Revision Date: December 21, 2010

Criteria and Process for Substantive Review of Individual Health Insurance Rates Filed in Arizona for the Period November 1, 2010 through April 30, 2011

Milestone 1.B.i.

Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, has developed the criteria and process to be utilized in the substantive review for individual health insurance rates filed in Arizona. The following processes address Milestone 1.B.i. and are based upon our conversations with the Arizona Department of Insurance (ADOI) staff, Mercer's preliminary review of a few individual rate filings accessed through the SERFF system and Mercer's professional experience in actuarial rate development. As we apply the review criteria and processes to the rate filings, there may be components that are identified through our review or through discussions with ADOI which result in additions, deletions or changes to this initial process document.

The revised substantive review process will be applied to 100% of administratively complete initial rate filings and at least 75% of rate revisions, as required in Milestone 1.B.ii. The results of our findings will be summarized and provided to ADOI in order to determine how often the actuarial certification of compliance is supported by the substantive review process (Milestone 1.B.iii.).

The process includes a list of items to be checked and results recorded. As Mercer performs the review, we will be looking for ways to improve upon these initial criteria for the review process. Accordingly, we may modify the criteria by adding or deleting items. Based on the findings of the review process, Mercer will make recommendations for changes to the existing forms and related filing requirements (Milestone 1.B.iv.).

The following describes the process steps and criteria to be used in this review:

1. Identify the types of insurance (TOI) included in the substantive review process.

   This initial step will narrow the scope of filings under review that are stored in the SERFF system. The process will include a review of individual health form/rate and rate filings for certain types of insurance, as identified in Table 1. Table 1 contains information on historical individual health form/rate and rate filings that will be used to form the basis for the selection of filings to review. This information will also be used to clarify the precise types of insurance filings to be reviewed. For example, the substantive review process

would include SERFF filings for Individual Health Specified Disease insurance type (H07I TOI Code) but exclude filings for Individual Health Short Term Care insurance type (H13I).

The list of the types of insurance filings to be reviewed is identified in the top section of Table 1. The filings Mercer will review include a significant majority of covered persons with comprehensive major medical (or similar) renewal coverage. The list of filings would also cover 100% of all administratively complete initial filings of the insurance types being reviewed and at least 75% of revision filings submitted between November 1, 2010 and April 30, 2011. In addition to the medical filings, Mercer will also review a sampling of the Dental (H10I TOI Code) and Vision (H20I TOI Code) filings as they reflect a sizeable portion of the total filings received by ADOI. The number of filings listed in Table 1 representing closed filings, with filing dates between October 1, 2009 and September 30, 2010, will assist in determining which filings are to be the reviewed. The bottom section of Table 1 reflects the list of filings, which will not be reviewed through the substantive review process.

Table 1 – SERFF individual health rate filings

Types of insurance filings to be reviewed		
TOI code	TOI	# of filings*
H071	Specified disease (dread disease, dread disease-cancer only, critical illness, HIV indemnity)	77
H081	Intensive care – limited benefit	3
H10I**	Dental	36
H141	Hospital indemnity	23
H151	Hospital/medical surgical expense	11
H161	Health major medical	60
H20I**	Vision	7

Types of insurance filings excluded from the review process		
TOI code	TOI	# of filings*
H021	Accident only	0
H031	Accidental death & dismemberment	0
H04	Health – blanket accident/sickness	0
H06	Conversion	0
H09I	Organ and tissue transplant – limited benefit	0
H11I	Disability income	0

Types of insurance filings excluded from the review process		
TOI code	TOI	# of filings*
H12I	Health excess stop loss	0
H13I	Short term care	4
H17I	Rx	0
H18I	Sickness	4
H19I	Health rate filings – travel	0

* Based on time period from October 1, 2009 through September 30, 2010, with closed state status and form/rate or rate type of filings

** A sampling of the Dental and Vision filings will be reviewed. However, the review will encompass less than the stated requirement for medical filings that 100% of administratively complete initial filings and 75% of revisions be reviewed.

2. Review the form/rate and rate filing submissions for acceptable documentation including following rate filing instructions for the following major categories:
   a) Rate filing checklist standards
   b) Certification of qualified actuary forms
   c) Actuarial memorandum

Rate filing checklist standards

Appendix A contains three documents that are utilized in the existing rate review process today. They include a checklist for the review requirements for health insurance rate filings, a checklist for the review requirements for individual health indemnity forms, and a certification of qualified actuary to be submitted with each rate filing. These documents are included as reference items for our rate review process. As one component of our review process, we will review these documents for applicability in the rate filings for initial filings as well as rate revisions. Items related specifically to rate development and rate structure will be included as a part of the review process. This will comprise one component of the overall rate review process. Many other components of the rate review process are detailed further in this document.

1. Complete a checklist review for individual health filings that covers the following:
   a) All legal requirements for any to-be-reviewed coverage (see Appendix A)
   b) Any ADOI interpretations of regulation, such as reasonableness of rates in relation to premium beyond the requirements in Arizona statute
   c) Applicability for each SERFF insurance type being reviewed

2. The table in Appendix A for individual health indemnity filings (forms checklist) will be used to identify current requirements to be met for each filing.
   a) Checklist element applicability will be reviewed for each bid
   b) Checklist element signoff will be reviewed for each bid

3. Determine potential checklist revisions based on this review and/or a proposal for a new checklist based on individualized insurance types to meet the following:
   a) All legal requirements for the type of insurance coverage
   b) Reasonableness of benefits in relation to premium as determined in Arizona Administrative Code Section R 20-6-607 for specific insurance types

Certification of qualified actuary forms

1. Review the rate certifications for form/rate and rate filings for completeness.
   a) Determine whether the rate certifications were filed with the following criteria:
      i) Was the actuarial certification form properly filled out?
      ii) Did the filing include a statement as to whether the filing applies only to new business, only to in-force business, or both?
      iii) Was the rate filing in compliance with applicable laws and regulations of the State?
      iv) Are the benefits reasonable in relation to the premiums, including showing the anticipated loss ratio? The anticipated loss ratio standards, as established for the different renewal clauses, as defined by Optionally Renewable (OR), Conditionally Renewable (CR), Guaranteed Renewable (GR) or Non-Cancelable (NC) coverage.
      v) Review the carriers' development and submission of the anticipated loss ratio metric. Determine the level of consistency and appropriateness in reporting this metric amongst the carriers.
      vi) Was an estimate of the expected average effect on premiums provided for previously approved forms?
      vii) Was the certification signed by a credentialed actuary?
      Arizona statute requires that rate filings be certified by a qualified actuary who is defined in statute as a member of the American Academy of Actuaries or an individual acceptable to the Director of the Department of Insurance. This assures that the rate certification is performed only by persons recognized as qualified to do so. Actuaries attain membership in the American Academy of Actuaries by satisfying education requirements demonstrated through examination as well as experience requirements and annual continuing education requirements. Their work is subject to actuarial standards of practice promulgated by the Actuarial Standards Board.
         (1) Check the actuarial credentials of the person signing the actuarial certification of the rate filing. The online Directory of Actuarial Memberships can be accessed through www.actuary.org , the Website of the American Academy of Actuaries. The online directory provides an up-to-date look at actuaries' credentials, so recent additions would be included.
         (2) The expectation is that the signing actuary is a current member of the American Academy of Actuaries. Exceptions would be noted for follow-up.
         (3) Actuary is listed as an MAAA; note year.

(4) Actuary is not listed as an MAAA, but is an Associate of the Society of Actuaries (ASA); note year for possible follow-up (could have recently applied for MAAA).
(5) Actuary is not listed as an MAAA, but is a Fellow of the Society of Actuaries (FSA); note year for possible follow-up (could have recently applied for MAAA).
(6) Exceptions to be noted for follow-up (It would be unusual for casualty actuaries (ACAS, FCAS) and pension actuaries (EA, MSPA, FSPA) to sign health rate filings).

b) Review the carriers' development and submission of the anticipated loss ratio metric.
   i) Determine the level of consistency and appropriateness in reporting this metric amongst the carriers.
c) Review the various forms that are submitted with the individual rate filings for both new filings and rate revisions.
   i) Determine if standardizing the forms and/or naming conventions will streamline the rate review process and cut down on questions and follow-up to the carriers.
   ii) Determine if separating the forms, or creating separate sections within a form, will streamline the rate filing and rate review processes.
   iii) Determine if updates or revisions to the "Rate Filing Instructions" will enhance the submission process and allow for better consistency and standardization of the reported information.
d) Review the individual filings for new carriers and/or new policy forms.
   i) Determine the level of consistency amongst these submissions.
   ii) Observe potential best practices in terms of new filings.
e) Collaborate with ADOI staff related to contacting individual signing actuaries to clarify questions or resolve issues observed throughout the review process.
f) Review the carriers' response to question 6 on the Certification of Qualified Actuary form.
   i) Determine the frequency of carriers that report an actual value versus those that only provide general information, such as "greater than 55%".
g) Reviews will be made, and potential rate certification form improvements will be considered. As transparency and public disclosure are key elements in the scope of work, ADOI and stakeholder input will be collected prior to finalizing any proposed changes to the rate certification forms.

Actuarial memorandum

Determine if the actuarial memorandum and support documentation submitted with each filing contain sufficient detail associated with the following topics:

1. Review the Actuarial Memorandums and support documents for rate form/rate filings to determine whether they include:
   a) A statement of the scope and reason for the revision.

b) A calculation of the anticipated loss ratio expressed as the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage.
c) An estimate of the expected average effect on premiums.
d) A history of the most recent five (5) years contiguous experience under existing rates for each plan number. The history may include the ratios of actual claims to the claims expected, according to the assumptions underlying the existing rates.
e) The number of members (including number of Arizona covered lives) enrolled for each form and the combined enrollment for all forms in the filing.
f) Schedule of rates which show the amount to be charged to the insured enrollees.
g) A rate history with dates of rate changes and the percentage of each change including the ratio of actual claims to the claims expected.
h) Justification and explanation of expense increases.
i) Any other additional data, including any substitution of actual claim run-offs for claim reserves and liabilities, benefit/deductible/coinsurance factors, lapse rates, trend factors and adjustment of premiums to an annual mode basis.

2. Review the Actuarial Memorandums to determine whether they meet Actuarial Standards of Practice for rate filings and actuarial communications for the following:
   a) Review the Actuarial Memorandum that accompanies the rate filing for consistency with the requirements of Actuarial Standard of Practice No. 8 *Regulatory Filings for Health Plan Entities* (ASOP 8). ASOP 8 provides binding requirements on professional work performed by actuaries who file rate certifications with state regulatory authorities. Other more general ASOP's are also applicable to portions of rate filing work such data quality, measurement of claims liabilities and actuarial communications. The review checklist would include expected responses, with exceptions noted for potential follow-up with the carriers.

3. Sources of information:
   a) Company experience on the same or similar products.
   b) Expected cost levels provided by proprietary industry studies or consulting firms.
   c) Publicly available information, such as industry or government studies or published research.
   d) Other, to be noted for potential follow-up.

4. Any material information supplied by others and the extent of the actuary's reliance on such information:
   a) No mention of reliance on information supplied by others
   b) Expected cost levels (base data, trend) provided by proprietary industry studies or consulting firms
   c) Rating factors (age/gender, geographic, tobacco use, benefit plan design) provided by proprietary industry studies or consulting firms
   d) Other, to be noted for potential follow-up

5. Any unresolved concerns the actuary may have about the information that could have a material effect on the rate filing:
   a) No mention of such unresolved concerns
   b) Any mention of such concerns will be noted for potential follow-up

6. Limitations on the use of the rate filing:
   a) Typically limited to the use by the filing company for purposes of demonstrating to regulatory authorities compliance with rate filing requirements
   b) No mention of such limitations will be noted for potential follow-up

7. Any conflicts arising from applicable law:
   a) No conflicts mentioned
   b) Any mention of such conflicts will be noted for potential follow-up

8. Any assumptions or methods prescribed by applicable law:
   a) No mention of such assumptions or methods
   b) Any mention of such assumptions or methods will be noted for potential follow-up

9. Documentation, communication and disclosure:
   a) Clear, internally consistent, and uses reasonable conclusions from available data
   b) Any ambiguities, inconsistencies or apparent unreasonable conclusions will be noted for potential follow-up

10. Earned premium and incurred claims used as base data:
    a) From sources other than experience of filing company
    b) Developed from experience of filing company within a year of rate filing date
    c) Developed from experience of filing company, but more than a year older than the rate filing date, noted for potential follow-up
    d) Other, noted for potential follow-up

11. Health care cost trends used to project base period data to rate effective period and changes within rate effective period (note trend rates for tracking):
    a) Developed from sources other than experience of filing company
    b) Developed from experience of filing company within a year of rate filing date
    c) Developed from experience of filing company, but more than a year older than the rate filing date, noted for potential follow-up
    d) Description and support for the factors involved in the annual trend computation
    e) Other, noted for potential follow-up

12. Health care rate development factors (age/gender, durational morbidity, lapse rates, geographic area):
    a) Explanation of the purpose and the effect on new or revised rates
    b) Developed from sources other than experience of filing company
    c) Developed from experience of filing company within two years of rate filing date

d) Developed from experience of filing company, but more than two years older than the rate filing date, noted for potential follow-up
e) Other, noted for potential follow-up

Appendix A

Please see accompanying PDF document.