ACTUARIAL STANDARDS BOARD

• EXPOSURE DRAFT •

Proposed Revision of
Actuarial Standard of
Practice No. 8

Regulatory Filings for Health Benefits, Health Insurance, and Entities Providing Health Benefits

Comment Deadline:
October 15, 2013

Developed by the
Task Force to Revise ASOP No. 8 and the
Health Committee of the
Actuarial Standards Board

Approved for Exposure by the
Actuarial Standards Board
June 2013

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APPENDIX

June 2013

TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Regulatory Filings for Health Benefits, Health Insurance, and Entities Providing Health Benefits

FROM: Actuarial Standards Board (ASB)

SUBJ: Proposed Revision of Actuarial Standard of Practice (ASOP) No. 8

This document contains an exposure draft of a revision of ASOP No. 8 now titled *Regulatory Filings for Health Benefits, Health Insurance, and Entities Providing Health Benefits*.

Please review this exposure draft and give the ASB the benefit of your comments and suggestions. Each written response and each response sent by e-mail to the address below will be acknowledged, and all responses will receive appropriate consideration by the drafting committee in preparing the final document for approval by the ASB.

The ASB accepts comments by either electronic or conventional mail. The preferred form is e-mail, as it eases the task of grouping comments by section. However, please feel free to use either form. If you wish to use e-mail, please send a message to **comments@actuary.org.** You may include your comments either in the body of the message or as an attachment prepared in any commonly used word processing format. Please do not password-protect any attachments. Include the phrase "ASB COMMENTS" in the subject line of your message. Please note: Any message not containing this exact phrase in the subject line will be deleted by our system's spam filter.

If you wish to use conventional mail, please send comments to the following address:

ASOP No. 8 Revision
Actuarial Standards Board
1850 M Street, NW, Suite 300
Washington, DC 20036

The ASB posts all signed comments received to its website to facilitate transparency and dialogue. Anonymous comments will not be considered by the ASB nor posted to the website. The comments will not be edited, amended, or truncated in any way. Comments will be posted in the order that they are received. Comments will be removed when final action on a proposed standard is taken. The ASB website is a public website and all comments will be available to the general public. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

Deadline for receipt of responses in the ASB office: **October 15, 2013**

Background

The new federal Affordable Care Act (ACA), current publicity concerning health insurance premium rate increases, and state activity in the rate increase review sponsored by federal grants has resulted in very high visibility on this actuarial activity. Due to the significant number of changes in the rate filing and rate review process due to the ACA, the American Academy of Actuaries' Health Practice Council believed that changes to the current ASOP No. 8, *Regulatory Filings for Health Plan Entities*, were needed and made a recommendation to the ASB. The ASB reviewed the recommendation and agreed that the current ASOP No. 8 did not provide adequate guidance in the current environment.

Revisions to ASOP No. 8 will give guidance to actuaries that must prepare rate filings under more rigorous state and federal requirements for filing health insurance premium rate increases. It also provides further guidance to actuaries reviewing regulatory filings either as peer reviewers or as regulatory actuaries.

ASOP No. 8 was revised to add guidance on the preparation and review of health insurance rate filings for medical lines of business that are required by state or federal regulations. The standard will apply to actuaries preparing the rate filing, peer reviewing the rate filing, and reviewing the rate filing on behalf of state and federal regulators.

Key Changes

Revisions include clarifications as to the applicability of the standard and additional definitions for terms used in the new guidance. Also, the following sections have been revised with the largest changes reflected in section 3.2.2 (now 3.4) Assumptions, which has been significantly expanded. In addition, the following sections have been added:

- Section 3.3, Legal and Regulatory Requirements;
- Section 3.5, Rating Calculations; and
- Section 3.9, Rating Factors.

Request for Comments

The ASB is issuing a revised version of ASOP No. 8 as an exposure draft to provide members of actuarial organizations governed by the ASOPs and other interested parties an opportunity to comment.

The Health Committee would appreciate comments on the proposed changes and would draw the readers' attention to the following areas in particular:

1. This ASOP addresses regulatory filings for health plan entities. The proposed revisions provide additional guidance on rate filings, specifically to address requirements of the Affordable Care Act. Do you believe that this exposure draft has the appropriate level of detail on rate filing and review?

2. Is it clear that the scope is broader than medical expense benefits and includes regulatory filings related to such benefits as VEBA, long-term care, and disability?

3. For some filings, such as those for individual and small group medical, the assumptions discussed in section 3.4 are generally used for setting rates and calculating regulatory benchmarks. For others, such as those for disability income and long term care, they may only be used in calculating regulatory benchmarks. Is it clear that the guidance in section 3.4 applies to regulatory filings only?

4. As with the current ASOP No. 8, this exposure draft covers actuaries preparing filings and regulatory actuaries reviewing filings. As written, this draft does not have a separate section for regulatory actuaries. Unless otherwise indicated, it is assumed that the same general guidance is appropriate for all actuaries producing or reviewing filings. Is the exposure draft clear as to which guidance pertains to filing actuaries, which to regulatory/reviewing actuaries, and which pertains to both? Do you believe this structure gives appropriate guidance to regulatory actuaries?

5. There may be cases where the regulatory actuary exercises judgment according to this ASOP and makes a determination that is not accepted by the person designated under the law to make a final determination, generally the commissioner or other chief insurance regulator. This may involve disapproving a rate filing that the actuary intended to approve or approving a rate filing that the actuary intended to disapprove. Is the guidance provided sufficient for this situation?

6. Section 3.2.10 provides guidance to the actuary on regulatory benchmarks. Does this section adequately address these benchmarks, and in particular, is the guidance related to adequate or excessive rates appropriate?

The ASB voted in June 2013 to approve this exposure draft.

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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.

EXPOSURE DRAFT—June 2013

ACTUARIAL STANDARD OF PRACTICE NO. 8

REGULATORY FILINGS FOR HEALTH PLAN BENEFITS, HEALTH INSURANCE, AND ENTITIES PROVIDING HEALTH BENEFITS

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 when performing professional services with respect to preparing or reviewing required regulatory filings related to rates or financial projections for health plan benefits, health insurance, and entities providing health benefits.

1.2 Scope—This standard applies to actuaries when performing professional services with respect to preparing or reviewing health filings, as defined in section 2.5, required by and made to state insurance departments, state health departments, the federal government, and other regulatory bodies. In some instances, the standard applies only to a filing actuary or a regulatory actuary, as defined below.

Health filings require projection of future contingent events and can be categorized into two broad categories: rate or benefit filings and financial projection filings. Some of these filings are made on behalf of health plan entities, such as filings made in conjunction with applications for licensure. Other filings are required for health benefit plans provided by health plan entities, such as filings for approval of rates. Such filings may be required for new and existing health plan entities, for new health benefit plans, and for revisions to existing health benefit plans.

The filings covered by this standard do not include filings to certify compliance with rating methods and other actuarial practices applicable to carriers for small employer health benefit plans (see ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*); statements of actuarial opinion relating to statutory financial statements of health plan entities (see ASOP No. 22, *Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life and Health Insurers*, and ASOP No. 28, *Compliance with Statutory Statement of Actuarial Opinion Requirements for Hospital, Medical, and Dental Service or Indemnity Corporations, and for Health Maintenance Organizations*); financial projections subject to ASOP No. 6, *Measuring Retiree Group Benefit Obligations*; filings related to benefits provided by casualty insurance policies; and filings that are solely experience reports and do not require projection of future contingent events.

This standard is not meant to provide a complete set of recommended practices for the determination of health rates, financial projection entries, or other numerical information required to be included in health filings.

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

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

1.4 Effective Date—This standard will be effective for any actuarial work product covered by this standard's scope issued on or after four months after adoption by the Actuarial Standards Board (ASB).

Section 2. Definitions

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

2.1 Filing Actuary—An actuary who prepares, supervises the preparation of, or peer reviews a health filing on behalf of a health plan issuer. This includes actuaries employed by the health plan issuer and consulting actuaries. This does not include a "reviewing actuary," as defined in section 2.9.

2.2 Financial Projection—A projection of covered lives, premiums, claims, expenses, capital and surplus, or other financial quantities that may be required by applicable law.

2.3 Health Benefit Plan—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, or service benefit basis, irrespective of the type of health plan entity that provides the benefits.

2.4 Health Filing—A required regulatory filing for health benefits, 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;

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; and

e. other filings of a 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.

2.5 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.

2.6 Regulatory Benchmark—A measurement, such as a loss ratio or capital ratio, specified by applicable law, which is used by the regulatory authority as a basis upon which to evaluate a health filing.

2.7 Reviewing Actuary—An actuary who is responsible for reviewing a health filing on behalf of a government agency. This includes actuaries employed by the government agency and consulting actuaries engaged to review a health filing on behalf of the government agency.

2.8 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.

Section 3. Analysis of Issues and Recommended Practices

3.1 Introduction—Many jurisdictions require health filings that demonstrate compliance with applicable law, which may vary considerably as to the requirements and procedures for these filings. In many cases, such law may be silent as to the assumptions and methodology to be used, thus giving the actuary significant discretion to exercise professional judgment in preparing and reviewing the filings.

3.2 Purpose of Filing—When preparing a filing, the filing actuary should include in the filing a statement of its purpose, identifying the applicable law with which it is intended to comply. For example, the filing actuary might state, “The purposes of this rate filing are to document the rates and to demonstrate that the anticipated loss ratio of this product with those rates meets the minimum requirements of Section XX of the statutes of [name of state]. This filing may not be appropriate for other purposes.”

3.3 Legal and Regulatory Requirements—When an actuary prepares or reviews a regulatory filing, the actuary should have the necessary knowledge and understanding of applicable law. If the actuary believes applicable law is silent or ambiguous on a relevant issue, the actuary should consider obtaining guidance from an appropriate expert. The actuary should describe how the requirements were interpreted when preparing or reviewing the filing.

3.4 Assumptions—The actuary should determine which assumptions are necessary for the filing and select appropriate assumptions. These assumptions may include, but are not limited to, the list below.

3.4.1 Premium Levels and Future Rate Changes—The actuary should consider current premium levels and expectations for future rate changes.

3.4.2 Projections of Covered Lives—The actuary should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition.

3.4.3 Levels and Trends in Morbidity, Mortality, and Lapsation—The actuary should consider current levels of and historic trends in morbidity, mortality, and lapsation rates.

3.4.4 Non-Benefit Expenses, Including but Not Limited to Administrative Expenses, Commissions, Broker Fees, and Taxes—The actuary should consider the appropriate methods and assumptions for calculating the non-benefit expenses component of premium rates. Possible methods include, but are not limited to, the use of a target loss ratio or the estimation of costs appropriately attributed to the health benefit on a percentage of premium or fixed dollar basis. When estimating the latter amounts, the actuary should consider the health plan entity's own experience when appropriate, reasonably anticipated internal or external future events, inflation, and business plans. The actuary may also consider relevant industry and government studies. The actuary should consider the adequacy of the non-benefit expense component of premium rates relative to projected costs.

3.4.5 Investment Earnings and the Time Value of Money—The actuary should consider whether to reflect investment earnings and the time value of money in the calculations used in the filings. When applicable, the actuary should select assumptions for the rate of investment return and the discount rate that are individually reasonable, mutually consistent, and reflective of the terms of the contracts.

3.4.6 Health Cost Trends—The actuary should consider historical experience trends when estimating future trends. When medical expense trends are projected, the actuary should consider detail by service category (for example, inpatient, outpatient, professional, and drug), separated by cost and utilization, if available,

credible, and determined by the actuary to improve the accuracy of the calculation used in the filing.

The actuary should consider changes in benefit provisions when projecting future trends from historical trends, as the change in unit costs and utilization may differ from prior periods.

The actuary should consider whether an adjustment for leveraging is needed for products with fixed-dollar, member-cost sharing elements such as co-pays, deductibles, and out-of-pocket limits.

The actuary should select an estimate of the trend based on the actuary's professional judgment. For example, historical trends may or may not be the best predictor of future trends.

3.4.7 Expected Financial Results, such as Profit Margin/Surplus Contribution, Loss Ratio, or Surplus Level—The actuary should consider the appropriate methods and assumptions for calculating the profit margin/surplus contribution. Possible methods include, but are not limited to, the use of a target loss ratio or a target return on capital. When a target return on capital is used, the actuary should consider the relationship between risk and return.

The actuary should consider the adequacy of the profit margin/surplus in relation to current surplus levels.

The actuary should consider whether provisions for adverse deviation are appropriate to provide a margin for variability and uncertainty in projected health costs. The actuary should consider the cumulative effect of any such provisions built into other assumptions.

3.4.8 Expected Impact of Known Contractual Arrangements with Health Care Providers and Administrators—A health plan entity may have many health care provider contracts with a wide variety of payment structures such as fee-for-service and capitation. When estimating the impact of health care provider contracts on future periods, the actuary should consider the appropriate level of detail needed to produce reasonable results.

3.4.9 Expected Impact of Reinsurance and Other Financial Arrangements—The actuary should consider how risk sharing, risk adjustment, or reinsurance payments should be reflected in the base period data, and how these amounts should be estimated and reflected in the projected premium rates, including their impact on financial results.

3.5 Rating Calculations—The actuary should review and understand the formulas used to calculate premium rates and determine that, based on the available data and relevant assumptions, they are appropriate for the purpose of setting premium rates.

3.6 Use of Business Plans to Project Future Results—The filing actuary should request and, if available, review relevant business plans for the health plan entity or health benefit plan that is the subject of the filing. The filing actuary should consider the information therein along with any other information relevant to the business plan as a part of the setting of the assumptions and methodologies used in the filing. The filing actuary is not required to use assumptions identical to those in the business plan in developing the rate filing.

3.7 Use of Past Experience to Project Future Results—The actuary should determine whether past claims experience can be used to project future results. The actuary should also determine the extent to which past experience trends are relevant to assumed future trends.

In making these determinations, the actuary should consider the applicability and credibility of the data. These considerations may differ for the total claims in a period, the claims for a particular service category, and the experience trends. To the extent that the actuary concludes that the experience data is not applicable or credible for a particular use, the actuary should identify additional sources that are appropriate (see ASOP No. 25, *Credibility Procedures*).

When using past experience to project future results, the actuary should make adjustments to reflect any known or expected changes that, in the actuary's professional judgment, are likely to have a material effect on expected future results. These may include, but are not limited to, changes in the following:

a. selection of risks;

b. demographic and risk characteristics of the insured population;

c. policy provisions, including but not limited to benefits, limits, and cost sharing;

d. business operations, including how health coverages are marketed, distributed, underwritten, and managed, and changes in the product portfolio;

e. provider contracts;

f. premium rates, claim payments, expenses, and taxes;

g. seasonality in incurred claims;

h. trends in mortality, morbidity, and lapse;

i. the impact of catastrophic claim variability; and

j. administrative procedures, including claim payment practices.

The actuary should make adjustments to past experience, as appropriate, in a way that reasonably matches claim experience to exposure. For example, the actuary should not use ratios of paid claims to collected premiums to project future incurred loss ratios except with appropriate adjustments.

The filing actuary should update prior earned premium and incurred claim estimates to reflect premium and claim development experience to date when, in the actuary's professional judgment, the difference is material.

3.8 Recognition of Plan Provisions—The actuary should consider pertinent plan documents or contracts, established administrative procedures, and any arrangements with providers of health care that affect plan administration.

3.9 Rating Factors—For medical expense coverages, the actuary should be familiar with the rating factors used for the plans and the structure of those factors. The actuary should be familiar with the regulatory requirements for rating factors and structures.

Rating factors for medical expense coverages should be based on actuarially derived variation to the extent permitted by law or regulation. In this regard, the actuary should refer to ASOP No. 12, *Risk Classification*, for guidance.

3.10 New Plans or Benefits—The actuary should consider available data relevant to new plans or benefits. In the absence of sufficient data, the actuary should use data from similar benefits or plans of coverage that are reasonably consistent with the new plans or benefits.

3.11 Projection of Future Capital and Surplus—As part of a health filing, the filing actuary may be called upon to project future capital and surplus for the entire health plan entity or a portion of it, such as a business unit. In doing so, the filing actuary should base the projection on reasonable assumptions that take into account any internal or external future actions known to the filing actuary that, in the filing actuary's professional judgment, are likely to have a material effect on capital or surplus.

3.12 Regulatory Benchmark—The actuary may be called upon to project results in relation to a regulatory benchmark for the entire health plan entity or a portion of it, such as a line of business. The actuary should base the projection on appropriate available information about the relevant book of business.

Regulatory benchmarks might include, but are not limited to, the following:

3.12.1 Rate Adequacy—Rates may be considered adequate if they provide for payment of claims, administrative expenses, taxes, regulatory fees, and have reasonable contingency or profit margins.

3.12.2 Rates Not Excessive—Rates may be considered excessive if they exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins.

3.12.3 Rates Not Unfairly Discriminatory—Rates may be considered unfairly discriminatory if the rates result in premium differences among insureds within similar risk categories that: (1) are not permissible under applicable law or regulation; or (2) in the absence of an applicable law or regulation, do not reasonably correspond to differences in expected costs.

3.12.4 Projected Loss Ratio—A projected loss ratio may be considered unreasonable if it does not meet or exceed a threshold under applicable law or regulation.

3.13 Reasonableness of Assumptions—The actuary should review the assumptions employed in the filing for reasonableness. The assumptions should be reasonable in the aggregate and for each assumption individually. The support for reasonableness should be determined based on the actuary's professional judgment, using relevant information available to the actuary. This information may include, but is not limited to, business plans; past experience of the health plan entity or the health benefit coverage; and any relevant industry and government studies that are generally known and reasonably available to the actuary. The actuary should make a reasonable effort to become familiar with such studies.

The filing actuary may rely upon others to provide assumptions for developing the regulatory filing. However, the filing actuary should review the assumptions for reasonableness. The filing actuary should use any such assumption only if the actuary believes it is reasonable. The filing actuary should disclose any such reliance in accordance with ASOP No. 41, *Actuarial Communications*.

3.14 Reliance on Data or Other Information Supplied by Others—When relying on data or other information supplied by others, the filing actuary should refer to ASOP No. 23, *Data Quality*, for guidance. The filing actuary should disclose any such reliance in accordance with ASOP No. 41.

3.15 Documentation—The actuary should prepare and retain documentation in compliance with the requirements of ASOP No. 41. The actuary should also prepare and retain documentation to demonstrate compliance with the disclosure requirements of section 4.1.

Section 4. Communications and Disclosures

4.1 Communications and Disclosures—When issuing actuarial communications relating to health filings for health plan entities, the actuary should refer to ASOP Nos. 23 and 41. A health filing will usually require the completion of an actuarial report, as defined by ASOP No. 41. In addition, such actuarial communications should disclose the following:

a. the sources of information;

b. any material information supplied by others and the extent of the actuary's reliance on such information;

c. any unresolved concerns the actuary may have about the information that could have a material effect on the actuarial work product;

d. any material changes to rating methodology, plan provisions, sources or quality of experience data, or assumptions since a substantially similar previous filing, if any. This includes, but is not limited to, changes in covered services, cost sharing, rating factors, and non-benefit expenses;

e. limitations on the use of the actuarial work product;

f. any conflicts arising from applicable law;

g. the definition of "actuarially sound," if that term is used to describe a process or result;

h. the disclosure in ASOP No. 41, section 4.2, if any material assumption or method was prescribed by applicable law (statutes, regulations, and other legally binding authority);

i. 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

j. 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

Background and Current Practices

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

Background

Many jurisdictions require the filing of actuarial memoranda or similar documents in connection with health plan entities. An actuary may be involved in the preparation or review of these filings. The applicable laws differ as to their content, scope, and requirements. Beginning in 2013, rate filings for the individual and small group market must comply with federal and state requirements.

Current Practices

Actuarial Practices Relating to Preparing, Reviewing and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act (October 2012) published by the American Academy of Actuaries (http://www.actuary.org/files/RRPN_100512_final.pdf) and a supplement to this practice note published as an exposure draft in April 2013 (http://www.actuary.org/files/RRPN_042613_updated_exposure_draft_final.pdf) provide information to actuaries providing rate filings subject to the Affordable Care Act. These documents provide information on current practice to actuaries preparing, reviewing, or commenting on rate filings in accordance with Section 2794 of the Public Health Service Act, as amended by the Affordable Care Act for the 2014 filings prepared in 2013. The addendum to the practice note addresses issues not addressed in the original note because official Department of Health and Human Services (HHS) guidance regarding certain items had not been finalized when the original note was published (for example, essential health benefits, actuarial value, reinsurance, risk adjustment, etc.).

HHS and the states will revise regulations and interpretations periodically. HHS has provided instructions for the preparation of actuarial memoranda and certifications as well as for the completion of the various required formats for submission of rate filings. These instructions should be reviewed and are located on the System for Electronic Rate and Form Filing (SERFF) website of the National Association of Insurance Commissioners (NAIC) at the following link: http://www.serff.com/documents/plan_management_data_templates_help_partIII_actuarial_memo.pdf .

Other useful information can be found on the Centers for Medicare & Medicaid Services (CMS) website at the following link: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.

Presentations and other training material presented by CMS may also be found on the CMS website at the following link: http://www.cms.gov/CCIIO/Resources/Training-Resources/index.html.