ACTUARIAL STANDARDS BOARD

Actuarial Standard
of Practice
No. 5

Revised Edition

Incurred Health and Disability Claims

Developed by the
Task Force to Revise ASOP No. 5 of the
Health Committee of the
Actuarial Standards Board

Adopted by the
Actuarial Standards Board
March 2017

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ASOP No. 5—Doc. No. 186

March 2017

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

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice (ASOP) No. 5

This document contains a final revision of ASOP No. 5, *Incurred Health and Disability Claims*.

Background

ASOP No. 5, then titled *Incurred Health Claim Liabilities,* was adopted in 1991. Under direction from the ASB and its Health Committee, a task force revised ASOP No. 5, retitled *Incurred Health and Disability Claims,* which was adopted in 2000 and updated for deviation language in 2011.

This revision of ASOP No. 5 reflects a number of changes to other standards that have been made since the 2000 revision, including updating the ASOP, where appropriate, to incorporate reference to new standards that have been issued since the 2000 revision, eliminate guidance that does not conform to current ASOP practices regarding references to other standards of practice, and make consistent the definitions used in the standard with those of other standards of practice. In addition, this revision of ASOP No. 5 has been updated to reflect relevant legal, regulatory, and practice developments that have occurred since the 2000 revision.

Exposure Draft

The exposure draft was released in December 2015 with a comment deadline of April 30, 2016. Eleven letters were received. The task force considered all comments received and made appropriate changes where needed. For a summary of the substantive issues contained in the comment letters on the exposure draft and the responses, please see appendix 2.

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;

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;

3. expanding the guidance regarding provider contractual arrangements;

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;

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"; and

6. adding a requirement to disclose any explicit provision for adverse deviation.

The ASB voted in March 2017 to adopt this standard.

Task Force to Revise ASOP No. 5

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The ASB establishes and improves standards of actuarial practice. These ASOPs identify what the actuary should consider, document, and disclose when performing an actuarial assignment. The ASB's goal is to set standards for appropriate practice for the U.S.

ASOP No. 5—Doc. No. 186

ACTUARIAL STANDARD OF PRACTICE NO. 5

INCURRED HEALTH AND DISABILITY CLAIMS

STANDARD OF PRACTICE

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

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries estimating or reviewing **incurred claims** when preparing or reviewing financial reports, claims studies, rates, or other actuarial communications as of a **valuation date** under a **health benefit plan**, as defined in section 2.7 of this standard.

1.2 Scope—This standard applies to actuaries who estimate or review **incurred claims** under **health benefit plans** on behalf of **risk-bearing entities**, such as managed-care entities, self-funded employer plans, health care **providers**, government-sponsored plans or risk contracts, or government agencies. This standard does not provide guidance to actuaries regarding reserves such as policy reserves, premium reserves, or claim settlement expense reserves, although such reserves may be required for financial reporting. This standard does not address interpretations of statutory or generally accepted accounting practices.

This standard applies to the actuary only with respect to **incurred claim** estimates that are communicated as an actuarial finding (as described in ASOP No. 41, *Actuarial Communications*). Actions taken by the actuary's principal regarding the use of such estimates are beyond the scope of this standard.

If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority) or for any other reason the actuary deems appropriate, the actuary should refer to section 4.

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard is effective for any actuarial work product covered by this standard's scope issued on or after September 1, 2017.

Section 2. Definitions

The terms below are defined for use in this actuarial standard of practice.

2.1 Block of Business—All policies of a common coverage type (for example, major medical, preferred **provider** organization, or capitated managed care), demographic grouping (for example, size, age, or area), contract type, or other segmentation used in estimating **incurred claims** or used by a **risk-bearing entity** for evaluating its business.

2.2 Capitation—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.

2.3 Carve-Outs—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.

2.4 Contract Period—The time period for which a contract is effective.

2.5 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**.

2.6 Exposure Unit—A unit by which the cost for a **health benefit plan** is measured. For example, an **exposure unit** may be a contract, an individual covered, $100 of weekly salary, or $100 of monthly benefit.

2.7 Health Benefit Plan—A contract, such as an insurance policy, or other financial arrangement providing medical, prescription drug, dental, vision, disability income, long-term care, or other health-related benefits, whether on a reimbursement, indemnity, or service benefit basis, regardless of the form of the **risk-bearing entity**.

2.8 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 plan**s 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.

2.9 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**.

2.10 Long-Term Product—A **health benefit plan** that provides medical or disability benefits for an extended period of time. Some examples are cancer, long-term care, and long-term disability policies. The plan's benefits may not begin for several years after policy purchase and claims usually extend beyond the **valuation date**.

2.11 Projection Method—The application of an adjusted historical claim metric to an appropriate exposure base, in order to estimate **incurred claims**.

2.12 Providers—Individuals, groups, or organizations providing health care services or supplies, including but not limited to doctors, hospitals, independent physician associations, accountable care organizations, physical therapists, medical equipment suppliers, and pharmaceutical suppliers.

2.13 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.

2.14 Tabular Method—The seriatim application of factors to a 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**).

2.15 Time Value of Money—The principle that an amount of money available at an earlier point in time has different usefulness and value than the same amount of money has at a later point in time.

2.16 Trends—Measures of rates of change, over time, of the elements, such as cost, incidence, and severity, affecting the estimation of **incurred claims**.

2.17 Unpaid Claims Liability—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 provision for all unpaid claims incurred during the current and prior periods.

2.18 Valuation Date—The date as of which the liabilities are estimated.

Section 3. Analysis of Issues and Recommended Practices

3.1 Introduction—The estimation of incurred health and disability claims is fundamental to the practice of health actuaries. It is necessary for the completion of financial statements, for the analysis and projection of **trends**, for the analysis or development of rates, and for the development of various management reports, regardless of the type of **risk-bearing entity**.

3.2 Considerations for Estimating Incurred Claims—The actuary should include items associated with the estimation that, in the actuary's professional judgment, are applicable, material, and are reasonably foreseeable to the actuary at the time of estimation.

In determining which items to include in the estimation of **incurred claims**, the actuary should consider items including but not necessarily limited to those described below, and may rely on others as described in sections 3.6 and 3.7.

3.2.1 Health Benefit Plan Provisions and Business Practices—The actuary should consider the **health benefit plan** provisions and related business practices, including special group contract holder requirements and **provider** arrangements, which in the actuary's judgment may materially affect the cost, frequency, and severity of claims. These include, for example, elimination periods, deductibles, preexisting conditions limitations, maximum allowances, and managed-care restrictions.

The actuary should make a reasonable effort to understand any changes in plan provisions or business practices made since the last estimate of **incurred claims**. The actuary should consider how such changes are likely to affect the estimation of claim costs and claim liabilities.

3.2.2 Economic and Other External Influences—The actuary should consider items such as changes in price levels, unemployment levels, medical practice, managed care contracts, cost shifting, **provider** fee schedule changes, medical procedures, epidemics or catastrophic events, and elective claims processed in recessionary periods or prior to contract termination.

3.2.3 Behavior of Claimants—The actuary should consider reasonably available information regarding claimant behavior, such as pent-up demand for new benefits, or impending benefit changes, which may impact **incurred claims**.

3.2.4 Organizational Claims Administration—The actuary should consider items that may affect claims administration practices, such as staffing levels, variable claim processing and investigation time (for example, for complicated claims or claims submitted on paper), computer system changes or downtime, seasonal backlogs of claims submitted, increased electronic submission of claims by **providers**, governmental influences, and cash flow considerations. The actuary should also be aware that the administration practices of external contracted parties (for

example, pharmacy benefit managers and third party administrators) can affect the **unpaid claims liability**. The actuary should make reasonable efforts to obtain information from appropriate personnel and evaluate whether there have been material changes in operational practices that impact the **incurred claim** estimate and, if so, make appropriate adjustments.

3.2.5 Claim Seasonality—The actuary should understand how seasonality may impact the estimation of **incurred claims** and make appropriate adjustments. Claim seasonality may be exhibited in the pattern of claims incurral and submission, or in the manner that costs actually emerge within the **health benefit plan** provisions, such as plans with high deductibles.

3.2.6 Credibility—The actuary should consider how the credibility of the data affects the development of **incurred claim** estimates and refer to ASOP No. 25, *Credibility Procedures*, for further guidance.

3.2.7 Risk Characteristics and Organizational Practices by Block of Business—The actuary should consider how marketing, underwriting, and other business practices can influence the types of risks accepted, and how the pattern of growth or contraction and relative maturity of a **block of business** can influence **incurred claims**.

3.2.8 Legislative Requirements—The actuary should consider relevant legislative and regulatory changes as they pertain to the estimation of **incurred claims**. For example, governmental mandates can influence the provision of new benefits; risk characteristics; rating, reserving, and underwriting practices; methods used to estimate **incurred claims**; or claims processing practices.

3.2.9 Carve-Outs—The actuary should consider the pertinent benefits, payment arrangements, and separate reporting of those benefits subject to **carve-outs** in **incurred claims** estimates.

3.2.10 Special Considerations for Long-Term Products—The actuary should consider the variety of benefits available in **long-term products**, such as lump-sum, fixed, or variable payments for services; provisions such as cost of living adjustments and inflation protection; payment differences based on institutional or home-based care; social insurance integration; and the criteria for benefit eligibility.

3.3 Analysis of Incurred Claims—After reviewing the considerations in sections 3.2.1–3.2.10 above, the actuary should follow the relevant procedures highlighted in sections 3.3.1–3.3.6 below.

3.3.1 Unpaid Claims Liability—Using incurral and processing dates as appropriate, the actuary should estimate **unpaid claims liabilities** for claims incurred as of the **valuation date**.

a. Purpose or Use of the Unpaid Claim Estimate—The actuary should identify the intended purpose or use of the unpaid claim estimate. Potential purposes or uses of unpaid claim estimates include, but are not limited to, establishing liability estimates for external financial reporting, internal management reporting, and various special purpose uses such as appraisal work and scenario analyses. Where multiple purposes or uses are intended, the actuary should consider the potential conflicts arising from those multiple purposes and uses and should consider adjustments to accommodate the multiple purposes to the extent that, in the actuary's professional judgment, it is appropriate and practical to make such adjustments.

b. Plan Provisions—The actuary should review the relevant plan provisions to determine if they create obligations for services or payments after the **valuation date** (for example, medical benefits that extend beyond the **contract period**, or long-term disabilities). The actuary should determine if these obligations are part of the current or future period's liability, or if these obligations make up a separate reserve.

c. Data and Reporting—The actuary should consider the relevant reporting systems for processed claims, **exposure units**, and premium rates, and the various dating methods the systems use (for example, loss recognition, service rendered, reporting, or payment status). The actuary should use professional judgment in estimating the extent to which an adjustment to the reported data is needed, based on the dating methodology.

d. Provision for Adverse Deviation—Recognizing that the estimation of liabilities for incurred but unpaid health and disability claims involves an estimate of the true obligations that will emerge, the actuary should consider what explicit provision for adverse deviation, if any, might be appropriately included. If a provision for adverse deviation is included, the **unpaid claims liability** should be appropriate, in the actuary's judgment, for the intended use. For example, in certain situations, a provision for moderately adverse deviation may be appropriate. In other situations, the appropriate provision for adverse deviation may vary as the level of uncertainty varies, for example, based on credibility of the data or stability of payment patterns.

e. Time Value of Money—The actuary should consider if the **time value of money** will have a material effect in the estimation of **incurred claims**. The use of any interest discounts depends on the purpose for which **incurred claims** are being estimated and should reflect any applicable accounting standards.

f. Consistency of Assumptions and Methodology—The actuary should use assumptions and methodology consistent with those used for estimating

related liabilities and reserves, such as claim settlement expense reserves, unless it would be inappropriate to do so.

3.3.2 Categories of Incurred Claims—The actuary should consider separate estimation of **incurred claims** for each category that may exhibit different lag patterns, costs per **exposure unit**, **trends**, or **exposure unit** growth rates. If separate estimation is performed, the actuary should define categories of **incurred claims** in a manner that is appropriate to the available data and to estimation method(s) being used. Categories may be defined broadly, such as fee-for-service claims paid to health care **providers**, **capitation** payments to **providers**, or disability income paid to insureds. Categories might be further refined to more accurately analyze or project costs and utilization data, for example, by method of payment (such as electronic vs. manual), type of contract, type of service, geographic area, premium rating method, demographic factors, distribution method, and **provider** risk-sharing arrangements.

3.3.3 Reinsurance Arrangements—The actuary should consider the effect of reinsurance arrangements in estimating the **incurred claims**. In particular, the actuary should consider the effect of different lag patterns due to the extended reporting or recovery periods often associated with certain types of reinsurance.

3.3.4 Large Claims—The actuary should consider the effect of large claims, as defined by the actuary using professional judgment. Specifically, large claims can distort claim payment patterns or historical per-unit claim levels that the actuary considers when estimating **incurred claims**. The actuary should understand how large claims, if any, impact the particular method being employed to estimate **incurred claims** and make appropriate adjustments. For example, **incurred claim** estimates may be overstated if completion factors are applied to processed claims levels that include an unusually high number or amount of large claims.

3.3.5 Coordination of Benefits (COB), Subrogation, and Government Programs—The actuary should make a reasonable effort to understand the relevant organizational practices and regulatory requirements related to COB, subrogation, and government programs (state or federal). The actuary should consider how these items are reflected in the data (for example, negative claims or income) and make appropriate adjustments for COB, subrogation, and payments or recoveries resulting from government programs.

3.3.6 Provider Contractual Arrangements—The actuary should consider the relevant contractual arrangements with **providers** and any changes in such arrangements. These arrangements can affect **trends**, claim cost levels, and claims processing.

The actuary should consider any relevant variation in these arrangements by region or product, and any **provider** contractual arrangements that do not provide for reimbursement through the claim payment process. Some examples of these latter arrangements include the following:

a. **capitation**;

b. amounts initially withheld from **provider** payments, which may later become payable based upon contractually defined experience outcomes;

c. reimbursement of services based on the expected cost for an episode of care, in which more services are at risk than would normally be the case for a given fee-for-service event;

d. bonuses or other contractual incentive payments based on financial results or achievement of contractually defined quality metrics; and

e. stop-loss contracts which limit the **provider's** risk for certain high cost, infrequent services.

The arrangements will typically specify what portion of the risk, if any, has been shifted to the **providers**. Under **provider** risk-bearing contracts, **provider** insolvency may result in reimbursement of claims on a fee-for-service basis. If **provider** insolvency may have a material effect on the **risk-bearing entity**'s ultimate liability, the actuary should disclose this risk. However, the actuary is not required to quantify the likelihood of **provider** insolvency. Depending on the purpose of the analysis, the actuary should consider any statutory limitations on the credits for such transfers of risk.

Certain contractual arrangements may also result in amounts due from **providers** (for example, risk sharing receivables, pharmacy rebates) based on financial results or other experience metrics. The actuary should consider the impact of unpaid medical costs resulting from failed **providers** bearing a material portion of the risk or losses incurred by **providers** deemed to be related parties.

3.4 Methods Used for Estimating Incurred Claims—Various methods may be used to estimate **incurred claims**. Some methods are based on statistical analysis and projection of the costs or rates at which claims were processed in recent periods.

Because no single method is necessarily better in all cases, the actuary should consider the use of more than one method to assess the reasonableness of results. The actuary should evaluate the method(s) chosen and the results obtained in light of the purpose, constraints, and scope of the assignment. The actuary should consider the reasonableness of the assumptions underlying each method used, and should consider the sensitivity of the **incurred claim** estimates to the use of reasonable alternative assumptions. The actuary should also consider the effect of **trends** both in previous periods and the current period for estimating **incurred claims**. The actuary should choose the outcome that, in the actuary's professional judgment, is the most reasonable provision for **incurred claims**, whether from a single method or a combination of several methods. Sections

3.4.1–3.4.3 below discuss some of the more common methods for estimating **incurred claims**.

3.4.1 Development Method—This method is appropriate and widely used for short-term benefits with claims subject to processing and payment (i.e. not **capitation**) and may also be appropriate for claims associated with **long-term products**.

The actuary should consider using metrics to assess the reasonableness of results for periods where historical development patterns are less credible. For example, the actuary might evaluate the ratio of estimated **incurred claims** to earned premiums or **exposure units** for reasonableness.

3.4.2 Projection Methods—**Projection methods** may be used to estimate **incurred claims** when the incidence of claims or volume of available data is limited or not sufficiently credible for other estimation methods, to supplement the **development method** for the most recent incurral months, or as a reasonableness check for other estimation methods. This method starts with the development of a historical claim metric (for example, cost per claim, cost per member per month, loss ratio) and then multiplies this value times the appropriate base for the period being estimated (for example, claim volume, member **exposure units**, earned premium, respectively.) The actuary may adjust the historical claim metric when appropriate, for example as a result of **trend**. The actuary may use utilization metrics (for example, authorized days per thousand members) to improve the projected cost levels for recent months, and to adjust for the impact of catastrophic claims. The actuary may also consider using risk adjustment techniques or other indicators such as pharmacy claims to help project shifts in the morbidity of the block.

3.4.3 Tabular Method—The **tabular method** is generally used for **long-term products** for which a reported claim event triggers an expected series of payments. This method applies factors to items such as individual claims, waived rates, or other volume measures based on previous experience in order to estimate the **unpaid claims liability** for known claims. The factors are based on items such as the age and gender of the insured, elimination period, cause of claim, length of disablement on the **valuation date**, and remaining benefit period, as appropriate to the coverage.

When using the **tabular method**, the actuary should take into account specified benefit changes throughout the lifetime of the claim and the assumptions used to develop the factors, and should select the appropriate factors to estimate the **unpaid claims liability** given the risk characteristics of the policy.

The actuary should recognize the specific impacts that recovery, mortality, and government offsets may have on tabular factors.

The **tabular method** is not appropriate by itself for estimating unreported claims.

When the **tabular method** is used, the actuary should consider whether an additional adjustment is necessary to reflect unreported **incurred claims**.

Greater availability of data and advances in computing power have resulted in alternative approaches that the actuary may consider to estimate **incurred claims**. These include (but are not necessarily limited to) regression, time series, and other statistical and econometric models, as well as different approaches to categorizing and aggregating data (for example, summarizing by weekly data cells or estimating the cost of reported claims separately from incurred but not reported claims.)

3.5 Follow-Up Studies—The actuary may conduct follow-up studies that involve performing tests of reasonableness of the prior period asset or liability estimates and the methods used over time. When conducting such follow-up studies, the actuary should, to the extent practicable, do the following:

a. acquire the data to perform such studies;

b. perform studies in the aggregate or for pertinent blocks of business; and

c. utilize the results, if appropriate, in estimating **incurred claims**.

3.6 Reliance on Data or Other Information Supplied by Others—When relying on data or other information supplied by others, the actuary should refer to ASOP No. 23, *Data Quality*, for guidance.

3.7 Reliance on Assumptions and Methods Selected by Others—When relying on assumptions and methods selected by others, the actuary should refer to ASOP No. 41 for guidance.

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

Section 4. Communications and Disclosures

4.1 Actuarial Communication—When issuing an actuarial communication subject to this standard, the actuary should consider the intended purpose or use of the **incurred claim** estimate and refer to ASOP No. 41 for further guidance. The actuary should include the following items, as applicable, in an actuarial communication. This list includes certain pertinent items from ASOP No. 41 as well as additional items.

a. important dates used in the analysis such as the incurral, processing, and **valuation dates**;

b. significant limitations, if any, that constrained the actuary's **incurred claim**

estimate analysis such that, in the actuary's professional judgment, there is a significant risk that a more in-depth analysis would produce a materially different result;

c. specific significant risks and uncertainties, if any, with respect to whether actual results may vary from the **incurred claim** estimate;

d. any explicit provision for adverse deviation, as described in section 3.3.1;

e. the risk that **provider** insolvency may have a material effect on the **risk-bearing entity**'s ultimate liability (see section 3.3.6);

f. any follow-up studies the actuary may have utilized in the development of the **incurred claim** estimate, as described in section 3.5; and

g. when updating a previous estimate, 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. The actuary may need to disclose these changes in cases other than when updating a previous estimate, consistent with the purpose or use of the **incurred claim** estimate. This standard does not require the actuary to measure or quantify the impact of such changes.

4.2 Additional Disclosures—The actuary should also include the following, as applicable, in an actuarial communication:

a. the disclosure in ASOP No. 41, section 4.2, if any material assumption or method was prescribed by applicable law;

b. the disclosure in ASOP No. 41, section 4.3, if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and

c. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

Appendix 1

Background and Current Practices

Note: This appendix is provided for informational purposes, but is not part of the standard of practice.

Background

The estimation of incurred claims is an integral, fundamental part of the work of most health actuaries. It is necessary to set proper financial statements for ratemaking, planning, and projections. Incurred claims are part of the estimation of unpaid claim liabilities for financial reporting purposes. Incurred claims are often the starting point for premium rate development. The incurred claims from a period are adjusted to project the incurred claims for a future period.

The estimation of incurred claims has become more challenging with the proliferation of provider contracts that share risk in different ways. Having accurate data continues to be an issue.

Current Practices

Practices differ among actuaries and among types of coverage. The tabular, development, projection, and other approaches to evaluating incurred claims, as described in the standard, are representative of the range of current practices.

Appendix 2

Comments on the Exposure Draft and Responses

The exposure draft of this revision of ASOP No. 5, *Incurred Health and Disability Claims,* was issued in December 2015 with a comment deadline of April 30, 2016. Eleven comment letters were received, some of which were submitted on behalf of multiple commentators, such as by firms or committees. For purposes of this appendix, the term "commentator" may refer to more than one person associated with a particular comment letter. The task force carefully considered all comments received, and the Health Committee and ASB reviewed (and modified, where appropriate) the proposed changes.

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

The term "reviewers" includes the task force, Health Committee, and the ASB. Unless otherwise noted, the section numbers and titles used below refer to those in the exposure draft.

TRANSMITTAL MEMORANDUM	
Question 1: Is it appropriate to change the language in the first sentence of section 3.2 from "should consider" to "should include"?	
Comment	Several commentators supported the change, while several other commentators stated that the use of "should include" is inconsistent with the use of "should consider" in the remainder of the section.
Response	The reviewers changed "should include" to "should consider" and added language to clarify the meaning.
Question 2: Is the guidance in section 3.3.6 on "provider contractual arrangements" too detailed?	
Comment	One commentator considered certain provider payments discussed in this standard to be "non-claim benefit expenses" instead of "claims" and recommended changing the name of the ASOP accordingly. Another commentator believed that the discussion of example provider arrangements is more detail than is necessary. The majority of commentators agreed that the level of detail is appropriate.
Response	The reviewers believe that the payments referenced are consistent with the definition of "incurred claims" in the standard and made no change.
Question 3: Is the required disclosure on "provider insolvency risk," as discussed in section 3.3.6, appropriate?	
Comment	Several commentators agreed that the required disclosure is appropriate.
Comment	One commentator suggested that this disclosure is unnecessary because it would result in ubiquitous disclosure.
Response	The reviewers believe the standard of materiality would apply in this situation and made no change.

Comment	Two commentators suggested that the actuary is not required to assess the likelihood of provider insolvency.
Response	The reviewers agree and added clarifying language.
Question 4: Which common methods, if any, are appropriate to include in section 3.4?	
Comment	Most commentators agreed that the list of common methods is appropriate.
Comment	One commentator suggested that the following sentence be deleted: "Because no single method is necessarily better in all cases, the actuary should consider the use of more than one method."
Response	The reviewers believe this sentence sets appropriate context and made no change.
Comment	One commentator suggested including the loss ratio method.
Response	The reviewers believe this is covered by the discussion of projection methods and made no change.
Question 5: Are the methods included in section 3.4 described in appropriate detail?	
Comment	Several commentators believe the level of detail is appropriate.
Comment	One commentator suggested changes to the discussion of projecting incurred claims by category of service.
Response	The reviewers agree and deleted this language because it is already discussed in section 3.3.2.
Comment	One commentator suggested clarifying the definition of "long-term claim."
Response	The reviewers agree and made corresponding changes.
Comment	One commentator suggested that long-term disability should not be mentioned without also mentioning long-term care.
Response	The reviewers agree and made corresponding changes.
Comment	One commentator suggested that the reference to evaluating ratios in section 3.4.1 is too specific.
Response	The reviewers added language clarifying that this guidance is appropriate considering the particular drawbacks of the development method.
Comment	One commentator suggested focusing on reasonability of results in the discussion of the development method.
Response	The reviewers agree and made corresponding changes.
Comment	One commentator suggested that the methods used for estimating incurred claims should be defined in section 3 instead of in section 2.
Response	The reviewers believe it is appropriate to include these definitions in section 2 and made no change.
Comment	One commentator suggested using a more specific description of the development method.
Response	The reviewers clarified that the development method is used to estimate incurred claims rather than the unprocessed portion of incurred claims.
Comment	One commentator suggested removing language in section 3.4.1 that is redundant because it is discussed in detail in section 3.2.
Response	The reviewers agree and removed the language.

Comment	One commentator suggested moving language regarding morbidity shifts from section 3.4.3 to section 3.2.
Response	The reviewers believe this language is appropriately specific to the projection method and made no change.
Comment	One commentator suggested moving section 3.4.3, Projection Methods, immediately after section 3.4.1, Development Method, because they are related.
Response	The reviewers agree and made this change.
Question 6: Is the requirement to disclose explicit provision for adverse deviation (PAD), as discussed in section 4.1, appropriate?	
Comment	One commentator said the disclosure is not appropriate and several commentators said the disclosure is appropriate.
Response	The reviewers believe the required disclosure is appropriate and did not change the requirement.
Comment	One commentator questioned the motivation for changing language from "moderately adverse margin for uncertainty" to "provision for adverse deviation."
Response	The reviewers retained the "provision for adverse deviation" language and revised this section to include a discussion of "moderately adverse" deviation.
SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.2, Scope	
Comment	One commentator suggested identifying "principal" as coming from ASOP No. 41, *Actuarial Communications*, and as defined in the *Code of Professional Conduct.*
Response	The reviewers believe the context makes this reference clear and made no change.
Comment	One commentator suggested adding "self-funded employer plans" to the list of risk-bearing entities in section 1.2.
Response	The reviewers agree and made the change.
Comment	One commentator suggested removing "regulatory agencies" from the list of risk-bearing entities in section 1.2.
Response	The reviewers changed this item to "government agencies" in order to clarify the meaning.
Comment	One commentator suggested moving the list of risk-bearing entities to the definition section.
Response	The reviewers believe the list is appropriately included in section 1.2.
Comment	One commentator suggested removing the words "insured or non-insured" in section 1.2.
Response	The reviewers agree and made the change.
SECTION 2. DEFINITIONS	
Section 2.3, Carve-Outs	
Comment	One commentator suggested moving the definition of "carve-outs" to section 3.2.9.
Response	The reviewers believe the definition is appropriately included in section 2.3 and made no change.

Comment	One commentator suggested that the definition of "carve-outs" implies that dental services are always a carve-out.
Response	The reviewers added the word "contractually" to clarify that carve-outs are defined in the contract and not globally.
Section 2.7, Health Benefit Plan	
Comment	One commentator suggested including "insurance policy" in the definition of "health benefit plan" because policies are referred to later on.
Response	The reviewers agree and made the change.
Section 2.8, Incurred Claims (now section 2.9)	
Comment	Two commentators suggested clarifying the difference between incurred claims in the two definitions discussed.
Response	The reviewers agree and made clarifying changes.
Comment	One commentator was concerned that the definition of "incurred claims" could be interpreted not to apply to the unpaid claim liabilities booked for balance sheet and income statement purposes.
Response	The reviewers agree and made clarifying changes to the definition.
Section 2.11, Providers (now section 2.12)	
Comment	Two commentators suggested using the language "including but not limited to."
Response	The reviewers agree and made the change.
Comment	One commentator suggested expanding the list of individuals, groups, or organizations.
Response	The reviewers agree and added two more examples.
Section 2.13, Tabular Method (now section 2.14)	
Comment	One commentator suggested clarifying the definition by adding the word "seriatim."
Response	The reviewers agree and made the change.
Comment	One commentator suggested clarifying the meaning of "long-term claims."
Response	The reviewers agree and added examples.
Section 2.14, Time Value of Money (now section 2.15)	
Comment	One commentator suggested changing "different…than" to "different…from."
Response	The reviewers believe the current language is clearer and made no change.
Section 2.15, Trends (now section 2.16)	
Comment	One commentator suggested being more specific about the "elements" affecting incurred claims.
Response	The reviewers agree and added examples.
Section 2.16, Unpaid Claims Liability(now section 2.17)	
Comment	One commentator suggested adding a fourth category for future benefits paid on a claim.
Response	The reviewers agree that this category should be included and added it to the definition of "incurred claims" in section 2.9.

Comment	One commentator requested clarification of the meaning of "appropriate period."
Response	The reviewers agree this would be helpful and made clarifying changes.
Comment	One commentator observed a conflict related to "processed claims" and "paid claims" between the definitions of the "development method" and "unpaid claims liability."
Response	The reviewers agree and made changes to both definitions in this section and section 2.5.
SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Section 3.2, Considerations for Estimating Incurred Claims	
Comment	One commentator suggested changing "management" to "principal."
Response	The reviewers agree that reliable sources of information extend beyond management and changed "management" to "another party."
Section 3.2.1, Health Benefit Plan Provisions and Business Practices	
Comment	One commentator suggested clarifying the relationship between "plan provisions" and "business practices."
Response	The reviewers agree and made a clarifying change by adding the word "related."
Comment	One commentator suggested adding "benefit periods" and "lifetime maximums" to the list.
Response	The reviewers believed these items are generically covered by "maximum allowances" and did not include them.
Comment	One commentator suggested that a high standard is being set for the actuary regarding identifying differences between business practices and plan provisions.
Response	The reviewers removed the language related to identifying differences between business practices and plan provisions, and clarified that "reasonable effort" is the appropriate standard to apply to the understanding of changes in business practices.
Section 3.2.3, Behavior of Claimants	
Comment	One commentator suggested recognizing the difference between observed behavior and assumed behavior.
Response	The reviewers believe this distinction is covered by "reasonably available information" and made no change.
Section 3.2.4, Organizational Claims Administration	
Comment	One commentator suggested changing "electronic submission of claims" to "method of claims submission."
Response	The reviewers believe the specific example is appropriate and made no change.
Section 3.2.8, Legislative Requirements	
Comment	One commentator suggested adding "for example" to the beginning of this list.
Response	The reviewers agree and made the change.
Comment	One commentator suggested referring to developing regulatory provisions regarding estimation of incurred claims for certain long-term products.
Response	The reviewers note, as described in section 1.2, that this standard does not address interpretation of statutory or generally accepted accounting principles, and added "methods used to estimate incurred claims" to the list of example influences of government mandates.

Section 3.2.10, Special Considerations for Long-Term Products	
Comment	Several commentators suggested reversing the order of the sentences in this section.
Response	The reviewers agree and made the change.
Section 3.3.1, Unpaid Claims Liability	
Comment	One commentator suggested removing "purpose or use of the unpaid claim estimate" from the list.
Response	The reviewers believe the current discussion is appropriate and did not make this change because different estimates may be appropriate depending on the intended use.
Comment	One commentator suggested adding "as appropriate" after "using incurral and processing dates."
Response	The reviewers agree this improves clarity and made the change.
Section 3.3.1(f), Consistency of Bases (now titled "Consistency of Assumptions and Methodology")	
Comment	One commentator suggesting adding a caveat to address situations when, for example, a consulting actuary's review is limited to the unpaid claims liabilities reserve.
Response	The reviewers believe the use of consistent assumptions and methodology are also appropriate in this situation and made no change.
Comment	One commentator suggested clarifying the meaning of "bases" and "related liabilities and reserves."
Response	To improve clarity of meaning, the reviewers changed consistent basis to consistent assumptions and methodology, and included the example of claim settlement expense reserves.
Section 3.3.2, Categories of Incurred Claims	
Comment	Several commentators suggested adding detail specific to certain estimation methods, for example considerations regarding categories of incurred claims that would be specific to the development method.
Response	The reviewers note that this section is intentionally broad because of the variety of estimation methods in use, and made changes intended to clarify this point.
Section 3.3.4, Large Claims	
Comment	One commentator suggested noting that large claims could result in an understatement.
Response	The reviewers believe overstatement is an appropriate example in this context and did not make this change.
Comment	One commentator suggested defining large claims.
Response	The reviewers added language to clarify that large plans are "as defined by the actuary using professional judgment."
Section 3.3.5, Coordination of Benefits (COB), Subrogation, and Government Programs	
Comment	One commentator noted that section 3.2.1 uses "reasonable effort."
Response	The reviewers agree that there is not intended to be a difference in the meaning and added "reasonable effort."
Section 3.3.6, Provider Contractual Arrangements	
Comment	Two commentators requested clarity on the definitions of "material" and "disclosure."

Response	The reviewers note that materiality is defined in ASOP No. 1, *Introductory Standard of Practice*, and that section 4 of this standard refers to disclosure in an actuarial communication.
Section 3.4, Methods Used for Estimating Incurred Claims	
Comment	One commentator expressed concern that this section does not address developing regulatory provisions (for statutory reporting) regarding estimation of incurred claims for certain long-term products.
Response	The reviewers note, as described in section 1.2, that this standard does not address interpretation of statutory or generally accepted accounting principles, and believes that the description of the tabular method is broad enough to include required adjustments, such as required use of company experience.
Section 3.4.2, Tabular Method (now section 3.4.3)	
Comment	One commentator suggested adding "benefit periods or lifetime maximums" to the list of factors.
Response	The reviewers added language to clarify that this list is not intended to be exhaustive.
Comment	One commentator noted that "long-term disability" is mentioned, but not "long-term care," although they are similar.
Response	The reviewers agree and removed this language.
Comment	One commentator suggested noting that the tabular method is not appropriate "by itself" for estimating unreported claims.
Response	The reviewers agree and made the change.
Comment	One commentator suggested using "reported/unreported" instead of "known/unknown."
Response	The reviewers agree and made the change.
Section 3.4.3, Projection Method (now section 3.4.2)	
Comment	One commentator questioned the inclusion of the specific example of pharmacy claims.
Response	The reviewers believe it is common practice to rely on pharmacy claims because, for example, they are believed to complete more quickly than other claims, and they are an indicator of morbidity. The reviewers made no change.
Section 3.5, Follow-Up Studies	
Comment	One commentator questioned the removal of the requirement to perform testing of the reserve methodology.
Response	The reviewers believe the language removed was educational only, and does not impact any obligation to perform follow-up studies that may exist.
SECTION 4. COMMUNICATIONS AND DISCLOSURES	
Section 4.1, Actuarial Communication	
Comment	In subsection (a), one commentator suggested referring to a range of incurral and processing dates.
Response	The reviewers believe the current language is adequate and would include date ranges.
Comment	One commentator suggested combining the disclosure items regarding variation of actual results compared to estimates (c) and risk of provider insolvency (f).
Response	The reviewers believe these are distinct types of risks and made no change.
Comment	In section (d), one commentator requested clarification of the need for documentation of follow-up studies.

Response	The reviewers changed the wording of this item to improve clarity.
Section 4.2, Changes in Assumptions, Procedures, Methods, or Models (now section 4.1(g))	
Comment	One commentator suggested defining "material impact."
Response	The reviewers note that materiality is defined in ASOP No. 1 and made no change.
Comment	One commentator suggested changing the structure of the sentences in this paragraph to improve clarity.
Response	The reviewers agree, moved the section into 4.1(g), and made clarifying changes.