ACTUARIAL STANDARDS BOARD

Actuarial Standard
of Practice
No. 8

Regulatory Filings for Health Plan Entities

Revised Edition

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

Adopted by the
Actuarial Standards Board
December 2005

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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 Plan Entities

FROM: Actuarial Standards Board (ASB)

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

This booklet contains the final version of the revision of ASOP No. 8, now titled *Regulatory Filings for Health Plan Entities*.

Background

The ASB originally adopted ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans* (Doc. No. 010), in 1989. Under the guidance of the ASB Health Committee, the Task Force to Revise ASOP No. 8 has prepared this revision to be consistent with the current ASOP format and to reflect current, generally accepted actuarial practices with respect to regulatory filings for health plan entities.

Exposure Draft

The exposure draft of this ASOP was issued in September 2004 with a comment deadline of March 31, 2005. Fourteen comment letters, showing thoughtful insight of the issues, were received and considered in developing the final ASOP. For a summary of the substantive issues contained in the exposure draft comment letters and the responses, please see appendix 2.

The most significant changes since the exposure draft were as follows:

1. The language on applicable law in section 1.2 was updated to be consistent with current boilerplate language to be used in other ASOPs and removed from section 2.1.

2. The task force modified the language regarding section 3.2.2, Consistency with Business Plans (now section 3.2.3, Use of Business Plans to Project Future Results), to address commentators' concerns regarding the actuary's use of any relevant information from any business plan(s) as part of the process of setting assumptions and methodologies used in the filing. The task force also removed the requirement of consistency in assumptions between the business plan and the filing.

3. The task force modified section 3.2.3, Reasonableness of Assumptions, in the exposure draft and moved it to the last section within 3.2, Issues and Recommended Practices for Health

Filings. The language clarifies the requirements when the actuary reviews the reasonableness of assumptions.

4. The task force modified the language in section 3.2.6, New Plans or Benefits, to address the issues regarding data raised by the commentators.

5. The task force modified section 3.3, Reliance on Others (now Reliance on Data or Other Information Supplied by Others), to use language consistent with other recent ASOPs.

6. The task force changed the language in section 4.3, Deviation from Standard, to be consistent with that used in other recent ASOPs.

The Health Committee thanks all those who commented on the exposure draft.

The ASB voted in December 2005 to adopt this standard.

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ASOP No. 8—December 2005

ACTUARIAL STANDARD OF PRACTICE NO. 8

REGULATORY FILINGS FOR HEALTH PLAN ENTITIES

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 for health plan entities and health benefit plans provided by health plan entities.

1.2 Scope—This standard applies to actuaries when performing professional services with respect to preparing or reviewing health filings, as defined in section 2.3, required by and made to state insurance departments, state health departments, the federal government, and other regulatory bodies. 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*); 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. It represents areas of inquiry and analysis that an actuary should consider when preparing or reviewing a required health filing for purposes of compliance with applicable law.

The actuary should satisfy the requirements of applicable law (statutes, regulations, case law, and other legally binding authority) and this standard. However, to the extent

applicable law conflicts with this standard, compliance with such applicable law shall not be deemed a deviation from this standard, provided the actuary discloses that the actuarial assignment was performed in accordance with the requirements of such applicable law.

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 all applicable filing work performed on or after May 1, 2006.

Section 2. Definitions

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

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

2.2 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.

2.3 Health Filing—A required regulatory filing, at least one element of 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 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.

2.4 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.

2.5 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.

2.6 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 Issues and Recommended Practices for Health Filings—The actuary should consider the following:

3.2.1 Purpose of Filing—When preparing a filing, the actuary should include in the filing a statement of its purpose, identifying the applicable law it is intended to comply with. For example, the actuary might state, "The only 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."

If, in the actuary's professional judgment, applicable law is ambiguous, the actuary should describe how the actuary interpreted the requirements when preparing the filing. For example, the statute may say, "Provide a business plan demonstrating future solvency." The actuary then might state, "This projection of financial results is intended to demonstrate that the business plan reasonably anticipates surplus exceeding $XX million for the following Y years."

3.2.2 Assumptions—The actuary should consider which assumptions are necessary for the filing. Such assumptions may include the following:

a. premium levels and future rate changes;

b. enrollment projections;

c. morbidity, mortality, and lapsation levels and trends;

d. expenses, commissions, and taxes;

e. investment earnings and the time value of money;

f. health cost trends;

g. expected financial results, such as profit margin, surplus contribution, and surplus level;

h. expected impact of contractual arrangements with health care providers and administrators; and

i. expected impact of reinsurance and other financial arrangements.

3.2.3 Use of Business Plans to Project Future Results—The actuary should request and review any existing and relevant business plans for the health plan entity or health benefit plan that is the subject of the filing. The 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.

3.2.4 Use of Past Experience to Project Future Results—When setting assumptions, the actuary should adjust past experience for any known or expected changes that, in the actuary's professional judgment, are likely to materially affect 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;

d. business operations;

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

f. trends in mortality, morbidity, and lapse; and

g. administrative procedures.

The actuary should make adjustments to past experience based on earned premiums and incurred claims, 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 adjustment.

The 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.

The actuary may express past experience in terms of aggregate premium, claim, and reserve amounts, or in terms of unit results, such as incidence rates and average premium and claim amounts.

The actuary should consider the applicability and statistical credibility of the data and make appropriate modifications, if necessary.

3.2.5 Recognition of Plan Provisions—The actuary should consider pertinent plan documents or contracts and, as described to the actuary, established administrative procedures, any plan interpretations that are not written in the plan documents, and any arrangements with providers of health care.

3.2.6 New Plans or Benefits—The actuary should consider available data relevant to new plans or benefits. If using a model (for example, in the absence of sufficient data), the actuary should use a model that is reasonable and consistent with similar benefits or plans of coverage, if any, and that, if appropriate for the plan or benefit, takes into account the general characteristics of the health care delivery system.

3.2.7 Projection of Future Capital and Surplus—As part of a health filing, the 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 actuary should base the projection on reasonable assumptions that take into account any internal or external future actions as described to the actuary that, in the actuary's professional judgment, are likely to have a material effect on capital or surplus.

3.2.8 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.

3.2.9 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 plan; 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.

3.3 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.

3.4 Documentation—The actuary should prepare and retain documentation in compliance with the requirements of ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*, if applicable, and ASOP No. 41, *Actuarial Communications*. 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 regulatory filings for health plan entities, the actuary should refer to ASOP No. 23 and 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. limitations on the use of the actuarial work product;

e. any conflicts arising from applicable law; and

f. any assumptions or methods prescribed by applicable law.

4.2 Prescribed Statement of Actuarial Opinion—This ASOP does not require a prescribed statement of actuarial opinion as described in the *Qualification Standards for Prescribed Statements of Actuarial Opinion* promulgated by the American Academy of Actuaries. However, law, regulation, or accounting requirements may also apply to an actuarial communication prepared under this standard, and as a result, such actuarial communication may be a prescribed statement of actuarial opinion.

4.3 Deviation from Standard—The actuary must be prepared to justify to the actuarial profession's disciplinary bodies, or to explain to a principal, another actuary, or other intended users of the actuary's work, the use of any procedures that depart materially

from those set forth in this standard. If a conflict exists between this standard and applicable law or regulation, compliance with applicable law or regulation is not considered to be a deviation from this standard.

Appendix 1

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. Many laws are silent as to procedures and assumptions to be employed, thus giving the actuary significant discretion to exercise professional judgment in these areas.

Current Practices

The previous ASOP No. 8 had been in place since 1989. Although the task force believes that the previous standard represented generally accepted practice, this revision more accurately reflects current practices.

Appendix 2

Comments on the Exposure Draft and Responses

The exposure draft of this revised actuarial standard of practice (ASOP), *Regulatory Filings for Health Plan Entities,* was issued in September 2004, with a comment deadline of March 31, 2005. Fourteen 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 to Revise ASOP No. 8 carefully considered all comments received. Summarized below are the significant issues and questions contained in the comment letters and responses to each, which may have resulted from ASB, Health Committee, or task force discussion. Unless otherwise noted, the section numbers and titles used below refer to those in the exposure draft.

GENERAL COMMENTS	
Comment	One commentator questioned whether credit disability filings were subject to ASOP No. 8 since typically such filings require only that the actuary conform to the state's published "prima facie" rates and, thus, the filings are not "projections of future contingent events." The commentator questioned whether ASOP No. 8 should exclude credit disability in these situations.
Response	The task force did not think such a specific exclusion was appropriate and believed the general description of inclusions and exclusions was sufficient.
Comment	One commentator noted that some other standards (for example, ASOP Nos. 26 and 28) describe specific "regulatory filings for health plan entities" and that, either the relationship between these standards and ASOP No. 8 needed to be clarified in the latter, or that the name of the proposed standard was too broad and needed to be replaced.
Response	The task force noted that these filings are already specifically excluded in the second paragraph of section 1.2 and that these exclusions should adequately address these concerns.
Comment	One commentator was concerned that the scope of the proposed ASOP was too broad, stating individual health insurance carriers are often asked by regulators about the benefit cost(s) of mandates and that, depending on what the definition of a benefit filing is, almost every request could require more work or even an actuarial memorandum. Also, in many cases, the regulatory entity has a prescribed form that does not lend itself to many of the proposed requirements. For example, many states have electronic forms that allow for entering only a number or a few numbers; in most cases, there is not room to provide all of the qualifications or caveats that could be included. In addition, there is often no means to follow up with a full report.
Response	The task force believes that the definition of section 2.4 adequately addresses these concerns. The task force does not believe requests for information regarding, for example, benefit cost(s) of mandates would fall under the category of required filings.
Comment	One commentator suggested adding materiality criteria in the section that discusses reasonableness of assumptions.
Response	The task force chose not to make a distinction between levels of materiality of assumption. The task force did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.

SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.1, Purpose	
Comment	One commentator stated that "required regulatory filings" is less clear than the language in the prior standard. One of the most common types of filings is a filing for a rate increase. Most often, the filing is made to increase rates, not to meet a regulatory requirement to file. The commentator suggested striking the work "required" and striking it in the second to last paragraph of section 1.2.
Response	The task force noted that it had previously considered this issue and concluded purposely to insert the word "required" to differentiate between filings that are required by regulatory authorities, such as those required when filing for a rate increase, and other information that actuaries may submit to health regulators, such as a regulator's request for an estimate of the cost impact of a proposed regulation.
Section 1.2, Scope	
Comment	The transmittal memorandum of the exposure draft asked whether the scope was appropriate. One commentator agreed it was but believed that the second sentence could be clearer if worded as follows: "Health filings covered by this standard are filings that require projection of future contingent events in order to meet the given regulatory requirements. These health filings can be categorized into two broad categories: rate or benefit filings and financial projection filings."
Response	The task force believes that these concerns are adequately covered in sections 1.2 and section 2.3. The task force noted that most of the commentators on the first three questions asked in the transmittal memorandum agreed that the scope was appropriate and that the ASOP was clear as to whom it applied and to what types of health filings were covered.
Comment	The transmittal memorandum of the exposure draft asked whether the ASOP was clear that it applies to projections relating to capital and surplus requirements, which would include, for example, minimum risk-based capital and surplus requirements in states that have adopted the NAIC Risk-Based Capital (RBC) for Health Organizations Model Act. One commentator stated that, if the ASB wishes to further emphasize application to projections related to capital and surplus requirements, then it could include the example given above.
Response	The task force believed the descriptions were sufficiently clear to provide guidance on which filings were subject to the standard, noting that two other commentators agreed with this.
Comment	One commentator was concerned with the last paragraph regarding conflict with applicable law and believed that the last phrase should be strengthened to require the actuary to disclose items such as the nature of the departure from the requirements of the standard, the financial effects thereof, and the specific provisions of the applicable law.
Response	The task force updated the wording to be consistent with the current language to be used in other ASOPs and believed the revised language more closely addressed some of the commentator's concerns. The task force did not agree that the standard should specify what the actuary's disclosure should contain in the event of the standard conflicting with applicable law and believed that the revised wording, in combination with section 4, Communications and Disclosures, provided adequate guidance.
Comment	One commentator was concerned that including "case law" and "statutes" in a definition of applicable law might unreasonably require the actuary to be knowledgeable about court interpretations or even require the unauthorized practice of law.
Response	The definition of "applicable law" was deleted since it is now defined in "boilerplate" language in section 1.2. The task force does not believe the definition puts actuaries in the position of unauthorized practice of law, but the standard does require actuaries to be knowledgeable of applicable law germane to the actuarial assignment.

Comment	One commentator suggested that a discussion of any conflict between the standard and applicable law should be placed in the body of the standard rather than in the scope.
Response	The task force believed the current placement was appropriate and consistent with other ASOPs.
SECTION 2. DEFINITIONS	
Section 2.2, Financial Projection (now section 2.1)	
Comment	One commentator suggested inserting "covered" before "expenses."
Response	The task force believed that, if this word were added, the actuary could interpret it to mean expenses covered, for example, by premiums. Financial projections should include all expenses, which may or may not be covered by premiums. As such, the task force concluded not to add this word.
Comment	One commentator stated that a projection of covered lives in the absence of financial quantities was not considered a "financial projection" and that "covered lives" should be removed from the list. The commentator also suggested changing "administrative expenses" to "expenses" since claims are expenses too and noted that in other places in the standard "expenses" means "administrative expenses."
Response	The task force believed that covered lives often are included in financial projections and should be included in the projection. The task force also believed that "expenses" as a general term provided adequate guidance, particularly since claims are mentioned as a separate item.
Section 2.3, Health Benefit Plan (now section 2.2)	
Comment	One commentator expressed concern that "health benefit plan" is a defined term in numerous state insurance laws, but the ASOP defines it differently. The commentator suggested substituting a term such as "health coverage plan."
Response	The task force believed that the definition needed to be sufficiently broad and inclusive to cover all states' requirements and that definition contained in the exposure draft was sufficiently clear to avoid confusion with statutory language. The task force noted that terms in section 2 are defined only for their use within this standard and may depart from definitions used in other actuarial literature.
Comment	One commentator suggested adding "hospital" before "medical" and adding this sentence to the end of the paragraph: "A discount-only plan is not a health benefit plan."
Response	The task force agreed and made the first suggested change. On the second suggestion, the task force noted that, at this time, this type of product would not be subject to this ASOP since it would not require a health filing as defined under section 2.4 and believed it was unnecessary to add this sentence.
Section 2.4, Health Filing (now section 2.3)	
Comment	One commentator suggested that a definition of "manual rates" be included and that ASOP No. 8 should be expanded to cover the derivation and proper use of manual rates.
Response	The task force believed the term "manual rates" was well enough understood in the context of health filings and did not need to be defined in this ASOP. The task force did not believe that a discussion of the derivation or use of manual rates was an appropriate subject for this ASOP.

Comment	One commentator was concerned that the definition was too restrictive and questioned whether the phrase "certification of benefit values" includes filings where an actuary certifies that two sets of benefits are equivalent, which would not always require a projection into the future and may be strictly based on the current experience.
Response	The task force intends that, for a filing to be subject to this ASOP, the filing be required by a regulatory authority and that at least one element of the filing requires projection of future contingent events. If the filing does not have both of these requirements, the filing is not subject to this ASOP. In the example given by the commentator, if the benefit equivalence calculation requires a projection of future contingent events, and the actuary chooses to use current experience with zero trend, and the filing is required by a regulatory authority, the filing would be subject to this ASOP.
Comment	One commentator suggested striking the phrase "as may be defined by the regulatory body" because it does not help to strengthen the section and may in fact do harm, as applicable law can define anything as "actuarial soundness" or "rate adequacy." The power of the "regulatory body" should not be defined to dictate unsound practice.
Response	The task force noted that it had previously considered this issue and had intentionally concluded to add this language. The task force had discussed including a definition of "actuarial soundness" in this ASOP but concluded that "actuarial soundness" is a broader industry issue and decided to limit its inclusion to cover those situations in which states have specific requirements, for example, that the actuary opine that the rates are reasonable in relation to the benefits provided or that the rates meet mandated minimum loss ratio requirements.
Comment	One commentator recommended replacing the last paragraph of the section with the following: "A financial projection or business plan filing includes, but is 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."
Response	The task force noted that the suggested wording was basically the same as that contained in the exposure draft except adding the wording about business plan. The task force did not believe the reference to business plan in this paragraph was necessary.
Comment	One commentator stated that the term "health filing" is based on the undefined term "required regulatory filing." As a result, the scope of the definition is left unclear. No distinction is made between a legal requirement and an administrative request that is unsupported by statute or regulation. The commentator suggested adding the following definition of a required regulatory filing: "A required regulatory filing is a filing required by statute or regulation."
Response	The task force believed the definition of "health filing" in the exposure draft provided adequate guidance and that the proposed definition was circular.
Section 2.7, Time Value of Money (now section 2.6)	
Comment	One commentator suggested dropping the phrase "usefulness and" and leaving the term defined in terms of value only, perhaps by adding the word "monetary" before "value." Another commentator believed the definition and references to "earlier" and "later" in particular were not clear.
Response	The task force considered the wording in light of the comments but concluded that the definition, which is used in other ASOPs, was sufficiently clear.

SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Section 3.2.1, Purpose of Filing	
Comment	One commentator noted that the example in the second paragraph appeared to provide more precision than appeared to be implied by the requirement in the first sentence of this paragraph, which required the actuary only to "describe" the interpretation of the regulatory requirements. The commentator questioned what level of precision is appropriate for the description and believed that "describe" does not provide any notion of the degree of completeness needed.
Response	The task force believed the wording was appropriate and did not believe the standard should be too prescriptive.
Section 3.2.2, Consistency With Business Plan (now section 3.2.2, Assumptions, and section 3.2.3, Use of Business Plans to Project Future Results)	
Comment	One commentator suggested alternative language that would require assumptions to be consistent with contemporaneous health filings relating to the health benefit plan subject to the current filing; one commentator suggested strengthening the requirement that "the actuary should use assumptions and methodologies that are consistent with the business plan…."
Response	Section 3.2.2 from the exposure draft was reorganized into new sections 3.2.2, Assumptions, and 3.2.3, Use of Business Plans to Project Future Results, to better address these different but connected issues.
Comment	One commentator noted that the term "persistency" appears without definition. While the term has an unambiguous meaning in an individual life insurance setting, it could have multiple applications in the health insurance arena.
Response	The task force considered this and believed that the meaning should be clear within the context of each filing. The task force did not believe a definition was necessary.
Comment	One commentator stated that, in any given filing, certain assumptions may not be material and that this should be so noted in the ASOP.
Response	The task force did not believe such a statement was necessary. As noted in the task force's response to the last comment under General Comments, the task force chose not to make a distinction between levels of materiality of assumptions and did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.
Comment	Several commentators expressed concerns and raised important issues and questions on the opening paragraph of this section, including the following: One commentator found that certain terms such as "business plan," "sales results," and "overall" in "overall business results" were undefined. One commentator questioned whether the relevant sections of the business plan should be disclosed in the actuarial communication. One commentator believed the phrase "as known to the actuary" was too lenient and that the actuary should review the components of the business plan that are relevant to the determination of reasonable assumptions. One commentator noted that business plans developed by health plans to support the internal plan management serve a different purpose than the projections used to support pricing and regulatory filings. For example, they are often intended to set challenging performance goals rather than most likely outcome. The commentator stated that it would be inappropriate to base pricing assumptions on such projections, as there is no guarantee that they represent a reasonable expectation of future experience. Further, the commentator suggested that business plans subject to regulatory filing and review should be included in the definition of a health filing.

Response	The task force agreed with many of the comments and renamed the title and rewrote the section to address these issues. It is recognized there are many types of business plans, ranging from formal written documents to informal verbal discussions. To avoid being prescriptive, the language was changed to require the consideration of relevant information from whatever business plan exists and included wording about requesting such plan, although obvious. The task force removed references to consistent assumptions. The task force believed that the issue regarding documentation is adequately covered in sections 3.4 and section 4.1.
Comment	One commentator found that sections 3.2.2 and 3.2.3 of the exposure draft when read together were troublesome. Section 3.2.2 would have required consistency with the business plan. Section 3.2.3. would have described a review for reasonableness versus, among other factors, the business plan. The commentator proposed several changes to both sections, including a proposed redraft of section 3.2.2.
Response	The task force substantially rewrote sections 3.2.2 and 3.2.3, (now sections 3.2.2, 3.2.3, and 3.2.9, Reasonableness of Assumptions) and believes that these revisions adequately address the concerns mentioned.
Section 3.2.3, Reasonableness of Assumptions (now section 3.2.9)	
Comment	One commentator questioned whether the actuary should state the extent to which the assumptions are the actuary's own or that he or she is reviewing those of some other technician (who may or may not be an actuary) and perhaps assessing them to meet only the lower standard of "not unreasonable" or "in a reasonable range." The commentator stated that two aspects should be reported: (a) the applicable standard of reasonableness; and (b) who the author is. The commentator noted that, in assessing anything prepared by an actuary, the actuary's assessment is going to be strongly affected by whether the assumptions were devised by the signing actuary or by someone else and, for that matter, whether the actuary was independent or employed by the organization from which the assumptions came and questioned whether that should be the case.
Response	The task force rewrote this section and believes that this revision addresses many of the commentator's concerns.
Comment	One commentator stated that two ideas seem important here. First, the model chosen can be important because some models make assumptions explicit while other models make the same assumptions implicit. Second, it seems inappropriate to exempt implicit assumptions from the same scrutiny as the explicit assumptions. The commentator suggested renaming the section "Reasonableness of Projection Model and Assumptions."
Response	The task force believed that no change was necessary since this section applies to all assumptions, both implicit and explicit.
Comment	Two commentators raised the issue regarding materiality of assumptions and suggested wording changes to the effect that "each material assumption should be reasonable."
Response	The task force believed that it was important that all assumptions be identified and that the support for reasonableness of the assumptions be based on the actuary's professional judgment. As noted in the task force's response to the last comment under General Comments, the task force chose not to make a distinction between levels of materiality of assumptions and did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.
Comment	One commentator recommended retaining the old language in this section requiring assumptions to be reasonable based on all information available to the actuary and suggested replacing the last two sentences with the following: "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, past experience of the health plan entity or the health benefit plan, and any relevant industry and government studies."
Response	The task force substantially agreed with most of the commentator's comments and made appropriate changes to this section while adding another sentence outlining the actuary's duty to make a reasonable effort to become familiar with relevant studies.

Section 3.2.4, Use of Past Experience to Project Future Results	
Comment	One commentator suggested striking "in the actuary's professional judgment," citing it extraneous.
Response	The task force believed that decisions about materiality often depend on the actuary's professional judgment and, as such, concluded not to strike those words.
Comment	One commentator suggested that, in 3.2.4(d) the comma between "benefit" and "expense" be replaced with the word "and."
Response	The task force clarified this section (now section 3.2.4 (e)) with revised wording.
Comment	One commentator recommended including the concept of "known" changes in the first paragraph and noted that there may be changes that have taken place between the end of the experience period and the date of the filing that are known and will materially affect expected future results.
Response	The task force agreed and made the change.
Comment	One commentator noted the wording of item 3.2.4(e) is potentially confusing and recommended using either "trends in mortality and morbidity" or "trends in mortality and in the utilization and cost of services."
Response	The task force agreed and revised the section (now section 3.2.4(f)) for clarity.
Comment	One commentator stated that the discussion in the second paragraph refers to paid and incurred "claims" and to "earned premiums," etc., and yet the principles are more general and extend beyond premiums and claims to any financial flows with similar characteristics, for example, capitation income and payments, government subsidy or "reinsurance" payments, risk adjustments, state risk pool assessments, etc. The commentator asked whether more general language should be used.
Response	The task force believed that more general language was not necessary. The items mentioned are, for the most part, an element of premiums or incurred claims, for example, capitation income would be part of earned premiums and capitation payments are a part of incurred claims.
Section 3.2.5, Recognition of Plan Provisions	
Comment	One commentator stated that the phrase "as described to the actuary" in this context should be acceptable only if such descriptions are carefully documented with sufficient specificity to designate the contract provisions precisely.
Response	The task force believed that this is adequately covered with the requirements in sections 3.4 and section 4.1.
Comment	One commentator found the meaning "plan documents" unclear and questioned whether it could include employer contracts, employee certificates, group administration manuals, provider contracts, etc.
Response	The task force believed that plan documents and unwritten procedures, such as those mentioned by the commentator, can provide useful information about the plan. The task force believed that further clarification was not necessary.

Section 3.2.6, New Plans or Benefits	
Comment	One commentator suggested that the first sentence could be shortened to say, "The actuary should consider available relevant data," because the wording as it stands almost limits the paragraph to an actuary on the filing end and excludes the actuary on the reviewing end.
Response	The task force agreed and rewrote this sentence to clarify the language.
Comment	One commentator recommended rewording the second sentence of this section as follows: "In the absence of such data, the actuary should use a reasonable model that is consistent with similar benefits or plans of coverage offered by the health plan entity and that, if appropriate for the plan or benefit, takes into account the general characteristics of the health care delivery system." Another commentator believed that the second sentence was incomplete in that the model, by itself, does nothing and that the standard should state what to do with the model. The commentator believed that the standard meant that the actuary should consider the elements of the new benefits, find other existing coverages that have matching benefits to the new plan, see if the experience would apply to the new plan, and, if it does not, keep looking until a match is found.
Response	This section was rewritten. Although the wording is very similar, the phrasing has been rearranged somewhat for clarification. With regards to the second comment, the task force means that the actuary is to select a model that is intended to develop data that can be used for estimating the value of new plans or benefits from data on existing plans, when directly relevant data on the new plan are not available. The language does not require that the benefits and the experience match exactly. As with all other items under section 3.2, the results of such a model would be considered for the health filing.
Section 3.2.7, Projection of Future Capital and Surplus	
Comment	One commentator stated that the phrase "as described to the actuary" should not be used without a requirement to document what was described to the actuary.
Response	The task force believes that this is adequately covered with the requirements in sections 3.4 and section 4.1.
Section 3.2.8, Investment Income	
Comment	One commentator recommended revising section 3.2.8 of the exposure draft by substituting "reasonable earnings rates" for "a reasonable earnings rate." This would (a) allow for earnings rates varying by the average duration of liabilities; and (b) leave room for stochastic interest rate studies (admittedly rare at present, but a concern for very long-term products such as LTC). The present wording seems to require use of a single rate.
Response	This section was deleted but the term "investment earnings" has been included without further description in the list of assumption in new section 3.2.2, Assumptions.
Section 3.2.9, Regulatory Benchmark (now section 3.2.8)	
Comment	One commentator believed that the second sentence was a general statement that applied to any filing and, thus, belonged in section 3.2.4. The commentator suggested that, if it is desirable to mention regulatory benchmark in the standard, it should be done in section 3.2.1.
Response	The task force believed that sections 3.2.4 and 3.2.6 already provide for the use of appropriate relevant information in their respective descriptions. The task force considered the commentator's second suggestion regarding having regulatory benchmark be a part of section 3.2.1. The task force concluded to keep it as a separate subsection under section 3.2 because of the importance and relative uniqueness of these types of projections.

Section 3.3, Reliance On Others (now Reliance on Data or Other Information Supplied by Others)	
Comment	One commentator recommended that the word "descriptions" be included so that it would read, "…on information, including data and descriptions…." Another commentator expressed concern about the reliance on information supplied by others and any due diligence the actuary should perform on that information.
Response	The task force revised this section to be consistent with language used in other current ASOPs and notes that ASOP No. 23, *Data Quality*, provides expanded guidance on these issues.
SECTION 4. COMMUNICATIONS AND DISCLOSURES	
Section 4.1, Communication and Disclosures	
Comment	One commentator expressed concern with item 4.1(b), stating actuaries will adopt blanket boilerplate statements that absolve them of the responsibility to inform the employer or client who may rely on their judgments and what they relied on.
Response	The task force agreed and modified the language.
Comment	One commentator expressed a concern about whether the actuary has been required to estimate the extent that adopting an assumption dictated by laws or regulations has changed the results of the calculations. The commentator suggested that one way to do this would be to make section 4.1(e) more explicit, for example, by stating, "any conflicts arising from applicable law or regulations and their effects on the calculations."
Response	The task force decided not to change the language from that contained in the exposure draft. The task force believed that this suggested requirement would put a greater burden on the actuary and does not necessarily reflect generally accepted practice. It may be a good thing to know but would not be part of a required regulatory filing.