

Note: This version of ASOP No. 8 is no longer in effect.
It was superseded in 2006 by ASOP No. 8, Doc. No. 100.



ACTUARIAL STANDARDS BOARD

**Actuarial Standard
of Practice
No. 8**

**Regulatory Filings for Rates and
Financial Projections for Health Plans**

**Developed by the
Health Committee of the
Actuarial Standards Board**

**Adopted by the
Actuarial Standards Board
January 1989**

Reformatted and Reprinted 1990

(Doc. No. 010)

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January 1989

TO: Members of the American Academy of Actuaries and Other Persons with an Interest in Health-Related Actuarial Topics

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice No. 8

This booklet contains the final version of Actuarial Standard of Practice (ASOP) No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*.

Background

This booklet contains an actuarial standard of practice concerning regulatory filings for rates and financial projections for health plans. This standard has been prepared by the Health Committee of the ASB.

The standard was submitted to the members of the American Academy of Actuaries and other interested persons in exposure draft form in April 1988 and comments were received into June 1988. The Health Committee has considered these comments in preparing a revised standard for adoption by the ASB. A detailed report of the comments received and the committee's disposition of them follows this background information.

The standard contained in this booklet was submitted to the ASB in October 1988 and after further revision was adopted by the ASB on January 12, 1989. The ASB set April 12, 1989, as the effective date of the standard.

Change in Format Between Exposure Draft and This Final Version

Because a uniform format for actuarial standards of practice was adopted by the ASB after this standard was drafted, the document was reformatted before being submitted to the ASB for adoption. The term, *Recommendation*, denoting a standard of practice in the exposure draft, was deleted in most instances. This reflects a decision by the ASB that all of the material in the document under the new subtitle, STANDARD OF PRACTICE, is to be considered an integral part of the standard—not just the statements formerly labeled *Recommendation*.

The introductory statement in the exposure draft became section 1, Purpose, Scope, and Effective Date. New sections 2 (Definitions), 3 (Background and Historical Issues), and 4 (Current Practices and Alternatives), and a sentence specifying the effective date, were added by the Health Committee. The numbered Recommendations in the exposure draft were embodied in the

new section 5, Analysis of Issues and Recommended Practices. A new section 6, Communications and Disclosures, incorporates the final paragraph of the former introductory statement.

Responses to Comments on Exposure Draft

The Health Committee of the ASB is grateful to the respondents who submitted comments on the exposure draft. A total of twenty-one individuals responded. A majority of the respondents either expressed explicit support for the exposure draft or offered points for consideration without specific comments as to overall merit of the proposed standard. The responses of the remaining six members were generally nonsupportive of the proposed standard for various reasons. All of the comments submitted have been carefully considered by the Health Committee, and a number of changes have been made to the exposure draft as a result of the comments received.

One of the major changes made to the exposure draft was to amend the title from *Recommendations and Interpretations Concerning Health Rate Filings* to *Actuarial Standard of Practice No. 8, Regulatory Filings for Rates and Financial Projections for Health Plans*. While the revised title is longer, the committee believes that it is preferable for several reasons.

1. The revised title more clearly denotes the scope of the standard as concerning filings for both rates and financial projections.
2. As drafted, the standard does not contain any Interpretations.
3. The key words, *Actuarial Standard of Practice*, are now a required part of the titles of standards of practice.

The portion of the exposure draft that brought forward the most comments was the subject of the use of interest in calculating loss ratios, as contained in the Discussion Memorandum that preceded the standard and in Recommendation No. 4, now section 5.4.

The exposure draft document stated first (in the background portion) that the Discussion Memorandum formed a part of the standard itself, but then stated later that it did not form part of the standard. The Discussion Memorandum was meant to highlight potential views on a particular issue of which the committee wanted members to be particularly aware. The Discussion Memorandum does *not* form a part of the standard itself.

The wording in the exposure draft concerning reasonableness of assumptions as to the time value of money in Recommendation No. 4 (now section 5.4) has not been changed. Although the Discussion Memorandum sent with the exposure draft did contain the word *require* in several places, the committee believes that the wording in the exposure draft, which has been sustained in the final standard, does not require or mandate the use of any interest rate, per se, in determining loss ratios for purposes of regulatory filings. The standard does require that actuarial assumptions in general, including any assumptions as to the time value of money, be reasonable.

Section 5.4 provides that “such reasonableness should be determined using all information available to the actuary and the actuary's judgment.” Such information and judgment includes the provisions of the applicable regulation with respect to the handling of the time value of money, and the actuary's interpretation of such regulatory provisions, if any. The actuary should always be prepared to support the assumptions employed.

In section 1, the committee has clarified the scope of the standard and the change in title. A sentence has been added as to the compliance nature and setting of the standard.

The title of Recommendation No. 3, now section 5.3, has been changed to focus more on the consistency of the business plan and actuarial assumptions. In addition, the list of items that may be included in the business plan has been reduced somewhat.

Several changes have been made to Recommendation No. 5, now section 5.5. An addition was made to clarify that past experience includes not only aggregate experience data but also unitized data such as frequency and severity data. A paragraph was added that requires the actuary to review for reasonableness any past experience data employed in the filing.

In addition, a number of other changes were made throughout the exposure draft to conform with the changes described above.

The final standard contains a new section, section 6.3, which deals with deviations from the standard. It is the intention of the ASB to make this provision in all actuarial standards of practice.

The Health Committee considered closely whether these changes warranted sending another exposure draft to the membership, or whether the revised standard should be submitted for approval as a final standard. The committee decided that re-exposure of the document was not necessary.

The Health Committee wishes to thank all of the members who provided their input and comments on the exposure draft. This input has improved the final standard.

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ACTUARIAL STANDARD OF PRACTICE NO. 8

REGULATORY FILINGS FOR RATES AND FINANCIAL PROJECTIONS FOR HEALTH PLANS

PREAMBLE

Section 1. Purpose, Scope, and Effective Date

- 1.1 Purpose—Many jurisdictions require the filing of actuarial memoranda or similar documents in connection with the filing of rates and financial projections for health plans. The purpose of this standard of practice is to set forth recommended practices for actuaries involved in the preparation and/or the review of these health filings.
- 1.2 Scope—This standard is intended to apply to filings submitted to state insurance departments and other regulatory bodies for benefits provided by individual and group health plans and contracts and to filings made in conjunction with applications for licensure and rates for health maintenance organizations, hospital and medical service organizations, etc. Such filings may be required both for new plans and for revisions to existing plans.

This standard applies to the extent not inconsistent with the regulatory requirements with which the filing is to comply. This standard of practice is not meant to be a complete set of general recommended practices for health rates and financial projections. It represents areas of inquiry and analysis that an actuary must consider when preparing or reviewing a health filing for purposes of compliance with regulatory authorities or regulations. For example, the standard does not address the issue of rate adequacy.

The final decision as to the approval or disapproval of a filing may not rest ultimately in the hands of an actuary. Nevertheless, both the preparer and the reviewer should be guided by this standard.

- 1.3 Effective Date—This standard is effective April 12, 1989.

Section 2. Definitions

- 2.1 Health Plans—The term includes all contracts providing medical, dental, vision care, disability income, accidental death and dismemberment, and similar benefits, on either a reimbursement or service-benefit basis, sold by insurance companies, health maintenance organizations, hospital and medical service organizations, and other entities subject to regulatory authorities.
- 2.2 Health Filings—In this standard, the term is used to denote regulatory filings for rates or financial projections for health plans.
- 2.3 Plan Provisions—The term includes administrative practices, plan interpretations, and arrangements with providers of health care.

Section 3. Background and Historical Issues

Many jurisdictions require the filing of actuarial memorandums or similar documents in connection with the filing of rates and financial projections for health plans. Both the preparation and the review of these filings may require the involvement of an actuary. The applicable regulations differ as to their content, scope, and requirements. Most of these regulations, however, leave room for the actuary to exercise considerable professional judgment and variation in practice. For example, the regulations are usually silent as to the choice of actuarial assumptions.

This standard serves to guide both the preparing and reviewing actuary by setting forth certain generally accepted, fundamental actuarial procedures and considerations that pertain to these filings.

Section 4. Current Practices and Alternatives

Applicable regulations vary considerably as to the requirements and the procedures for these filings. Many are silent as to procedures and assumptions to be employed, thus giving the actuary wide latitude in these areas.

Proper actuarial practice in this area involves the use of reasonable and appropriate assumptions and procedures. Given the regulatory nature of these filings, it is possible that techniques may be employed and assumptions may be chosen so as merely to meet the regulatory requirements, without consideration of sound actuarial principles and practices. A purpose of this standard is to guide the actuary in avoiding such a practice.

STANDARD OF PRACTICE

Section 5. Analysis of Issues and Recommended Practices

- 5.1. Purpose of Filing—This provision relates to the need for an actuary preparing a health filing to include in that filing a statement of purpose.

The filing should include a statement that the filing has been prepared for the purpose of demonstrating compliance with regulatory authority and may not be appropriate for other purposes.

The filing should clearly identify the specific regulatory requirements with which the filing is intended to comply. An example of such a statement might be, “The purpose of this rate filing is to demonstrate that the anticipated loss ratio of this product meets the minimum requirement of your state. This rate filing is not intended to be used for other purposes.”

If the specific requirements are unclear or ambiguous, the actuary should outline the interpretation employed in the health filing.

- 5.2. Recognition of Benefit Plan Provisions—This provision relates to the need to recognize all pertinent plan provisions when preparing or reviewing a health filing.

The actuary preparing the filing should be familiar with pertinent plan documents or contracts and with established administrative procedures and plan interpretations not written in the plan documents.

The actuary should be aware of applicable regulatory requirements which may supersede provisions of the plan documents.

- 5.3. Consistency of Business Plan and Assumptions—This provision relates to the requirement of consistency between the business plan and assumptions used in the filing.

The actuary should obtain a knowledge and understanding of the business plan for the health plan(s) addressed in the filing as a part of the setting of the assumptions used in the filing.

The actuary should be satisfied that the assumptions used in a health filing are consistent with the business plan. The business plan may include but is not limited to:

- a. expected sales results;
- b. expected characteristics of the insured population based on underwriting practices, etc.;

- c. expected commissions and expenses;
- d. expected overall financial results;
- e. planned method of sale and renewal;
- f. expected timing and magnitude of future rate increases; and
- g. health care delivery system contracts.

5.4 Reasonableness of Assumptions—This provision relates to the requirement that assumptions employed in health filings be reasonable.

An actuary involved in the preparation or review of health filings should be satisfied that the assumptions employed in the filing are reasonable. Such reasonableness should be determined using all information available to the actuary and the actuary's judgment.

For example, it may not be appropriate to use net annual claim costs or net annual premiums from a valuation table for rate filing purposes without appropriate adjustment.

The assumptions should include reasonable provisions for policy terminations if material and appropriate for the filing being made.

The assumptions employed should make a reasonable provision for the time value of money, if material and appropriate for the filing being made and if such provision is not inconsistent with the regulatory requirement with which the filing is to comply.

5.5 Use of Past Experience to Project Future Results—This provision relates to the use of past experience in health filings. Past experience is frequently used in health filings for both new and revised rates.

Past experience may be expressed in terms of aggregate premium, claim and reserve amounts, or in terms of unit results, such as incidence rates and average claim amounts.

Past experience must be adjusted for any material differences in elements affecting expected future results. Such elements may include but are not limited to the following:

- a. changes in selection of risks and demographic characteristics,
- b. changes in policy provisions,
- c. changes in business operations,
- d. changes in premium and benefit levels,
- e. changes in utilization and cost of services,

- f. changes in administrative procedures, and
- g. changes in the health care delivery system.

Past experience based on earned premiums and incurred claims should be adjusted as appropriate in a way that reasonably matches claim experience to exposure. It is not, for example, appropriate to use ratios of paid claims to collected premiums for health filing purposes without appropriate adjustment.

Prior claim reserve estimates should be updated to reflect claim development experience to date when the difference is material.

The past experience data employed should be reviewed by the actuary for reasonableness and consistency in construction from period to period.

The actuary should consider the level of the statistical credibility of the data. If the data are determined not to be fully credible, the actuary should make appropriate modifications.

- 5.6 New Plans or Benefits—This provision addresses the situation where a new plan of coverage or a new benefit within an existing plan of coverage is being developed and where no relevant data are available.

The actuary should have made a reasonable effort to obtain relevant data.

The actuary should base the health filing on a logically consistent model that is reasonable and that, if appropriate for the plan or benefit, takes into account the general characteristics of the health care delivery system.

Section 6. Communications and Disclosures

- 6.1 Interpretative Opinion 3 Applies—Actuaries preparing or reviewing regulatory filings for rates and financial projections for health plans should be mindful that provisions of Interpretative Opinion 3 of the American Academy of Actuaries *Guides to Professional Conduct* apply, as the filing constitutes a *required actuarial document*, as defined therein.
- 6.2 Statement of Purpose—Actuaries preparing health filings should include in the filings a statement of purpose, as described in section 5.1.
- 6.3 Deviation from Standard—An actuary who uses a procedure which differs from this standard should include, in the actuarial communication disclosing the result of the procedure, an appropriate and explicit statement with respect to the nature, rationale, and effect of such use.