Comment #4 – 3/16/16/ - 1 p.m.

Comments on ASOP No. 5 Revision, December 2015 Exposure Draft

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These comments are submitted solely on my own behalf. General comments are followed by my specific reactions to certain sections of the Exposure Draft.

Comments on Key Changes

Key Changes

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

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

Overall, I agree that the exposure draft represents an improvement over the existing ASOP No. 5. in clarity and consistency. I would like to offer, below, a few comments on areas that are less clear.

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

Similarly, an improvement … with specific comments below.

3. expanding the guidance regarding provider contractual arrangements;

This is very useful information, and seems to be consistent with the level of educational material included in the current ASOP and the rest of the Exposure Draft.

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

The updated discussion of methods reads well.

5. making the standard consistent with the revised guidance in ASOP No.1, *Introductory Actuarial Standard of Practice*, regarding use of the language "should consider." (no comment required)

Responses to Specific Request for Comments

Request for Comments

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

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

I answer with a qualified Yes:

- Presuming that the "should consider" language in 3.2.1 through 3.2.10 results in the actuary making a judgment of which items considered are applicable, material and reasonably foreseeable, it is reasonable to "include" items that qualify as such, in the actuary's professional judgment. (The current Standard has an explicit statement that refers to "those [items] highlighted in sections 3.2.1–3.2.7 below", which is absent in the Exposure Draft.);
- That said, the word "factors" should be changed, perhaps to "items" or similar non-multiplicative terminology. (The specific phrase in the current ASOP mentions "environmental factors" as one in a list of things that should be considered, but to "include factors" conjures a mathematical application, which is probably not intended.)

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

No, it's good.

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

No. As written, the requirement is either so general as to be meaningless, or so specific as to place the actuary in the position of an auditor. There will always be a risk of insolvency among a population of contracted providers. A general disclosure of this risk would be ubiquitous and therefore provide little value. If the risk is considered material due to a concentration of capitation or other financial arrangement with a specific provider, perhaps the risk should be characterized as a concentration risk and disclosed along with any other risks as may be required by Section 4.1(c).

The actuary should not be placed in a position of opining on the solvency of another entity. Unless a specific provider has actually been declared insolvent, and the effect on claims and/or provider reimbursements can be quantified, it would be beyond the scope of an actuary's assignment to require disclosure of potential insolvency of a contracted provider.

4. Which common methods, if any, are appropriate to include in section 3.4?
5. Are the methods included in section 3.4 described in appropriate detail?

The methods presented are fine. The simpler descriptions of the development and tabular methods are an improvement over the current ASOP.

We may need a definition of a "long-term" claim. The modifying phrase in 3.4.2., "for which a claim event triggers a series of payments" is vague (although perhaps necessarily so). What constitutes a "series of payments"? A medical claim for treatment of an ongoing condition can result in a series of payments to a hospital and other providers. For that matter, an LTD claim or an LTC claim could result in only one payment before death. Maybe we should say "an expected series of periodic payments".

I also note that long-term disability is specifically called out in its own short paragraph, whereas long-term care coverage is not. Perhaps a reference to ASOP No. 18 should be included for LTC considerations, or a similar ASOP be prepared for LTD. The major thrust of ASOP No. 5 really is health claims (as originally envisioned) with long-term claims shoehorned in.

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

It doesn't hurt, but perhaps there should be a discussion of the motivation for the change from the "moderately adverse" "margin for uncertainty" language that is found in the current ASOP.

Comments on Specific Sections

1.2: Regulatory agencies should not be included in the list of risk-bearing entities. Either parenthesize "such as … risk contracts" or move the list to the definition of risk-bearing entity.

2.1: "used in" and "used by" are much more clear than the former "useful for".

2.7: "Insurance policy" is not included in the definition of a health benefit plan (maybe the definition should say "contract, insurance policy, or other financial arrangement"). Section 3.2.10 refers to "policy purchase" and "[LTD] policies".

Also, this section contains the only antecedent I could find for the term "basis", which appears subsequently in section 3.3.1(f). As noted below, the context for this term is very unclear.

2.11: Providers can also include nursing homes, assisted living facilities, and probably entities that have yet to be invented. I suggest saying "including, but not limited to" if we need to have a list.

2.13: See above comment regarding "long-term" claims. Is there a definition of "long-term" in any ASOP?

2.15: Can we be more specific about "elements" affecting incurred claims for trend (e.g. cost, incidence, severity)? There should be something to differentiate this term from the "considerations for estimating incurred claims" in Section 3.2, in which certain "factors" (or "items") are specified to be considered.

3.2.3: This paragraph regarding claimant behavior is new. We must be careful to recognize what is observable "claimant behavior" versus what are actuarial assumptions regarding claimant behavior in response to new benefits or benefit changes. "Reasonably available" information may or may not relate to the specific population of the benefit plan whose incurred claims are being estimated.

3.2.10: Reversing the sentence order in this paragraph was a mistake. It reads better in the current ASOP; "these health benefit plans" needs to have an earlier reference within the paragraph. The term "Products" in the title should be changed; nowhere else is this metaphor used or defined in the ASOP. Maybe use "Long-Term Benefits" instead (or "Policies"). Another example of the difficulty of defining "long-term" coverage in the context of health benefit claims – the last sentence refers to "policy purchase" but is having a policy part of the definition of long-term coverage?

3.3.1: I suggest inserting "as appropriate" after "Using incurral and processing dates". An actuary may need to estimate an IBNR reserve on a new policy form for which there have been no reported claims (cf. 3.2.10: "the plan's benefits may not begin for several years after policy purchase").

3.3.1(f): This paragraph should be rewritten or removed. It is unclear what the paragraph is even referring to. "Basis" was earlier defined as "reimbursement, indemnity or service benefit basis" in Section 2.7. The current ASOP, section 3.3.7, mentioned "claim settlement expense reserves". The new draft keeps the "related liabilities and reserves" language, but drops "not covered by this standard" (understandably). Does this mean active life reserves for LTD or LTC coverages? Unless there is a specific cross-reference intended, I don't think this paragraph adds anything but vagueness to ASOP No. 5.

ASOP No. 42, Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims "complements ASOP No. 5, Incurred Health and Disability Claims" so perhaps a cross-reference to that Standard would be in order here.

3.3.2: Delete “and to the task being performed”; presumably, the actuary is performing the separate development just referred to earlier in the sentence.

3.3.5: The actuary “should understand” relevant organizational practices related to COB, subrogation, and government programs. How is this different from “The actuary should make a reasonable effort to understand” internal business practices, in Section 3.2.1?

4.1(a): Should this disclosure refer to the range of incurral and processing dates?

4.1(c): If there is a specific concern about concentration of provider risk, it could be disclosed here, and remove 4.1(f).

4.1(d): I would like to see more clarity about requiring disclosure of “the need” for any follow-up studies. Does this mean communicating that follow-up studies are required (by regulation or otherwise)? Nothing in this Standard requires an actuary to perform follow-up studies. (In fact, the new Section 4.2 contemplates situations where an actuary may not even know if there have been any changes in methods or assumptions compared to previous studies.) Perhaps the disclosure in 4.1(d) is more of a recommendation that follow-up studies be performed, and if so, under what circumstances. Then, as mentioned in Section 1.2, “Actions taken by the actuary’s principal regarding such estimates are beyond the scope of this standard.”

Thank you for the opportunity to comment and hopefully contribute to the improvement of Actuarial Standards of Practice.

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