



April 29, 2016

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

Dear Sir or Madam,

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

We would like to thank the Task Force for the effort that went into the preparation of the proposed revision of ASOP No. 5. We appreciate the opportunity to provide our comments.

The following comments were developed by committee members of the Aon Health & Benefits Actuarial Practice focused on compliance. They are submitted on behalf of our practice.

We will first address the specific issues where comments were requested:

- 1) The new wording "should include" is not consistent with the subsections in section 3.2. We recommend a return to the "should consider" wording given the guidance in ASOP No. 1 ("the phrase 'should consider' is often used to suggest potential courses of action. If, after consideration, in the actuary's professional judgment an action is not appropriate, the action is not required and failure to take this action is not a deviation from the guidance in the standard.") An alternative wording that uses "should consider" but still emphasizes the need for action on the actuary's part if necessary could be: "The actuary should consider the items described below. If, in the actuary's professional judgment, an item is applicable, material, and reasonably foreseeable to the actuary at the time of estimation, the actuary should make appropriate adjustments when developing the incurred claim estimate."
- 2) The level of detail in section 3.3.6 is appropriate.
- 3) Requiring a disclosure on "provider insolvency risk" is not appropriate.
 - a) The phrase "the actuary *should* disclose this risk" (our emphasis) seems too prescriptive in light of how difficult or even impossible it may be for the actuary to determine if such insolvencies may have a "material effect on the risk-bearing entity's ultimate liability." Analyzing the solvency considerations of even one provider risk (e.g. could business interruption insurance payments provide for the honoring of a provider's risk contracts in the event of halting operations while a legal matter is resolved?) let alone the web of risks from multiple contracts (e.g. within a region or between subsidiaries or complex ownership structures) seems like a high burden to place on the actuary. Even collecting all such contracts for analysis may be beyond the scope of traditional health actuarial analysis, and in general seems like a higher standard than ASOP No. 23 *Data Quality*.

- b) If the actuary is somehow able to determine if insolvency may have a material effect based on known information, this may introduce a bias as there will certainly be unknown cases that are not addressed.
- 4) The methods included (development, projection, tabular, and other) are appropriate.
- 5) The methods in section 3.4 are generally described in appropriate detail, but we recommend that this section be reorganized and some information shifted to section 3.2 for succinctness and readability.
 - a) Each of the methods has a definition in section 2, but those definitions are only referenced in section 3.4. A definition for a term seems most appropriate when the term is referenced throughout the document. Sections 3.4.2 Tabular Method and 3.4.3 Projection Methods then restate the definitions and include more detail. Removing the definitions from section 2 and only including them in the text of section 3 would allow the reader to get a full picture of the methods discussion without switching between sections.
 - b) The description of the development method “the actuary estimates the percentage or amount of completion needed to project all future yet unrecorded claims accruable to the valuation period...” was removed. In our opinion, this wording was the clearest description of the method and a similar description should be added back to the text. “All future yet unrecorded...” is vague given the other wording in the ASOP; perhaps “the unpaid claims liability” would be better given definition 2.16.
 - c) The wording about special considerations in section 3.4.1 Development Method (“When using the development method... significant changes in medical practices”) is redundant since these considerations were already discussed in detail in section 3.2.
 - d) Section 3.4.3 Projection Methods mentions additional considerations (“using risk adjustment techniques or pharmacy claims to help project shifts in the morbidity of the block”) that may be more appropriate in section 3.2.
 - e) To improve flow, it may more sense to put section 3.4.3 Projection Methods immediately after Section 3.4.1 Development Method. The projection method often supplements the development method and this is referenced in the text.
- 6) The requirement to disclose explicit provision for adverse deviation is appropriate.

We also believe the following items merit further consideration:

- 1) Section 1.2 Scope
 - a) The addition of “risk-bearing” before “entities” in the exposure draft could be read as “insured risk-bearing entities,” which may not have been intended. Perhaps the wording “insured or noninsured” is no longer necessary and can be removed.
- 2) Definition 2.3 Carve-Outs
 - a) We noted that this description was moved from section 3.2.6 of the current ASOP to its own definition in section 2 of the exposure draft. We believe it is still more appropriate to include the

description in section 3.2.9 (of the exposure draft), consistent with our point earlier regarding definitions that are only used in one place in the text.

- b) The new phrase “Designated services provided by specific providers” is misleading. Strictly reading the definition of carve-outs, dental would be considered a carve-out because it is a “designated service provided by (a) specific provider,” namely, a dentist. But in the context of 3.2.9, dental would not be a carve-out if it falls under the medical plan.
 - c) Including a description of carve-outs at the beginning of section 3.2.9 rather than leading with the “should consider” statement does not maintain the symmetry with the other sections, but in our opinion the improvement in readability outweighs this concern.
- 3) Definition 2.8 Incurred Claims
- a) The very end of this statement says “less the estimate of **unpaid claims liabilities** at the end of the prior valuation date.”
 - b) “At the end of” should just be “as of” since “valuation period” from the prior document was changed to “valuation date” here.
- 4) Definition 2.11 Providers
- a) Including examples of groups or organizations, e.g. IPAs or ACOs, may improve this definition and further clarify the discussion in section 3.3.6.
- 5) Section 3.2.1 Health Benefit Plan Provisions and Business Practices
- a) The section begins with “The actuary should consider the **health benefit plan** provisions and business practices...” The health benefit plan is defined as a contract or other financial arrangement in definition 2.7, and it’s unclear how a contract or financial arrangement can have business practices. Are the business practices that should be considered those of the risk-bearing entity (for example, how a self-insured employer makes decisions on how plan provisions are ultimately administered when faced with appeals), or perhaps an external contracted party (as mentioned in section 3.2.4 Organizational Claims Administration)? If so, (a) clarifying adjective(s) could be included before “business practices.”
 - b) The second paragraph beginning with “The actuary should make a reasonable effort...” would be clearer if business practices were clarified above. The additional word “internal” added before “business practices” in this paragraph is not enough to clarify.
 - c) It would also make sense to add plan provisions to the second sentence of the second paragraph: “The actuary should also be familiar with any changes in *plan provisions* or internal business practices...” As it reads currently, it seems to only reference changes in business practices.
- 6) Section 3.2.10 Special Considerations for Long-Term Products
- a) The reorganization of the sentences in this section makes it difficult to follow. The “should consider” sentence comes first and references “*these* health benefit plans.” The definition then

follows and describes what *these* means, requiring the reader to go back to the first sentence again to reread it in the proper context. The description needs to come before the reference.

- b) Similar to our point on carve-outs above, moving the “should consider” sentence away from the first sentence in this section does not maintain the symmetry with the other sections, but readability is improved.

7) Section 3.4.2 Tabular Method

- a) This section uses the terms “known” and “unknown” (as it does in the current ASOP). It would be more appropriate to use “reported” and “unreported” to be consistent with definitions 2.13 and 2.16.

8) Section 4.2 Changes in Assumptions, Procedures, Methods or Models

- a) It doesn't seem necessary to lead with “In addition to those in section 4.1,” as it's given that the actuary should already be following section 4.1 in the actuarial communication.
- b) It may improve readability to reorder the section and lead with the clarification of when this disclosure is necessary: “When the **incurred claim** estimate is an update of a previous estimate, the actuary should disclose changes in assumptions, procedures, methods, or models that the actuary believes to have a material impact on the **incurred claim** estimate, as well as the reasons for such changes to the extent known by the actuary.”
- c) This reorganization results in the replacement of “may need to disclose” with “should disclose.” If the intent is that the actuary may also disclose this in other situations (subject to the actuary's judgment), the section could also say “The actuary may need to disclose such changes in other cases, consistent with the purpose or use of the **incurred claim** estimate.”
- d) The language about not requiring the actuary to measure or quantify the impact of such changes would remain.

9) Precision of the terms “paid” and “processed”

- a) The definition of **unpaid claims liability** is: “The value of the **unpaid** portion of incurred claims, including (1) unreported claims; (2) reported but **unprocessed** claims; and (3) **processed** but **unpaid** claims.”
- b) The definition of the **development method** states: “The **processing date** is typically the date the claim is received, adjudicated, or **paid** by the claim payer. The **development method**...is used to help estimate the **unprocessed** portion of **incurred claims**.”
 - i) The definition of the development method blurs the distinction between paid and processed established in the definition of unpaid claims liability. It enables paid and processed to be the same thing, while the definition of unpaid claims liability suggests they are not. It also implies that the development method can estimate unprocessed claims, but not processed but unpaid claims.
 - ii) Definitions of “paid” and “processed” would clarify this distinction.



Again, we appreciate the Task Force's time and consideration.

Sincerely,

Actuaries from Aon Consulting, Inc. and Hewitt Associates LLC, both Aon Hewitt companies

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