ACTUARIAL STANDARDS BOARD

Actuarial Standard
of Practice
No. 8

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

Revised Edition

Developed by the
Task Force on Regulatory Filings of the
Health Committee of the
Actuarial Standards Board

Adopted by the
Actuarial Standards Board
March 2014

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March 2014

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

FROM: Actuarial Standards Board (ASB)

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

This document is a final version of a revision of ASOP No. 8, now titled *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*.

Background

The new federal Affordable Care Act (ACA), current publicity concerning health insurance premium rate increases, and state activity in the rate increase review sponsored by federal grants have resulted in very high visibility on this actuarial activity. Due to the significant number of changes in the rate filing and rate review process due to the ACA, the American Academy of Actuaries' Health Practice Council requested that the ASB revise ASOP No. 8, *Regulatory Filings for Health Plan Entities*. The ASB reviewed the request and agreed that the current ASOP No. 8 should be expanded to provide additional guidance. The ASB authorized a task force of the Health Committee to draft a revised version of this standard. To gather input on the direction of the scope, a discussion draft was released in January 2013 before an exposure draft of the revision was issued in June 2013.

This revision to ASOP No. 8 provides guidance to actuaries who prepare or review regulatory filings under state and federal requirements for filing health insurance premium rate increases. It also provides further guidance to actuaries reviewing regulatory filings. Furthermore, ASOP No. 8 was revised to add guidance on the preparation and review of health insurance rate filings for medical lines of business that are required by state or federal regulations.

Many health regulatory filings under ACA will become due summer 2014. Although the effective date for this standard is September 1, 2014, as noted in ASOP No. 1, *Introductory Actuarial Standard of Practice*, section 3.1.7, this standard is now a part of the actuarial literature and may provide useful information to actuaries preparing filings prior to its effective date.

Exposure Draft

The exposure draft of this revised ASOP was issued in June 2013 with a comment deadline of October 15, 2013. The task force carefully considered the six comment letters received and made changes to the language in several sections in response. For a summary of the substantive issues

contained in the exposure draft comment letters and the task force's responses, please see appendix 2.

The most significant change from the exposure draft was the deletion of section 3.8, Recognition of Plan Provisions, as it was duplicative of other guidance in the ASOP. Additional changes were made to clarify language throughout the ASOP. The ASB voted in March 2014 to adopt this standard.

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The ASB establishes and improves standards of actuarial practice. These ASOPs identify what the actuary should consider, document, and disclose when performing an actuarial assignment. The ASB's goal is to set standards for appropriate practice for the U.S.

ACTUARIAL STANDARD OF PRACTICE NO. 8

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

STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries when performing professional services with respect to preparing or reviewing required regulatory filings related to rates or **financial projection**s for health plan benefits, health insurance, and entities providing health benefits.

1.2 Scope—This standard applies to actuaries when performing professional services with respect to preparing or reviewing **health filings**, as defined in section 2.5, required by and made to state insurance departments, state health departments, the federal government (including those required by the Affordable Care Act), and other regulatory bodies. This includes reviewing actuaries when called upon to testify or review filings on behalf of consumers. Where specified, the guidance in this standard applies only to **filing actuaries**. Where not specified, the guidance applies to both **filing actuaries** and **reviewing actuaries**, as defined in section 2.

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

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

filings that are solely experience reports and do not require projection of future contingent events.

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 September 1, 2014.

Section 2. Definitions

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

2.1 Discount Rate—The rate used to discount projected cash flow to determine their present value.

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

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

2.4 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, service benefit, or other basis, irrespective of the type of **health plan entity** that provides the benefits.

2.5 Health Filing—A required regulatory filing for health benefits, accident and health insurance, and entities providing health benefits, which requires projection of future contingent events, for rates or benefits, or **financial projections**.

Rate or benefit filings include, but are not limited to, the following:

a. filings of manual rates, rating factors, or underwriting manuals;

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, such as actuarial value or actuarial equivalence, for example, as required by the Affordable Care Act; and

e. other filings of a similar nature as may be required by a regulatory body.

Financial projection filings include, but are not limited to, any filings in which the **financial projection**s 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.

2.6 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.

2.7 Rate of Investment Return—Investment income earned on funds held over time, expressed as a percentage of those funds.

2.8 Regulatory Benchmark—A measurement that may be used by the regulatory authority in evaluating a **health filing**. Possible benchmarks may include loss ratios, capital ratios, or actuarial values.

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

2.10 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 discretion to exercise professional judgment in preparing and reviewing the filings.

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

3.3 Applicable Law—When an actuary prepares or reviews a regulatory filing, the actuary should have knowledge and understanding of applicable law. If the actuary believes applicable law is silent or ambiguous on a relevant issue, the actuary should consider obtaining guidance from an appropriate expert. In this situation, the actuary should describe how the relevant issue was addressed when preparing or reviewing the filing.

3.4 Assumptions—The actuary should determine which assumptions are necessary for the filing and select appropriate assumptions. Assumptions the actuary should consider selecting include, but are not limited to, the following:

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

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

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

3.4.4 Non-Benefit Expenses, Including but Not Limited to Administrative Expenses, Commissions, Broker Fees, and Taxes—The actuary should use appropriate methods and assumptions for calculating the non-benefit expenses component of premium rates. Possible methods include, but are not limited to, the use of a target loss ratio or the estimation of expenses 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, reasonably anticipated internal or external future events, inflation, and business plans. The actuary may also consider relevant external studies. The actuary should consider the reasonableness of the non-benefit expense component of premium rates relative to projected expenses.

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

individually reasonable, mutually consistent, and reflective of the terms of the contract.

3.4.6 Health Cost Trends—The actuary should consider historical experience trends when estimating future trends. Projected trends may be based on insured or population data. When medical expense trends are projected, the actuary should consider detail by service category (for example, inpatient, outpatient, professional, and drug) or service setting (for example, nursing home, home care, or assisted living facility), separated by cost and utilization, if relevant, reasonably available, and credible.

The actuary should consider changes in benefit provisions and provider contracting when projecting future trends from historical trends, as the change in unit costs and utilization may differ from prior periods. The actuary should be aware that historical trends may not be the best predictor of future trends.

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.

In analyzing trend, the actuary should make a reasonable effort to remove and separately analyze other factors that affect cost. Examples include, but are not limited to, demographic changes, plan mix changes, durational effects, and underwriting.

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

The actuary should consider the reasonableness of the profit margin/surplus contribution in relation to the degree of risk accepted by the plan sponsor.

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

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

3.4.10 Provisions for Adverse Deviation—The actuary should consider whether the aggregate provisions for adverse deviation are sufficient to cover anticipated costs under moderately adverse experience.

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

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

3.7 Use of Past Experience to Project Future Results—The actuary should determine whether past claims experience can be used to project future results. The actuary should also determine the extent to which past experience trends are relevant to assumed future trends. The actuary should refer to ASOP No. 23, *Data Quality*, for guidance on data selection.

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

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

a. selection of risks;

b. demographic and risk characteristics of the insured population;

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

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

e. provider contracts;

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

g. seasonality in incurred claims;

h. trends in mortality, morbidity, and lapse;

i. catastrophic claim variability;

j. administrative procedures, including claim payment practices;

k. federal or state regulations (for example, risk adjustment, reinsurance, risk corridors, underwriting requirements, and benefit mandates);

l. medical practice (for example, changes in medical technology and provider organization);

m. cost containment procedures or quality improvement initiatives; and

n. economic conditions.

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

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

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

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

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

3.10 Projection of Future Capital and Surplus—As part of a **health filing**, the **filing actuary** may be called upon to project future capital and surplus for the entire **health plan entity** or a portion of it, such as a business unit. In doing so, the **filing actuary** should base the projection on reasonable assumptions that take into account any internal or external

future actions known to the **filing actuary** that, in the **filing actuary**'s professional judgment, are likely to have a material effect on capital or surplus.

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

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

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

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

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

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

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

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

3.13 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. The **filing actuary** should disclose any such reliance in accordance with ASOP No. 41.

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

Section 4. Communications and Disclosures

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

a. the sources of information;

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

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

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

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

f. the reasons that the **filing actuary** departed from the guidance set forth in this standard in order to comply with applicable law, or for any other reason the actuary deemed appropriate;

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

h. the actuary's understanding of pertinent sections of applicable law that are silent or ambiguous, as required by section 3.3;

i. any adjustments to past experience used to project future results, as discussed in section 3.7;

j. 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);

k. 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

l. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

Appendix 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 or health insurance policy filings. 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.

The recently enacted Affordable Care Act (ACA) added additional filing requirements for medical expense policies for the individual and small group markets. Beginning in 2011, rate filings for the individual and small group market must comply with new federal and state requirements resulting from the passage of the Affordable Care Act (ACA).

Current Practices

Current practices for some forms of health insurance, such as disability income and long term care are well established. However, the passage of the ACA changed the landscape for medical expense coverages.

A practice note related to ACA filings, *Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act* (October 2012) (http://www.actuary.org/files/RRPN_100512_final.pdf) was published in October 2012 by the American Academy of Actuaries. A supplement to this practice note (http://www.actuary.org/files/RRPN_042613_updated_exposure_draft_final.pdf) was published as an exposure draft in April 2013. These documents provide information to actuaries providing rate filings subject to the Affordable Care Act. These documents provide information on current practice to actuaries preparing, reviewing, or commenting on rate filings in accordance with Section 2794 of the Public Health Service Act, as amended by the Affordable Care Act for the 2014 filings prepared in 2013. The addendum to the practice note addresses a revised Department of Health and Human Services (HHS) form filing called the uniform rate review template (URRT) and actuarial memorandum instructions. The originally published practice note discussed the preliminary justification form, which was replaced by the URRT and actuarial memorandum instructions by HHS.

HHS and the states will revise regulations and interpretations periodically. HHS has provided instructions for the preparation of actuarial memoranda and certifications as well as for the completion of the various required formats for submission of rate filings. These instructions should be reviewed and are located on the System for Electronic Rate and Form Filing (SERFF)

website of the National Association of Insurance Commissioners at the following link: http://www.serff.com/documents/plan_management_data_templates_help_partIII_actuarial_memo.pdf .

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

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

Appendix 2

Comments on the Exposure Draft and Responses

The exposure draft of ASOP No. 8, *Regulatory Filings for Health Benefits, Health Insurance, and Entities Providing Health Benefits*, now titled *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits* was issued in June 2013 with a comment deadline of October 15, 2013. Six 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 on Regulatory Filings and the Health Committee of the Actuarial Standards Board carefully considered all comments received, and the Health Committee and ASB reviewed (and modified, where appropriate) the changes proposed by the task force.

Summarized below are the significant issues and questions contained in the comment letters and the responses.

The term "reviewers" in appendix 2 includes the task force, Health Committee, and the ASB. Also, unless otherwise noted, the section numbers and titles used in appendix 2 refer to those in the exposure draft.

GENERAL COMMENTS	
Comment	One commentator was concerned that the proposed revised title for the ASOP may not clearly indicate that this ASOP is intended to apply to a broader definition of health benefits (for example, long-term care or disability insurance), and suggested revising the title to include reference to "accident" or "disability"—for example, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits.*
Response	The reviewers agree and made the change.
Comment	One commentator noted that all references to "reviewing actuaries" are intended to reflect the perspective of the regulatory reviewing actuary only and not the peer-reviewing actuary. In order to clarify that different standards apply to regulatory actuaries as opposed to filing/peer reviewing actuaries, the commentator suggested the following changes to paragraphs 2 and 3 on page v: • Revisions to ASOP No. 8 will give guidance to actuaries that must prepare **or peer review** rate filings under more rigorous state and federal requirements for filing health insurance premium rate increases. It also provides further guidance to actuaries reviewing regulatory filings ~~either as peer reviewers or as regulatory actuaries~~. • ASOP No. 8 was revised to add guidance on the preparation and review of health insurance rate filings for medical lines of business that are required by state or federal regulations. The standard will apply to actuaries preparing **or peer reviewing** the rate filing, ~~peer reviewing the rate filing~~, and **to actuaries** reviewing the rate filing on behalf of state and federal regulators. In addition, the commentator noted that item 6 on page vi should reference section 3.12 rather than section 3.2.10.
Response	The reviewers removed the distinction of peer reviewers or regulatory actuaries in the first paragraph but retained the distinction of three roles in the second paragraph. The definition of "filing actuary" in

	section 2.2 of this final ASOP includes reference to peer review activity. In addition, the reviewers made sure the reference is correct.
SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.2, Scope	
Comment	Several commentators noted that in section 1.2 the reference to health filings being defined in section 2.4 instead of 2.5 is incorrect.
Response	The reviewers agree and made sure the reference is correct.
Comment	One commentator suggested that in section 1.2, Scope, the ASB consider including within the scope of this ASOP actuaries who may be called upon to testify and/or review filings on behalf of consumers.
Response	The reviewers agree and added language to include those actuaries.
Comment	One commentator suggested that, in order to draw attention to the primacy of statute/regulation over standards of practice, the last paragraph of this section be revised to state: "This Standard applies to the extent it is not inconsistent with the regulatory requirements with which the filing is to comply. If the actuary departs from the guidance set forth in this standard in order to comply with applicable laws (statutes, regulations, and other legally binding authority), or for any other reason the actuary deems appropriate, the actuary should refer to section 4. It is noted that the final decision as to the approval or disapproval of a filing may not rest ultimately in the hands of the reviewing actuary."
Response	The reviewers note that the ASOP already contemplates the primacy of applicable law and, therefore, made no change.
Comment	One commentator suggested that the scope of the guidance in ASOP No. 8 should include filings made within the scope of ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans.*
Response	The reviewers believe that the purpose of filings made within the scope of ASOP No. 26 is different than that of filings made within the scope of ASOP No. 8 and, therefore, retained the exclusion for filings subject to ASOP No. 26.
Comment	One commentator noted that, despite the last sentence in section 1.2, explicit disclosure of such a departure is not included in section 4 and, therefore, recommended 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."
Response	The reviewers agree and made the change to section 4.1(f) of this final ASOP. The reviewers also refer the commentator to ASOP No. 41.
Comment	One commentator suggested that the sentence in section 1.1 that refers to "performing professional services with respect to preparing or reviewing required regulatory filings related to rates or financial projections" and the sentence in section 1.2 that 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" are inconsistent.
Response	The reviewers agree and removed the language from section 1.2.
SECTION 2. DEFINITIONS	
Comment	One commentator stated it was not clear what would constitute a "peer review," and that adding a definition would be helpful.
Response	The reviewers believed that the term peer review is commonly used and made no change.

Comment	One commentator noted the difference between "rate of investment return" and "discount rate" is not clear and suggested that definitions be provided for both of these items.
Response	The reviewers agree and added definitions.
Section 2.1, Filing Actuary	
Comment	Several commentators noted that the reference to section 2.9 should be section 2.7.
Response	The reviewers checked the reference in the final version, and it is now correctly referred to as section 2.9.
Comment	One commentator noted that this section refers to work "on behalf of a health plan issuer" but that there is no definition of "health plan issuer." The commentator suggested this section refer to "health plan entity" to be consistent with the definition in section 2.5.
Response	The reviewers agree and made the change.
Comment	One commentator noted that it could be interpreted that this definition only applies to the actuary(ies) who are ultimately responsible for the filing and believed that it should apply to any actuary who worked in any way on the filing.
Response	The reviewers note that ASOP No. 1, *Introductory Actuarial Standard of Practice*, section 4.3 requires each individual actuary to be responsible for determining which ASOPs apply to the actuary's work. When the actuary is only responsible for part of the rate filing development or review, the actuary should follow the appropriate ASOPs that are applicable to the task at hand. Therefore, no change was made.
Section 2.2, Financial Projection	
Comment	One commentator noted an inconsistency in that sometimes instead of "applicable law" reference is made only to "law" (as is in section 3.9) and suggested "or regulation" be removed and a definition be added to explain "law."
Response	The reviewers agree and modified the language to remove "or regulation" as the scope has a parenthetical making it clear that the definition extends beyond "law."
Section 2.3, Health Benefit Plan	
Comment	One commentator noted that this section defines a health benefit plan to include a broad range of coverages, including vision, disability income, long-term care, etc., but most of the examples in the remaining sections seem to deal primarily with medical insurance. Therefore, the commentator felt that more non-medical examples should be included.
Response	The reviewers note that changes in the prior ASOP No. 8, which covered all lines of business, were reviewed and believe the revised ASOP No. 8 is still appropriate for the lines of business outlined in the scope, and made no change.
Comment	One commentator noted that 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.
Response	The reviewers agree and made the change.

Section 2.4, Health Filing	
Comment	One commentator felt that since some companies present substandard rating factors only in their underwriting manuals without referring to them elsewhere, that this section should be revised to read "a. filing of manual rates, rating factors, and underwriting manuals."
Response	The reviewers agree and made the change.
Comment	One commentator felt that an item should be added to the list of rate or benefit filings such as "determinations of the actuarial value or actuarial equivalence."
Response	The reviewers agree and made the change.
Section 2.5, Health Plan Entity	
Comment	One commentator questioned what is the definition of a "health benefit plan sponsor"?
Response	The reviewers note that this is a commonly used term that refers to the entity responsible for the health benefit plan and made no change.
Section 2.6, Regulatory Benchmark	
Comment	One commentator suggested it could be made clearer that the specific quantities referenced (loss ratio or capital ratio) are illustrative examples only and suggested the following rephrasing: "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."
Response	The reviewers agree and modified the language.
Section 2.7, Reviewing Actuary	
Comment	Two commentators suggested changing the term "reviewing actuary" to "regulatory actuary" so that it is clear that the reviewing actuary is always the regulatory actuary.
Response	The reviewers believe that "regulatory actuary" is a subset of "reviewing actuary" and made no change.
Comment	One commentator felt that "reviewing actuary" should be defined as an actuary who is responsible for reviewing a health filing on behalf of the health plan issuer. The commentator said; "This would include actuaries employed by the health plan issuer and consulting actuaries, as there seems to be a trend of health plan issuers obtaining independent review of health filings by an actuary either employed by the health plan issuer or by a consulting actuary." The commentator believes this to be a different role than a peer review.
Response	The reviewers believe that the definitions of "filing actuary" and "reviewing actuary" are clear as written, and made no change.

SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Section 3.1, Introduction	
Comment	One commentator noted that the phrase "thus giving the actuary significant discretion to exercise professional judgment" 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 commentator felt that the use of the modifier would appear to give the actuary a greater degree of latitude than simply indicating that the actuary has discretion. For clarity, the commentator 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."
Response	The reviewers removed the term "significant" but believe the recommended additional language was not necessary.
Section 3.3, Legal and Regulatory Requirements	
Comment	One commentator noted that, in the current ASOP No. 8, the predecessor of the new section 3.3 is a second paragraph of 3.2.1, which deals with the statement of the purpose of the filing. The new 3.3 is more general. The commentator suggests that the greater generality requires some changes in wording.
Response	The reviewers agree and changed section 3.3 and added an item (h) under section 4.
Comment	One commentator recommended 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." The commentator also recommended that after this sentence, the following sentence should be inserted: "The name, credentials and qualifications, and guidance received from such an expert should be disclosed."
Response	The reviewers made revisions based on the first suggestion. With respect to the second, the reviewers do not believe it is necessary to disclose the name, credentials, and qualifications of anyone who was consulted, and made no change.
Comment	One commentator noted that this section indicates that "the actuary should have the necessary knowledge and understanding of applicable law." The commentator noted that laws and regulations governing health filings are very extensive. The commentator believed that either this standard or a practice note should indicate that it is extremely difficult for an actuary to know the nuances of every law or regulation in every state.
Response	The reviewers believe the actuary has always been required to understand the applicable laws where the filing is being made, and made no change.
Section 3.4, Assumptions	
Comment	Two commentators noted that the introductory paragraph contains inconsistencies and also appears to be very prescriptive. One commentator suggested adding clarification that the assumptions listed be reviewed by the actuary for "necessity and relevancy" to the rate filing.
Response	The reviewers agree and made clarifying changes to this section.
Section 3.4.4, Non-Benefit Expenses	
Comment	One commentator indicated that 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.
Response	The reviewers agree with the commentator's suggestion and removed the phrase "when appropriate."

Comment	One commentator noted that the last sentence states "The actuary should consider the adequacy of the non-benefit expense component of premium rates relative to projected costs." The commentator went on to say that the same section, however, notes that an acceptable method for reflecting non-benefit costs is the "use of a target loss ratio."
Response	The reviewers agree and changed "adequacy" to "reasonableness" in sections 3.4.4 and 3.4.7.
Comment	One commentator stated that it is unclear why reference is made only to "relevant industry and government studies." The commentator believed that other entities such as academic institutions and public interest groups could also have published relevant studies.
Response	The reviewers agree and modified the language to include relevant external studies.
Section 3.4.5, Investment Earnings and the Time Value of Money	
Comment	One commentator noted that 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 and that the actuary should be required to consider these factors.
Response	The reviewers believe that there are situations where these considerations are immaterial and made no change.
Section 3.4.6, Health Cost Trends	
Comment	One commentator noted that trends are addressed solely in terms of medical insurance. The commentator indicated that there probably should be some mention of LTC or DI. For long-term care the commentator recommended the following: "When long-term care trends are projected, the actuary should consider the frequency, utilization, and duration of future claims by care setting (for example, nursing home, home care, or assisted living facility)."
Response	The reviewers agree and revised the section to be more general, as well as included examples from other lines of business, to address the commentator's concerns.
Comment	One commentator suggested that a statement indicating that trends may be based on insured or population data should be included.
Response	The reviewers agree and included a sentence in section 3.4.6.
Comment	One commentator noted that the last paragraph states that, "the actuary should select an estimate of the trend based on the actuary's professional judgment. For example, historical trends may or may not be the best predictor of future trends." The commentator felt that the paragraph is probably not necessary since the process of selecting assumptions is almost always based on professional judgment.
Response	The reviewers agree and modified the language.
Comment	One commentator noted that this section includes a number of items that should be considered when determining trend. The commentator recommended also including items that should not be considered, essentially identifying factors that are outside of trend. The commentator suggested adding language such as, "In analyzing trend, the actuary should make an effort to remove and separately analyze other factors that affect cost."
Response	The reviewers agree and revised the language accordingly.
Comment	One commentator suggested adding "provider contracting" to the following: "The actuary should consider changes in benefit provisions and provider contracting when projecting future trends from historical trends, as the change in unit costs and utilization may differ from prior periods."
Response	The reviewers agree and made the change.

Comment	One commentator stated that 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.
Response	The reviewers made changes to clarify the guidance.
Comment	One commentator asked if the qualifier "credible" means that the data needs to be 100% credible, or that less than fully credible data could be used to the extent of its credibility.
Response	As discussed in ASOP No. 25, *Credibility Procedures*, the reviewers believe that the determination of "credible" is up to the actuary's professional judgment and, therefore, made no change.
Comment	One commentator stated that, 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.
Response	The reviewers agree and removed the language.
Section 3.4.7, Expected Financial Results, such as Profit Margin/Surplus Contribution, Loss Ratio, or Surplus Level	
Comment	One commentator stated that the last sentence that states "The actuary should consider the adequacy of the profit margin/surplus in relation to current surplus levels" is not universally consistent with current practices nor should it be. The commentator believes that this section should be much less prescriptive than "should consider" with respect to any particular rate filing. Another commentator stated that part of that consideration of profit margin should be consistency between the target return on capital and the investment return on assets.
Response	The reviewers agree with both comments and made appropriate changes to the section.
Comment	One commentator stated it may not be clear to all actuaries what the significance of Profit Margin/Surplus Contribution is. The commentator noted that the last paragraph reads "The actuary should consider whether the provisions for adverse deviation are appropriate to provide a margin for variability and uncertainty in projected health costs. The actuary should consider the cumulative effect of any such provisions built into other assumptions." The commentator recommended the following language: "The actuary should consider whether the aggregate provisions for adverse deviation are sufficient to cover anticipated costs under moderately adverse experience."
Response	The reviewers agree and added this language as a new section 3.4.10.
Comment	One commentator stated that 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 (for example, loss ratio target), the actuary need not consider the relationship between risk and return. The commentator felt that this is incorrect and that the actuary should always consider the relationship between risk and return when determining an appropriate "Profit Margin/Surplus Contribution."
Response	The reviewers agree and modified the language.

Comment	One commentator stated that 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 commentator stated that "The actuary should consider the cumulative effect of any such provisions built into other 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. The commentator felt that; "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."
Response	The reviewers believe that it is up to the actuary to determine the appropriate accounting and actuarial practice for the placement of margins for adverse experience. The reviewers removed the language in section 3.4.7 and added 3.4.10 regarding adverse deviation.
Section 3.4.9, Expected Impact of Reinsurance and Other Financial Arrangements	
Comment	One commentator stated that the sentence "The actuary should consider how risk sharing, risk adjustment, or reinsurance payments should be reflected ..." should be made more expansive. The commentator suggested possible wording: "The actuary should consider how risk sharing, risk adjustment, reinsurance payments, risk corridors and other financial arrangements should be reflected ...."
Response	The reviewers agree and added the phrase "and other financial arrangements."
Section 3.6, Use of Business Plan	
Comment	Two commentators noted that business plans are not generally reviewed for every rate filing. One commentator suggested that "should consider" be replaced with "may consider" while the other commentator suggested adding "If appropriate,…"
Response	The reviewers note "should consider" implies only that the actuary consider if business plans are relevant to the rates being filed, and made no change.
Comment	One commentator suggested that if the actuary considered business plans in preparing the filing, it should be explicitly stated in the filing, along with whether the filing actuary used the assumptions contained in the business plan. The commentator felt that; "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."
Response	The reviewers note that a business plan is only one potential data point in preparing assumptions for a rate filing and, therefore, made no change.
Comment	One commentator suggested that this section would benefit from language that helps distinguish how business plans should be used to develop rates versus disclosed in filings. The commentator further suggested the addition of the following sentence, "The regulatory actuary should consider requesting this information when it is important to the consideration of rate adequacy for solvency."
Response	The reviewers believe that the guidance provided by this standard is adequate for appropriate practice, and made no change.

Section 3.7, Use of Past Experience to Project Future Results	
Comment	One commentator noted that in this section there is a statement that refers to "claims of a particular service category" but that it may not be clear what the term "service category" refers to.
Response	The reviewers note that in section 3.4.6, the parenthetical identifies "service categories" and made no change.
Comment	One commentator noted that this section indicates that "The filing actuary should update prior earned premium and incurred claim estimates to reflect premium and claim development experience…" but feel that that it should state: "*When appropriate*, the filing actuary…"
Response	The reviewers note that in the phrase "in the actuary's professional judgment" implies "when appropriate" and made no change.
Comment	One commentator recommended adding two more items to the list of items to which any changes may have a material effect on expected future results. Specifically the commentator suggested: One new item (k) would be "changes to federal or state regulations (e.g., risk adjustment, reinsurance, risk corridors, underwriting requirements, and benefit mandates)." The second new item (l) would be "underlying change in medical practice (e.g., changes in medical technology and provider organization)." While this could be included in item (f), listing it separately may help actuaries think about changes to these areas specifically.
Response	The reviewers agree and made the change.
Comment	One commentator suggested the following language be inserted between the second and the third paragraphs of section 3.7: "The actuary should consider the most recent data available for the plan, giving appropriate consideration to the degree of maturity likely to be present in the claim and claim liability reserves. The actuary should consider the principles of ASOP No. 23, *Data Quality*, in the use and application of the data."
Response	The reviewers agree and added a sentence to indicate that data should be selected in accordance with ASOP No. 23, *Data Quality*.
Comment	One commentator suggested adding "The filing actuary should provide adequate documentation for such adjustments" to the paragraph.
Response	The reviewers agree and added section 4.1(i).
Comment	One commentator noted that in the sentence "To the extent that the actuary concludes that the experience data is not applicable or credible for a particular use, the actuary should identify additional sources that are appropriate (see ASOP No. 25, *Credibility Procedures*)", both instances of "actuary" be changed to "filing actuary," feeling the reviewing actuary should not be required to identify additional experience sources for use in the filing.
Response	The reviewers agree and made the change.

Comment	One commentator noted that 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. The commentator felt that 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.
Response	The reviewers disagree and made no change.
Comment	One commentator questioned 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?
Response	The reviewers note that selection of risks is still practiced for some of the products covered by this ASOP, such as disability income, long-term care, and grandfathered plans and excepted products under ACA. The reviewers made no change.
Comment	One commentator stated that 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. The commentator went on to say; "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 documented."
Response	The reviewers believe the guidance is clear and appropriate, and made no change.
Comment	One commentator suggested that other considerations in selecting trends can include: • Impact of higher cost sharing on decreasing utilization • Impact of the out-of-pocket expenses • Impact of narrower networks on decreasing utilization • Impact of cost containment or quality improvement initiatives, and • Impact of economic conditions on utilization and unit costs.
Response	The reviewers determined that cost sharing and out-of-pocket costs are covered in section 3.7(c). The reviewers determined that considerations for narrower networks are covered in 3.7(e). The reviewers added language in section 3.7(m) to address cost containment and quality improvement initiatives, and in section 3.7(n) to address the impact of economic conditions.
Section 3.8, Recognition of Plan Provisions	
Comment	One commentator expressed concern that the expectations of section 3.8 were overly broad and did not represent typical practices of actuaries.
Response	The reviewers disagree with the assertion that actuaries do not typically consider these items. However, the reviewers deleted the section as it duplicated guidance provided in other sections.
Section 3.9, Rating Factors	
Comment	One commentator noted the word "variation" in the first sentence of the second paragraph should be "variations."
Response	The reviewers agree and made the change.

Section 3.10, New Plans or Benefits	
Comment	One commentator suggested changing both instances of "actuary" to "filing actuary," as the reviewing actuary will not generally have access to the same data resources as the filing actuary.
Response	The reviewers note both the "filing actuary" and the "reviewing actuary" have a role to consider the available data relevant to new plans or benefits, and made no change.
Section 3.12, Regulatory Benchmarks	
Comment	One commentator noted that the use of the word "may" is weak and could imply that the rate may not be considered adequate under those circumstances. The commentator went on to say; "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." Another commentator noted that rates must be considered unfairly discriminatory if they are based on differences that cannot be considered under applicable law or regulation. A third commentator expressed concerns with the phrase "reasonable contingency and profit margins," and suggested using the term "not unreasonable" instead of "reasonable."
Response	The reviewers note that this section of the standard relates to regulatory benchmarks set by the regulatory process, and made no change.
Section 3.13, Reasonableness of Assumptions	
Comment	Two commentators expressed concerns that the list of study sources was too narrow.
Response	The reviewers agree and broadened the language.
Comment	One commentator suggested the last sentence of the first paragraph be revised to read, "The reviewing actuary should make a reasonable effort to become familiar with such studies provided by the filing actuary."
Response	The reviewers believe that both the filing and reviewing actuary should become familiar with such studies, and made no change.
Comment	One commentator noted that section 3.13 allows for the actuary to use his or her professional judgment to determine reasonableness of assumptions, stating that for any given assumption, it may be reasonable to vary the level of review of that assumption based on the materiality of the issue. To address this issue, the commentator suggests adding the following language: "The support for reasonableness should be determined based on the actuary's professional judgment, using relevant information available to the actuary, *and taking into account all aspects of the filing.*"
Response	The reviewers note that ASOP No. 1 includes guidance on the term "reasonable" and determined that the requirement that the actuary's professional judgment be applied is appropriate. As a result, the reviewers believe that the additional language is not needed, and made no change.
Comment	One commentator noted it may be worth commenting in this section on assumptions that are regulated, as this is covered in section 4.1, but also could be added here in the second paragraph as follows "The filing actuary should use any such assumption only if the actuary believes it is reasonable, *unless it is prescribed by applicable law*."
Response	The reviewers agree and added the phrase to section 3.12 of this final ASOP.

Comment	One commentator noted that 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 commentator stated that 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.
Response	The reviewers note that actuaries are always responsible for determining if the assumptions that they relied on are reasonable, unless prescribed by law. ASOP No. 41 requires that if actuaries disclaim responsibility for material assumptions, that disclaimer, and the reasons, must be disclosed. Therefore, no change was made.
Section 3.14, Reliance on Data or Other Information Supplied by Others	
Comment	One commentator suggested deleting "filing" from the first sentence, feeling this section should apply to both filing and reviewing actuaries.
Response	The reviewers agree and made the change.
SECTION 4. COMMUNICATIONS AND DISCLOSURES	
Section 4.1, Communications and Disclosures	
Comment	One commentator suggested the following be added: • 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.
Response	The reviewers agree and made the change.
Comment	One commentator suggested adding that filings should be complete with respect to data templates and other documentation required by the applicable regulatory authority, and submitted in the form and manner defined by that regulatory authority. The commentator felt that the ASOP should specify that this requirement only applies to templates typically completed by the filing actuary or actuary's staff as, typically, these are the templates based upon financial projections and/or premium rates.
Response	The reviewers note that the scope of this ASOP is limited to the actuarial components of a regulatory filing. The actuary should always follow applicable law, and section 4.1 provides guidance for disclosure in the event that the law requires deviation from the guidance in the ASOP. Therefore, no change was made.
APPENDIX 1	
Comment	One commentator noted that the last sentence in the opening paragraph says "Beginning in 2013…." Since HHS promulgated its "10% threshold for unreasonable rate increases" in 2011, should "2013" be "2011" (or perhaps even 2010 with the passage of the ACA).
Response	The reviewers agree and made the change.

Comment	One commentator noted that clarification related to the discussion of the rate review practice note and addendum is needed and suggested the following language: "The addendum to the practice note addresses a revised HHS form filing called the uniform rate review template (URRT) and actuarial memorandum instructions. The commentator went on to say that the originally published practice note provided guidance on the preliminary justification form, which was replaced by the URRT and actuarial memorandum instructions by HHS."
Response	The reviewers agree and modified the language.