



ACTUARIAL STANDARDS BOARD

**DEFINITIONS FROM
ACTUARIAL STANDARDS OF PRACTICE OF THE
ACTUARIAL STANDARDS BOARD**

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A

Accounting Date—The stated cutoff date for reflecting events and recording amounts in a financial statement or accounting system. The accounting date is sometimes known as the “as of date.” (ASOP Nos. 20 and 36)

Actual Experience—[1] Historical results within a dividend factor class and trends in those results. (ASOP No. 15); [2] Historical results and trends in those results. (ASOP No. 24)

Actual-to-Expected (A/E) Analysis—The process of calculating and analyzing A/E ratios over a selected time period; for example, across different ages, genders, and durations. This is also known as an A/E study. (ASOP No. 48)

Actual-to-Expected (A/E) Ratio—Actual deaths (either face amount or number of lives) in a group of lives being evaluated, over a specified period divided by the expected deaths over the same period. (ASOP No. 48)

Actuarial Accrued Liability, Actuarial Liability, Accrued Liability, or Actuarial Reserve—The portion of the actuarial present value of projected benefits (and expenses, if applicable), as determined under a particular actuarial cost method, that is not provided for by future normal costs. Under certain actuarial cost methods, the actuarial accrued liability is dependent upon the actuarial value of assets. (ASOP Nos. 4, 6, and 51)

Actuarial Appraisal—An appraisal of an insurance business presenting a set of actuarial appraisal values. A set of actuarial appraisal values is based on a range of discount rates or a range of assumption sets, but may, in certain circumstances, present a single unique value for the business. (ASOP No. 19)

Actuarial Appraisal Value—The present value, calculated as of the appraisal date, of projected distributable earnings of an insurance business where the distributable earnings are based on a set of assumptions. (ASOP No. 19)

Actuarial Assumption—The value of a parameter or other actuarial choice having an impact on an estimate of a future cost or other actuarial item under evaluation. (ASOP No. 17)

Actuarial Balance Sheet—A measure of the assets and liabilities, as of the valuation date, associated with current contractual residents or current members. (ASOP No. 3)

Actuarial Central Estimate—An estimate that represents an expected value over the range of reasonably possible outcomes. (ASOP No. 43)

Actuarial Communication—A written, electronic, or oral communication issued by an actuary with respect to actuarial services. (ASOP No. 41)

Actuarial Contribution—The contribution a particular policy or class of similar eligible policies has made to the company’s statutory surplus and the asset valuation reserve, plus the present value of contributions that the same policy or class of similar eligible policies is expected to make in the future. (ASOP No. 37)

Actuarial Cost Method or Funding Method—A procedure for allocating the actuarial present value of projected benefits (and expenses, if applicable) to time periods usually in the form of a normal cost and an actuarial accrued liability. For purposes of this standard, a pay-as-you-go method is not considered to be an actuarial cost method. (ASOP Nos. 4 and 6)

Actuarial Document—An actuarial communication in any recorded form (such as paper, e-mail, spreadsheets, presentations, audio or video recordings, web sites, and court or hearing transcripts). Notes taken by someone other than the actuary are not considered actuarial documents. (ASOP No. 41)

Actuarial Finding—The result (including advice, recommendations, opinions, or commentary on another actuary’s work) of actuarial services. (ASOP No. 41)

Actuarial Memorandum—A written actuarial report (as defined in ASOP No. 41, *Actuarial Communications*) that provides information regarding the analyses completed in support of statements of actuarial opinion regarding health insurance assets and liabilities. (ASOP No. 28)

Actuarial Method—A procedure by which data or assumptions are analyzed or utilized for the purpose of estimating a future cost or other actuarial item. (ASOP No. 17)

Actuarial Present Value—The value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of actuarial assumptions with regard to future events, observations of market or other valuation data, or a combination of assumptions and observations. (ASOP Nos. 3, 4, 6, and 51)

Actuarial Present Value of Projected Benefits—[1] The actuarial present value of benefits that are expected to be paid in the future, taking into account the effect of such items as future service, advancement in age, and anticipated future compensation (sometimes referred to as the “present value of future benefits”). (ASOP No. 4); [2] The actuarial present value of benefits that are expected to be paid in the future, taking into account the effect of such items as future service, advancement in age, and expected future per capita health care costs (sometimes referred to as the “present value of future benefits”). (ASOP No. 6)

Actuarial Report—The set of actuarial documents that the actuary determines to be relevant to specific actuarial findings that is available to an intended user. (ASOP No. 41)

Actuarial Services—Professional services provided to a principal by an individual acting in the capacity of an actuary. Such services include the rendering of advice, recommendations, findings, or opinions based upon actuarial considerations. (ASOP Nos. 1 and 41)

Actuarial Soundness—[1] The phrase “actuarial soundness” has different meanings in different contexts and might be dictated or imposed by an outside entity. In rendering actuarial services, if the actuary identifies the process or result as “actuarially sound,” the actuary should define the meaning of “actuarially sound” in that context. (ASOP No. 1); [2] Small employer health benefit plan premium rates are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital. For either a retrospective or a prospective certification, the determination of actuarial soundness is based on information available at the time the premium rates were established. (ASOP No. 26)

Actuarial Status—A measure of the relative value of program income and program assets to program costs over a specified period of time. (ASOP No. 32)

Actuarial Valuation—[1] The measurement of relevant pension obligations and, when applicable, the determination of periodic costs or actuarially determined contributions. (ASOP No. 4); [2] The measurement of relevant retiree group benefits obligations and, when applicable, the determination of periodic costs or actuarially determined contributions. (ASOP No. 6); [3] The determination, as of a measurement date, of the actuarial present value of a retirement plan benefit and any related benefits. (ASOP No. 34); [4] The measurement of relevant pension obligations and, when applicable, the determination of the actuarial value of assets, periodic costs, or contributions. (ASOP No. 44)

Actuarial Value—A measure of the proportion of total allowed medical costs for a specified population that the health insurance plan is contractually obligated to pay. (ASOP No. 50)

Actuarial Value of Assets or Valuation Assets—The value of pension plan investments and other property, used by the actuary for the purpose of an actuarial valuation (sometimes referred to as *valuation assets* or *market-related value of assets*). (ASOP No. 44)

Actuarially Determined Contribution—[1] A potential payment to the plan as determined by the actuary using a contribution allocation procedure. It may or may not be the amount actually paid by the plan sponsor or other contributing entity. (ASOP Nos. 4 and 51); [2] A potential payment, other than by a retired participant, to prefund the retiree group benefits program, as determined by the actuary using a contribution allocation procedure. It may or may not be the amount actually paid by the plan sponsor or other contributing entity. This does not include the development of premiums or budget rates. (ASOP No. 6)

Actuarially Sound/Actuarial Soundness—Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes. (ASOP No. 49)

Additional Fee—An amount that may be payable by a contractual resident or member, in accordance with a residency agreement or membership agreement, for services made available but not covered by the advance fee and the periodic fees. Examples of additional fees include fees for guest meals, additional meals, barber/beauty shop, use of a carport, and non-covered health care services. (ASOP No. 3)

Advance Fee—An amount payable by a contractual resident at the inception of a residency agreement or by a member at the inception of a membership agreement. The advance fee is usually specified in the residency agreement or membership agreement and is usually payable prior to occupancy of the residence or receipt of benefits. (ASOP No. 3)

Adverse Capital Event—A modeled or actual event that either a) causes capital to be significantly less than the risk capital target(s) or b) causes capital to be less than the risk capital target(s) or risk capital threshold(s). (ASOP No. 55)

Adverse Selection—Actions taken by one party using risk characteristics or other information known to or suspected by that party that cause a financial disadvantage to the financial or personal security system (*sometimes referred to as anti-selection*). (ASOP No. 6 and 12)

Advice—An actuary’s communication or other work product in oral, written, or electronic form setting forth the actuary’s professional opinion or recommendations concerning work that falls within the scope of this standard. (ASOP No. 12)

Age- or Service-Dependent Benefits—Benefits for which the amount or timing of benefit payments depends on the covered party’s age or length of service. (ASOP No. 34)

Allocation Date—The date through which the benefits earned during the marriage are determined. Generally, this is the last day of the allocation period. (ASOP No. 34)

Allocation Method—A method used to determine the portion of retirement plan benefits that is included in marital property. (ASOP No. 34)

Allocation of Retirement Plan Benefits—The allocation of retirement plan benefits into two or more portions: a portion that is fully considered to be marital property and a portion that is not marital property, and perhaps a portion that is determined to be partially marital property. (ASOP No. 34)

Allocation Period—The period over which the retirement plan benefits deemed attributable to the marriage are determined. The period typically starts from the date of marriage or, if later, the hire date or plan entry date. The period typically ends at the date of marital separation, the date of court order formally ending the marriage, or the date of separation from service or actual retirement. (ASOP No. 34)

Amortization Method—A method under a contribution allocation procedure or cost allocation procedure for determining the amount, timing, and pattern of recognition of the unfunded actuarial accrued liability. (ASOP Nos. 4 and 6)

Anticipated Experience Assumption—An expectation of future experience for a risk factor given available, relevant information pertaining to the assumption being estimated. (ASOP No. 52)

Anticipated Experience Factor—An assumption of future experience used in the determination of NGEs. Examples of anticipated experience factors include rates of investment income, mortality, morbidity, policy persistency, and expense. (ASOP No. 2)

Applicable Actuarial Guideline (Applicable AG)— An NAIC actuarial guideline that provides guidance on the application of the Model. Such actuarial guidelines may include NAIC Actuarial Guideline XLIX (AG 49) and Actuarial Guideline XLIX-A (AG 49-A). (ASOP No. 24)

Applicable Law—Federal, state, and local statutes, regulations, case law, and other binding authority that may govern the conversion of the subject mutual life insurance company to a stock life insurance company, including conversion to a mutual holding company structure. (ASOP No. 33)

Appraisal—An assessment of the value of an insurance business including, but not limited to, an actuarial appraisal. (ASOP No. 19)

Appraisal Date—The date as of which an appraisal value is assessed. (ASOP No. 19)

Appropriate Data—Data suitable for the intended purpose of an analysis and relevant to the system or process being analyzed. (ASOP No. 23)

Asset—[1] A resource that can generate revenue cash flows or reduce disbursement cash flows. (ASOP No. 7); [2] Any resource that can generate revenue cash flows or reduce disbursement cash flows. (ASOP No. 22)

Asset Adequacy Analysis—An analysis of the adequacy of reserves and other liabilities being tested, in light of the assets supporting such reserves and other liabilities, as specified in the statement of actuarial opinion. (ASOP No. 22)

Asset Valuation Method—A method used by the actuary to determine the actuarial value of assets. (ASOP No. 44)

Assisted Living Facility—A facility that provides residents some assistance with activities of daily living. Residents have apartments, rooms, or shared dwellings and often share community living and dining areas with other residents. Usually meals, utilities, housekeeping, laundry, ambulation assistance, and personal care supervision are provided. Staff members may supervise the self-administration of medication. (ASOP No. 18)

Assuming Entity—The entity accepting insurance risk in a reinsurance agreement, such as an insurer accepting risk from a stop-loss program, a reinsurer accepting risk from an insurance company, or a retrocessionaire accepting risk from a reinsurer. (ASOP No. 11)

Assumption—[1] A type of explicit input to a catastrophe model that is derived from data, represents possibilities based on professional judgment, or may be prescribed by law or others. When derived from data, an assumption may be statistical, financial, economic, mathematical, or scientific in nature, and may be described as a parameter. (ASOP No. 38) [2] A type of explicit input to a model that is derived from data, represents possibilities based on professional judgment, or may be prescribed by law or by others. When derived from data, an assumption may be statistical, financial, economic, mathematical, or scientific in nature, and may be described as a parameter. (ASOP No. 56)

At Home Program—An organization that provides social and health care services in return for some combination of an advance fee, periodic fees, and additional fees. At Home Programs differ from CCRCs in that they do not provide a direct independent living unit for members. (ASOP No. 3)

Audit—A formal and systematic examination of a set of data for the purpose of testing its accuracy and completeness. (ASOP No. 23)

Auditor—The external firm or professional engaged to conduct a financial audit or financial review in accordance with the generally accepted auditing standards for the purpose of issuing an opinion on a financial statement. (ASOP No. 21)

Available Capital—The excess of assets over liabilities that is available to cover the required capital, calculated on a basis consistent with required capital. (ASOP No. 58)

AV Calculator (AVC)—Data and methodology released or approved by Health and Human Services (HHS) that is used to determine the AV of a health insurance plan. (ASOP No. 50)

AVC-AV—The AV calculated using the AVC, including any adjustments for non-standard plan designs. (ASOP No. 50)

B

Base Data—The historical data set used by the actuary to develop the capitation rates. The data may be from Medicaid fee-for-service data, MCO data, or from a comparable population data source. (ASOP No. 49)

Basic Reserves—Reserves calculated in accordance with section 5 of the model NAIC *Standard Valuation Law*. (ASOP No. 40)

Benefit Options—Choices that a benefit plan member may make under a benefit plan including basic coverages (for example, choice of medical plans) and additional coverages (for example, contributory dental coverage). (ASOP No. 6)

Benefit Plan—An arrangement providing medical, prescription drug, dental, vision, legal, death, long-term care, or other benefits (excluding retirement income benefits) to participants of the retiree group benefits program, whether on a reimbursement, indemnity, or service benefit basis. (ASOP No. 6)

Benefit Plan Member—An individual covered by a benefit plan. (ASOP No. 6)

Best-Estimate Assumption—An assumption that reflects anticipated experience with no provision for risk of adverse deviation. (ASOP No. 10)

Block of Business—**[1]** 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. (ASOP No. 5); **[2]** 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. (ASOP No. 42)

C

Capital—**[1]** The funds intended to assure payment of obligations from insurance contracts, over and above those funds backing the liabilities. (ASOP No. 30); **[2]** The excess of the value of assets over the value of liabilities, which depends on the valuation basis chosen. (ASOP No. 55)

Capital Adequacy Assessment—An assessment of capital of an insurer relative to its risk capital target(s) or risk capital threshold(s). (ASOP No. 55)

Capitation—**[1]** 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. (ASOP No. 5); **[2]** 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. (ASOP No. 42)

Capitation Rate—A monthly fee paid for each member assigned or each event (for example, maternity delivery) regardless of the number or actual cost of services provided under a system of reimbursement for MCOs. Capitation rates can vary by member based on demographics, location, covered services, or other characteristics. Capitation rates can be structured so that an MCO is fully at risk, or so that an MCO shares the risk with other parties. (ASOP No. 49)

Carrier—Any entity subject to state regulation that offers health benefit plan coverage for sale. *Carrier* includes an insurance company, a prepaid hospital or medical service plan, a fraternal benefit society, a health maintenance organization, and any other entity offering for sale a plan of health insurance or health benefits. (ASOP No. 26)

Carve-Outs—[1] Contractually 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. (ASOP No. 5); [2] A medical service or condition not covered by the program under review or covered under a different reimbursement arrangement, such as a capitation. A common carve-out is mental health services. (ASOP No. 45)

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. (ASOP No. 42)

Cash and Investment Balance—The value of cash, cash equivalents, and marketable securities (historically referred to as “cash balance” by industry organizations). This excludes the value of the physical property assets. (ASOP No. 3)

Cash Flow—[1] A receipt, disbursement, or transfer of cash or equivalent assets. (ASOP No. 7); [2] A receipt, disbursement, or transfer of cash or equivalent assets. Cash flows may include underwriting cash flows, investment cash flows, and other cash flows. Cash flows may include historical amounts or prospective estimates. (ASOP No. 20); [3] Any receipt, disbursement, or transfer of cash or asset equivalents; includes policy cash flows and cash flows that are not policy related, such as cash flows from assets, corporate expenses, and litigation costs. (ASOP No. 22)

Cash Flow Analysis—[1] An evaluation of cash flow risks. Cash flow analysis may include cash flows from assets, liabilities, or both assets and liabilities. Examples of types of cash flow analysis include cash flow testing, gross premium valuation methods, loss ratio methods, risk theory techniques, and profitability projections. (ASOP No. 7); [2] An evaluation or projection of cash flows. A cash flow analysis may include discounted cash flows. (ASOP No. 20)

Cash Flow Model—A model designed to simulate asset and liability cash flows. (ASOP No. 52)

Cash Flow Risk—[1] A risk associated with the amount or timing of cash flows, including the mismatching of cash flows between assets and liabilities. (ASOP No. 7); [2] The risk that the amount or timing of cash flows will differ from expectations or assumptions. (ASOP No. 22)

Cash Flow Testing—The projection and comparison of the timing and amount of cash flows under one or more scenarios in order to evaluate cash flow risks. (ASOP No. 22)

Catastrophe—A relatively infrequent event or natural phenomenon that produces large aggregate losses. (ASOP No. 39)

Catastrophe Model—A model of low-frequency events with high-severity or widespread potential effects. Catastrophe models may be used to explain a system, to study effects of different components, or to derive estimates. (ASOP No. 38)

Catastrophe Ratemaking Procedures—Ratemaking procedures that adjust for the impact of catastrophe losses in the experience data and determine a provision for catastrophe losses and loss adjustment expenses. (ASOP No. 39)

Ceding Entity—The entity that is transferring insurance risk in a reinsurance agreement, such as an employer transferring risk under a stop-loss arrangement, an insurance company transferring risk to a reinsurer, or a reinsurer transferring risk to a retrocessionaire. (ASOP No. 11)

Claim—A demand for payment under the coverage provided by a plan or contract. (ASOP No. 28)

Claim Adjustment Expense—The costs of administering, determining coverage for, settling, or defending claims even if it is ultimately determined that the claim is invalid. (ASOP No. 43)

Claim Estimate—An estimate on an undiscounted basis of the obligation for future loss and loss adjustment expenses resulting from claims due to past events or an estimate of loss and loss adjustment expenses associated with prospective property/casualty risk transfer or risk transfer or risk retention. Claim estimates may include elements, such as case reserves, developed by individuals other than actuaries. (ASOP No. 20)

Closed Block—A mechanism to preserve (over time) the reasonable dividend expectations of policyholders with individual life, health, or annuity policies. A closed block comprises a defined, limited group of policies and a defined set of assets, and is governed by a set of operating rules. All cash flows arising from the closed block are exclusively committed to supporting the policies in the closed block as specified in the operating rules. (ASOP No. 33)

Coding—The process of recording and submitting information (for example, diagnoses or services provided) on claims forms. (ASOP No. 45)

Cohort—A grouping of insurance contracts or policies for the purpose of measuring the liability for future policy benefits, DPAC, and any other related balances. (ASOP No. 10)

Cohort of New Contractual Residents or New Members—A hypothetical group of new contractual residents or members assumed to enter a CCRC or At Home Program over a specified period of time and assumed to have certain demographic characteristics. (ASOP No. 3)

Collectability—[1] The likelihood of receiving the amount of money owed. (ASOP No. 42); [2] The likelihood of receiving the amount of money owed or the asset accrued. (ASOP No. 28)

Collectability of Reinsurance Proceeds—The ability of the counterparty to obtain funds owed to it according to the terms of the reinsurance program. (ASOP No. 11)

Condition Category—A grouping of medical conditions that have similar expected healthcare resource use or clinical characteristics. (ASOP No. 45)

Commission and Brokerage Fees—Compensation associated with the acquisition and service of business. These fees are paid to agents, brokers, or other parties, including ceding insurance companies. (ASOP No. 29)

Consideration—The consideration a policyholder receives in a demutualization in exchange for relinquishing membership rights (sometimes referred to as *policyholder consideration*). (ASOP No. 37)

Contagion—A lack of independence between the occurrence of losses among different entities. (ASOP No. 39)

Contingency Provision—A provision for the expected differences, if any, between the estimated costs and the average actual costs, that cannot be eliminated by changes in other components of the ratemaking process. (ASOP No. 30)

Contract Performance—The fulfillment of an entity's obligations required by a contract, for example, compliance under the provisions of a reinsurance contract or under a contract that includes a retrospective rate adjustment. (ASOP No. 21)

Contract Period—The time period for which a contract is effective. (ASOP Nos. 5 and 42)

Contract Reserve—[1] A liability 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. (ASOP No. 28); [2] 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. (ASOP No. 42)

Contractual Resident—A person who has signed a residency agreement. (ASOP No. 3)

Contribution Allocation Procedure—[1] A procedure that determines one or more actuarially determined contributions for a plan. The procedure uses an actuarial cost method and may use an asset valuation method, an amortization method, or an output smoothing method. The procedure may produce a single value, such as normal cost plus an amortization payment of the unfunded actuarial accrued liability, or a range of values, such as the range from the ERISA minimum required contribution to the maximum tax-deductible amount. (ASOP No. 4) [2] A procedure that uses an actuarial cost method, and may include an asset valuation method, an amortization method, and an output smoothing method, to determine the actuarially determined contribution for prefunding a retiree group benefits program. It may produce a single value, such as normal cost plus an amortization payment of the unfunded actuarial accrued liability, or a range of values. This term does not relate to the process of determining the participant contribution. (ASOP No. 6) [3] A procedure that uses an actuarial cost method, and may include an asset valuation method, an amortization method, and an output smoothing method, to determine the actuarially determined contribution for a plan. The procedure may produce a single value, such as normal cost plus an amortization payment of the unfunded actuarial accrued liability, or a range of values, such as the range from the ERISA minimum required contribution to the maximum tax-deductible amount. (ASOP No. 51)

Contribution Principle—The concept that aggregate divisible surplus is allocated to policies to reflect the proportion that the policies, as part of their dividend factor classes, are considered to have contributed to divisible surplus. (ASOP No. 15)

Contribution Risk—The potential of actual future contributions deviating from expected future contributions, for example, that actual contributions are not made in accordance with the plan's funding policy, that withdrawal liability assessments or other anticipated payments to the plan are not made, or that material changes occur in the anticipated number of covered employees, covered payroll, or other relevant contribution base. (ASOP No. 51)

Cost(s)—All benefit payments and expenses associated with issuing, maintaining (to the extent allowable by authoritative GAAP guidance), and settling a company's insurance policies and contracts, with no provision for profit. (ASOP No. 10)

Cost Allocation Procedure—[1] A procedure that determines the periodic cost for a plan (for example, the procedure to determine the net periodic pension cost under accounting standards). The procedure uses an actuarial cost method, and may use an asset valuation method or an amortization method. (ASOP No. 4); [2] A procedure that uses an actuarial cost method, and may include an asset valuation method and an amortization method, to determine the periodic cost for a retiree group benefits program (for example, the procedure to determine the net periodic postretirement benefit cost under some accounting standards). (ASOP No. 6)

Cost of Capital—[1] The rate of return that capital could earn in an alternative investment of equivalent risk. The source of the capital may be internal or external. (ASOP No. 26); [2] The rate of return that capital could be expected to earn in alternative investments of equivalent risk; also known as *opportunity cost*. (ASOP No. 30)

Counterparty—[1] Another entity involved in the reinsurance program including, but not limited to, ceding entity, assuming entity, or a service provider. (ASOP No. 11); [2] Another entity involved in a financial transaction. (ASOP No. 28); [3] An entity with which the insurance company or other property/casualty risk financing system has a contractual relationship including, but not limited to, a ceding entity, an assuming entity, an insured, or a service provider. (ASOP No. 36)

Counterparty Risk—[1] The risk that any counterparty does not fulfill its contractual obligations. (ASOP Nos. 11 and 28)

Coverage—[1] The terms and conditions of a plan or contract, or the requirements of applicable law, that create an obligation to pay benefits, expenses, or claims associated with contingent events. (ASOP Nos. 20, 29, and 53); [2] The terms and conditions of a plan or contract, or the requirements of applicable law, that create an obligation for claim payment associated with contingent events. (ASOP Nos. 13, 36, and 43)

Covered Party—The party in a domestic relations action who is covered by the retirement plan. (ASOP No. 34)

Covered Population—Active and retired participants, participating dependents, and surviving dependents of participants who are eligible for benefit coverage under a retiree group benefits program. The covered population may also include dependents and contingent participants. (ASOP No. 6)

Credibility—A measure of the predictive value in a given application that the actuary attaches to a particular set of data (*predictive* is used here in the statistical sense and not in the sense of predicting the future). (ASOP Nos. 12, 25, 45, and 52)

Credibility Procedure—A process that involves the following:

- a. the evaluation of subject experience for potential use in setting assumptions without reference to other data; or
- b. the identification of relevant experience and the selection and implementation of a method for blending the relevant experience with the subject experience. (ASOP No. 25)

Currently Payable Scale—A scale of non-guaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next 95 days. (ASOP No. 24)

D

Data—[1] Numerical, census, or classification information, or information derived mathematically from such items, but not general or qualitative information. Actuarial assumptions are not data, but data are commonly used in the development of actuarial assumptions. (ASOP No. 17); [2] Numerical, census, or classification information, or information derived mathematically from such items, but not general or qualitative information. Assumptions are not data, but data are commonly used in the development of actuarial assumptions. (ASOP No. 23); [3] Facts or information that are either direct input to a catastrophe model or inform the selection of input. Data may be collected from sources such as records, experience, experiments, surveys, observations, benefit plan or policy provisions, or output from other models. (ASOP No. 38); [4] Facts or information that are either direct input to a model or inform the selection of input. Data may be collected from sources such as records, experience, experiments, surveys, observations, benefit plan or policy provisions, or output from other models. (ASOP No. 56)

Data Element—An item of information, such as date of birth or risk classification. (ASOP No. 23)

Debits and Credits—The components of a system used by underwriters to determine a set of mortality multiples to apply to a base mortality table. Debits increase the mortality multiple due to various impairments that an insured may have; credits reduce the mortality multiple due to good health characteristics. (ASOP No. 48)

Dedicated Assets—Assets designated for the exclusive purpose of satisfying the retiree group benefits program obligations. Examples include the following: (a) life insurance policies held by the plan sponsor's retired participant death benefits; (b) welfare benefit trusts (for example, voluntary

employees' beneficiary associations); (c) Internal Revenue Code section 401(h) accounts in a qualified pension plan; and (d) Internal Revenue Code section 115 trusts sponsored by governmental entities for retiree group benefits. (ASOP No. 6)

Deferred Policy Acquisition Cost (DPAC)—An asset representing the unamortized portion of capitalized policy acquisition expenses. (ASOP No. 10)

Deferred Sales Inducements (DSI)—An asset representing the unamortized portion of capitalized sales inducements to policyholders. (ASOP No. 10)

Deficiency Reserves—The excess, if greater than zero, of minimum reserves calculated in accordance with section 8 of the model NAIC *Standard Valuation Law* over basic reserves. (ASOP No. 40)

Demand Surge—A sudden and usually temporary increase in the cost of materials, services, and labor due to the increased demand for them following a catastrophe. (ASOP No. 39)

Demutualization—The conversion of a mutual company to a stock company. (ASOP No. 37)

Dependents—Individuals who are covered or may be covered under a retiree group benefits program by virtue of their relationship to an active or retired participant. (ASOP No. 6)

Determination Policy—The insurer's principles or objectives for determining NGEs. For example, the determination policy could include the insurer's governing principles and requirements, profitability objectives, capital objectives, guidelines for drafting policy provisions related to NGEs, principles for addressing illustration requirements, and requirements for and frequency of reviews of NGEs on in-force products. (ASOP No. 2)

Deterministic Reserve—A reserve amount calculated under a defined scenario and a single set of assumptions. (ASOP No. 52)

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 paid. The development method uses these groupings to create a claims payment pattern, which is used to help estimate the incurred claims. (ASOP No. 5)

Deviation—The act of departing from the guidance of an ASOP. (ASOP Nos. 1 and 41)

Diagnostic Services—Services (for example, lab or radiology) provided to determine whether a medical condition exists. Having these services performed does not by itself indicate a condition exists, although the result of the test may indicate it does. (ASOP No. 45)

Direct User—A present or prospective client or employer who has the opportunity to select the actuary and is able to communicate directly with the actuary about the actuary's qualifications, work, or recommendations. (ASOP No. 34)

Disciplined Current Scale—A scale of nonguaranteed elements for a policy form, certified annually by the illustration actuary, constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on recent actual experience and that satisfies the requirements set forth in the Model. (ASOP No. 24)

Discount Rate—[1] The rate used to discount projected cash flow to determine their present value. (ASOP No. 8); [2] The rate used to discount projected earnings to determine the present value used in an appraisal. (ASOP No. 19)

Discounted Cash Flow—The actuary's estimate of the present value of a cash flow. (ASOP No. 20)

Discounted Claim Estimate—The actuary's estimate of the present value of the claim estimate. (ASOP No. 20)

Disproportionate Share Hospital (DSH) Payments—Additional amounts paid to hospitals that serve a disproportionately large number of Medicaid or uninsured patients. These payments may be subject to a hospital-specific limit. An annual allotment to each state limits federal financial participation in these payments. These payments are subject to requirements set forth in Section 1923(i) of the Social Security Act. (ASOP No. 49)

Distributable Earnings—Amounts that an insurance business can distribute while retaining the level of capital required to support its ongoing operations. Distributable earnings consist of earnings of an insurance business computed using the applicable regulatory accounting basis, adjusted to allow for the injection or release of regulatory capital and surplus, in recognition of appropriate capital and surplus levels needed to support the ongoing operations. A regulatory accounting basis is the basis required by the insurance supervisory authority in a particular jurisdiction to be used for financial statement filings by insurance companies and similar entities in that jurisdiction. (ASOP No. 19)

Dividend Determination—Given the dividend framework, the process by which the divisible surplus is allocated to policies including the determination of dividend factors. (ASOP No. 15)

Dividend Factor—A value or set of values, other than the policy factors, used in the determination of the dividend on a particular policy. A dividend factor reflects the experience of the dividend factor class of policies to which the particular policy belongs. Examples of dividend factors include those related to mortality, morbidity, expense, investment income, policy termination, tax, and experience premiums. (ASOP No. 15)

Dividend Factor Class—A group of policies for which dividends are determined by using the same value or set of values for a particular dividend factor. (ASOP No. 15)

Dividend Framework—The structure by which the insurer allocates divisible surplus among participating policies. This includes the assignment of policies to dividend factor classes, the method of allocating income and costs, and the structure of the formulas or other methods of using dividend factors. (ASOP No. 15)

Divisible Surplus—The aggregate amount available to be distributed to policyholders as dividends. (ASOP No. 15)

Domestic Relations Action—Prenuptial, postnuptial, separation, divorce, and support agreements, and other domestic relations proceedings. (ASOP No. 34)

Domestic Relations Order (DRO)—A court order dividing retirement plan benefits between the covered party and spouse, or a proposed court order for such purpose. (ASOP No. 34)

Duration—The length of time, measured in years, since a life expectancy estimate was issued. (ASOP No. 48)

E

Eligibility Date—Date (or dates) as of which a policy must be deemed in force, according to the plan of conversion, for the policyholder to be eligible to receive consideration. (ASOP No. 37)

Eligible Policyholder—The owner of one or more policies eligible to receive consideration under the plan of conversion. (ASOP No. 37)

Emerging Risk—New or evolving risks that may be difficult to identify, manage, or measure because they have not been experienced previously and therefore their likelihood, magnitude, timing, or interdependency with other risks are more uncertain. (ASOP No. 58)

Encounter Data—Information about an interaction between a provider of health care services and a member that is documented through the submission of a claim to an MCO and shared between the MCO and the state Medicaid agency. (ASOP No. 49)

Enhanced or Additional Benefits—Benefits offered by MCOs to their Medicaid members that are above and beyond the benefits offered by the state Medicaid plan. Common examples are adult dental services, non-emergency transportation, and adult vision services. (ASOP No. 49)

Enterprise Risk Management (ERM) Framework—The collection of processes by which the organization identifies, classifies, mitigates, measures, monitors, and manages its risk exposures. These processes are repeated periodically. (ASOP No. 58)

Entity—An institution, company, corporation, partnership, government agency, university, employee benefit plan, or other organization that may be subject to a financial audit, financial review or financial examination, as well as the individuals who are authorized to act on behalf of the organization. (ASOP No. 21)

Essential Health Benefits (EHBs)—The specific items and services that the ACA requires issuers to cover in benefit plans offered in the individual and small group markets. EHBs must include any benefit defined by the Secretary of Health and Human Services. In addition, some EHBs may be defined by individual states. (ASOP No. 50)

Estimation Period—The period for which differences in morbidity are being quantified by the risk adjustment methodology. (ASOP No. 45)

Event—The incident or activity that triggers potential for claim or claim adjustment expense payment. (ASOP No. 43)

Examiner—An employee of or contractor to state or federal regulators performing a financial examination on behalf of the governmental agency responsible for oversight of the financial condition of the entity. (ASOP No. 21)

Expected Deaths—The number of deaths statistically expected in a given time interval. (ASOP No. 48)

Expense Provisions—Future cost estimates related to the risk transfer or risk retention other than the following: losses, loss adjustment expenses that are combined with losses in the determination of the provision for losses, the provisions for profit and contingencies, the cost of capital, investment expenses, and federal and foreign income taxes. (ASOP No. 29)

Expenses—**[1]** Administrative or investment fees or other payments borne or expected to be borne by the plan. (ASOP No. 4); **[2]** Administrative or investment expenses borne or expected to be borne by the benefit plan or retiree group benefits program. (ASOP No. 6)

Experience Factor—A numerical value or set of numerical values that reasonably represents recent actual experience for a policy form. Examples of experience factors include rates of mortality, expense, investment income, persistency, and taxes. (ASOP No. 24)

Experience Factor Class—A group of policies for which nonguaranteed elements are determined by using common values of a particular experience factor. (ASOP No. 24)

Experience Period—The period of time to which historical data used for actuarial analysis pertains. (ASOP Nos. 13 and 28)

Expert—**[1]** One who is qualified under the evidentiary rules applicable in the forum to testify as an expert, whether explicitly or by acceptance of the actuary's testimony. An actuary who has been engaged to testify, or permitted to testify, with the expectation that the actuary will ultimately qualify as an expert is treated as an expert for purposes of this standard, even if the actuary does not testify or is later determined not to qualify as an expert. (ASOP No. 17) **[2]** One who is qualified by knowledge, skill, experience, training, or education to render an opinion concerning the matter at hand. (ASOP Nos. 38 and 45)

Explicit Risk Margin—An explicit provision for uncertainty in a reserve. (ASOP No. 36)

Exposure Base—A basic unit that is used to measure the future cost of risk transfer and risk retention. This unit can vary by element of cost. (ASOP No. 53)

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. (ASOP Nos. 5 and 42)

F

Federally Qualified Health Center (FQHC)—An organization that (1) receives grants under Section 330 of the Public Health Service Act; (2) does not receive a grant under the Section 330 of the Public Health

Service Act, but otherwise meets all requirements to receive such a grant; or (3) is an outpatient health clinic associated with tribal or Urban Indian Health Organizations (UIHO). The organization must have also applied for recognition, and been approved as a federally qualified health center for Medicare and Medicaid, as described in Sections 1861(aa)(3) and 1905(1)(2) of the Social Security Act. Payments to these organizations are subject to requirements set forth in Section 2901 (bb) of the Social Security Act. (ASOP No. 49)

Fee Structure—A combination of fees that includes advance fees and periodic fees, and that may include additional fees. (ASOP No. 3)

Filing Actuary—An actuary who prepares, supervises the preparation of, or peer reviews a health filing on behalf of a health plan entity. This includes actuaries employed by the health plan entity and consulting actuaries. This does not include a “reviewing actuary,” as defined in section 2.9. (ASOP No. 8)

Financial Adequacy—A condition in which program costs are projected not to exceed the sum of program income and program assets over a specified period of time. (ASOP No. 32)

Financial Audit—An evaluation of financial statements or internal controls over financial reporting by an auditor, conducted under generally accepted auditing standards, with a view to expressing an opinion on whether the financial statements are presented fairly in all materials respects within the applicable financial reporting framework or on the effectiveness of the entity’s internal controls over financial reporting. (ASOP No. 21)

Financial Examination—An evaluation of an entity’s financial condition by an examiner. It will generally include a review of the financial statement and will often include a review of financial strength, corporate governance, or management oversight. (ASOP No. 21)

Financial or Personal Security System—A private or governmental entity or program that is intended to mitigate the impact of unfavorable outcomes of contingent events. Examples of financial or personal security systems include auto insurance, homeowners insurance, life insurance, and pension plans, where the mitigation primarily takes the form of financial payments; prepaid health plans and continuing care retirement communities, where the mitigation primarily takes the form of direct service to the individual; and other systems, where the mitigation may be a combination of financial payments and direct services. (ASOP No. 12)

Financial Projection—A projection of covered lives, premiums, claims, expenses, capital and surplus, or other financial quantities that may be required by applicable law. (ASOP No. 8)

Financial Report—A report that conveys the performance or experience of an assuming entity or ceding entity at a specific point in time or over an accounting or measurement period. The financial report may be based on any financial reporting regime appropriate to the assignment. Examples of financial reports include, but are not limited to, statutory statements, own risk and solvency assessment (ORSA) reports, enterprise risk (ERM) reports, GAAP financial statements, asset adequacy analysis reports, and experience study reports. (ASOP No. 11)

Financial Review—An evaluation, by performing limited procedures, of financial statements or internal controls over financial reporting by an auditor, conducted under generally accepted auditing standards. The evaluation supports an auditor’s opinion on whether any material modifications should be made to the financial statements or to the entity’s internal controls over financial reporting. A financial review is often performed on interim financial statements. For this standard, a financial review does not include a review conducted for any other purpose, such as in support of a potential M&A or IPO transaction. (ASOP No. 21)

Financial Statements—Reports on the financial position and the financial activities of an entity, prepared in accordance with accounting requirements prescribed or permitted by insurance regulators and accounting standards. (ASOP No. 21)

Forecast Period—The future time period to which the historical data are projected. (ASOP No. 13)

Full Credibility—[1] The level at which the subject experience is assigned full predictive value, often based on a selected confidence interval. (ASOP No. 25); [2] The level at which a particular body of data is assigned full predictive value based on a selected confidence interval. (ASOP No. 40)

Funded Status—[1] Any comparison of a particular measure of plan assets to a particular measure of pension obligations. (ASOP No. 4); [2] Any comparison of a particular measure of plan assets to a particular measure of plan liabilities. (ASOP No. 6); [3] Any comparison of a particular measure of plan assets to a particular measure of plan obligations. (ASOP No. 51)

Funding Valuation—A measurement of pension obligations or projection of cash flows performed by the actuary intended to be used by the principal to determine plan contributions or to evaluate the adequacy of specified contribution levels to support benefit provisions. (ASOP Nos. 4 and 51)

G

GAAP Net Premium—The portion of gross premiums that provides for certain costs, as defined by authoritative GAAP guidance. (ASOP No. 10)

Gain and Loss Analysis—An analysis of the effect on the plan's funded status between two measurement dates resulting from the difference between expected experience based upon a set of assumptions and actual experience. (ASOP No. 4)

Generally Accepted Auditing Standards—Sets of standards promulgated by various standards-setting bodies by which audits or reviews are performed and against which the quality of audits or reviews may be judged. (ASOP No. 21)

General Administrative Expenses—Operational and administrative expenses (other than investment expenses) not specifically defined elsewhere in this section. (ASOP No. 29)

Governance—The structure of an organization's personnel, committees, and boards; the processes for review, referral, notification, escalation, and decision-making; and the identification of responsible parties for these processes. (ASOP No. 58)

Governance and Controls—The application of a set of procedures and an organizational structure designed to reduce the risk that the model output is not reliably calculated or not utilized as intended. (ASOP No. 56)

Graduation—The process of making adjustments to experience results in order to have a smooth progression in the mortality rates over the whole age range. (ASOP No. 48)

Granularity—The level of detail built into model components, such as time intervals, cell structure, or assumptions that vary by cell. (ASOP No. 52)

Gross Premium—Amounts contractually required to be paid or anticipated to be contributed by the policyholder. (ASOP No. 10)

Gross Premium Reserve—The actuarial present value of future benefits, expenses, and related amounts less the actuarial present value of future gross premiums and related amounts. (ASOP No. 22)

Gross Premium Reserve Test—The comparison of the gross premium reserve computed under one or more scenarios to the financial statement reserves and other liabilities. (ASOP No. 22)

Group—Affiliated group of individual entities, of which at least one is an insurer. (ASOP No. 55)

Guaranteed Element—A premium, value, charge, or benefit that limits an NGE. Guaranteed elements are specified in the policy. Examples of guaranteed elements include maximum premium charges, maximum expense charges, minimum credited interest rates, maximum cost of insurance charges, maximum gross premiums, minimum index parameters, maximum mortality and expense (M&E) risk charges, and maximum policy loan interest rates. (ASOP No. 2)

H

Health Benefit Plan—[1] 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. (ASOP No. 5, 28, and 42); [2] A contract or other financial arrangement providing hospital, medical, prescription drug, dental, vision, disability income, accidental death and dismemberment, long-term care, or other health-related benefits, whether on a reimbursement, indemnity, service benefit or other basis, irrespective of the type of health plan entity that provides the benefits. (ASOP No. 8); [3] A contract, such as an insurance policy, or other financial arrangement providing medical, prescription drug, dental, vision, disability income, long-term care, critical illness, accidental death and dismemberment, or other health-related benefits, whether on a reimbursement, indemnity, or service benefit basis, regardless of the form of the risk-bearing entity. (ASOP No. 11); [4] Any hospital or medical policy or certificate; medical expense insurance; or subscriber contract or contract of insurance provided by a prepaid hospital, medical service plan, or health maintenance organization. (ASOP No. 26).

Health Care Guarantee—A clause in a residency agreement or membership agreement guaranteeing access to health care and defining the type of health care services to be provided to the contractual resident or member. These health care services may be offered with or without adjustments to the periodic fees. (ASOP No. 3)

Health Center—A facility associated with a CCRC or At Home Program where health care is provided to contractual residents or members in accordance with the residency agreement or membership agreement. The facility typically includes some combination of assisted living, memory care, and nursing care units. Non-contractual residents may also live in the facility. (ASOP No. 3)

Health Filing—A required regulatory filing for health benefits, accident and health insurance, and entities providing health benefits, which requires projection of future contingent events, for rates or benefits, or financial projections. Rate or benefit filings include, but are not limited to, the following: (a) filings of manual rates and rating factors or underwriting manuals; (b) filings of rating methodology, such as experience rating formulas and factors; (c) statements of actuarial soundness or rate adequacy, as may be defined by the regulatory body, for future rating periods; (d) certification of benefit values, such as actuarial value or actuarial equivalence, for example, as required by the Affordable Care Act; and (e) other filings of similar nature as may be required by the regulatory body. Financial projection filings include, but are not limited to, any filings in which the financial projections are a stand-alone requirement, such as those for licensure requirements, or are a requirement of a broader filing, such as a rate filing or projections of future capital and surplus or other regulatory benchmark requirements. (ASOP No. 8)

Health Insurance Asset (Asset)—An asset included in the scope of the statement of actuarial opinion related to health benefit plans. Examples may include risk adjustment transfer payment receivables, pharmacy rebate receivables, provider settlement receivables, and Medicare Part D settlement receivables. (ASOP No. 28)

Health Insurance Liability (Liability)—A liability included in the scope of the statement of actuarial opinion related to health benefit plans. Examples may include unpaid claims liabilities, unpaid loss adjustment expenses, medical loss ratio rebates, liabilities for settlements of provider contracts, contract reserves, experience refund liabilities, premium deficiency reserves, premium stabilization reserves, and liabilities for reinsurance payable. (ASOP No. 28)

Health Insurance Plan—A contract or other financial arrangement providing hospital, medical, prescription drug, dental, or vision benefits, including self-insured employer plan. (ASOP No. 50)

Health Plan Entity—An insurance company, health maintenance organization, hospital or medical service organization, self-insured health benefit plan sponsor, governmental health benefit plan sponsor, or any other health benefit plan sponsor from which health filings are required. (ASOP No. 8)

Health Status Based—Using healthcare claims, pharmacy claims, lab test results, health risk appraisal or other data based on underlying conditions or treatment as well as demographic information such as age and gender. (ASOP No. 45)

Historical A/E Mortality Basis—Mortality assumptions developed from a base mortality table using information such as underwriting, multipliers, improvement factors, medical records and other pertinent information relevant to the individual life expectancies as of their associated underwriting dates. (ASOP No. 48)

Historical Contribution—The contribution a particular policy or class of similar eligible policies has made to the company's statutory surplus and asset valuation reserve in a given year. (ASOP No. 37)

Hold-Out Data—A subset of data that is withheld intentionally when developing a predictive model so that the model may be validated later with data that were not used to develop the model. (ASOP No. 56)

Home Care—Care received at the patient's home, such as part-time skilled nursing care, custodial care, speech therapy, physical or occupational therapy, part-time services of home health aides, or help from homemakers or chore workers. (ASOP No. 18)

Homogeneity—The degree to which the expected outcomes within a risk class have comparable value. (ASOP No. 12)

I

Illustrated Scale—A scale of non-guaranteed elements currently being illustrated that is not more favorable to the policyholder than the lesser of the disciplined current scale or the currently payable scale. (ASOP No. 24)

Illustration Actuary—An actuary who is appointed in accordance with the requirements set forth in the *Model*. (ASOP No. 24)

Immediate Gain Actuarial Cost Method—[1] An actuarial cost method under which actuarial gains and losses are included as part of the unfunded actuarial accrued liability of the pension plan, rather than as part of the normal cost of the plan. (ASOP No. 4); [2] An actuarial cost method under which actuarial gains and losses are included as part of the unfunded actuarial accrued liability of the retiree group benefits program, rather than as part of the normal cost of the retiree group benefits program. (ASOP No. 6)

Impaired Mortality—A mortality assumption that has been adjusted for impairments. (ASOP No. 48)

Impairment—A health factor or condition that tends to increase an insured's probability of death. (ASOP No. 48)

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 plans where the claim must exceed a minimum threshold, for example, where there is a deductible or elimination period, the incurral date may be the date claims begin to accumulate toward the threshold. (ASOP No. 5)

Incurred but not Reported (IBNR) Deaths—Adjustment to observed deaths in a given time period to account for deaths that have occurred but have not been reported due to the time lag in reporting systems or errors and incomplete information available from reporting sources regarding deaths. (ASOP No. 48)

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 and, for certain coverages such as long-term care and long-term disability, projection of future payments on reported claims. This definition is different than an alternate definition of incurred claims used for a risk-bearing entity's income statements, for which incurred claims include payments on all claims between the prior valuation date and the current valuation date plus the estimate of unpaid claims liabilities as of the current valuation date less the estimate of unpaid claims liabilities as of the prior valuation date. (ASOP No. 5)

Incurred Death—A death occurring during a period of exposure being analyzed, whether reported during that period or not. (ASOP No. 48)

Independent Living Unit—Living quarters designed for contractual residents capable of living independently. A contractual resident could receive home health care in the independent living unit, but a contractual resident who needs full-time health care on either a temporary or permanent basis is normally transferred to the health center. (ASOP No. 3)

Individual Policy—Any policy (or contract) that is defined as an individual policy under state insurance law or by the terms of the policy. Any certificate issued under any other policy that is sold to a passive trust but is marketed to individuals is also defined as an *individual policy* for purposes of this standard. (ASOP No. 33)

Inflation—General economic inflation, defined as price changes over the whole of the economy. (ASOP No. 27)

Initial Assets—The assets allocated to a closed block at its inception. The assets of the closed block may be either of the following: (a) a distinct segment of assets (which may contain either 100% or a specified fraction of each designated asset) associated exclusively with the closed block; or (b) a defined share of a larger segment of assets. Such larger segment may also contain assets associated with participating business sold after the date of conversion. Such defined share will vary from time to time according to the methodology specified in the operating rules. (ASOP No. 33)

Initial Liabilities—The obligations ascribed to the closed block at its inception by the operating rules. (ASOP No. 33)

Input—[1] Data or assumptions used in a catastrophe model to produce output. (ASOP No. 38); [2] Data or assumptions used in a model to produce output. (ASOP No. 56)

Insurance Business—An enterprise involved in assuming insurance risk, such as one or any combination of the following: insurance company or health maintenance organization; a collection of policies or contracts in-force that cover insurance risk; and a distribution system that sells such policies or contracts. (ASOP No. 19)

Insurance Cash Flows—Funds from premiums and miscellaneous (non-investment) income from insurance operations, and payments for losses, expenses, and policyholder dividends. Associated income taxes are recognized when the analysis is on a post-tax basis. (ASOP No. 30)

Insurance Risk—The extent to which the amount or timing of actual insurance cash flows is likely to differ from expected insurance cash flows. (ASOP No. 30)

Insured—An individual whose life is covered by a life insurance policy. (ASOP No. 48)

Insurer—An entity that accepts the risk of financial losses or, for a specified time period, guarantees stated benefits upon the occurrence of specific contingent events, typically in exchange for a monetary consideration. For purposes of this standard, "insurer" also refers to an entity that sponsors LTC benefit plans that may be funded by sources other than premiums paid by the potential beneficiary. (ASOP No. 18)

Intended Audience—The persons to whom an appraisal report is directed and with whom the actuary, after discussion with the principal, intends to communicate. Unless otherwise specifically agreed, the principal is always a member of the intended audience. In addition, other persons or organizations, such as investors or regulators, may be designated by the principal, with consent of the actuary, as members of the intended audience. (ASOP No. 19)

Intended Purpose—[1] The goal or question, whether generalized or specific, addressed by the catastrophe model within the context of the assignment. (ASOP No. 38); [2] The goal or question, whether generalized or specific, addressed by the model within the context of the assignment. (ASOP No. 56)

Intended User—[1] Any person who the actuary identifies as able to rely on the actuarial findings. (ASOP Nos. 41 and 51); [2] Any person whom the actuary identifies as able to rely on the model output. (ASOP No. 56)

Intergovernmental Transfer (IGT)—A transfer of public funds between governmental entities (for example, county government to state government or state university hospital to state Medicaid agency.) (ASOP No. 49)

Internal Capital Assessment—A methodology used to calculate the assets in excess of liabilities necessary to withstand shocks based on an internal quantification of financial risk exposures. An internal capital assessment may indicate capital levels that are higher or lower than levels specified by regulators or rating agencies. (ASOP No. 58)

Investment Cash Flows—All cash flows related to investment operations, including investment purchases, sales, income, and expenses. (ASOP No. 20)

Investment Income—Proceeds (other than the return of principal) derived from the investment of assets, minus investment expenses. Associated income taxes are recognized when the analysis is on a post-tax basis. (ASOP No. 30)

Investment Income from Insurance Operations—The income associated with the investment of insurance cash flows. (This is sometimes referred to as *investment income on policyholder-supplied funds*.) (ASOP No. 30)

Investment Risk—The extent to which the level or timing of actual investment proceeds is likely to differ from what is expected. (ASOP No. 30)

J

Judge—The judicial officer presiding over a domestic relations action, or an arbitrator, mediator, or special master acting in a similar adjudicatory capacity. (ASOP No. 34)

K

Known—ASOPs frequently refer to circumstances, factors, practices of the principal, or other items that are known to the actuary. In many cases, the actuary must rely upon the principal and others acting on the principal's behalf to supply relevant information. Unless an ASOP clearly indicates otherwise, "known" means that the actuary had actual knowledge of the item in question at the time the actuary rendered actuarial services. (ASOP No. 1)

L

Level(s) of Care—Varying degrees of care based on a contractual resident's or member's health status. Typical levels of care include independent living, assisted living, nursing care, and memory care. The levels of care may be dictated by state licensure. (ASOP No. 3)

Leverage—A measure of the relative amount of risk to which capital is exposed, typically expressed as the ratio of an exposure measure (such as premium or liabilities) to the capital amount. (ASOP No. 30)

Liability—[1] Any commitment by, or requirement of, an organization that can reduce revenue cash flows or generate disbursement cash flows. (ASOP No. 7); [2] Any commitment by, or requirement of, an insurer that can reduce revenue cash flows or generate disbursement cash flows. (ASOP No. 22)

Liability for Future Policy Benefits—An accrued obligation to policyholders that relates to insured events, such as death or disability, measured as the present value of future policy benefits minus the present value of future GAAP net premiums. (ASOP No. 10)

Life Expectancy (LE)—The expected future lifetime of an insured. Two primary types of life expectancies, mean and median, are reported by LE providers in the life settlements market. (ASOP No. 48)

Life Expectancy Provider (LE Provider)—An entity that applies medical underwriting analysis to determine a mortality assumption or life expectancy. (ASOP No. 48)

Life Settlement—The life insurance policy or policies sold to an investor. The term “life settlement” includes viatical and other life settlements. Generally, a viatical life settlement is any life settlement where the insured has a life expectancy of less than two to three years depending on state regulation. (ASOP No. 48)

Living Unit—The various living quarters of a CCRC, including independent living units and health center units. (ASOP No. 3)

Lock-in—A requirement to continue using original basis assumptions (as set at issue, acquisition, or prior redetermination. (ASOP No. 10)

Long-Range Period—A period long enough to discern the general pattern and level of future costs. For some Programs this means a period long enough to cover the future lifetime of essentially all Program participants as of the valuation date. (ASOP No. 32)

Long-Term Care (LTC)— A wide range of health and social services, which may include adult day care, custodial care, home care, hospice care, intermediate nursing care, respite care, and skilled nursing care, but generally not care in a hospital. Long-term care is sometimes referred to as long-term services and supports (LTSS). (ASOP No. 18)

Long-Term Care Benefit Plan or (LTC Benefit Plan)—A policy, contract, or arrangement providing LTC benefits, either on a stand-alone basis or as part of a plan that provides other benefits as well (except where the LTC benefits are an immaterial feature). The plan may describe requirements for benefit eligibility, covered services, benefit amount, benefit payment duration (including short-term and long-term), maximum benefit amount, and other coverage features. (ASOP No. 18)

Long-Term Product—A health benefit 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 begin for several years after policy purchase and claims usually extend beyond the valuation date. (ASOP No. 5 and 42).

Loss—The cost that is associated with an event that has taken place and that is subject to coverage. It is also known as “claim amount.” The term “loss” may include loss adjustment expenses as appropriate (ASOP No. 36)

Loss Adjustment Expenses (LAE)—[1] The costs of administering, investigating, validating, estimating, settling, or defending claims. Such costs are also known as “claim adjustment expenses.” (ASOP No. 29); [2] The costs of administering, determining coverage for, settling, or defending claims even if it is ultimately determined that the claim is invalid. It is also known as “claim adjustment expense.” (ASOP No. 36)

M

Managed Care Organization (MCO)—The entity contracting with the state Medicaid agency to provide health care services for selected subsets of the Medicaid population. (ASOP No. 49)

Margin—An amount included in the assumptions, except when the assumptions are prescribed, used to determine the modeled reserve that incorporates conservatism in the calculated value consistent with the requirements of the various sections of the *Valuation Manual*. It is intended to provide for estimation error and adverse deviation. (ASOP No. 52)

Marital Property—Assets of the marital estate as determined under the laws and regulations of the applicable jurisdiction. (ASOP No. 34)

Market-Consistent Present Value—**[1]** An actuarial present value that is estimated to be consistent with the price at which benefits that are expected to be paid in the future would trade in an open market between a knowledgeable seller and a knowledgeable buyer. The existence of a deep and liquid market for pension cash flows or for entire pension plans is not a prerequisite for this present value measurement. (ASOP No. 4); **[2]** An actuarial present value that is estimated to be consistent with the price at which benefits that are expected to be paid in the future would trade in an open market between a knowledgeable seller and a knowledgeable buyer. The existence of a deep and liquid market for retiree group benefits program cash flows or for entire retiree group benefits programs is not a prerequisite for this present value measurement. (ASOP No. 6)

Market-Estimate Assumption—An assumption that represents what a typical market participant would use in assessing the amount the participant would pay to acquire a given asset, or the amount the participant would require to assume a given liability (also known as an “exit market” price). (ASOP No. 10)

Market Risk Benefit—A contract or contract feature in a long-duration contract issued by an insurance entity that both protects the contract holder from other-than-nominal capital market risk and exposes the insurance entity to other-than-nominal capital market risk by providing a benefit in excess of account value. (ASOP No. 10)

Market Value—The price that would be received to sell an asset in an orderly transaction between market participants at the measurement date (sometimes referred to as *fair value*). (ASOP No. 44)

Materiality—“Materiality” is a consideration in many aspects of the actuary’s work. An item or a combination of related items is material if its omission or misstatement could influence a decision of an intended user. When evaluating materiality, the actuary should consider the purposes of the actuary’s work and how the actuary anticipates it will be used by intended users. The actuary should evaluate materiality of the various aspects of the task using professional judgment and any applicable law (statutes, regulations, and other legally binding authority), standard, or guideline. In some circumstances, materiality will be determined by an external user, such as an auditor, based on information not known to the actuary. The guidance in ASOPs need not be applied to immaterial items. (ASOP No. 1)

Mean Life Expectancy—The average life expectancy based on the assumed survival curve. (ASOP No. 48)

Measurement Date—**[1]** The date as of which the values of the pension obligations and, if applicable, assets are determined (ASOP Nos. 4 and 51); **[2]** The date as of which the values of the retiree group benefits obligation and, if applicable, the assets are determined (sometimes referred to as the “valuation date”). (ASOP No. 6); **[3]** The date as of which the values of the pension obligations and, if applicable, assets are determined. (ASOP Nos. 27); **[4]** The date as of which the actuarial present value is determined. The measurement date may be different from the allocation date. (ASOP No. 34); **[5]** The date as of which the actuarial value of assets is determined (sometimes referred to as the *valuation date*). (ASOP No. 44)

Measurement Period—[1] The period subsequent to the measurement date during which the chosen assumptions or other model components will apply. The period often ends at the time the last participant is expected to receive the final benefit. (ASOP No. 6); [2] The period subsequent to the measurement date during which a particular assumption will apply in a given measurement. (ASOP No. 27)

Median Life Expectancy—The point in time, at which, based on the assumed survival curve, there is a 50% probability that the person will still be alive. (ASOP No. 48)

Medical Education Payments—Payments for graduate medical education as part of the rate structure for inpatient hospital payments or as supplemental payments under 42 CFR 447.272. These payments may include direct graduate medical education (GME) or indirect medical education (IME) costs. These payments may be included as part of Medicaid managed care capitation rates or may be made directly to providers for managed care enrollees. (ASOP No. 49)

Medicare Integration—The approach to determining the portion of a Medicare-eligible claim that is paid by the benefit plan, after adjustment for Medicare reimbursements for the same claim. Types of Medicare integration include the following:

- a. Full Coordination of Benefits (Full COB)—The health plan pays the difference between total eligible charges and the Medicare reimbursement amount, or the amount it would have paid in the absence of Medicare, if less.
- b. Exclusion—The health plan applies its normal reimbursement formula to the amount remaining after Medicare reimbursements have been deducted from total eligible charges.
- c. Carve-Out—The health plan applies its normal reimbursement formula to the total eligible charges, and then subtracts the amount of Medicare reimbursement. (ASOP No. 6)

Member—A person who has signed a membership agreement with an At Home Program. (ASOP No. 3)

Membership Agreement—A contract between one or more members and an At Home Program that describes the services to be provided, the obligations of the parties, the health care guarantee, and any refund guarantee. The contract is usually of long duration and may be for the life of each member. (ASOP No. 3)

Membership Rights—Any rights a member of a mutual company has by virtue of ownership of an insurance policy, other than the contractual insurance rights under the policy. Typical membership rights include voting rights and the rights, if any, the member has upon liquidation of the company. (ASOP No. 37)

Method—[1] A systematic procedure for estimating unpaid claims. (ASOP No. 43) [2] A systematic procedure for developing, reviewing, or revising future cost estimates or elements thereof. (ASOP No. 53)

Minimum Medical Loss Ratio—A provision that requires the MCO to use no less than a stated portion of its earned premium for defined medical or care management expenditures. (ASOP No. 49)

Minimum Reserve—The reserve described in section 2 of VM-20 that is based on one or more of the following calculations: net premium reserve, stochastic reserve, and deterministic reserve. (ASOP No. 52)

Minimum Value (MV) Requirement—The minimum required AV for certain employer-sponsored health insurance plans, as defined by regulations issued pursuant to the ACA. (ASOP No. 50)

Model—[1] A simplified representation of relationships among real world variables, entities, or events using statistical, financial, economic, mathematical, non-quantitative, or scientific concepts and equations. (ASOP No. 11); [2] A simplified representation of relationships among real world variables, entities, or events using statistical, financial, economic, mathematical, non-quantitative, or scientific concepts and equations. A model consists of three components: an information input component, which delivers data and assumptions to the model; a processing component, which transforms input into output; and a results component, which translates the output into useful business information.

(ASOP No. 38); **[3]** A mathematical or empirical representation of a specified phenomenon. (ASOP No. 43); **[4]** A simplified representation of relationships among real world variables, entities, or events using statistical, financial, economic, mathematical, or scientific concepts and equations. (ASOP No. 53); **[5]** A simplified representation of relationships among real world variables, entities, or events using statistical, financial, economic, mathematical, non-quantitative, or scientific concepts and equations. A model consists of three components: an information input component, which delivers data and assumptions to the model; a processing component, which transforms input into output; and a results component, which translates the output into useful business information. (ASOP No. 56)

Model Risk—**[1]** The risk that the methods are not appropriate to the circumstances or the models are not representative of the specified phenomenon. (ASOP No. 43); **[2]** The risk of adverse consequences resulting from reliance on a model that does not adequately represent that which is being modeled, or the risk of misuse or misinterpretation. (ASOP No. 56)

Model Run—The process of transforming a particular set of input to a particular set of output in a model. A model run could include the whole transformation process or part of the process, as applicable. (ASOP No. 56)

Model Segment—A group of policies and associated assets that are modeled together to determine the path of net asset earned rates. (ASOP No. 52)

Modeling Cell—**[1]** A group of policies or assets that are treated in a model as being completely alike with regard to relevant risk factors and contractual provisions and that may, therefore, be represented by a single composite policy or asset. (ASOP No. 52); **[2]** Policies or contracts that are treated in a model as being completely alike with regard to, for example, demographic characteristics, assumptions, policy provisions, and underwriting class. (ASOP No. 54)

Moderately Adverse Conditions—**[1]** Conditions that include one or more unfavorable, but not extreme, events that have a reasonable probability of occurring during the testing period. (ASOP No. 22); **[2]** Conditions that include one or more unfavorable, but not extreme, events that have a reasonable probability of occurring. (ASOP No. 28)

Modification Factor—A factor that is used to adjust standard mortality to reflect rating classification. This may include such items as flat extras, mortality multiples and age ratings. (ASOP No. 48)

Modified A/E Mortality Basis—Mortality assumptions other than the historical A/E basis. Use of this basis may result in life expectancy estimates that differ from those originally provided. (ASOP No. 48)

Morbidity—**[1]** The incurral of an illness or disability requiring the transfer to a different level of care. The permanent transfer rates and the temporary transfer rates together comprise the rate of morbidity. (ASOP No. 3); **[2]** The incidence of or resource use associated with a medical condition or group of conditions. (ASOP No. 45)

Mortality Assumption—A set of values representing mortality rates or the survival curve period by period. This may reflect an assumption of future mortality improvement or deterioration or modification factors. This term may apply to either a single insured or group of insureds. (ASOP No. 48)

Mortality Multiple—A modification factor typically determined from a debit/credit underwriting methodology. (ASOP No. 48)

Mutual Company—A mutual life insurance company, or a mutual holding company formed in conjunction with the demutualization of a mutual life insurance company. (ASOP No. 37)

MV Calculator (MVC)—Data and methodology released by HHS that is used to determine whether the MV requirement is met. (ASOP No. 50)

MVC-AV—The AV calculated using the MVC, including any adjustments for non-standard plan designs. (ASOP No. 50)

N

Net GAAP Liability—The GAAP policy benefit liability less any associated intangible balances, such as DPAC, VOBA, and DSI. (ASOP No. 10)

Net Liabilities—Reserves (net of reinsurance reserve credits), plus any other liabilities (such as amounts due the assuming entity), less any other assets arising from a reinsurance program (such as amounts receivable from the assuming entity or deferred acquisition costs), for the reinsured block of business. (ASOP No. 11)

Net Premium Reserve—The amount determined in section 3 of VM-20. (ASOP No. 52)

Net Retained Business—The portion of the business written or assumed by the ceding entity that is not subject to the reinsurance program. (ASOP No. 11)

Non-Contractual Resident—A person living in the CCRC without a health care guarantee and without a refund guarantee. Non-contractual residents normally pay for all health care services received on a fee for service basis. Examples of non-contractual residents are rental or lease residents, and direct admissions to the health center. (ASOP No. 3)

Nonforfeiture Benefits—Benefits that are available if premiums are discontinued. (ASOP No. 18)

Nonguaranteed Element (NGE)—[1] Any premium, charge, or benefit within an insurance policy that 1) affects policy costs or values, 2) is not guaranteed in the policy, and 3) can be changed at the discretion of the insurer. An NGE may provide a more favorable value to the policyholder than a guaranteed element. For the purpose of this ASOP, an NGE reflects expectations of future experience as opposed to, for example, a dividend, which reflects participation in past experience. Examples of premiums, charges, or benefits that can be changed at the discretion of the insurer may include credited interest, cost of insurance (COI) charges, bonuses, indeterminate premiums, index parameters used to determine credited interest, and expense charges. (ASOP No. 2); [2] Any element within an insurance policy that affects policy costs or values that is not guaranteed or not determined at issue. A nonguaranteed element may provide a more favorable value to the policyholder than that guaranteed at the time of issue of the policy. Examples of nonguaranteed elements include policy dividends, excess interest credits, mortality charges, expense charges, indeterminate premiums, and index parameters such as cap rates and participation rates. (ASOP No. 24)

NGE Framework—[1] The determination policy, methodology for establishing policy classes, and any additional practices, methods, and criteria used by the insurer to determine NGE scales that might not be part of the determination policy or methodology for establishing policy classes. (ASOP No. 2); [2] The structure by which the insurer determines nonguaranteed elements. This includes the assignment of policies to experience factor classes, the method of allocating income and costs, and the structure of the formulas or other methods of using experience factors. For participating policies, this would include the dividend framework defined in ASOP No. 15. For life policies within the scope of ASOP No. 2, the nonguaranteed element framework would include the concepts of policy class, determination policy, and anticipated experience factors. (ASOP No. 24)

NGE Scale—For each NGE, a series of one or more rates or values as determined by the insurer at a point in time. The elements of an NGE scale may vary by one or more parameters or may not vary by any parameter. Examples include the following:

- a. COI rates that could vary based on issue age, underwriting class, and duration;
- b. an expense load that could vary by duration and be applicable over a limited number of policy years; and
- c. an interest rate that does not vary by any parameter. (ASOP No. 2)

Nonguaranteed Reinsurance Elements—Any premium, charge, or benefit within a reinsurance program that affects reinsurance costs or values, is not guaranteed in the reinsurance program, and can be

changed at the discretion of the assuming entity or service provider. A nonguaranteed reinsurance element may provide a more favorable value to the ceding entity than an element that is guaranteed in the policy. Examples of nonguaranteed reinsurance elements are the premiums in a yearly renewable term reinsurance agreement that are defined as nonguaranteed and service provider fees that can be contractually changed. (ASOP No. 11)

Nonproportional Feature—A feature of a reinsurance agreement that makes the assuming entity's loss experience disproportionate to that of the ceding entity, such as the assuming entity agreeing to reimburse the ceding entity for losses above a predetermined aggregate level and up to an aggregate reimbursement limit. Other examples of such nonproportional features include aggregate claim limits, deductibles, limited coverage periods, stop-loss coverage, layers of claims covered (such as claims starting and ending at defined levels), and separate but related reinsurance agreements (i.e., where the results of one reinsurance agreement affect the operation of the other). (ASOP No. 11)

Non-Standard Plan Designs—Plan designs that include benefits not reflected in the AVC or MVC. (ASOP No. 50)

Normal Cost—The portion of the actuarial present value of projected benefits (and expenses, if applicable) that is allocated to a period, typically twelve months, under the actuarial cost method. Under certain actuarial cost methods, the normal cost is dependent upon the actuarial value of assets. (ASOP Nos. 4, 6 and 51)

Normative Database—Data compiled from sources that are expected to be typical of the retiree group benefit program, rather than from plan-specific experience. Examples of normative databases include published mortality and disability tables, proprietary premium manuals, and experience on similar retiree group benefit programs. (ASOP No. 6)

Nursing Home—A facility that provides skilled, intermediate, or custodial care. (ASOP No. 18)

O

Occupancy Rate—The number of occupied units at each level of care by contractual and non-contractual residents, relative to available units. (ASOP No. 3)

Operating Profit—The sum of underwriting profit, miscellaneous (non-investment) income from insurance operations, and investment income from insurance operations. Associated income taxes are recognized when the analysis is on a post-tax basis. (ASOP No. 30)

Operating Rules—All portions of the plan of conversion that specify the methods and procedures for setting up, maintaining, and monitoring the operations of a closed block. (ASOP No. 33)

Oral Communication—An actuarial communication made orally that has not, to the knowledge of the actuary, been recorded or transcribed verbatim. Such an oral communication is an actuarial communication but is not an actuarial document. (ASOP No. 41)

Organization—[1] An entity that accepts, self-insures, or retains the risk of financial losses or guarantees stated benefits upon the occurrence of specific contingent events. Examples include insurance companies, risk-bearing healthcare provider organizations, health maintenance organizations, securitization vehicles, and self-insured employers or corporations. (ASOP No. 7) [2] The entity or entities to which the ERM framework applies. Examples include public or private companies (individual or a group), government entities, and associations, whether for profit or not for profit. Components of an ERM framework may function differently at the company level or be unified across the whole group. (ASOP No. 58)

ORSA Report—A summary of an ORSA addressed to senior management and boards. It may also be submitted to insurance regulators. (ASOP No 58)

Other Acquisition Expenses—Costs, other than commission and brokerage fees, associated with the acquisition of business. (ASOP No. 29)

Other Cash Flows—All cash flows not characterized as underwriting cash flows or investment cash flows. Examples include shareholder dividends, capital contributions, income taxes, and non-risk bearing fee income. (ASOP No. 20)

Other User—[1] Any user of an appraisal report who is not a principal or member of the intended audience. (ASOP No. 19); [2] Any recipient of an actuarial communication who is not an intended user. (ASOP No. 41)

Output—[1] The results of the catastrophe model including, but not limited to, point estimates, likely or possible ranges, and data or assumptions (as input for other models), behavioral expectations, or qualitative criteria on which decisions could be based. (ASOP No. 38); [2] The results of a model including, but not limited to, point estimates, likely or possible ranges, data or assumptions (as input for other models), behavioral expectations, or qualitative criteria on which decisions could be made. (ASOP No. 56)

Output Smoothing Method—[1] A method to reduce volatility of the results of a contribution allocation procedure. The output smoothing method may be a component of the contribution allocation procedure or may be applied to the results of a contribution allocation procedure. Output smoothing methods include techniques such as 1) phasing in the impact of assumption changes on contributions, 2) blending a prior valuation with a subsequent valuation to determine contributions, or 3) placing a corridor around changes in the dollar amount, contribution rate, or percentage change in contributions from year to year. An output smoothing method may involve a combination of techniques. For purposes of this standard, an asset valuation method is not an output smoothing method. (ASOP No. 4); [2] A method used by the actuary to adjust the results of a contribution allocation procedure to reduce volatility. (ASOP No. 6)

Overfitting—A situation where a model fits the data used to develop the model so closely that prediction accuracy materially decreases when the model is applied to different data. (ASOP No. 56)

Own Risk and Solvency Assessment (ORSA)—An internal assessment of the adequacy of an organization's risk management and current and prospective solvency position, including action plans produced from the assessment. ORSA is a widely recognized key component of the ERM frameworks of many insurance organizations. ORSA is a requirement in most insurance regulatory regimes globally, although in some regimes it is not mandated for certain organizations. Nevertheless, some organizations elect to perform non-mandated ORSAs. (ASOP No. 58)

ORSA Report—A summary of an ORSA addressed to senior management and boards. It may also be submitted to insurance regulators. (ASOP No. 58)

P

Parameter—[1] A type of statistical, financial, economic, mathematical, or scientific value that is used as input to catastrophe models. Examples of parameters include expected values in probability distributions and coefficients of formula variables. (ASOP No. 38); [2] A type of statistical, financial, economic, mathematical, or scientific value that is used as input to certain types of models. Examples of parameters include expected values in probability distributions and coefficients of formula variables. Some types of models, such as predictive or statistical models, produce estimates of parameters as output, which may be used as input to other models. (ASOP No. 56)

Parameter Risk—The risk that the parameters used in the methods or models are not representative of future outcomes. (ASOP No. 43)

Participant—[1] An individual who satisfies the requirements for participation in the plan. (ASOP Nos. 4 and 51); [2] An individual who (a) is currently receiving benefit coverage under a retiree group benefits program, (b) is reasonably expected to receive benefit coverage under a retiree group benefits

program upon satisfying its eligibility and participation requirements, or (c) is a dependent of an individual described in (a) or (b). (ASOP No. 6)

Participant Contributions—Payments made by a participant to a retiree group benefits program. (ASOP No. 6)

PBR Actuarial Report—The supporting information prepared by the company as required by VM-31. (ASOP No. 52)

Performance Incentive—A payment mechanism under which an MCO may receive funds in addition to the capitation rates for meeting targets specified in the contract between the state and the MCO. (ASOP No. 49)

Performance Withhold—An amount included in the capitation rates that is paid if the MCO meets certain state requirements that may be related to quality or operational metrics. The amount may be withheld or paid up front with the monthly capitation rate. (ASOP No. 49)

Periodic Cost—**[1]** The amount assigned to a period using a cost allocation procedure for purposes other than funding. This may be a function of pension obligations, normal cost, expenses, or assets. In many situations, periodic cost is determined for accounting purposes. (ASOP No. 4); **[2]** The amount assigned to a period using a cost allocation procedure for purposes other than funding. This may be a function of plan obligations, normal cost, expenses, and assets. In many situations, periodic cost is determined for accounting purposes. (ASOP No. 6)

Periodic Fee—Amounts payable periodically (usually monthly) by a contractual resident or member. The amounts are typically adjusted from time to time to reflect changes in operating costs. (ASOP No. 3)

Permanent Transfer—A move from one level of care to another level of care without expectation of returning to the former level of care. (ASOP No. 3)

Physical Property—Physical assets, such as land, building, furniture, fixtures, or equipment. These assets, excluding land, are assumed to depreciate over their respective lifetimes. These assets are also referred to as the fixed assets. (ASOP No. 3)

Plan of Conversion—The plan under which a mutual company converts to a stock company. (ASOP No. 37)

Plan Provisions—The relevant terms of the plan document and any relevant administrative practices known to the actuary. (ASOP No. 4)

Plan Sponsor—An organization that establishes or maintains a retiree group benefits program. Examples of plan sponsors include employers and Taft-Hartley Boards of Trustees. (ASOP No. 6)

Policies—Individual participating policies and contracts for life insurance, disability insurance and annuities, and group certificates for these same types of business that operate in substantially the same manner as individual participating policies and contracts. (ASOP No. 15)

Policy— **[1]** An individual life insurance policy, an individual annuity contract, or a group certificate that has NGEs that operate in substantially the same manner as NGEs in an individual life insurance policy or an individual annuity contract. A policy includes any attached rider or endorsement. (ASOP No. 2); **[2]** Unless otherwise specified, the term *policy* (and its plural form, *policies*) in this standard includes both insurance policy and annuity contract. In some demutualizations it may also include supplementary contracts. (ASOP No. 37)

Policy Benefit Liability—An accrued obligation to policyholders that relates to the payment of future costs (including unpaid claim reserves for incurred and future claims) and amounts accrued for unearned revenue. (ASOP No. 10)

Policy Class—Policies that are grouped together for the purposes of determining an NGE. (ASOP No. 2)

Policy Factor—Financial components of a policy based on the guarantees or actuarial components underlying the policy. Examples of policy factors include cash values, reserves and their associated

net premiums, gross premiums, policy loan interest rates, and the rates of interest, mortality, and morbidity used in calculating cash values or reserves. (ASOP No. 15)

Policyholder Dividends—Nonguaranteed returns of premium or distributions of surplus. (ASOP No. 29)

Pooled Health Plan—A health benefit plan in which premiums are based at least in part on the claims experience of groups other than the group being valued. The use of projection assumptions that are not based solely on the claims experience of the group being valued (for example, the health care cost trend rate assumption) would not by itself create a pooled health plan. (ASOP No. 6)

Population Projection—An estimate of the expected number of contractual residents or members at various future times. (ASOP No. 3)

Practical—Realistic in approach, given the purpose, nature, and scope of the assignment and any constraints, including cost and time considerations. (ASOP No. 12)

Practical or Practicable—ASOPs frequently call upon actuaries to undertake certain inquiries, perform certain analytical tests, or make disclosures if it is “practical” or “practicable” to do so. These terms are intended to suggest that all possible steps need not always be taken to complete an assignment. A professional assignment frequently requires the actuary to adopt a course of action that is likely to yield an appropriate result without being unnecessarily time-consuming, elaborate, or costly relative to the principal’s needs. Thus, it is appropriate for the actuary, exercising professional judgment, to decide that the circumstances surrounding a particular assignment are such that it would not be necessary to undertake a particular task. (Note: ASOPs commonly use “practical” and “practicable” interchangeably.) (ASOP No. 1)

Premium—The price charged by a risk-bearing entity, such as an insurance or managed care company, to provide risk coverage. (ASOP No. 6)

Premium Deficiency—A condition that exists when the sum of the net GAAP liability and the present value of future gross premiums is less than the present value of future benefits and expenses using current best-estimate assumptions. (ASOP No. 10)

Premium Deficiency Reserve—A liability representing the deficiency, if any, in future revenues and current reserves less future claims and related expenses. (ASOP No. 42)

Prescribed Asset Valuation Method—A specific asset valuation method that is mandated by law, regulation, or other binding authority. For purposes of this standard, the plan sponsor would be considered a binding authority to the extent that law, regulation, or accounting standards give the plan sponsor responsibility for selecting such an asset valuation method. (ASOP No. 44)

Prescribed Assumption or Method Set by Another Party—**[1]** A specific assumption or method that is selected by another party, to the extent that law, regulation, or accounting standards gives the other party responsibility for selecting such an assumption or method. For this purpose, an assumption or method selected by a governmental entity for a plan that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is deemed to be a prescribed assumption or method set by another party. (ASOP Nos. 4 and 51); **[2]** A specific assumption or method that is selected by another party, to the extent that law, regulation, or accounting standards gives the other party responsibility for selecting such an assumption or method. For this purpose, an assumption or method set by a governmental entity for a retiree group benefits program that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is deemed to be a prescribed assumption or method set by another party. (ASOP No. 6); **[3]** A specific assumption or method that is selected by another party, to the extent that law, regulation, or accounting standards give the other party responsibility for selecting such an assumption or method. For this purpose, an assumption or method selected by a governmental entity for a plan that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is a prescribed assumption or method set by another party. (ASOP Nos. 27)

Prescribed Assumption or Method Set by Law—[1] A specific assumption or method that is mandated or that is selected from a specified range or set of assumptions or methods that is deemed to be acceptable by applicable law (statutes, regulations, or other legally binding authority). For this purpose, an assumption or method set by a governmental entity for a plan that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is not deemed to be a prescribed assumption or method set by law. (ASOP No. 4); [2] A specific assumption or method that is mandated or that is selected from a specified range or set of assumptions or methods that is deemed to be acceptable by applicable law (statutes, regulations, and other legally binding authority). For this purpose, an assumption or method set by a governmental entity for a retiree group benefits program, which such governmental entity or a political subdivision of that entity directly or indirectly sponsors, is not deemed to be a prescribed assumption or method set by law. (ASOP No. 6); [3] A specific assumption or method that is mandated or that is selected from a specified range or set of assumptions or methods that is deemed to be acceptable by applicable law. For this purpose, an assumption or method selected by a governmental entity for a plan that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is not a prescribed assumption or method set by law. (ASOP No. 27)

Pricing—The process of determining charges for, and benefits provided by, an insurance policy or annuity contract at issue, including evaluating the product’s profitability and underlying risks. Examples of charges include premiums, cost of insurance charges, separate account charges, surrender charges, and policy fees. Examples of benefits include death benefits, surrender benefits, interest credits, dividends, and income benefits. (ASOP No. 54)

Pricing Valuation—A measurement of pension obligations or projection of cash flows performed by the actuary to estimate the impact of proposed changes to plan benefit provisions on the plan contributions or to determine whether the proposed benefit provisions are supportable by specified contribution levels. (ASOP No. 51)

Principal—[1] A client or employer of the actuary. (ASOP Nos. 1, 41, 44, and 51); [2] Subject to the rules of evidence and procedure and any other rules applicable in the forum, the client or employer of the actuary with regard to the expert testimony, depending on the facts and circumstances surrounding the engagement. (ASOP No. 17); [3] The actuary’s client or employer. (ASOP No. 19); [4] The actuary’s client or employer. In situations where the actuary has both a client and an employer, as is common for consulting actuaries, the facts and circumstances will determine whether the client or the employer (or both) is the principal with respect to any portion of this standard. (ASOP No. 43)

Principle-Based Reserve—A reserve amount that results from a principle-based valuation, which is defined in the NAIC’s model *Standard Valuation Law*.

Process Risk—The risk associated with the projection of future contingencies, that are inherently variable, even when the parameters are known with certainty. (ASOP No. 43)

Professional Judgment—Actuaries bring to their assignments not only highly specialized training, but also the broader knowledge and understanding that come from experience. For example, the ASOPs frequently call upon actuaries to apply both training and experience to their professional assignments, recognizing that reasonable differences may arise when actuaries project the effect of uncertain events. (ASOP No. 1)

Profitability Analysis—An evaluation of a product’s expected financial results using a set of assumptions, a specified model, and specified profitability metric(s). (ASOP No. 54)

Profitability Metric—A measurement used to assess a product’s projected level of financial results. (ASOP Nos. 2 and 54)

Program—[1] A term used interchangeably with Social Insurance Program. (ASOP No. 32); [2] Health benefit programs including but not limited to commercial and employer sponsored health insurance,

self-funded employer health insurance, and government sponsored health insurance, such as Medicaid and Medicare. (ASOP No. 45)

Program Assets—The investments held by the trust fund and any cash balance available to meet Program costs. (ASOP No. 32)

Program Cost—The Program’s expenditures for benefits (sometimes referred to as “claim costs”) and administrative or general expenses. The amount required to attain and maintain a target trust fund level may also be included in Program cost. (ASOP No. 32)

Program Income—The Program’s earmarked tax income, investment income, premiums, general fund revenue, and any other receipts and income. (ASOP No. 32)

Projection Method—The application of an adjusted historical claim metric to an appropriate exposure base, in order to estimate incurred claims. (ASOP No. 5)

Providers—[1] 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. (ASOP No. 5 and 42).

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. (ASOP No. 42)

Provision for Adverse Deviation—An explicit amount to make some provision for uncertainty in an asset or liability. This sometimes is called a provision for uncertainty or a margin for uncertainty. (ASOP No. 28)

Prudent Estimate Assumption—A risk factor assumption developed by applying a margin to the anticipated experience assumption for that risk factor. (ASOP No. 52)

Q

Qualified Actuary—An individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the *Valuation Manual*. (ASOP No. 52)

R

Rate—An estimate of the expected value of future costs. (ASOP No. 30)

Rate of Investment Return—Investment income earned on funds held over time, expressed as a percentage of those funds. (ASOP No. 8)

Rating Period—The time period for which managed care Medicaid capitation rates are being developed. (ASOP No. 49)

Reasonable—In many instances, the ASOPs call for the actuary to take “reasonable” steps, make “reasonable” inquiries, select “reasonable” assumptions or methods, or otherwise exercise professional judgment to produce a “reasonable” result when rendering actuarial services. The intent is to call upon the actuary to exercise the level of care and diligence that, in the actuary’s professional judgment, is necessary to complete the assignment in an appropriate manner.

Because actuarial practice commonly involves the estimation of uncertain events, there will often be a range of reasonable methods and assumptions, and two actuaries could follow a particular ASOP, both using reasonable methods and assumptions, and reach different but reasonable results. (ASOP No. 1)

Reasonable Dividend Expectations—The expectations that the current dividend scale will be maintained if the experience underlying the current scale continues, and that the dividend scale will be adjusted appropriately if the experience changes. (ASOP No. 33)

Recalibration—The process of modifying the risk adjustment model, usually the risk weights. Recalibration is often used to make the risk adjustment model more specific to the population, data, and other characteristics of the project for which it is being used. (ASOP No. 45)

Recoverable—An amount (for example, deductibles, ceded reinsurance, salvage, or subrogation) that may be collected from a counterparty. (ASOP No. 36)

Refund Guarantee—A clause in a residency agreement or membership agreement that provides for a refund of any portion of the advance fee upon termination of the agreement. (ASOP No. 3)

Regulatory Benchmark—A measurement that may be used by the regulatory authority in evaluating a health filing. Possible benchmarks may include loss ratios, capital ratios, or actuarial values. (ASOP No. 8)

Reinsurance Agreement—An agreement whereby one or more elements of risk contained in insurance contracts or self-insured benefit plans are transferred from a ceding entity to an assuming entity in return for some consideration. (ASOP No. 11)

Reinsurance Assumed—Reinsurance as it affects the assuming entity under a reinsurance agreement. (ASOP No. 11)

Reinsurance Ceded—Reinsurance as it affects the ceding entity under a reinsurance agreement. (ASOP No. 11)

Reinsurance Program—The combination of the reinsurance agreement(s), its associated service contracts, and their implementation. Activities under a reinsurance program include but are not limited to sales, underwriting, claims adjudication, and administration, which might be affected by volume-based or performance-based fees or commissions. When using the term reinsurance program in this standard, the term will also include reference to similar risk transfer programs, such as employer stop-loss insurance, government-sponsored reinsurance pools and programs, or securitization products. (ASOP No. 11)

Reinvestment Rate—The assumed yield rate on assets to be purchased with the closed block's cash flows. (ASOP No. 33)

Relevant Experience—[1] Sets of data, that include data other than the subject experience, that, in the actuary's judgment, are predictive of the parameter under study (including but not limited to loss ratios, claims, mortality, payment patterns, persistency, or expenses). Relevant experience may include subject experience as a subset. (ASOP No. 25); [2] Experience that exhibits characteristics that are sufficiently similar to the characteristics of the liabilities, assets, and environments being simulated to make the experience appropriate, in the actuary's professional judgment, as a basis for determining the anticipated experience assumptions. (ASOP No. 52)

Reliance—Actuaries frequently rely upon others for information and professional judgments that are pertinent to an assignment. Similarly, actuaries often rely upon others to perform some component of an actuarial analysis. Accordingly, some ASOPs permit the actuary to rely in good faith upon such individuals, subject to appropriate disclosure of such reliance, if required by applicable ASOPs (for example, ASOP Nos. 23, *Data Quality*, and 41). (ASOP No. 1)

Required Capital—The minimum level of excess of assets over liabilities necessary to withstand shocks based on a quantification of financial risk exposures. Required capital may be based on internal calculations, regulatory requirements, or rating agency recommendations. (ASOP No. 58)

Reserve—An amount recorded in a financial statement or accounting system to reflect potential obligations. (ASOP No. 36)

Reserve Evaluation—The process of evaluating the reasonableness of a reserve. (ASOP No. 36)

Residency Agreement—A contract between one or more residents and a CCRC that includes a health care guarantee or a refund guarantee and describes the services to be provided and the obligations of the parties. The contract is usually of long duration and may be for the life of each contractual resident. (ASOP No. 3)

Residual Market Expenses—Assessments for the entity’s share of residual market profits or losses. (ASOP No. 29)

Responding Actuary—An actuary who is authorized by the entity to respond to the auditor or examiner on behalf of the entity being audited, reviewed, or examined with respect to specified elements of the entity’s financial audit, financial review, or financial examination that are based on actuarial considerations. Any given financial audit, financial review, or financial examination may involve one or more responding actuaries. (ASOP No. 21)

Retiree Group Benefits—Medical, prescription drug, dental, vision, legal, death, long-term care, or other benefits (excluding retirement income benefits) that are provided during retirement to a group of individuals, on account of an employment relationship. (ASOP 6)

Retiree Group Benefits Program—The program specifying retiree group benefits, including eligibility requirements, participant contributions, and the design of the benefits being provided. (ASOP No. 6)

Retirement Plan—An employment-related arrangement for determining the amount and timing of retirement benefit payments, eligibility for payments, etc. A retirement plan may be a defined benefit pension plan, a defined contribution plan, or a hybrid plan with both defined benefit and defined contribution elements. (ASOP No. 34)

Review—An informal examination of the obvious characteristics of data to determine if such data appear reasonable and consistent for purposes of the assignment. A review is not detailed as an audit of data. (ASOP No. 23)

Reviewing Actuary—[1] An actuary who is responsible for reviewing a health filing on behalf of a government agency or consumers. This includes actuaries employed by the government agency and consulting actuaries engaged to review a health filing on behalf of the government agency or consumers. (ASOP No. 8); [2] An actuary designated by the auditor or examiner to assist with the financial audit, financial review, or financial examination with respect to specified elements of the financial audit, financial review, or financial examination that are based on actuarial considerations. Any given financial audit, financial review, or financial examination may involve one or more reviewing actuary. (ASOP No. 21)

Review Date—The date (on or after the valuation date) through which material information known to the actuary is included in forming the statement of actuarial opinion. This date is sometimes known as the “information date.” (ASOP No. 36)

Risk(s)—[1] Individuals or entities covered by financial or personal security systems. (ASOP No. 12); [2] The potential of actual future measurements deviating from expected future measurements resulting from actual future experience deviating from actuarially assumed experience. For purposes of this ASOP, risk includes contribution risk. (ASOP No. 51)

Risk Adjustment—The process by which relative risk factors are assigned to individuals or groups based on expected resource use and by which those factors are taken into consideration and applied. (ASOP Nos. 45 and 49)

Risk Adjustment Data Validation (RADV)—The process of verifying the accuracy of information submitted for use in a risk adjustment model. (ASOP No. 42)

Risk Appetite—[1]The level of aggregate risk that an organization chooses to take in pursuit of its objectives. (ASOP No. 55); [2]The risks an organization is willing to accept in pursuit of its business objectives. Such risks may or may not be measurable or estimable. Risk appetite may refer to individual risks or risks in the aggregate. (ASOP No. 58)

Risk Appetite Framework—A framework used to identify, measure, and place limits on risks an organization is willing to accept in pursuit of its business objectives. (ASOP No. 58)

Risk Appetite Limit—The level that a risk measure should not exceed for the organization to remain within its risk appetite. Risk appetite limits may be applied in aggregate or specifically to a risk type. They may also apply at a line of business level, company level, or group level, possibly with different limits at each defined level. (ASOP No. 58)

Risk Appetite Statement—A statement by management of an organization (or a part of an organization) of its risk appetite. There may be several risk appetite statements pertaining to individual risks or a single statement across an organization. (ASOP No. 58)

Risk-Bearing Entity—The entity with respect to which the actuary is estimating liabilities 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, government-sponsored plans or risk contracts. (ASOP Nos. 5 and 42)

Risk Capital—The amount of capital a company chooses to hold to meet a business objective, given its risk profile. (ASOP No. 54)

Risk Capital Target—The preferred level of capital based on specified criteria, which is expressed as a function of a measure of risk. A risk capital target can be a single value or a range. There may be multiple risk capital targets based on different risk metrics at any one time. A risk capital target is aligned with the insurer's risk tolerance and may include individual company, regulatory, and rating agency developed targets. (ASOP No. 55)

Risk Capital Threshold—The minimum level of capital necessary for an entity to operate effectively based on specified criteria and expressed as a function of a measure of risk. There may be multiple risk capital thresholds based on different risk metrics at any one time. A risk capital threshold is aligned with the insurer's risk tolerance and may include individual company, regulatory, and rating agency developed thresholds or targets. (ASOP No. 55)

Risk Characteristics—Measurable or observable factors or characteristics that are used to assign each risk to one of the risk classes of a risk classification system. (ASOP Nos. 12 and 25)

Risk Class—A set of risks grouped together under a risk classification system. (ASOP No. 12)

Risk Classification—The process of establishing a system for evaluating, prioritizing, and cataloging risks, normally involving the creation of a risk inventory and an associated risk taxonomy. (ASOP No. 58)

Risk Classification System—A system used to assign risks to groups based upon the expected cost or benefit of the coverage or services provided. (ASOP Nos. 12 and 25)

Risk Factor—An aspect of future experience that is not fully predictable on the valuation date. (ASOP No. 52)

Risk Inventory—A regularly updated list of the risks to which an organization is exposed. Also commonly referred to as a risk register. (ASOP No. 58)

Risk Margin—A provision for uncertainty in a cash flow analysis, reflecting process risk, parameter risk, or model risk. A risk margin may be implicit or explicit. A risk margin is sometimes referred to as a risk load. (ASOP No. 20)

Risk of Adverse Deviation—The risk that actual experience may differ from best-estimate assumptions in a manner that produces costs higher than assumed or revenues less than assumed. (ASOP No. 10)

Risk Profile—The risks to which an organization is exposed over a specified period of time. (ASOP No. 55)

Risk Retention—**[1]** A risk-management and risk-control strategy for the assessment, management, or financing of retained risk associated with the specific coverage. Examples of risk retention include individual and group self-insurance and large deductible programs. (ASOP Nos. 20 and 29); **[2]** A risk-management and risk-control strategy for the assessment, management, or financing of retained risk associated with the specific coverage. Examples of risk retention include self-insurance and certain types of single parent captives. (ASOP No. 53)

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. (ASOP No. 42)

Risk Taxonomy—A tiered structure with broad risk classifications and more narrowly defined classifications to the level of granularity that is appropriate for the organization. Risk inventories typically use taxonomy to index their risks. (ASOP No. 58)

Risk Tolerance—The aggregate risk-taking capacity of an organization. (ASOP No. 55)

Risk Transfer—[1] A risk-management and risk-control strategy, involving legally binding agreements, that shifts responsibility from one party to another or indemnifies one party by another party for the financial obligations associated with the coverage. Examples of risk transfer include insurance, prospective reinsurance such as quota share or excess of loss treaties, and retroactive reinsurance such as loss portfolio transfers. (ASOP No. 20); [2] A risk-management and risk-control strategy, involving legally binding agreements, that shifts responsibility from one party to another or indemnifies one party by another party for the financial obligations associated with the coverage. Examples of risk transfer include insurance, reinsurance, captive insurance, and loss portfolio transfers. (ASOP Nos. 29); [2] A risk-management and risk-control strategy, involving legally binding agreements, that shifts responsibility from one party to another or indemnifies one party by another party for the financial obligations associated with the coverage. Examples of risk transfer include insurance, reinsurance, and loss portfolio transfers. (ASOP No. 53)

Risk Weight—The value assigned to each condition category that indicates the expected contribution of that condition category to an individual's estimated resource use. (ASOP No. 45)

Rural Health Clinic (RHC)—A clinic that meets certain requirements for providing primary care services in specific areas, as outlined in the Public Health Service Act and defined in Section 1905(l)(1) of the Social Security Act. Medicaid payment rates to RHCs may be specified in applicable law. (ASOP No. 49)

S

Scenario—[1] A set of economic and other assumptions used in performing cash flow analysis. (ASOP No. 7); [2] A set of economic and other assumptions used in asset adequacy analysis. (ASOP No. 22); [3] A projected sequence of events used in the cash flow model, such as future interest rates, equity performance, or mortality. (ASOP No. 52)

Scenario Analysis—A process for assessing the impact of one possible event or several simultaneously or sequentially occurring possible events. Scenario analysis may include a narrative description or numerical calculations. (ASOP No. 58)

Scenario Test—A process for assessing the impact of one possible event, or several simultaneously or sequentially occurring possible events, on a plan's financial condition. (ASOP No. 51)

Sensitivity Analysis—Analysis performed by changing an assumption or set of assumptions and comparing the results to those resulting from the baseline assumption(s). (ASOP No. 54)

Sensitivity Test—A process for assessing the impact of a change in an actuarial assumption on an actuarial measurement. (ASOP No. 51)

Sensitivity Testing—The process of calculating the effect of varying one or more assumptions. (ASOP No. 52)

Service Provider—An entity other than the assuming entity and ceding entity providing contractual services related to a reinsurance agreement, such as reinsurance intermediaries, managing general underwriters, captive manager, third-party administrators (TPAs), claims managers, investment advisors, investment managers, information technology providers (such as cloud data services and

credit reporting agencies), and trustees. (ASOP No. 11)

Significance/Significant—Significance can have different meanings. A result may be deemed to be statistically significant if it is determined that the probability that the result was produced by random chance is small. An event may be described as significant if the likelihood of its occurrence is more than remote. In addition, a result may be significant because it is of consequence. Other uses may be encountered in actuarial practice. The actuary should exercise care in interpreting or using these words. (ASOP No. 1)

Short-Range Period—A period long enough to encompass a complete economic cycle or planning cycle, whichever is appropriate. (ASOP No. 32)

Small Employer—Any person, firm, corporation, partnership, or organization that employs a number of eligible employees within a statutorily specified range that has an upper bound and that satisfies any other statutorily defined criteria. (ASOP No. 26)

Social Influences—The impact on insurance costs of societal changes such as changes in claim consciousness, court practices, and legal precedents, as well as in other noneconomic factors. (ASOP No. 13]

Social Insurance Program—A program with all of the following characteristics:

- a. key features, including benefits and financing method, are prescribed by statute or regulation;
 - b. financing is, in whole or in part, by contributions (for example, taxes or premiums) from or on behalf of individual participants according to a formula that may take into account the wages and other income of the individual participants but that does not take into account directly and fully the risk profile of, or the amount of potential future benefits payable to, the individual participants. These contributions may be supplemented by government income from other sources. Explicit accountability of benefit payments and income usually is provided in the form of a trust fund;
 - c. participation is universally (or almost universally) compulsory for a defined population, or the contribution is set at such a subsidized level that the vast majority of the eligible population participates;
 - d. eligible individuals are not required to demonstrate financial need to participate. However, certain program features could vary with individual circumstances. For example, a dependency status may need to be established, benefit reductions may apply to those who continue to work while receiving a benefit, or premium increases may apply to those who exceed an income threshold;
 - e. benefits for any individual are not directly related to contributions made by or with respect to that individual;
 - f. the system is administered or at least supervised by the government; and
 - g. the system is not established by the government solely for its present or former employees.
- (ASOP No. 32)

Spouse—A party to the domestic relations action who is not the covered party. Normally, the term refers to the current spouse or former spouse of the covered party, but may on occasion refer to a child (or children) or other party to the domestic relations action. (ASOP No. 34)

Spread Gain Actuarial Cost Method—**[1]** An actuarial cost method under which actuarial gains and losses are included as part of the current and future normal costs of the plan. (ASOP No. 4); **[2]** An actuarial cost method under which actuarial gains and losses are included as part of the current and future normal costs of the retiree group benefits program. (ASOP No. 6)

Starting Assets—A portfolio of assets that will be used to fund projected policy cash flows arising from the policies funded by those assets. (ASOP No. 52)

State Plan Services—The benefits provided to Medicaid beneficiaries who are eligible under a qualifying category of Medicaid assistance in a state. (ASOP No. 49)

Statutory Assessment Expenses—Mandated assessments that are permitted by applicable law to be included in the expense provisions. Statutory assessment expenses do not include residual market expenses. (ASOP No. 29)

Stochastic Analysis—Analysis performed using a model that estimates distributions of potential outcomes by allowing random variation in one or more inputs to the model. (ASOP No. 54)

Stochastic Modeling—A process for generating numerous potential outcomes by allowing for random variations in one or more inputs over time for the purpose of assessing the distribution of those outcomes. (ASOP No. 51)

Stochastic Reserve—The amount determined by applying a measure (e.g., a prescribed CTE level) to the distribution of scenario reserves over a broad range of stochastically generated scenarios and using prudent estimate assumptions for all assumptions not stochastically modeled. (ASOP No. 52)

Stop-Loss Coverage—Insurance protection providing reimbursement of all or a portion of claims in excess of a stated amount. Stop-loss coverage may be either individual or aggregate (sometimes referred to as excess loss coverage). (ASOP No. 6)

Stress Test—A process for assessing the impact of adverse changes in one or relatively few factors affecting a plan’s financial condition. (ASOP No. 51)

Stress Testing—A scenario analysis that measures the impact of adverse changes affecting an organization’s financial position. (ASOP No. 58)

Subject Experience—A specific set of data drawn from the experience under consideration for the purpose of predicting the parameter under study. (ASOP No. 25)

Subsequent Events—**[1]** Material events that occur after the valuation date and before the date the statement of actuarial opinion is signed. (ASOP No. 22 and 57); **[2]** Events (1) that have occurred since the end of the certification period and before the date of the certification, (2) that could materially affect current or future certifications rendered, and (3) about which the actuary has knowledge. (ASOP No. 26)

Sufficient—Containing enough data elements or records for the analysis. (ASOP 23)

Survival Curve—The probability data set representing the assumed probability of survival to the end of every period in the future for an insured. (ASOP No. 48)

Surviving Dependent—A dependent who qualifies as a participant under the retiree group benefits program following the death of the associated participant. (ASOP No. 6)

Survivor—A spouse or dependent who continues as a participant under the retiree group benefit plan following the death of a participating employee or retiree. (ASOP No. 6)

Sustainability—The capacity of a Social Insurance Program to continuously support the benefits provided by laws applicable to the Program, when considering the applicable financing mechanism and the potential future demographic and economic environment in which it will operate. (ASOP No. 32)

T

Tabular Method—The seriatim application of factors to 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 products). (ASOP No. 5)

Taxes, Licenses, and Fees—Taxes, license costs, and miscellaneous fees except federal and foreign income taxes. (ASOP No. 29)

Temporary Transfer—A move from one level of care to another level of care with the expectation of returning to the former level of care. (ASOP No. 3)

Testimony—Communication of opinions or findings presented in the capacity of an expert witness at trial, in hearing or dispute resolution, in deposition, by declaration or affidavit or by any other means through which testimony may be received. Such testimony may be oral or written. (ASOP No. 17)

Three Lines—A common model for governance of an organization’s ERM framework. The “first line” refers to business and process owners within the organization who own and manage risk. The “second line” identifies where there is separate oversight of risk taking activities, with some independence from the first line. The “third line” audits the effectiveness of the implemented ERM framework. “Three lines” is also known as “three lines of defense.” (ASOP No. 58)

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. (ASOP Nos. 5, 8, and 42)

Tontine—An outcome of a closed block in which relatively few last surviving policyholders receive dividends substantially disproportionate to those previously received by other policyholders in the same closed block, particularly policyholders who had persisted for a considerable period. (ASOP No. 33)

Total Return—The sum of operating profit and investment income on capital, usually after income taxes, often expressed in percentage terms. (ASOP No. 30)

Trend(s)—**[1]** Measure of rates of change, over time, that affects revenues, costs, or actuarial assumptions. (ASOP No. 3); **[2]** Measures of rates of change, over time, of the elements, such as cost, incidence, and severity, affecting the estimation of incurred claims. (ASOP No. 5); **[3]** A measure of the rate of change, over time, of the per capita benefit payments (ASOP No. 6); **[4]** Measures of rates of change, over time, of the elements, such as cost, incidence, and severity, affecting the estimation of certain assets or liabilities. (ASOP No. 42)

Trending Period—The time over which trend is applied in projecting from the experience period to the forecast period. (ASOP No. 13)

Trending Procedure—A process by which the actuary evaluates how changes over time affect items such as claim costs, claim frequencies, expenses, exposures, premiums, retention rates, marketing/solicitation response rates, and economic indices. Trending procedures estimate future values by analyzing changes between exposure periods (for example, accident years or underwriting years). A trending procedure does not encompass the process commonly referred to as “development,” which estimates changes over time in losses (or other items) within a given exposure period. (ASOP No. 13)

Trust Fund—An account to which income is credited and from which expenditures for benefits and often administrative or general expenses are deducted for a specified Program. (ASOP No. 32)

U

Underwriting—The process of evaluating medical and other information received on a given insured to determine modification factors reflecting risk classification for that insured. (ASOP No. 48)

Underwriting Cash Flows—All cash flows related to underwriting operations, including premiums, claims, claims expenses, and underwriting expenses. (ASOP No. 20)

Underwriting Expenses—All expenses except losses, loss adjustment expenses, investment expenses, policyholder dividends, and income taxes. (ASOP No. 30)

Underwriting Profit—Premiums less losses, loss adjustment expenses, underwriting expenses, and policyholder dividends. (ASOP No. 30)

Underwriting Profit Provision—The provision for underwriting profit in the actuarially developed rate, typically expressed as a percentage of the rate. (ASOP No. 30)

Unearned Premium Reserve—An amount established to reflect premiums that have been collected prior to the valuation date for coverage after the valuation date. (ASOP No. 42)

Unpaid Claim Estimate—The actuary's estimate of the obligation for future payment resulting from claims due to past events. (ASOP No. 43)

Unpaid Claim Estimate Analysis—The process of developing an unpaid claim estimate. (ASOP No. 43)

Unpaid Claims Liability—[1] The value of the unpaid portion of incurred claims, including unreported claims and reported but unpaid claims. For a risk-bearing entity's balance sheet, the unpaid claims liability includes provisions for unpaid claims incurred during the current and prior periods. (ASOP No. 5); [2] The value of the unpaid portion of incurred claims includes (a) unreported claims; (b) reported but unprocessed claims; and (c) processed but unpaid claims. For a risk-assuming entity's balance sheet, the unpaid claims liability includes provision for all unpaid claims incurred during the contract Period as of the current valuation date. (ASOP No. 42)

V

Valuation Basis—An accounting or economic framework for the recognition and measurement of assets and liabilities. (ASOP No. 55)

Valuation Date—[1] The date as of which the assets and liabilities of the CCRC or At Home Program are estimated. (ASOP No. 3); [2] The date as of which the liabilities are estimated. (ASOP No. 5); [3] The date as of which the assets or liabilities are estimated for the actuarial opinion provided. (ASOP No. 28); [4] The date(s) through which transactions are included in the data used in the analysis. (ASOP No. 36); [5] The date as of which the assets or liabilities are estimated. (ASOP No. 42); [6] The date when the reserve is to be valued as required by the *Standard Valuation Law*. (ASOP No. 52)

Valuation Mortality Table— A table prescribed for determining mortality rates within section 1 of VM-M of the *Valuation Manual* (ASOP No. 40)

Valuation Period—A defined period for which incurred claims are recorded. (ASOP No. 5)

Value of Business Acquired (VOBA)—The balance that arises in the application of GAAP purchase accounting as the difference between the reported value and the fair value of insurance contract liabilities, or comparable amounts determined in purchased insurance business combinations. (ASOP No. 10)

Voting Rights—The right to elect members of the board of directors of the mutual company and the right to vote on any proposed reorganization (including demutualization). (ASOP No. 37)

W

Withdrawal—The termination of a residency agreement or membership agreement by the contractual resident or member for reasons other than death. (ASOP No. 3)

X

X Factor Class—A group of policies under one or more plans of insurance to which a single set of X factors applies. (ASOP No. 40)

X Factors—The percentages that may be applied to select period mortality rates for the purpose of calculating deficiency reserves in the first segment only, for segments determined under the contract segmentation method defined in the *Model*. (ASOP No. 40)

APPENDIX 1: DEFINITIONS FROM CURRENT EXPOSURE DRAFTS OF THE ASB

Proposed Actuarial Standard of Practice, Pricing Reinsurance or Similar Risk Transfer Transactions Involving Life Insurance, Annuities, or Long-Duration Health Benefit Plans

Second Exposure, July 2026

Assuming Entity—An entity accepting risk from a ceding entity through a reinsurance transaction.

Ceding Entity—An entity transferring risk to an assuming entity through a reinsurance transaction.

Existing Reinsurance Transaction—A reinsurance transaction in which the assuming entity has priced and accepted risk or is already accepting risk through a reinsurance agreement.

Long-Duration Health Benefit Plan—An insurance policy or other financial arrangement that establishes health-related obligations for an extended period of time. Benefits may begin several years after plan inception or may extend for several years. Benefits may be on a reimbursement, indemnity, or service benefit basis. Examples of long-duration health benefit plans include long-term disability income, long-term care, and some critical illness and accidental death and dismemberment plans.

Model Output—Financial results generated from a model using a set of assumptions. Model output may be generated specifically for the pricing of the reinsurance transaction or another purpose such as an appraisal.

Nonguaranteed Reinsurance Element—An element of a reinsurance transaction that may be changed at the discretion of the assuming entity. Examples of nonguaranteed reinsurance elements may include yearly renewable term premiums, renewal rates or allowances, and reinsurance transaction termination.

Nonguaranteed Reinsurance Element Framework—The practices, methods, and criteria used by the assuming entity to determine nonguaranteed reinsurance elements.

Pricing—The process of determining initial or subsequent charges for, and benefits provided by, a potential reinsurance transaction or existing reinsurance transaction, including evaluating the profitability and underlying risks of the reinsurance transaction. Examples of potential charges and benefits include premiums, ceding commissions, allowances, death benefits, surrender benefits, indemnity benefits, income benefits, risk charges, and experience refunds.

Profitability Analysis—An evaluation of the expected or current financial results of a reinsurance transaction using a set of assumptions or actual experience, a specified model, and any specified profitability metrics.

Profitability Metric—A measurement used to assess the expected or current financial results of a reinsurance transaction. Examples of profitability metrics include internal rate of return, average return on equity, return on assets, profit margin, value of new business, embedded value, and break-even year.

Reinsurance Agreement—An agreement whereby one or more elements of risk contained in insurance contracts or self-insured benefit plans are transferred from a ceding entity to an assuming entity in return for some consideration.

Reinsurance Transaction—A transfer of one or more elements of risk through a reinsurance agreement. When the term “reinsurance transaction” is used in this standard, the term includes reference to similar risk transfer transactions, such as pension risk transfers, longevity swaps, financial reinsurance, retrocessions, and acquisitions of life, annuity, or long-duration health liabilities.

Risk Capital—The amount of capital a company chooses to hold to meet a business objective, given its risk profile.

Sensitivity Analysis—An analysis performed by changing an assumption or set of assumptions and comparing the results to those resulting from the baseline assumption(s).

Stochastic Analysis—An analysis performed using a model that estimates distributions of potential outcomes by allowing random variation in one or more inputs to the model.

Underlying Product—The source of the risk ceded in a reinsurance transaction. Examples of underlying products include life insurance, annuities, long-duration health benefit plans, pensions, and any associated riders.

Proposed Revision of ASOP No. 49 – Medicaid Managed Care Capitation Rates

Exposure Draft, May 2026

Actuarially Sound/Actuarial Soundness—Medicaid managed care capitation rates are actuarially sound if, when taken together with other applicable revenue sources and allowable special contract provisions related to payments, they are projected to provide for all reasonable, appropriate, and attainable costs.

Capitation Rate—A fee paid regardless of the number or actual cost of services provided under a system of reimbursement for MCOs. Capitation rates are generally paid monthly for each Medicaid managed care enrollee (“enrollee”) assigned or paid one time for each event (for example, maternity delivery) and can vary by individual based on demographics, location, covered services, or other characteristics.

Encounter Data—Information relating to the receipt of items or services by an enrollee that is documented through the submission of an administrative record to an MCO and shared between the MCO and the state Medicaid agency.

Enhanced, Value-Added, or Additional Benefits—Benefits offered by MCOs to their enrollees that are above and beyond state plan services or in-lieu-of services. Common examples are adult dental services, non-emergency transportation, and adult vision services.

In-Lieu-of Services—Benefits for services or settings approved as optional substitutes to state plan services.

Managed Care Organization (MCO)—An entity contracting with the state Medicaid agency to provide health care services for selected subsets of the Medicaid population. MCOs are sometimes known as “managed care plans (MCPs)”; “managed care entities (MCEs)”; “pre-paid in-patient health plans (PIHPs)”; and “pre-paid ambulatory health plans (PAHPs).”

MCO Actuary—An actuary providing actuarial services for an MCO.

Minimum Medical Loss Ratio—A provision that requires the MCO to use no less than a defined portion of its revenue for allowable benefit and non-benefit expenses as specified in the MCO contract.

MMC Program—A Medicaid managed care program.

Performance Incentive—A payment mechanism under which an MCO may receive funds in addition to the capitation rates for meeting targets specified in the MCO contract.

Performance Withhold—An amount included in the capitation rates that is contingent on the MCO meeting targets specified in the MCO contract that may be related to quality or operational metrics. The amount may be withheld from, or recouped if paid up front with, the monthly capitation rate.

Rating Period—The time period for which Medicaid managed care capitation rates are being developed.

Risk Adjustment—The process by which relative risk factors are assigned to individuals or groups based on expected resource use and by which those factors are taken into consideration and applied.

State Actuary—An actuary providing actuarial services on behalf of an MMC program.

State Plan Services—The benefits defined by the state and approved by Centers for Medicare and Medicaid Services (CMS), including benefits provided through waivers, that must be provided to enrollees who are eligible under a qualifying category of Medicaid assistance.

Proposed Revision of ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies

Exposure Draft, May 2026

Coding—The process of recording and submitting information (for example, diagnoses or services provided) on claims forms.

Credibility—A measure of the predictive value in a given application that the actuary attaches to a particular body of data (“predictive” is used here in the statistical sense and not in the sense of predicting the future).

Morbidity—The incidence of or resource use associated with a disability, medical condition, or group of conditions.

Program—Any health benefit program, including commercial and employer sponsored health insurance, self-funded employer health insurance, and government sponsored health coverage, such as Medicaid and Medicare.

Recalibration—The process of adjusting a risk adjustment model to be more specifically tailored to the population, data, or other characteristics of the program for which it is being used.

Risk Adjustment—The process of assigning relative risk factors (numerical risk factors are often called “risk scores”) to individuals or groups based on morbidity using a model and applying those factors using an implementation methodology.

Proposed Revision of ASOP No. 30, Profit Margins and Contingency Provisions in Property/Casualty Risk Transfer and Risk Retention

Second Exposure Draft, April 2026

Capital—The funds available to support payment of obligations from risk transfer or risk retention, in excess of the funds backing the liabilities.

Contingency Provision—A provision in the future cost estimate for anticipated shortfalls related to model or parameter risk. A contingency provision is not expected to be earned as profit.

Cost of Capital—The rate of return that capital could be expected to earn in alternative investments of equivalent risk; also known as opportunity cost.

Investment Income—Proceeds (other than the return of principal) derived from the investment of assets minus investment expenses.

Process Risk Margin—A provision in the future cost estimate for process risk. A process risk margin may be implicit or explicit.

Profit Provision—A provision in the future cost estimate for profit. The profit provision is the difference between all cash inflows and all cash outflows in the future cost estimate of the risk transfer or risk retention. The profit provision is also equal to the underwriting profit provision, plus the provision for investment income, minus the provision for income taxes, plus any process risk margins in the future cost estimate.

Risk Retention—A risk-management and risk-control strategy for the assessment, management, or financing of retained risk associated with the specific coverage. Examples of risk retention include individual and group self-insurance and large deductible programs.

Risk Transfer—A risk-management and risk-control strategy, involving legally binding agreements, that shifts responsibility from one party to another or indemnifies one party by another party for the financial obligations associated with the coverage. Examples of risk transfer include insurance, prospective reinsurance such as quota share or excess of loss treaties, and retroactive reinsurance such as loss portfolio transfers.

Proposed Revision of ASOP No. 39, Treatment of Catastrophe or Extreme Event Losses in Future Cost Estimates for Property/Casualty Risk Transfer and Risk Retention

Second Exposure Draft, April 2026

Catastrophe—A low-frequency event with high-severity or widespread potential effects. Catastrophes may cause unusually large aggregate losses and distort historical experience. Catastrophes include property and casualty events such as hurricanes, earthquakes, wildfires, cyber attacks, and pandemics. Catastrophes may be referred to as “extreme events.”

Catastrophe Model—A model of low-frequency events with high-severity or widespread potential effects. Catastrophe models may be used to explain a system, study effects of different components, or derive estimates. For example, stochastic models and deterministic scenario analyses can be used for catastrophe modeling.

Scenario Analysis—A process for assessing the impact of one possible event or several simultaneously or sequentially occurring possible events. Scenario analysis is often used when historical data are insufficient or other tools are unavailable. Scenario analysis may include a narrative description or numerical calculations.

Proposed Revision of ASOP No. 6, Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions

Exposure Draft, February 2026

Actuarial Accrued Liability—The portion of the actuarial present value of projected benefits (and expenses, if applicable), as determined under a particular actuarial cost method, that is not provided for by future normal costs. Under certain actuarial cost methods, the actuarial accrued liability is dependent upon the actuarial value of assets.

Actuarial Cost Method—A procedure for allocating the actuarial present value of projected benefits (and expenses, if applicable) to time periods, usually in the form of a normal cost and an actuarial accrued liability. For purposes of this standard, a pay-as-you-go method is not considered to be an actuarial cost method.

Actuarial Present Value—The discounted value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of assumptions with regard to future events, observations of market or other valuation data, or a combination of assumptions and observations.

Actuarial Present Value of Projected Benefits—The actuarial present value of benefits that are expected to be paid in the future, taking into account the effect of such items as future service, advancement in age, and expected future per capita health care costs (sometimes referred to as the “present value of future benefits”).

Actuarial Valuation—The measurement of relevant retiree group benefits program obligations and, when applicable, the determination of periodic costs or actuarially determined contributions.

Actuarially Determined Contribution—A potential payment, other than by a retired participant, to prefund the retiree group benefits program, as determined by the actuary using a contribution allocation procedure. It may or may not be the amount actually paid by the plan sponsor or other contributing entity. For the purpose of this standard, premiums and budget rates are not actuarially determined contributions.

Adverse Selection—Actions taken by one party using risk characteristics or other information known to or suspected by that party that cause a financial disadvantage to the retiree group benefits program

(sometimes referred to as antiselection).

Amortization Method—A method under a contribution allocation procedure or cost allocation procedure for determining the amount, timing, and pattern of recognition of the unfunded actuarial accrued liability.

Benefit Options—Choices that a participant may make under a benefit plan including basic coverages (for example, choice of medical plans) and additional coverages (for example, contributory dental coverage).

Benefit Plan—An arrangement providing medical, prescription drug, dental, vision, legal, death, long-term care, or other benefits (excluding retirement income benefits) to participants of the retiree group benefits program, whether on a reimbursement, indemnity, or service benefit basis.

Contingent Participant—An individual who is not a current participant but may reasonably be expected to become a participant through their future actions (for example, a retiree or other former employee who has opted out of medical coverage at retirement or termination but may later elect to resume or begin coverage).

Contribution Allocation Procedure—A procedure that determines one or more actuarially determined contributions for a retiree group benefits program. The procedure uses an actuarial cost method, and may use an asset valuation method, an amortization method, and an output smoothing method. The procedure may produce a single value, such as normal cost plus an amortization payment of the unfunded actuarial accrued liability, or a range of values. This term does not relate to the process of determining the participant contribution.

Cost Allocation Procedure—A procedure that determines the periodic cost for a retiree group benefits program (for example, the procedure to determine the net periodic postretirement benefit cost under accounting standards). The procedure uses an actuarial cost method and may use an asset valuation method or an amortization method.

Covered Population—Active, terminated, and retired participants, participating dependents, and surviving dependents of participants who are eligible for benefit coverage under a retiree group benefits program. The covered population may also include contingent participants.

Dedicated Assets—Assets designated for the exclusive purpose of satisfying the retiree group benefits program obligations. Examples include the following:

- a. life insurance policies held by the plan sponsor to cover some of the plan sponsor's retired participant death benefits;
- b. welfare benefit trusts (for example, voluntary employees' beneficiary associations);
- c. Internal Revenue Code section 401(h) accounts in a qualified pension plan; and
- d. Internal Revenue Code section 115 trusts sponsored by governmental entities for retiree group benefits.

Dependents—Individuals who are covered or may become covered under a retiree group benefits program by virtue of their relationship to an active, terminated, or retired participant.

Expenses—Administrative or investment fees or other payments borne or expected to be borne by the benefit plan or retiree group benefits program.

Funded Status—Any comparison of a particular measure of retiree group benefits program assets to a particular measure of program obligations.

Funding Valuation—A measurement of retiree group benefits program obligations or projection of cash flows performed by the actuary intended to be used by the principal to determine program contributions for prefunding or to evaluate the adequacy of specified contribution levels to support benefit provisions.

Immediate Gain Actuarial Cost Method—An actuarial cost method under which actuarial gains and losses are included as part of the unfunded actuarial accrued liability of the retiree group benefits

program, rather than as part of the normal cost of the retiree group benefits program.

Measurement Date—The date as of which the values of the retiree group benefits obligation and, if applicable, assets are determined.

Measurement Period—The period subsequent to the measurement date during which the chosen assumptions or other model components will apply. The period often ends at the time the last participant is expected to receive the final benefit.

Medicare Integration—For benefit plans that integrate with Original Medicare fee-for-service coverage, the approach to determining the portion of a Medicare-eligible claim that is paid by the benefit plan after adjustment for Medicare reimbursements for the same claim. Types of Medicare integration include the following:

- a. Full Coordination of Benefits (Full COB)—The health plan pays the difference between total eligible charges and the Medicare reimbursement amount, or the amount it would have paid in the absence of Medicare, if less.
- b. Exclusion—The health plan applies its normal reimbursement formula to the amount remaining after Medicare reimbursements have been deducted from total eligible charges.
- c. Carve-Out—The health plan applies its normal reimbursement formula to the total eligible charges, and then subtracts the amount of Medicare reimbursement.

Normal Cost—The portion of the actuarial present value of projected benefits (and expenses, if applicable) that is allocated to a period, typically twelve months, under the actuarial cost method. Under certain actuarial cost methods, the normal cost is dependent upon the actuarial value of assets.

Normative Database—Data compiled from sources that are expected to be typical of the retiree group benefits program, rather than from plan-specific experience. Examples of normative databases include published mortality and disability tables, proprietary premium manuals, and experience on similar retiree group benefits programs.

Output Smoothing Method—A method to reduce volatility of the results of a contribution allocation procedure. The output smoothing method may be a component of the contribution allocation procedure or may be applied to the results of a contribution allocation procedure. Output smoothing methods include techniques such as 1) phasing in the impact of assumption changes on contributions, 2) blending a prior valuation with a subsequent valuation to determine contributions, or 3) placing a corridor around changes in the dollar amount, contribution rate, or percentage change in contributions from year to year. An output smoothing method may involve a combination of techniques. For purposes of this standard, an asset valuation method is not an output smoothing method.

Participant—An individual who (a) is currently receiving benefit coverage under a retiree group benefits program, (b) is reasonably expected to receive benefit coverage under a retiree group benefits program upon satisfying its eligibility and participation requirements, or (c) is a dependent of an individual described in (a) or (b).

Participant Contributions—Payments made by a participant to a retiree group benefits program.

Periodic Cost—The amount assigned to a period using a cost allocation procedure for purposes other than funding. This may be a function of retiree group benefits program obligations, normal cost, expenses, and assets. In many situations, periodic cost is determined for accounting purposes.

Plan Sponsor—An organization that establishes or maintains a retiree group benefits program. Examples of plan sponsors include employers and Taft-Hartley Boards of Trustees.

Pooled Health Plan—A health benefit plan covering multiple plan sponsor groups (including the group under consideration) in which premiums are based at least in part on the claims experience of groups other than the group under consideration. The use of projection assumptions that are not based solely on the claims experience of the group under consideration (for example, the health

care cost trend rate assumption) would not by itself create a pooled health plan.

Premium—The price to provide coverage as set by a risk-bearing entity, such as an insurance or managed care company, or a self-insured plan sponsor.

Prescribed Assumption or Method Set by Another Party—A specific assumption or method that is selected by another party, to the extent that law, regulation, or accounting standards gives the other party responsibility for selecting such an assumption or method. For this purpose, an assumption or method set by a governmental entity for a retiree group benefits program that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is deemed to be a prescribed assumption or method set by another party.

Prescribed Assumption or Method Set by Law—A specific assumption or method that is mandated or that is selected from a specified range or set of assumptions or methods that is deemed to be acceptable by applicable law. For this purpose, an assumption or method set by a governmental entity for a retiree group benefits program, which such governmental entity or a political subdivision of that entity directly or indirectly sponsors, is not deemed to be a prescribed assumption or method set by law.

Retiree Group Benefits—Medical, prescription drug, dental, vision, legal, death, long-term care, or other benefits (excluding retirement income benefits) that are provided during retirement to a group of individuals, on account of an employment relationship.

Retiree Group Benefits Program—The program specifying retiree group benefits, including eligibility requirements, participant contributions, and the design of the benefits being provided.

Spread Gain Actuarial Cost Method—An actuarial cost method under which actuarial gains and losses are included as part of the current and future normal costs of the retiree group benefits program.

Stop-Loss Coverage—Insurance protection providing reimbursement of all or a portion of claims in excess of a stated amount. Stop-loss coverage may be either individual or aggregate (sometimes referred to as excess loss coverage).

Surviving Dependent—A dependent who qualifies as a participant under the retiree group benefits program following the death of the associated participant.

Trend—A measure of the rate of change, over time, of the per capita benefit payments. For the purpose of this standard, trend does not reflect changes in cost due to aging.

Proposed Revision of ASOP No. 41, Actuarial Communications

Third Exposure Draft, December 2025

Actuarial Communication—A written, electronic, or oral communication issued by an actuary with respect to actuarial services. An electronic communication is a written or oral communication issued by means of a computer or other electronic device.

Actuarial Report—An actuarial communication that the actuary issues in written or other recorded form to support a statement of actuarial opinion.

Actuarial Services—Professional services provided to a principal by an individual acting in the capacity of an actuary. Such services include the rendering of advice, recommendations, findings, or opinions based upon actuarial considerations.

Intended User—Any person or entity who the actuary identifies as able to rely on an actuarial communication. Intended users may be internal or external to the actuary's principal.

Information Date—The date(s) through which data or other information have been considered in the rendering of a statement of actuarial opinion.

Prescribed Assumption or Method Set by Law—A specific assumption or method that is mandated or that is selected from a specified range or set of assumptions or methods that is deemed to be

acceptable by applicable law. For this purpose, an assumption or method selected by a governmental entity for a benefit program that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is not a prescribed assumption or method set by law.

Principal—A client or employer of the actuary.

Statements of Actuarial Opinion—Advice, recommendations, findings, or opinions expressed by an actuary in the course of performing actuarial services and intended by the actuary to be relied upon by the intended user.

Subsequent Events—Events that (1) occur after the information date; (2) become known to the actuary before the actuarial report is issued; and (3) may have a material effect on the actuary’s statement of actuarial opinion.

Proposed Revision of ASOP No. 12, Risk Classification (for All Practice Areas)

Exposure Draft, January 2024

Adverse Selection—The result of actions regarding an element of choice taken by risk subjects, which could adversely impact the effectiveness of a risk classification framework or the viability of the financial or personal security system. Adverse selection is sometimes referred to as “antiselection.”

Financial or Personal Security System—A private or governmental program that is intended to mitigate the impact of unfavorable outcomes of contingent events. Financial or personal security systems include systems where the mitigation takes the form of financial payments, direct service to the risk subject, or both. Examples include insurance, self-funded programs, Medicare, and pension plans.

Risk Characteristics—Attributes used to assign risk subjects to risk classes.

Risk Class—A group of risk subjects based on risk characteristics.

Risk Classification Framework—The system, process, or schema used to assign risk subjects to risk classes, based on the risk characteristics of each risk subject.

Risk Measure—A measurement of the outcomes of a contingent event mitigated by the financial or personal security system. Examples of risk measures include mortality rates, healthcare costs, and claim frequency and severity.

Risk Subject—An individual or entity that is or may be covered by a financial or personal security system.

Unintended Bias—Impacts or outcomes on specific risk subjects resulting from the use of a risk classification framework that is not intentionally designed to result in such impacts or outcomes.

APPENDIX 2: Definitions from Repealed ASOPs of the ASB

Actuarial Report—A document, or other presentation, prepared as a formal means of conveying the actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, and of ensuring that the parties addressed are aware of the significance of the actuary's opinion or findings. (ASOP No. 9)

Actuarial Work Product—The result of an actuary's work. The term applies to the following actuarial communications, whether written or oral: statements of actuarial opinion, actuarial reports, statements of actuarial review, and required actuarial documents. (ASOP Nos. 9 and 31)

Assumption Format—The form in which a particular demographic assumption will be used or expressed. In some cases, the assumption will take the form of a table where the probability of the occurrence of a given event depends on parameters such as gender, age, service, or calendar year. In other cases, the assumption may be a point estimate, implying 100% probability of occurrence of a given event at the stated point. An example of a point estimate assumption is an assumption that 100% of the population will retire at age 62. The assumption format may include different tables or point estimates for different segments of the covered population. (ASOP No. 35)

Assumption Universe—For each demographic assumption, a universe consisting of the possible options that the actuary might reasonably use for the specific assumption. For example, an assumption universe for a mortality assumption might reasonably include relevant published or proprietary mortality tables and possible adjustments, such as projections of mortality improvement. For some pension plans, an assumption universe for a specific assumption might reasonably include a table or factors developed specifically for that plan. (ASOP No. 35)

Basis Risk—The residual risk that results from an imperfect risk offset or transfer process. For example, basis risk may arise from a hedge that pays off based upon an index while the exposure is an investment in a managed selection of individual stocks, or from a capital market hedge based upon industry-wide losses used to offset an insurer's specific storm exposure. (ASOP No. 47)

Capitation—The amount of money paid to a provider by an exposure-based payment system to provide certain health care services to an MCHP's members. The payment does not vary on the basis of the number or type of services actually rendered. The verb *to capitate* is used to indicate the act of entering into such an arrangement. *Capitation* is also used to mean the total medical cost or premium per enrollee, though it is not used in this manner in this document. (ASOP No. 16)

Cost of Capital—The rate of return that capital could be expected to earn in an alternative investment of equivalent risk. (ASOP No. 31)

Counterparty Risk—The risk that the party providing a risk offset or accepting a risk transfer does not fulfill its obligations. (ASOP No. 47)

Demographic Assumptions—Demographic and all other noneconomic assumptions (i.e., those assumptions not covered in ASOP No. 27), unless explicitly stated otherwise. Types of demographic assumptions may include retirement, mortality and mortality improvement, and other assumptions such as administrative expenses. (ASOP No. 35)

Economic Capital—The amount of capital an organization requires to survive or to meet a business objective for a specified period of time and risk metric, given its risk profile. (ASOP No. 46)

Emerging Risk—New or evolving risks that may be difficult to manage since their likelihood, impact, timing or interdependency with other risks are highly uncertain. (ASOP No. 46)

Enterprise Risk Management Control Cycle—The continuing process by which risks are identified, risks are evaluated, risk appetites are chosen, risk limits are set, risks are accepted or avoided, risk

mitigation activities are performed, and actions are taken when risk limits are breached. (ASOP Nos. 46 and 47)

Enterprise Risk Management—The discipline by which an organization in any industry assesses, controls, exploits, finances and monitors risks from all sources for the purpose of increasing the organization's short- and long-term value to its stakeholders. (ASOP Nos. 46 and 47)

Exclusive Provider Organization—An alternative delivery system which consists of a panel of providers (hospitals, physicians, or both) which are available to a group of subscribers on an annual election basis. If the subscribers do not utilize the services of participating providers "exclusively," their benefits are significantly reduced and in some cases, there are no benefits. (ASOP No. 16)

Experience Period—The period of time to which the historical data used for an actuarial analysis pertain. (ASOP No. 31)

Fee-For-Service—A method of reimbursing providers based on payment for each actual service rendered, in contrast to a salary or capitation payment basis. (ASOP No. 16)

Funding Arrangements—The financial mechanisms used to provide health benefits to covered individuals. They include insurance (either guaranteed cost or experience rated and minimum premium plans), which transfers financial risk to an insurance carrier; self-insurance, where the employer or employee group retains financial responsibility; and MCHPs where the financial risk is transferred to another financial security system. (ASOP No. 16)

Exposure Unit—A unit by which the cost for health benefit plan is measured. For example, an exposure unit may be a contract, an individual covered, \$100 of monthly benefit. (ASOP No. 31)

Group-Model HMO—An HMO which contracts with one or more medical groups to provide services to members. Generally, most ambulatory care services will be provided at a site(s) owned or leased whether by the group practice or the HMO. (Also known as *closed panels*). (ASOP No. 16)

Group Practice—The delivery of medical service by three or more physicians formally organized to provide medical care, consultation, diagnosis, and/or treatment through the joint use of facilities, equipment, and personnel, and with income from the medical practice distributed in accordance with methods previously determined by members of the group. May be single-specialty or multi-specialty. (Also known as *medical group*). (ASOP No. 16)

Health Benefit Plan—A contract providing medical, prescription, dental, vision, disability income, accidental death and dismemberment, long-term care, and similar benefits, whether on a reimbursement, indemnity, or service benefit basis, regardless of the form of the risk-bearing organization, including a benefit plan provided by self-insured plan sponsors. (ASOP No. 31)

Health Care Budget—A management tool used to develop the MCHP's financial and operating targets for a forthcoming fiscal year. The budget may include both financial projections, such as medical care costs, and operating expectations, such as utilization or enrollment targets. Some of the items in the budget may be used as risk-pool targets. (ASOP No. 16)

Health Maintenance Organization (HMO)—An organization which coordinates the delivery and financing of health care to an enrolled population. An HMO has the following characteristics:

- a. It is an organized system for providing or managing the delivery of health care services in a specified geographical area.
- b. It usually provides a comprehensive set of health care services.

For purposes of this standard, there are four types of HMOs: the group, IPA, mixed, and staff models. (ASOP No. 16)

Hold-Harmless Clause—A provision in a provider contract stating that the providers will hold the enrollee harmless for the payment of the cost of health care services for reasons including, but not limited to, non-payment by the MCHP or the MCHP's insolvency. This provision alleviates the enrollee's liability to providers. (ASOP No. 16)

Indemnity Plan—A type of benefit plan in which benefits are in the form of cash payments rather than services. The plan either pays the provider for service performed or reimburses the beneficiary for expenses after they are incurred. Most indemnity contracts set a maximum amount to be paid or covered services. Such plans are contrasted with prepaid health care plans. (ASOP No. 16)

Individual Practice Association (IPA)-Model HMO—An HMO which contracts with individual independent physicians to provide services to members. Generally, the services will be provided at the physicians' private offices; however, the physicians may work out of an HMO-owned facility. (ASOP No. 16)

Managed-Care Health Plan (MCHP)—A mechanism which integrates the financing and delivery of health care by the following elements:

- a. Arrangements with providers to furnish health care services to covered individuals
 - b. Organized arrangements for on-going quality assurance and utilization review
 - c. Significant financial incentives for covered individuals to use the providers affiliated with the plan
- Examples of such plans include HMOs and point-of-service products. (ASOP No. 16)

Measurement Date—The date as of which the values of the pension obligations and, if applicable, assets are determined. (ASOP No. 35)

Measurement Period—The period subsequent to the measurement date during which a particular demographic assumption will apply in a given measurement. (ASOP No. 35)

Mixed-Model HMO—An HMO which uses some combination of group, staff, or IPAs to provide services to its members. (Also known as a *network model*.) (ASOP No. 16)

Non-Indemnity Plan—Any type of benefit plan which provides benefits or services which are defined by some means other than reimbursement for expenses after services are performed. (ASOP No. 16)

Organization—The entity for which ERM is being performed. Examples include public or private companies, government entities, and associations, whether for profit or not for profit. (ASOP Nos. 46 and 47)

Point-of-Service Product—A plan that offers at least two different levels of benefits, depending on the choice of provider selected by the insured at the time the service is rendered. A higher level of benefits is available if the patient uses a provider designated by the plan. There may be required procedures to be followed in order to use the services of these designated providers; e.g., prior authorization to visit specialists. (ASOP No. 16)

Preferred Provider Organization (PPO)—A group of health care providers (which may include physicians and hospitals) that contracts with a plan administrator or sponsor to provide certain health care services, usually at a discounted rate. (ASOP No. 16)

Prepaid Health Care Plan—A plan which provides contracted health care services to a group of persons covered by a prepayment program through physicians and possibly other providers who are paid to provide necessary care through fixed payments or payments according to methods which are determined in advance. (ASOP No. 16)

Prescribed Assumption—A specific assumption or method that is selected by another party, to the extent that law, regulation, or accounting standards give the other party responsibility for selecting such an assumption or method. For this purpose, an assumption or method selected by a governmental entity for a plan that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is a prescribed assumption or method set by another party. (ASOP No. 35)

Prescribed Assumption or Method Set by Another Party—A specific assumption or method that is selected by another party, to the extent that law, regulation, or accounting standards give the other party responsibility for selecting such an assumption or method. For this purpose, an assumption or method selected by a governmental entity for a plan that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is a prescribed assumption or method set by another party. (ASOP No. 35)

Prescribed Assumption or Method Set by Law—A specific assumption or method that is mandated or that is selected from a specified range or set of assumptions or methods that is deemed to be acceptable by applicable law (statutes, regulations, and other legally binding authority). For this purpose, an assumption or method selected by a governmental entity for a plan that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is not a prescribed assumption or method set by law. (ASOP No. 35)

Primary Care Physician (PCP)—A physician who provides primary care; usually a family physician, general practitioner, internist, or pediatrician who provides a broad range of medical services and is generally the first point of contact for the patient. Primary care may be provided by obstetricians/gynecologists as well. The primary care physician may refer patients needing more specialized care to other specialists such as cardiologists, dermatologists, orthopedists, etc. Managed-care health plans frequently require the PCP to perform a gatekeeper function; that is, the PCP preapproves care by other providers if it is to be covered by the plan. (ASOP No. 16)

Providers—Individuals or organizations providing health care services, including doctors, hospitals, physical therapists, medical equipment suppliers, etc. (ASOP No. 16)

Rate—An estimate of the expected value of future costs over the rating period. The process of determining a rate is called *ratemaking*. (ASOP No. 31)

Rating Period—The period during which the rates are to apply. (ASOP No. 31)

Required Actuarial Document—An actuarial communication of which the formal content is prescribed by law or regulation. (ASOP No. 9)

Risk(s)—The potential of future losses or shortfalls from expectations due to deviation of actual results from expected results. (ASOP Nos. 46 and 47)

Risk Appetite—The level of aggregate risk that an organization chooses to take in pursuit of its objectives. (ASOP Nos. 46 and 47)

Risk Classification—The process of grouping risks with similar risk characteristics so that differences in expected costs may be appropriately recognized. (ASOP No. 31)

Risk Evaluation System—A combination of practices, tools, and methodologies within a risk management system used to measure the potential impacts of risk events on the performance metrics of an organization. (ASOP No. 46)

Risk Limit—A threshold used to monitor the actual risk exposure of a specific unit or units of the organization to ensure that the level of aggregate risk remains within the risk tolerance. (ASOP Nos. 46 and 47)

Risk Management System—A combination of practices, tools and methodologies that an organization uses to identify, assess, measure, mitigate and manage the risks it faces during the course of conducting its business. (ASOP Nos. 46 and 47)

Risk Metric—A measure of risk. Examples include value at risk, expected policyholders deficit, and conditional tail expectation. (ASOP No. 46)

Risk Mitigation—Action that reduces the frequency or severity of a risk. (ASOP Nos. 46 and 47)

Risk Pool—A mechanism for sharing risk between an MCHP and its providers, usually defined by contractual agreements. Generally, actual medical costs experience is compared to budgeted amounts in the risk pool. A settlement divides the resulting surpluses or deficits between the providers and the MCHP in some manner. (ASOP No. 16)

Risk Profile—The risks to which an organization is exposed over a specified period of time. (ASOP Nos. 46 and 47)

Risk Provision—A provision for adverse deviation added to the estimate of other future costs. (ASOP No. 31)

Risk Tolerance—The aggregate risk-taking capacity of an organization. (ASOP Nos. 46 and 47)

Risk Treatment—The process of selecting actions and making decisions to transfer, retain, limit, and avoid risk. This can include determining risk tolerance, choosing risk appetites, setting risk limits, performing risk mitigation activities, and optimizing organizational objectives relative to risk. (ASOP No. 47)

Scenario Test—A process for assessing the impact of one possible event or several simultaneously or sequentially occurring possible events on an organization’s financial position. (ASOP No. 46)

Stress Test—A process for measuring the impact of adverse changes in one or relatively few factors affecting an organization’s financial position. (ASOP No. 46);

Specialist—A professional provider whose practice is limited to a specific disease or group of diseases (e.g., rheumatology); part of the body (e.g., ear, nose and throat); age group (e.g., pediatrics), or procedure (e.g., oral surgery). Specialists may be board certified, board-eligible, or otherwise specially trained through post-graduate residencies, etc., or merely self-styled. (ASOP No. 16)

Staff-Model HMO—An HMO which hires its own physicians. Generally, most ambulatory care services will be provided in an HMO’s facility. (ASOP No. 16)

Statement of Actuarial Opinion—A formal statement of the actuary’s professional opinion on a defined subject. It outlines the scope of the work but normally does not include descriptive details. (ASOP No. 9)

Statement of Actuarial Review—A formally communicated appraisal of actuarial work done by another person. (ASOP No. 9)

Trend—A measure of a rate of change, over time, of the elements affecting costs. (ASOP No. 31)

Trending Period—The time between the average date of the experience period and the corresponding projected date in the forecast period. (ASOP No. 31)

Trending Procedure—A process by which the actuary evaluates how changes over time affect such items as claim costs, claim frequencies, expenses, and exposures; and integrates the trend assumptions into the ratemaking process. (ASOP No. 31)

Uncovered Expenditures—The costs to the MCHP for health care services that are the obligation of the MCHP for health care services that are the obligation of the MCHP, for which an enrollee may also be liable in the event of the MCHP’s insolvency, and for which no alternative arrangements have been made that are acceptable to the insurance regulatory commissioner, director, or superintendent. This concept currently applies only to HMOs, because of statutory requirements.

Withhold—Amount of funds normally payable to providers that is held back (not paid out) for the purpose of funding a risk pool. (ASOP No. 16)