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Comment #4 – 10/4/13 – 9:20 p.m.

To: The Actuarial Standards Board

Fr: Timothy Jost, Barbara Yondorf, Elizabeth Abbott, Lincoln Nehring, Adam Linker, Carrie Fitzgerald, Karrol Kitt, Jen Mishory, Cynthia Zeldin, Bonnie Burns, Marguerite Herman, Lynn Quincy, Christine Barber, Brendan Bridgeland, Kathleen Gmeiner, Joe Ditre, Amy Bach, Andrea Routh,
NAIC Consumer Representatives

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

Date: October 2, 2013

Thank you for the opportunity to comment on the Proposed Revision of Actuarial Standard of Practice (ASOP) No. 8. Please find our comments attached.

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NAIC CONSUMER REPRESENTATIVE COMMENTS ON ASOP 8 DRAFT

Section 1.1 – Purpose:

This sentence refers to "performing professional services with respect to preparing or reviewing required regulatory filings related to rates or financial projections."
In Section 1.2 a sentence states "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." (emphasis added)

These sentences appear to be inconsistent. Does this ASOP apply only to "regulatory filings related to rates or financial projections" or does it also apply to "other numerical information required to be included in health filings"? If the latter, what other numerical information would be included (e.g. actuarial value calculations)?

Section 1.2 – Scope:

Reference to section 2.5 should be 2.4

It is unclear why the guidance in ASOP 8 is not applicable for filings dealing with "Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans"

A sentence states "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." (emphasis supplied) This qualification weakens the application of the ASOP and appears to allow for much different practices to be used than those set forth in the ASOP. What recommended practices have been omitted or should supplement those recommended in ASOP No. 8?

The last sentence says, "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." However, explicit disclosure of such a departure is not included in section 4. We recommend adding the following to section 4.1: "k. in all instances where, and the reasons that, the filing actuary departed 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 deemed appropriate."

Section 2.1 – Filing Actuary:

It could be interpreted that this definition only applies to the actuary(ies) who are ultimately responsible for the filing. We believe that this should apply to any actuary who worked in any way on the filing.

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It is not clear what would constitute a "peer review". A definition of what constitutes a peer review would be helpful.

This refers to work "on behalf of a health plan issuer". There is no definition of "health plan issuer". Perhaps it should refer to "health plan entity" to be consistent with the definition in Section 2.5.

Reference to section 2.9 should be 2.7

Section 2.2 – Financial Projection:

The phrase "applicable law" appears in this definition and elsewhere. However, at other places in the ASOP there is a reference to "applicable law or regulation" (Section 3.12.3). This could be interpreted to mean that "applicable law" and "regulation" are different concepts. Sections 1.2 and 4.1.h parenthetically indicate that "applicable law" includes "statutes, regulations, and other legally binding authority". We believe this should be included as a fundamental definition and then reference can be consistently made in the ASOP to "applicable law" which would include the broader definition. Another inconsistency is that sometimes instead of "applicable law" reference is made only to "law" (Section 3.9)

Section 2.3 – Health Benefit Plan:

The reference to "whether on a reimbursement, indemnity, or service benefit basis" should be expanded to "whether on a reimbursement, indemnity, service benefit or other basis" to reflect possibly that other mechanisms may be used, such as capitation or bundled payment systems.

Section 2.4 – Health Filing:

Another item that should be added to the list of rate or benefit filings is "determinations of the actuarial value or actuarial equivalence."

Section 2.5—Health Plan Entity

What is the definition of a "health benefit plan sponsor"?

Section 2.6 – Regulatory Benchmark:

It could be made clearer that the specific quantities referenced (loss ratio or capital ratio) are illustrative examples only. Possible rephrasing could be:

"Regulatory Benchmark – A measurement which may be used by the regulatory authority in evaluating a health filing. Possible benchmarks include, but are not limited to, the loss ratio, a capital ratio, or actuarial value."

Section 3.1 – Introduction:

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The phrase "thus giving the actuary **significant** discretion to exercise professional judgment" (emphasis added) appears to make a distinction between "discretion" and "significant discretion". What is the reason for including the word "significant" as a modifier to "discretion"? The use of the modifier would appear to give the actuary a greater degree of latitude than simply indicating that the actuary has discretion. If there are levels or gradations or circumstances in which additional discretion can be exercised, these differences should be more precisely defined. We believe that, for the most part, it is desirable for the actuary who is allowed a certain amount of discretion to be able to describe the basis for that variability or the provision for the exception and the basis for it. We question whether "significant discretion" is equivalent to "unfettered discretion" which is not always defined, annotated, or explained sufficiently to establish whether or not good actuarial judgment is being exercised.

For clarity, we recommend adding: "This Section 3 and the following Section 4 provide guidelines for filing actuaries where the law may be silent as well as in other situations where actuaries have discretion to exercise professional judgment in preparing and reviewing filings."

Section 3.3—Legal and Regulatory Requirements

We recommend editing the second sentence to state: "If the actuary believes applicable law is silent or ambiguous on a relevant issue, **the actuary should disclose this** and should consider obtaining guidance from an appropriate expert." After this sentence, the following sentence should be inserted: **"The name, credentials and qualifications, and guidance received from such an expert should be disclosed."**

Section 3.4 – Assumptions:

The second sentence states "These assumptions may include" whereas the list of specific assumptions states "The actuary should consider". This appears to be inconsistent. Are these items the actuary "may" consider or "should" consider? ASOP No. 1, section 2.1 draws an important distinction between these terms.

Section 3.4.4 – Non-Benefit Expenses…:

In the sentence "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" it is unclear why the phrase "when appropriate" modifies only "the health plan entity's own experience" as opposed to any of the other items. It would seem that an actuary should take into account all relevant items to the extent those are appropriate to consider. There does not appear to be a reason to single out "the health plan entity's own experience" for special treatment. To the extent an actuary believes that certain data / information is appropriate or not appropriate to rely upon, this should be disclosed and the actuary should be able to support that decision. If this reference to experience is intended to refer to a situation where, for instance, the plan has only a year's experience or is a brand new plan or health insurance issuer (e.g., a co-op), the language should be rewritten to clarify this.

It is unclear why reference is made only to "relevant industry and government studies". Other entities such as academic institutions and public interest groups could also have published relevant studies. The actuary should consider generally known and reasonably available studies,

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as opposed to only "industry and government studies." Also, should relevant studies be subjected to some standard of quality, such as peer review, publication in a refereed journal, or publication by an all payer claims database? We are particularly concerned if any industry study could be considered authoritative.

Furthermore, consideration should be given to the issues of excessive expenses and unreasonable expenses by the health plan entity and the extent to which such expenses are or are not included in the analysis.

Section 3.4.5 – Investment Earnings and the Time Value of Money:

In the sentence "The actuary should consider whether to reflect investment earnings and the time value of money in the calculations used in the filings" the words "whether to reflect" should be removed. The actuary should be required to consider these factors.

The difference between "rate of investment return" and "discount rate" is not clear. Definitions should be provided for both of these items.

Section 3.4.6 – Health Cost Trends:

The sentence "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" is problematic.

The qualifier "if available" can be interpreted in different ways. For example, it could mean (i) that the actuary already has it in his/her possession, (ii) that another person in the health plan entity has the information, (iii) that the information is accessible from the records of the health plan entity or (iv) is available in some other fashion. It should be clarified that available should be interpreted in a broad manner and not just limited to what the actuary already has, and that if the actuary does not have that information but it is reasonably accessible from elsewhere, the actuary should make a reasonable effort to obtain that information.

Does the qualifier "credible" mean that the data need to be 100% credible, or that less than fully credible data could be used to the extent of its credibility. For example, if certain data are 90% credible as opposed to 100% credible, this does not necessarily mean that the actuary should not consider that data. Such data should be relied upon and considered even if it is only partially credible to the extent that it is of value with an annotation regarding its credibility percentage so the data can be evaluated accordingly.

With regard to the phrase "determined by the actuary to improve the accuracy of the calculation used in the filing", it is unclear how the actuary could make that determination until after the detailed trend data have been reviewed and analyzed. After performing that analysis, the actuary can determine whether the detailed loss trend data improve the accuracy of the calculation and whether to use that detailed trend data. But an actuary should not be relieved of having to

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evaluate the detailed data because he/she decided a priori that it would not improve the rate calculation.

Other considerations in selecting trends can include:

- Impact of higher cost sharing or narrower networks on decreasing utilization
- Impact of economic conditions on utilization and unit costs
- Impact of cost containment procedures or quality improvement initiatives that have been implemented or could reasonably be implemented on utilization and unit costs
- Impact of the specific mechanism used to increase the consumer's share of cost ("out-of-pocket expenses.") There have been documented instances in the health care marketplace and modeling of consumer choices that confirm that an increase in the deductible amount has the most significant impact on the actuarial value.

Section 3.4.7 – Expected Financial Results…:

The sentence "When a target return on capital is used, the actuary should consider the relationship between risk and return" could imply that when a procedure other than a target return on capital is used (e.g., loss ratio target), the actuary need not consider the relationship between risk and return. That is incorrect. The actuary should always consider the relationship between risk and return when determining an appropriate "Profit Margin/Surplus Contribution".

Part of that consideration should be consistency between the target return on capital and the investment return on assets. A low value for the assumed investment return on assets implies a lower level of investment risk, which should result in a lower value for the target return on capital.

Furthermore, even if the actuary uses an alternate method, such as a target loss ratio, the actuary should be able to demonstrate that the implied overall profit--taking into account underwriting profit, investment income (including capital gains / losses) and other income-- is a reasonable value.

The sentence "The actuary should consider the adequacy of the profit margin/surplus in relation to current surplus levels" is unclear. Does it mean that if a health care entity has a large surplus level that it can use a lower profit margin because it already has more than sufficient funds? Does it mean that if a health care entity has a large surplus level that it is entitled to a larger dollar profit because it should be allowed to earn the cost of capital on the entire surplus, even if the surplus is inflated and excessive? More explanation is needed about how an actuary should consider this item.

The sentences "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

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assumptions" appears to imply that the actuary can include hidden additional profit margins in various places in the filing by using values for various parameters / assumptions that are higher than the expected value. Such a procedure is not appropriate. All the projections in the filing for various costs such as benefits and expenses should be based upon the expected future reasonable values. If the actuary believes that various margins for variability and uncertainty need to be included in the rate, those provisions should be explicitly included as part of the underwriting profit provision instead of being hidden and dispersed in various other components of the rate calculation.

Section 3.4.9 – Expected Impact of Reinsurance and Other Financial Arrangements:

The sentence starting "The actuary should consider how risk sharing, risk adjustment, or reinsurance payments should be reflected …" should be made more expansive. Possible wording is "The actuary should consider how risk sharing, risk adjustment, reinsurance payments, risk corridors and other financial arrangements should be reflected …"

Section 3.6 – Use of Business Plans to Project Future Results:

If the actuary considered business plans in preparing the filing, that should be explicitly stated in the filing, along with whether or not the filing actuary used the assumptions contained in the business plan.

When the actuary uses the assumptions from the business plan, there should be an explanation of why that was appropriate.

Also, when the actuary does not use the assumptions in the business plan, there should be an explanation of why the actuary believed those assumptions were not appropriate for the filing.

Section 3.7 – Use of Past Experience to Project Future Results:

The sentences "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" implies that the actuary could choose not to use actual historical claims experience and trends for the filing. If the actuary makes that determination, there should be an explanation of why such data were not used, since typical actuarial analyses are based on the premise that the historical information forms an appropriate starting basis for making future projections.

The sentence "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" is unclear. Is that referring to a situation where the original data were in error and a correction has been made? Is it referring to a situation where more recent data are available than was originally used in preparing the filing? In any case, how can the actuary know whether "the difference is material" unless the actuary actually uses the new data and compares the results to that obtained from using the prior data. In any circumstance, the reason for a revision of interpretation of the data should be fully

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documented.

Finally, when would "selection of risks" be an appropriate consideration for an actuary updating past experience, unless the actuary was considering selection of risks in the past that is no longer legal?

Section 3.12.1 Rate Adequacy:

The use of the word "may" is weak and could imply that the rate may not be considered adequate under those circumstances. In addition, the wording implies that the rates are adequate to pay for the actual costs, when the proper actuarial criterion is that the rates should provide the payment of expected costs. Furthermore, only reasonable costs should be considered in making this determination. Excessive costs due to items such as inflated expenses and inefficient claim practices should be excluded.

Similar comments apply to Sections 3.12.2 Rates Not Excessive, 3.12.3 Rates Not Unfairly Discriminatory and 3.12.4 Projected Loss Ratio. In particular, rates **must** be considered unfairly discriminatory if they are based on differences that cannot be considered under applicable law or regulation.

Section 3.13 Reasonableness of Assumptions:

It is unclear why reference is made only to "relevant industry and government studies". Other entities such as academic institutions and public interest groups could also have published relevant studies. The actuary should consider all "generally known and reasonably available" studies, as opposed to only "industry and government studies".

The sentences "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" appears to be in conflict with Section 4.1.i. which discusses "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." The former appears to indicate that the actuary is responsible for the assumption even if someone else provided it, whereas the later states the actuary can disclaim responsibility for an assumption provided by another party.

Section 4.1—Communications and Disclosures

For the reason noted in our comments above regarding Section 1.2—Scope, add the following:

> k. all instances where, and the reasons that, the filing actuary departed 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 deemed appropriate.