider Risk-Bearing Entities	10
3.8	Claim Adjustment Expense Liabilities	10
3.9	Risk Adjustment Settlements	10
3.9.1	Market Neutrality	10
3.9.2	Risk Adjustment Payment Methodology	11
3.9.3	Risk Adjustment Data Validation (RADV) Audit	11
3.10	Other Assets and Liabilities	11
3.10.1	Liabilities for Payments to State Pools	11
3.10.2	Reserves for Unearned Premiums	11
3.10.3	Assets and Liabilities for Dividends, Experience Rating, and Premium Rebates	11
3.10.4	Reserves for Extension of Benefits and Contingent Benefits Provisions	11
3.10.5	Prescription Drug Rebates	11
3.10.6	Cost Sharing Subsidies	11
3.11	Follow-Up Studies	12

## **ASOP No. 42—Doc. No. 191**

3.12	Provision for Adverse Deviation	12
3.13	Evaluating Collectability	12
3.14	Reliance on Data or Other Information Supplied by Others	12
3.15	Reliance on Assumptions and Methods Selected by Others	12
3.16	Reliance on Experts	12
3.17	Documentation	13
Section 4. Communications and Disclosures		13
4.1	Actuarial Communication	13
4.2	Additional Disclosures	14

## **APPENDIXES**

Appendix 1—Background and Current Practices	15
Background	15
Current Practices	15
Appendix 2—Comments on the Exposure Draft and Responses	16

March 2018

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

**FROM:** Actuarial Standards Board (ASB)

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

This document contains the final version of a revision of ASOP No. 42, *Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims*.

#### History of the Standard

The ASB originally adopted ASOP No. 42, then titled *Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims*, in 2004 and updated the ASOP for deviation language in 2011.

This revision of ASOP No. 42 reflects a number of changes to other standards that have been made since its 2004 adoption, including updating the ASOP, where appropriate, to incorporate references to new standards that have since been issued, 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 revision of ASOP No. 42 reflects relevant legal, regulatory, and practice developments that have occurred since its initial adoption.

#### Exposure Draft

The exposure draft was released in May 2017 with a comment deadline of September 30, 2017. Five comment letters were received. For a summary of the issues contained in the comment letters on the exposure draft and the responses, please see appendix 2.

#### Notable Changes from the Exposure Draft

Notable changes include the following:

1. added a definition and guidance on collectability; and
2. added section 3.16, Reliance on Experts, to further support the guidance on collectability.

The ASB thanks everyone who took the time to contribute comments and suggestions on the exposure draft.

The ASB voted in March 2018 to adopt this standard.

**ASOP No. 42—Doc. No. 191**

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*The Actuarial Standards Board (ASB) sets standards for appropriate actuarial practice in the United States through the development and promulgation of Actuarial Standards of Practice (ASOPs). These ASOPs describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when communicating the results of those services.*

**ACTUARIAL STANDARD OF PRACTICE NO. 42**

**HEALTH AND DISABILITY ACTUARIAL ASSETS AND  
LIABILITIES OTHER THAN LIABILITIES FOR INCURRED CLAIMS**

**STANDARD OF PRACTICE**

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

- 1.1 **Purpose**—This actuarial standard of practice (ASOP) provides guidance to actuaries estimating or reviewing **health benefit plan** actuarial assets and liabilities, other than liabilities for incurred claims, when preparing or reviewing financial reports, claims studies, rates, or other actuarial communications as of a **valuation date**. This ASOP complements ASOP No. 5, *Incurred Health and Disability Claims*.
- 1.2 **Scope**—This standard applies to actuaries when performing actuarial services with respect to estimating or reviewing **health benefit plan** actuarial assets and liabilities, other than liabilities for incurred claims, on behalf of **risk-bearing entities**. This standard does not address interpretations of statutory or generally accepted accounting practices.

This standard does not apply to actuaries when estimating or reviewing assets or liabilities in accordance with other ASOPs, such as ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions*, and ASOP No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions*. Furthermore, this standard does not apply in situations where a health or disability benefit is included within, and is incidental to, a plan subject to another practice-specific standard, such as a disability benefit under a life plan or a 401(h) account that is part of a pension plan.

This standard applies to the actuary only with respect to asset and liability estimates that are communicated as an actuarial finding (as described in ASOP No. 41, *Actuarial Communications*). Actions taken by the actuary's principal regarding the use of 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 with a **valuation date** on or after August 1, 2018.

## **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 assets and liabilities for actuarial purposes, or used by a **risk-bearing entity** for evaluating its business.
- 2.2 **Capitation**—The amount of money paid to a **provider** on a periodic basis to provide specific health care services under a **health benefit plan** regardless of the number or types of services actually rendered during the contractual period. The payments are usually quantified on a per covered member basis.
- 2.3 **Carved-Out Services**—Contractually designated services such as prescription drugs or dental, or condition-specific services such as cancer, mental health, or substance abuse treatment, excluded from a **capitation**, **risk-sharing**, or other contractual arrangement.
- 2.4 **Collectability**—The likelihood of receiving the amount of money owed.
- 2.5 **Contract Period**—The time period for which a contract is effective.
- 2.6 **Contract Reserve**—An amount established when a portion of the premium due prior to the **valuation date** is designed to pay all or a part of the claims expected to be incurred after the **valuation date**. A **contract reserve** may or may not include a provision for the **unearned premium reserves**. A **contract reserve** may also be referred to as an active life reserve or policy reserve.
- 2.7 **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.
- 2.8 **Health Benefit Plan**—A contract, such as an insurance policy, 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**.
- 2.9 **Long-Term Product**—A **health benefit plan** that provides medical or disability benefits for an extended period of time. Some examples are cancer, long-term care, and long-term



disability policies. The plan's benefits may not become payable for several years after policy purchase and claims usually extend beyond the **valuation date**.

- 2.10 Premium Deficiency Reserve—A liability representing the deficiency, if any, in future revenues and current reserves less future claims and related expenses.
- 2.11 Providers—Individuals, groups, or organizations providing health care services or supplies, including but not limited to doctors, hospitals, independent physician associations, accountable care organizations, physical therapists, medical equipment suppliers, and pharmaceutical suppliers.
- 2.12 Provider-Related Asset or Liability—An amount established for expected future incentive payments or receipts or for non-claim related amounts such as **risk-sharing arrangement** and **capitation** payments or receipts.
- 2.13 Risk Adjustment Data Validation (RADV)—The process of verifying the accuracy of information submitted for use in a risk adjustment model.
- 2.14 Risk-Bearing Entity—The entity with respect to which the actuary is estimating liabilities or assets associated with **health benefit plans** or **risk-sharing arrangements**. Examples of risk bearing entities include but are not limited to managed-care entities, insurance companies, health care **providers**, self-funded employer plans, and government-sponsored plans or risk contracts.
- 2.15 Risk-Sharing Arrangement—An arrangement involving two or more entities, calling for payments contingent upon certain financial, operational, or other metrics. Examples include, but are not limited to, **provider risk-sharing arrangements** such as **provider** incentives, bonuses, and withholds or governmental **risk-sharing arrangements** such as risk corridor and risk-adjustment programs.
- 2.16 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.
- 2.17 Trends—Measures of rates of change, over time, of the elements, such as cost, incidence, and severity, affecting the estimation of certain assets or liabilities.
- 2.18 Unearned Premium Reserve—An amount established to reflect premiums that have been collected prior to the **valuation date** for coverage after the **valuation date**.
- 2.19 Valuation Date—The date as of which the assets or liabilities are estimated.

**Section 3. Analysis of Issues and Recommended Practices**

- 3.1 **Introduction**—The estimation of actuarial assets and liabilities 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 **Purpose or Use of the Asset or Liability Estimate**—The actuary should identify the intended purpose or use of the estimate. Potential purposes or uses of estimates include, but are not limited to, estimates for external financial reporting, pricing, internal management reporting, 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 making 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.
- 3.3 **Considerations for Estimating Assets and Liabilities**—The actuary should include items associated with the estimation that, in the actuary's professional judgment, are applicable, material, and are reasonably foreseeable to the actuary at the time of estimation.

In determining which items to include in the estimation of assets and liabilities, the actuary should consider items including but not necessarily limited to those described below and may rely on others as described in sections 3.14, 3.15, and 3.16.

- 3.3.1 **Health Benefit Plan Provisions and Business Practices**—The actuary should consider the **health benefit plan** provisions and related 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 any changes in plan provisions or business practices made since the last estimate of assets or liabilities. The actuary should consider how such differences or changes are likely to affect the estimation of assets or liabilities.

- 3.3.2 **Risk-Sharing Arrangement Provisions**—The actuary should consider the **risk-sharing arrangement** provisions that, in the actuary's professional judgment, are likely to materially affect the financial results of the **risk-sharing arrangement**. Examples of such provisions include the following:
- a. for **risk-sharing arrangements** including a **provider** organization, allowances for items such as number of enrolled lives included, the results of membership satisfaction surveys, and actual usage of certain facilities; and

- b. for **risk-sharing arrangements** including a governmental organization, such as medical loss ratio rebates, required adjustments to premiums or claims.

When estimating an asset related to an amount receivable by the **risk-bearing entity** under such a **risk-sharing arrangement**, the actuary should reflect **collectability**.

- 3.3.3 Economic and Other External Influences—The actuary should consider economic and other external influences 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 adverse selection sometimes experienced in recessionary periods or prior to contract termination.
- 3.3.4 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. Claims administration practices can influence claim rates and **trends** and in turn influence actuarial asset and liability estimates. Furthermore, the pattern of growth or contraction and relative maturity of a **block of business** can influence the magnitude of actuarial assets or liabilities.
- 3.3.5 Legislative and Regulatory Requirements—The actuary should consider relevant legislative and regulatory requirements and changes as they pertain to the estimation of assets and liabilities. For example, governmental mandates can influence the provision of new benefits, risk characteristics, care management practices, rating, reserving and underwriting practices, methods used to estimate assets and liabilities, or claims processing practices.
- 3.3.6 Coordination of Benefits (COB), Subrogation, and Government Programs—The actuary should make a reasonable effort to 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.
- 3.3.7 Carved-Out Services—The actuary should consider the pertinent benefits, payment arrangements, and separate reporting of those benefits subject to **carved-out services** in the estimation of assets and liabilities.
- 3.3.8 Time Value of Money—The actuary should consider if the **time value of money** will have a material effect in the estimation of assets and liabilities. The use of any interest discounts depends on the purpose for which assets and liabilities are

being estimated and should reflect any applicable regulation or accounting standards.

- 3.3.9 Special Considerations for Long-Term Products—The actuary should consider the benefits available in **long-term products**, such as lump-sum, fixed, or variable payments for services; provisions such as cost of living adjustments and inflation protections; payment differences based on institutional or home-based care; social insurance integration; and the criteria for benefit eligibility.
- 3.3.10 Reinsurance Arrangements—The actuary should consider the effect of reinsurance arrangements in estimating assets and liabilities. In particular, the actuary should consider the effect of extended reporting or recovery periods, **collectability**, collection delay, any amounts already received, and any regulatory limitations associated with certain types of reinsurance. Reinsurance arrangements may also include risk-sharing provisions.
- 3.3.11 Non-Claim Expenses—The actuary should consider whether an explicit provision for non-claim expenses should be included, or whether a particular asset or liability implicitly provides for future non-claim expenses.
- 3.3.12 Consistency of Assumptions and Methodology—The actuary should use assumptions and methodology consistent with those used for estimating related assets, liabilities and reserves, such as incurred **health benefit plan** claims, unless it would be inappropriate to do so.
- 3.4 Considerations for Estimating Contract Reserves—The actuary should estimate a **contract reserve** when such a reserve is required by the rating approach. For example, **contract reserves** are typically estimated for entry-age-rated **health benefit plans** (where premium rates are based on entry age and may be level over the lifetime of the contract), or where flat premium rate guarantees or premium rate change limitations apply for multiple-year periods. The actuary may estimate the reserve using a seriatim basis, grouping techniques, or a combination of both. The actuary should use assumptions that are reasonable and consistent with the purpose for which the reserve is being calculated, and reasonable in the aggregate. Certain assumptions may vary over time or be subject to durational effects.
- 3.4.1 Interest Rates—The actuary should use interest rates to reflect the **time value of money** in the present value calculation and should consider items such as the projection period and market conditions.
- 3.4.2 Morbidity—The actuary should use morbidity assumptions that reflect the underlying risk. These assumptions may reflect factors such as age, gender, and marital status of the insured as well as the elimination period and dependent status. In addition, the actuary should take into account the impact of durational effects such as risk selection and pre-existing condition limitations, changes in **health benefit plans**, changes in **provider** agreements, adverse selection due to

premium rate increases and plan design, and other factors that, in the actuary's professional judgment, materially affect future claim payments.

- 3.4.3 Persistency—The actuary should consider using persistency or termination assumptions that include both involuntary terminations, such as deaths and disablements, and voluntary terminations, as appropriate. Voluntary termination assumptions, if any, should reflect the expected impact of future premium rate increases.
  - 3.4.4 Non-Claim Expenses—The actuary should consider whether using an assumption is appropriate for expenses such as maintenance, acquisition, and claim settlement.
  - 3.4.5 Trend—The actuary should consider using trend assumptions for inflation, utilization, morbidity, and expense rates.
  - 3.4.6 Premium Rate Changes—When using an assumption to reflect premium rate changes in the reserve calculation, the actuary should use a premium rate change assumption that is reasonable in relation to the projected claims costs and the manner in which the rate change will be implemented (for example, on a given date for an entire **block of business** or on the next policy anniversary). This assumption should take into account factors such as market conditions, regulatory restrictions, and rate guarantees.
  - 3.4.7 Previous Assumptions for Estimating Contract Reserves—The actuary may determine that assumptions used as of a prior **valuation date** are no longer appropriate and may change them in accordance with the standards of the financial statements in which the reserves are reported. If the actuary determines that a change in assumptions is warranted, the actuary should follow the process set forth in sections 3.4.1-3.4.6 when selecting new **contract reserve** assumptions for future **valuation dates**.
  - 3.4.8 Valuation Method—For a new policy form, in addition to the assumptions discussed above, the actuary may need to determine the valuation method. Examples of valuation methods are the gross premium method, the net level premium method, and the full preliminary term (one- or two-year) method. Except where the valuation method is prescribed, the actuary should choose a method appropriate for the intended use of the reserve, such as in statutory financial statements or analysis of operating income. When not using a net level premium method, the actuary should consider the expense structure, such as higher first-year costs, in selecting the valuation method.
- 3.5 Considerations for Estimating Premium Deficiency Reserves—The actuary should estimate a **premium deficiency reserve** when such a reserve is required. **Premium deficiency reserves** are typically established for financial reporting purposes. They may also be established for other purposes such as management reporting. When estimating

**premium deficiency reserves**, the actuary should use reasonable assumptions that are appropriate for the intended purpose, and also reasonable in the aggregate.

- 3.5.1. Blocks of Business—The actuary should consider blocks of business in a manner consistent with applicable financial reporting requirements. The characteristics of a **block of business** may include, but are not limited to, benefit type (for example, major medical, preferred **provider** organization, or capitated managed care), contract type (for example, group or individual policies), demographic grouping (for example, group size or geographical area), and length of rate guarantee period. A **block of business** should be large enough so that its financial results are material relative to the **risk-bearing entity** as a whole. The actuary may need to estimate a **premium deficiency reserve** for a **block of business** where a premium deficiency exists even if the **contract period** has not started.
- 3.5.2. Time Period—The actuary should use the **valuation date** as the beginning of the time period used to project losses from a **block of business**. In determining the end of the time period, the actuary should take into account items including, but not limited to, the end of the **contract period**, anticipated renewal of coverage, and the point at which the block no longer requires a **premium deficiency reserve**.
- 3.5.3. Exposure—The actuary should consider reasonable increases and decreases in **exposure units** over the time period of the calculation in the **premium deficiency reserve** calculation. This assumption should reflect changes due to factors including, but not limited to, morbidity, mortality, lapses, and the impact of expected premium rate changes.
- 3.5.4. Premium Rate Changes—When using a premium rate change assumption, the actuary should use an assumption that is reasonable in relation to the projected claims costs and the **risk-bearing entity's** expectations. This assumption should consider factors such as market conditions, regulatory restrictions, and rate guarantees.
- 3.5.5. Claim Trend—The actuary should consider factors that may materially affect future claim payments, such as durational effects, changes in **health benefit plans**, changes in **provider** agreements, adverse selection due to premium rate increases, and plan design.
- 3.5.6. Risk-Sharing Arrangements—The actuary should consider **risk-sharing arrangements** between the **risk-bearing entity** and other entities, such as **providers**, governmental organizations, and employers. The actuary should reflect the **collectability** of any amounts under **risk-sharing arrangements**.

- 3.5.7 **Interest Rates**—When using an interest rate assumption to reflect the **time value of money** in a present value calculation, the actuary should consider items such as the projection period and market conditions.
- 3.5.8 **Reinsurance**—The actuary should consider the expected effects of reinsurance and changes in reinsurance premiums in estimating the **premium deficiency reserve**.
- 3.5.9 **Taxes**—The actuary should consider the effect of losses assumed in the calculation of the **premium deficiency reserve** on the **risk-bearing entity's** taxes and may include a tax credit in the calculations where appropriate.
- 3.5.10 **Non-Claim Expenses**—The actuary should consider total expenses of the **risk-bearing entity** in estimating a **premium deficiency reserve** and should consider whether the expenses allocated to the **block of business** are reasonable for the purpose of estimating **premium deficiency reserves**. If only a portion of expenses are allocated to the otherwise deficient **blocks of business**, the actuary should verify that the remaining blocks of business cover the remaining expenses.
- 3.5.11 **Applicable Authority**—The actuary should consider any applicable law, regulation, or other binding authority when estimating **premium deficiency reserves** for financial reporting.
- 3.6 **Reserve for Insufficient Administrative Fee for Self-Insured Contracts**—A liability under a self-insured contract may need to be established if the administrative fees are insufficient to cover the direct fixed and variable expenses allocated to the self-insured contract. When estimating such a liability, the actuary should consider the expected income and expense flows under the contract using methods that are similar to those used in estimating a **premium deficiency reserve** for an insured **health benefit plan** and assumptions that are appropriate for self-insured contracts (see section 3.5 for further discussion).
- 3.7 **Considerations When Estimating Provider-Related Assets and Liabilities**—**Provider-related liabilities** may arise for a **risk-bearing entity**. **Risk-sharing arrangements**, such as incentive arrangements, penalty arrangements, and **capitation** arrangements can create potential assets or liabilities.
- 3.7.1 **Provider Risk-Sharing and Capitation Arrangements**—The actuary should consider the relevant contractual arrangements with **providers** to determine whether the contractual arrangements require an asset or liability to be estimated.

The actuary should consider whether a **provider-related asset or liability** for contracts in effect or not fully settled as of the **valuation date** should be estimated. In estimating the asset or liability, the actuary should consider any amounts due to or due from the **provider**, the overall financial condition of the **provider** (see section 3.7.2 for further discussion), whether losses can be offset

with profits, risk transfer arrangements (such as stop loss or quota share provisions), the timing of receipts and payments, and **collectability**.

Similarly, the actuary should consider whether the risk of a **provider** failing or leaving a network creates a need to estimate a liability for the contingency of the payment by the **risk-bearing entity** of higher **capitations** or fees for services while a replacement **provider** is identified and suitable arrangements are concluded.

- 3.7.2 Provider Financial Condition—When a **risk-bearing entity** shares risk with a **provider** under a risk-sharing or **capitation** arrangement, the actuary should estimate, to the extent practical, whether the **provider's** overall financial condition will allow it to meet its obligations, and, if not, adjust the asset or liability accordingly. To the extent that these assets or liabilities are not otherwise included in the claim liabilities of the **risk-bearing entity**, such assets or liabilities should be included in the **provider-related assets or liabilities**.
- 3.7.3 Provider Incentive or Penalty Payments—If a **provider** agreement calls for incentive or penalty payments if certain conditions are met, such as quality of care standards or claim targets, the actuary should consider whether the **risk-bearing entity** should record a **provider-related asset or liability**.
- 3.7.4 Provider Risk-Bearing Entities—When the **risk-bearing entity** is a **provider**, the actuary should also consider relevant contractual arrangements with other **providers** as well as non-**provider** entities to determine whether the contractual arrangements require an asset or a liability to be estimated. One primary source of potential liability between **providers** is the receipt of **capitation** by one **provider** with payments due to other **providers** using fee-for-service.
- 3.8 Claim Adjustment Expense Liabilities—The actuary should estimate a liability for claim adjustment expenses associated with unpaid claims, unless such liabilities are included in the liability for unpaid claims, otherwise provided for appropriately, or not required by the relevant financial reporting guidance. The actuary may consider the company's cost allocation approach in the liability estimation.
- 3.9 Risk Adjustment Settlements—A risk adjustment settlement may exist that will be either an asset or a liability to the **risk-bearing entity**. In addition to the relevant guidance in ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*, the actuary should address the following components of the risk adjustment program, if applicable:
- 3.9.1 Market Neutrality—When the risk adjustment settlements are required to be revenue neutral across a market or other group of entities, the actuary should consider reasonably available aggregate market information, information specific to the **risk-bearing entity**, and **collectability**.



- 3.9.2 Risk Adjustment Payment Methodology—Risk adjustment payments typically follow a methodology that is governed by applicable law, regulation, or contractual arrangement. The actuary should review and understand the risk adjustment payment methodology used in estimating the settlement amounts.
- 3.9.3 Risk Adjustment Data Validation (RADV) Audit—The outcome of an **RADV** audit may be an amount that the insurer owes or is owed. When estimating the asset or liability that may be due from an **RADV** audit, the actuary should review relevant data validation reports.
- 3.10 Other Assets and Liabilities—The actuary may be requested to opine on the appropriateness of certain other assets or liabilities provided by another party. In some cases, the actuary may also estimate such assets and liabilities. When estimating or opining on such assets and liabilities, the actuary should refer to the appropriate section(s) below.
- 3.10.1 Liabilities for Payments to State Pools—The actuary should consider whether appropriate provision has been made for payments due under state assessment pools, such as insolvency pools, risk-sharing pools, or other arrangements.
- 3.10.2 Reserves for Unearned Premiums—The actuary should consider whether appropriate provision has been made for liabilities associated with the amount of premiums written and not yet earned.
- 3.10.3 Assets and Liabilities for Dividends, Experience Rating, and Premium Rebates—The actuary should consider the contract language or regulatory requirements defining the methodology prescribed for estimating the asset or liability, and refer to ASOP No. 5, if applicable.
- 3.10.4 Reserves for Extension of Benefits and Contingent Benefits Provisions—The actuary should consider whether the provisions of the **health benefit plan** require estimation of a reserve for extension of benefits or contingent benefits.
- 3.10.5 Prescription Drug Rebates—An asset may exist for an insurer receiving a rebate, or a liability may exist for a pharmaceutical firm or pharmacy benefits manager paying a rebate. The actuary should consider applicable rebate contracts or agreements. The actuary should consider any available historical drug usage, projected drug usage, and current emerging experience.
- 3.10.6 Cost Sharing Subsidies—Cost sharing subsidies may exist that pay for part or all of the cost sharing for eligible participants. Insurers may be paid on a budgeted basis with a final payment to or from the insurer based on the actual experience. The actuary should consider the following:
- a. applicable law, regulation, or other binding authority;

- b. the historical enrollment for members eligible for cost sharing subsidies;
  - c. any changes in the market that would impact the eligible enrollment;
  - d. any potential changes in the insurer's relative market position that could impact the eligible enrollment; and
  - e. **collectability.**
- 3.11 Follow-Up Studies—The actuary may conduct follow-up studies that involve performing tests of reasonableness of the prior period asset or liability estimates and the methods used over time. When conducting such follow-up studies, the actuary should, to the extent practicable, do the following:
- a. acquire the data to perform such studies;
  - b. perform studies in the aggregate or for pertinent blocks of business; and
  - c. utilize the results, if appropriate, in estimating assets and liabilities.
- 3.12 Provision for Adverse Deviation—Recognizing that assets and liabilities are an estimate of the value of true amounts 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 asset or liability should be appropriate, in the actuary's professional judgement, for the intended use.
- 3.13 Evaluating Collectability—The actuary should use professional judgment when evaluating **collectability** and may consider the following:
- a. materiality of the asset;
  - b. the expertise of other parties; and
  - c. other readily available information, such as financial statements.
- 3.14 Reliance on Data or Other Information Supplied by Others—When relying on data or other information supplied by others, the actuary should refer to ASOP No. 23, *Data Quality*, for guidance.
- 3.15 Reliance on Assumptions and Methods Selected by Others—When relying on assumptions and methods selected by others, the actuary should refer to ASOP No. 41 for guidance.
- 3.16 Reliance on Experts—An actuary may rely on experts in their field of knowledge when estimating or reviewing actuarial assets and liabilities. In determining the appropriate

level of reliance, the actuary should consider whether the individual or individuals upon whom the actuary is relying are experts in the applicable field. The actuary should disclose the extent of any such reliance.

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

#### Section 4. Communications and Disclosures

- 4.1 Actuarial Communication—When issuing an actuarial communication subject to this standard, the actuary should refer to ASOP Nos. 23 and 41. In addition, such actuarial communications should disclose the following, as applicable:
- a. important dates used in the analysis;
  - b. significant limitations, if any, which constrained the actuary's asset or liability 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 asset or liability estimate;
  - d. the risk that **provider** insolvency may have a material effect on the **risk-bearing entity's** ultimate asset or liability, as described in section 3.7.2;
  - e. any follow-up studies the actuary may have used in the development of the estimate of assets or liabilities, as described in section 3.11;
  - f. any explicit provision for adverse deviation, as described in section 3.12;
  - g. when updating a previous estimate, changes in assumptions, procedures, methods, or models that the actuary believes to have a material impact on the **health benefit plan** actuarial asset or liability estimate, as well as the reasons for such changes to the extent known by the actuary. The actuary may need to disclose these changes in cases other than when updating a previous estimate, consistent with the purpose or use of the **health benefit plan** actuarial asset or liability estimate. This standard does not require the actuary to measure or quantify the impact of such changes; and
  - h. any reliance on experts, as described in section 3.16.

- 4.2 Additional Disclosures—The actuary should also include the following, as applicable, in an actuarial communication:
- a. the disclosure in ASOP No. 41, 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**

Health benefit plan actuarial assets and liabilities other than incurred claims are important to many health lines of business. New forms of these assets and liabilities arose in recent years with the rapid increase in managed care provider risk arrangements and healthcare reform. The attention to financial statements enhanced the importance of these assets and liabilities.

#### **Current Practices**

Actuaries are able to obtain information relating to actuarial assets and liabilities for health benefit plan coverages from various publications from the National Association of Insurance Commissioners, including the following:

- the Accounting Practices and Procedures Manual;
- the Health Insurance Reserves Model Regulation; and
- the Health Reserves Guidance Manual.

Similar information on when assets and liabilities are required by Generally Accepted Accounting Principles is available in the Financial Accounting Standards Board's Statements of Financial Accounting Standards.

Estimating assets and liabilities may be necessary or useful in situations other than financial statement reporting, such as the acquisition of a block of a business or in experience analysis.

**Appendix 2**

**Comments on the Exposure Draft and Responses**

The exposure draft of this revision of ASOP No. 42, *Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims*, was issued in May 2017 with a comment deadline of September 30, 2017. Five comment letters were received, some of which were submitted on behalf of multiple commentators, such as by firms or committees. For purposes of this appendix, the term “commentator” may refer to more than one person associated with a particular comment letter. The Task Force carefully considered all comments received, and the Health Committee and ASB reviewed (and modified, where appropriate) the proposed changes.

Summarized below are the significant issues and questions contained in the comment letters and the responses to each.

The term “reviewers” includes the Task Force, Health Committee, and the ASB. Unless otherwise noted, the section numbers and titles used below refer to those in the exposure draft.

<b>GENERAL COMMENTS</b>	
Comment	One commentator stated that the idea of collectability is treated differently in different sections of the ASOP and that actuaries are not equipped to opine on collectability.
Response	The reviewers agree that collectability was treated differently in various sections. Therefore, the reviewers made it clear and consistent throughout the ASOP, and added a definition for collectability. However, the reviewers disagree and believe that actuaries are equipped to opine on collectability. In addition, the reviewers further clarified the guidance, including adding language on reliance on experts.
<b>SECTION 2. DEFINITIONS</b>	
<b>Section 2.1, Block of Business</b>	
Comment	One commentator suggested more clarification regarding the definition for “policy.”
Response	The reviewers believe that current language is clear with respect to what “policy” means, and made no change.
<b>Section 2.2, Capitation</b>	
Comment	One commentator suggested clarifying the definition of “capitation” by including a reference to “periodic payments.”
Response	The reviewers agree and modified the definition.
<b>Section 2.7, Health Benefit Plan (now section 2.8)</b>	
Comment	One commentator suggested further clarification on whether accidental death and disability coverage is within the scope of a health benefit plan.
Response	The reviewers believe the current language is sufficient and, to the extent that accidental death and disability coverage has health coverage, it is part of a health benefit plan. Therefore, no change was made.
<b>Section 2.8, Long-Term Product (now section 2.9)</b>	
Comment	One commentator suggested that the definition for long-term product be clarified.
Response	The reviewers believe that the definition of long-term product is sufficiently clear and made no change.

## **ASOP No. 42—Doc. No. 191**

Comment	One commentator suggested that the definition of long-term product could be more clear with respect to when the benefits commence and when the benefits become payable.
Response	The reviewers agree and revised the definition to be more clear when benefits are payable.
<b>Section 2.11, Provider-Related Asset or Liability (now section 2.12)</b>	
Comment	One commentator felt that the definition for provider-related asset or liability needed clarification.
Response	The reviewers agree and provided examples to clarify the language.
Comment	One commentator suggested adding examples to the definition for provider-related assets or liabilities that may not arise from a risk-sharing arrangement.
Response	The reviewers agree and provided an example to clarify the language.
<b>Section 2.12, Risk Adjustment Data Validation (RADV) (now section 2.13)</b>	
Comment	One commentator suggested changing the risk adjustment data validation definition to clarify there are numerous risk adjustment models and not just one model.
Response	The reviewers agree and modified the definition for clarity.
<b>SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES</b>	
<b>Section 3.3.3, Economic and Other External Influences</b>	
Comment	One commentator suggested revising the language regarding claims that might occur prior to contract termination.
Response	The reviewers agree and have revised the language.
<b>Section 3.3.6, Coordination of Benefits (COB), Subrogation, and Government Programs</b>	
Comment	One commentator suggested that the government programs described in section 3.3.6 are risk-sharing arrangements with the government and that this should be made clearer.
Response	The reviewers believe the government programs referred to may include provisions other than risk-sharing arrangements. Therefore, no change was made.
Comment	One commentator suggested that the governmental programs in section 3.3.6 be broken out or moved.
Response	The reviewers believe that governmental programs that are being referred to should be kept in this section since the section deals with similar adjustments that may be needed to the data due to governmental programs or coordination of benefits. Therefore, the reviewers made no change.
<b>Section 3.3.10, Reinsurance Arrangements</b>	
Comment	One commentator suggested that it should be clarified that the reinsurance risk-sharing provisions fall within risk-sharing arrangements.
Response	The reviewers believe that the wording is sufficiently clear, and made no change.
<b>Section 3.3.11, Expenses</b>	
Comment	One commentator suggested further clarification as to what expenses mean.
Response	The reviewers agree and have revised the language to reflect that expenses mean non-claim expenses.
<b>Section 3.5, Considerations for Estimating Premium Deficiency Reserves</b>	
Comment	Two commentators suggested clarification on the exposure units to be used for future contract periods. One commentator suggested further guidance on which time periods should be included in the calculation.
Response	The reviewers believe the current language strikes a balance of providing guidance while not being too prescriptive, and made no change.

## **ASOP No. 42—Doc. No. 191**

<b>Section 3.5.7, Interest Rates</b>	
Comment	One commentator suggested further clarification regarding duration.
Response	The reviewers agree and have provided more clarity by using projection period instead of duration.
<b>Section 3.7.1, Provider Risk-Sharing and Capitation Arrangements</b>	
Comment	One commentator suggested that the wording regarding the overall financial condition of the provider be consistent with section 3.7.2, Provider Financial Condition.
Response	The reviewers believe the language is appropriate in both sections and provided a reference in section 3.7.1 to see section 3.7.2 for further discussion.
<b>Section 3.8, Claim Adjustment Expense Liabilities</b>	
Comment	One commentator suggested clarification regarding to what items claims adjustment expenses apply.
Response	The reviewers believe the current wording is appropriate as it clarifies that claims adjustment expenses are associated with unpaid claims, and made no change.
<b>Section 3.11, Follow-Up Studies</b>	
Comment	One commentator suggested that the language should be changed to reflect that actuaries should conduct follow-up studies on the prior period asset or liability.
Response	The reviewers believe that follow-up studies are important but the section should not be overly prescriptive. The reviewers note that there are situations where actuaries may choose not to do a follow-up study, for example if the asset or liability is considered to be immaterial, and made no change.
<b>Section 3.12, Provision for Adverse Deviation</b>	
Comment	One commentator suggested additional clarification regarding when a provision for adverse deviation may be required or may be appropriate.
Response	The reviewers believe that the current language provides adequate guidance, and made no change.
<b>SECTION 4. COMMUNICATIONS AND DISCLOSURES</b>	
<b>Section 4.1, Actuarial Communication</b>	
Comment	One commentator suggested the wording of materiality in section 4.1(d) may be confusing.
Response	The reviewers believe the use of the word materiality is clear and direct the commentator to ASOP No. 1, <i>Introductory Actuarial Standard of Practice</i> , for the definition of materiality, and made no change.
Comment	One commentator suggested that an example in section 4.1(g) would clarify when an actuary may need to disclose changes.
Response	The reviewers believe the current wording is appropriate regarding when disclosure of changes is needed and made no change.
<b>APPENDIX (now Appendix 1)</b>	
Comment	One commentator suggested clarification of the organization that publishes the Statements of Financial Accounting Standards.
Response	The reviewers agree and added the organization that promulgates the Statements of Financial Accounting Standards.