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● **DISCUSSION DRAFT** ●

**Revision of  
Actuarial Standard of Practice No. 8,  
Regulatory Filings for Health Plan Entities,  
to Include Specific Issues Related to  
the Accountable Care Act and Additional Guidance on Rating**

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**Actuarial Standards Board**

**TABLE OF CONTENTS**

Transmittal Memorandum iii

**STANDARD OF PRACTICE**

Section 1. Purpose, Scope, Cross References, and Effective Date	1
1.1 Purpose	1
1.2 Scope	1
1.3 Cross References	2
1.4 Effective Date	2
Section 2. Definitions	2
2.1 Financial Projection	2
2.2 Health Benefit Plan	2
2.3 Health Filing	2
2.4 Health Plan Entity	3
2.5 Legal Expert	3
2.6 Regulatory Benchmark	3
2.7 Time Value of Money	3
Section 3. Analysis of Issues and Recommended Practices	3
3.1 Introduction	3
3.2 Issues and Recommended Practices for Health Filings	4
3.2.1 Purpose of Filing	4
3.2.2 Assumptions	4
3.2.3 Rating Calculations	6
3.2.4 Use of Business Plans to Project Future Results	6
3.2.5 Use of Past Experience to Project Future Results	7
3.2.6 Recognition of Plan Provisions	8
3.2.7 New Plans or Benefits	8
3.2.8 Projection of Future Capital and Surplus	8
3.2.9 Regulatory Benchmark	8
3.2.10 Reasonableness of Assumptions	9
3.3 Reliance on Data or Other Information Supplied by Others	9
3.4 Rating Factors	9
3.5 Documentation	9
Section 4. Communications and Disclosures	10
4.1 Communications and Disclosures	10

**September 2012 Version**

**DISCUSSION DRAFT**  
**Not an Exposure Draft - For Illustrative Purposes Only**  
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**Actuarial Standards Board**

**APPENDIX**

Appendix—Background and Current Practices

11

September 2012 Version

**DISCUSSION DRAFT**  
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September 2012

**TO:** Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Regulatory Filings and Rating for Health Plan Entities

**FROM:** Actuarial Standards Board (ASB)

**SUBJ:** Discussion Draft, Revision, and Expansion of Actuarial Standard of Practice (ASOP) No. 8

This document contains a discussion draft of a potential revision of ASOP No. 8, *Regulatory Filings for Health Plan Entities*. Alternatively, some of the language specific to *filing* could be included in a revised ASOP No. 8, and new language specific to rating, as opposed to filing, could ultimately be included in a proposed new ASOP, *Rating for Health Plan Entities*. The purpose of this discussion draft is to share a portion of that work in order to collect input from interested parties as the Health Committee of the ASB continues drafting the standard. Please note that since this is a work in progress, many changes and additions are likely.

The ASB has neither reviewed nor approved this discussion draft. This is not an exposure draft and there is no particular deadline for comments. However, the Health Committee is proceeding with this project, so earlier comments are more likely to affect the contents of a proposed exposure draft or drafts. Your feedback on this project is important to us. The Health Committee would like to receive your comments by November 15, 2012.

The Health Committee may create an exposure draft or drafts that would draw on the ideas in this discussion draft, modified by discussions with and comments received from interested parties and unfolding events. Any such exposure draft would go through the normal ASOP process as follows:

1. The Health Committee will submit the Exposure Draft (ED) to the ASB.
2. The ASB revises the ED as necessary and releases it to all actuaries and other interested parties for comment.
3. Following the end of the exposure period, the Health Committee revises the ED based on comments received and produces a proposed ASOP or a second ED (depending on the extent of changes). This document follows the same process as the original ED (and even if submitted as a proposed ASOP may be changed to a second ED by the ASB).
4. An ASOP will become effective only after final approval by the ASB.

## September 2012 Version

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#### Background

The ASB originally adopted ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans* (Doc. No. 010), in 1989. ASOP No. 8 was revised in 2005.

In 2011, the Health Practice Council of the American Academy of Actuaries submitted a proposal to the ASB for a revision of ASOP 8. The stated purpose of this revision was to provide guidance on new ACA requirements, and expanded guidance on rate filing in general in anticipation of increased public scrutiny of rate filings under health reform.

The ASB and the Health Committee agreed that new guidance was needed due to the new ACA requirements on rate filings. The Health Committee deferred a decision on whether the new guidance would be in a revision of ASOP 8, or in a new ASOP that augments ASOP 8. A Task Force was formed to recommend the content of the new guidance required

The Health Committee concluded that much of the new guidance recommended by the Task Force was on rating practices, as opposed to rate filing. While the Task Force thought this level of detail on rating was appropriate, the Health Committee was concerned that it was beyond what was needed for an ASOP on rate filing. The Health Committee also noted that there is no current ASOP on rating, and that much of the additional guidance proposed by the Task Force would fit well in such an ASOP.

The Health Committee was also concerned that some of the added language was too educational or too prescriptive.

This discussion draft is structured as a revision to ASOP No. 8.

#### Request for Comments

The Health Committee is releasing this discussion draft to provide members of actuarial organizations governed by the ASOPs and other interested parties an opportunity to comment. While all comments will be considered, the committee is particularly interested in the following questions:

1. Do you believe that the additional detail on specific rating issues is appropriate for an ASOP?
2. If so, do you believe this type of detail is appropriate in an ASOP on filing, or should it be in a new ASOP on rating?

**September 2012 Version**

**DISCUSSION DRAFT**

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3. As with the current ASOP No. 8, this discussion draft covers both actuaries preparing rate filings and regulatory actuaries reviewing rate filings. As written, this draft does not have a separate section for regulatory actuaries. Instead, it is assumed that the same general guidance is appropriate for all actuaries producing or reviewing rate filings. Do you believe this structure gives appropriate guidance to regulatory actuaries? Is specific guidance needed for any of the following issues?
- Both the filing and reviewing actuary should review the assumptions for reasonableness and consistency with other related documents. Should guidance address that filing and reviewing actuaries have access to different information, or may place different emphasis on available information? For example, the regulatory actuary might consider filings for similar products from other carriers when assessing the reasonableness of assumptions
  - Should any guidance about assessing a rate filing for consistency with past filings and annual statement information differ for filing actuaries and regulatory actuaries?
  - Should any guidance about conducting sensitivity tests of the impact of likely deviations from the assumptions used in the filing Differ for filing actuaries and regulatory actuaries?
  - Should any guidance about the consideration of surplus levels when assessing the rate adequacy or excessiveness differ for filing actuaries and regulatory actuaries?
  - There may be cases where the regulatory actuary exercises judgment according to this ASOP and make 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 which the actuary has found to be adequate or approving a rate filing that the actuary has found to be inadequate. Is guidance needed for this situation?
4. ASOP No. 8 currently covers two types of regulatory filings: financial projection filings and rate filings. Most of the new language added to this Discussion Draft was written with rate filings in mind, although some could also apply to financial projection filings. Does this new detail leave the ASOP unbalanced, with too much emphasis on rate filings?
5. Section 4.1 states: “A rate filing will usually require the completion of an actuarial report, as defined by ASOP No. 41.” Does this require the filing actuary to include sufficient detail to meet the needs or regulatory actuaries?

**September 2012 Version**

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Please review this discussion draft and give the Health Committee the benefit of your comments and suggestions. Comments will not be posted to the ASB website and will not receive individual responses; however, they all will receive appropriate consideration by the Health Committee in preparing the exposure draft for approval by the ASB. Comments can be sent to [discussion@actuary.org](mailto:discussion@actuary.org). Comments will be reviewed as they are received, but are encouraged to be sent by November 15,, 2012.

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

Health Rate Filing Risk Discussion Draft  
Actuarial Standards Board  
1850 M Street, Suite 300  
Washington, DC 20036

**September 2012 Version**

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Task Force to Revise ASOP No. 8

Donna Novak, Chairperson

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**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

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actuary should consider when preparing or reviewing a required health filing for purposes of compliance with applicable law.

The standard also applies to actuaries reviewing the rate filing on behalf of state and federal regulators.

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 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;

September 2012 Version

**DISCUSSION DRAFT**  
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**Actuarial Standards Board**

- 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 Legal Expert—A third party that the actuary relies on to interpret the law and regulations related to the regulatory filing. For regulatory actuaries, this could be the legal authority designated or authorized to provide such advice for the government organization to which the actuary is responsible.
- 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 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. The actuary should be familiar with the federal and state laws, and regulations that apply to the filing. 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.

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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 to which it is intended to comply. 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 silent or ambiguous on a relevant issue, the actuary should make a reasonable effort to confirm that there is no applicable law or resolve the ambiguity. This confirmation or resolution, when required, should be obtained in writing if possible from the appropriate legal expert. The actuary should describe how they 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

The actuary should consider the impact of future changes in the underlying insured population on the projected claims. This includes, but is not limited to, changes in demographics, risk profile, or family composition.

- c. morbidity, mortality, and lapsation levels and trends
- d. non-benefit expenses, including 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

**September 2012 Version**

**DISCUSSION DRAFT**

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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, business plans, and relevant industry and government studies.

The actuary should consider the adequacy of the non-benefit expense component of premium rates relative to projected costs.

- e. 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 premium rate development. When applicable, the actuary should select rate of investment return and discount rate assumptions that are individually reasonable, mutually consistent, and reflective of the term of the contracts.

- f. health cost trends

The actuary should consider historical experience trends when estimating future trends, including detail by service category and separated by cost and utilization, if available, credible, and determined by the actuary to improve the accuracy of the rating.

The actuary should consider benefit limitations when projecting future trends from historic trends, as both the change in unit costs and utilization may be muted relative to 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.

Historical trends may not be the best predictor of future trends. The actuary should select their estimate of the trend based on their professional judgment.

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

The actuary should consider the appropriate methods and assumptions for calculating the profit margin/surplus contribution component of premium

September 2012 Version

**DISCUSSION DRAFT**  
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rates. Possible methods include, but are not limited to, the use of a target loss ratio or a target return on capital. In estimating the cost of capital, the actuary should consider the relationship between risk and return.

The actuary should consider the adequacy of the profit margin/surplus contribution component of premium rates.

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

- h. expected impact of 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 credible results.

- i. 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.

3.2.3 Rating Calculations—The actuary should consider whether the formulas used to calculate premium rates, based on the available data and relevant assumptions, are appropriate for that purpose.

3.2.4 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. The actuary is not required to use identical assumptions in developing the rate filing.

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- 3.2.5 Use of Past Experience to Project Future Results—When projecting future results, the actuary should consider the applicability of past claims experience. The actuary should consider whether experience in a particular period is appropriate as a baseline to project future costs. The actuary should also consider to what extent past experience trends are relevant to assumed future trends. The actuary should adjust past experience for 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 the health plan is marketed, underwritten, and managed, and changes in the product portfolio;
  - e. premium rates, claim payments, expenses, and taxes;
  - f. seasonality in incurred claims;
  - g. trends in mortality, morbidity, and lapse; and
  - h. administrative procedures, including claim payment practices.

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.

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The actuary should consider the applicability and statistical credibility of the data. This consideration 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 statistically credible for a particular use, the actuary should identify additional sources that are appropriate.

The actuary should consider the appropriate treatment of catastrophic claims in the experience data to account for the random nature of such events.

- 3.2.6 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.
- 3.2.7 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.
- 3.2.8 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.
- 3.2.9 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:
- a. Rate Adequacy— Rates can be considered adequate if they provide for payment of claims, administrative expenses, and have contingency or profit margins.
  - b. Rates Not Excessive—Rates may be considered excessive if they exceed the rate needed to provide for payment of claims, administrative expenses, and reasonable contingency and profit margins.



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- c. Rates Not Unfairly Discriminatory—Rates may be considered unfairly discriminatory if the rates result in premium differences between 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.
- d. Projected Loss Ratio—[to be completed later]

3.2.10 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.

The actuary may rely upon others to provide assumptions for developing the rating justification. However, the actuary should review the assumptions for reasonableness. The actuary should use any such assumption only if he/she believes it is reasonable. The actuary should disclose any such reliance in accordance with ASOP 41, Actuarial Communications.

- 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 Rating Factors—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 should be based on reasonable expected variation to the extent permitted by law or regulation. In this regard, the actuary should refer to ASOP No. 12, *Risk Classification*, for guidance.

- 3.5 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.

**September 2012 Version**

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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 and follow ASOP No. 23 and ASOP No. 41. A rate 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. limitations on the use of the actuarial work product;
  - e. any conflicts arising from applicable law;
  - f. 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);
  - g. any material changes to rating methodology, plan provisions, sources or quality of experience data, or assumptions since the previous filing. This includes, but is not limited to, changes in covered services, cost sharing, rating factors, and non-benefit expenses.
  - h. 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
  - i. 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.

A rate or benefit filing is a statement of actuarial opinion as defined in the Qualification Standards for Actuaries Issuing Statements of Opinion in the United States.

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