July 29, 2011

Measurable Objective No. 1.B.iv

Arizona Department of Insurance

Final

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Measurable objective No. 1.B.iv

"Based on the conclusions developed in Milestone 1.B.iii, summarize and report to ADOI the specific reasons for non-compliance."

This is one of several measurable objectives in the contract between the Arizona Department of Insurance (ADOI) and Mercer Government Human Services Consulting (Mercer) for work under Arizona's Grant for Health Insurance Premium Review – Cycle I.

Milestone 1.B.iv.

"if the conclusion in the previous milestone (1.B.iii) is that the ADOI generally cannot rely on the actuarial certification, determine the reasons why."

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Background

Mercer, a part of Mercer Health & Benefits LLC, has conducted a substantive review for individual health insurance rate filings submitted with ADOI. The substantive review process was completed for 100% of administratively complete initial rate filings and at least 75% of rate revisions, as defined and required in Milestone 1.B.ii.

The criteria and process utilized in the substantive review were developed by Mercer based on form/rate and rate filing requirements for individual health insurance policies. These were developed based on interaction with the ADOI staff and Mercer's professional experience. The basis for the criteria and process included descriptive requirements found in ADOI rate filing instructions, ADOI review requirements checklists, Certification of a Qualified Actuary (P-124) form, Arizona Administrative Code documents and Actuarial Standards of Practice (ASOPs). The criteria and process was described and detailed as an outcome under Milestone 1.B.i.

The substantive review process was based on rate-filing documents downloaded from the System for Electronic Rate and Form Filing (SERFF). SERFF sponsorship is made through the National Association of Insurance Commissioners (NAIC) and ADOI. This initial step narrowed the scope of filings isolated for review based on Type of Insurance (TOI) designation. A summary list of the filings reviewed is provided in Appendix A. It includes TOI description and form/rate and rate-filing designation. The list for the types of insurance filings reviewed is identified in the top section of the table in Appendix A. The substantive review covered 100% of all administratively complete initial filings of the insurance types submitted between November 1, 2010 and April 30, 2011, and at least 75% of revision filings as required in the milestone/objectives. Additional reviews were made based on filings with significant volume.

The review was based on the status of filings downloaded from SERFF in February and April of 2011. A total of 70 filings were covered in this substantive review process. This included 38 form/rate filings and 32 rate filings. Rate filings consisted of rate revisions of

previously approved forms and rates, while form/rate filings usually reflected the initial introduction of a policy form and rates in the Arizona market.

The rate filings Mercer reviewed represented 64 of the filings from 36 different companies representing 151,307 Arizona policyholders. A few filings in SERFF included multiple Certification of a Qualified Actuary (P-124) forms and Actuarial Memoranda. These were segmented into separate reviews in the substantive review process to total 70 filings for potential review. Individual health major medical TOI denoted the most significant share of rate filings representing 16 of the 32 filings. Several of these rate filings represented closed blocks of business. For form/rate filings, 26 of the 38 represented either hospital indemnity coverage or specified disease coverage with limited benefits TOIs.

Arizona Administrative Code R20-6-607 listed as Appendix B was a primary guide in the substantive review process. Arizona law does not require ADOI approval in the individual health insurance market. Individual health insurance policy forms in Arizona are subject to a “file and use” system. Under ARS Section 20-1110 Approval of Forms (Appendix C), policies must be filed at least 30 days prior to their first use, and are deemed approved if not disapproved within that time. A review standards checklist sets forth a description of each legal requirement applicable to the form, the legal authority for each requirement and pertinent commentary, and includes a space for the filer to identify where in the form the element relating to those requirements can be found. The Health Insurance Rate Filing Review Requirements Checklist is required for all filings and an additional forms checklist is required to be submitted for form/rate filings.

The ADOI also provides guidance on rate-filing submission documentation by way of Rate Filing Instructions, including transmittal and certification form instructions. Documentation requested includes the Certification of Qualified Actuary (P-124) form with the attestation of a qualified actuary. The certification includes an attestation of the reasonableness of benefits in relation to premium charged and attestation that the anticipated loss ratio submitted is expected to develop over the period for which the rates are computed to provide coverage. The form includes several other requirement elements for filing support information.

It should be noted that rate filings generally differed from the form/rate filing counterpart due to the existence of historical experience and the absence of the policy form filing requirement. The following section summarizes and describes the observed variation as it relates to the filings for individual insurance actuarial certifications. The results of our findings are summarized and provide ADOI information to evaluate the compliance certification process for individual health insurance business in Arizona.

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Observed variation in filings

Anticipated loss ratio

Anticipated loss ratio information was required and detailed in the following three citations:

Arizona Administrative Code R20-6-607: Reasonableness of Benefits in Relation to Premium Charged

"C. General contents of all rate filings. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of 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."

"H. Rate revisions. With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in subsection (F) above.
1. The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;
2. The anticipated loss ratio derived by dividing (a) by (b) where a. is the sum of the accumulated benefits, from the original effective date of the form or the effective date of this regulation, whichever is later, to the effective date of the revision, and the present value of future benefits, and b. is the sum of the accumulated premiums from the original effective date of the form or the effective date of the regulation, whichever is later, to the effective date of the revision, and the present value of future premiums."

Rate filing instructions

"Arizona requires the most recent five (5) years contiguous experience data for each form number. If experience is combined for several forms, each form included must be identified. The current, cumulative and anticipated loss ratios should also be included."

Certification of a Qualified Actuary (P-124) form

"7. The basis upon which the proposed rates were determined and the calculation of the anticipated loss ratio is as follows (include the Actuarial Memorandum required under AAC R20-6-607 as a supplemental exhibit.): "

Variation

Mercer observed significant variation in the filed actuarial memoranda for individual filings. Documentation deficiency in meeting Anticipated Loss Ratio Standard was noted as form/rate filings were required to meet the standard over the entire future period of the rates. For rate revision filings, the standard was based on the entire future period of the revised rates, as well as the historical period from the first issue date of the policy.

In our review of the carriers' development and submission of the anticipated loss ratio metric, we found that many form/rate and rate filings only included responding to the actuarial certification form question that "*The anticipated loss ratio based on the rates proposed under this rate submission* is x %", with a value for "x" expressed for compliance purposes without detail or description as to the methods and processes used to determine compliance with the law. Though such a response my be found compliant with the administrative code that only specifies a "*memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio"*, Mercer did not consider these types of certifications to be compliant based on specific direction in the P-124 form requesting the calculation of the anticipated loss ratio.

Some certifications were very explicit in illustrating the anticipated loss ratio over the future period and from the original effective date of the form through the future period. Mercer considered filings that showed the calculated results without the actual calculations to be compliant based on this actuarial memorandum compliance information. Many of the form/rate filings only expressed the anticipated loss ratio without value calculation results. These filings were viewed as non-compliant. The anticipated loss ratio provided in some filings was shown as a range of results (between 68% and 78%) or only showed the anticipated loss ratio was greater than 55% (>55%), the minimum specified by law. These also were viewed as non-compliant.

Statutory requirements

To determine compliance, Mercer verified that the actuarial memorada contained sufficient support for developing the anticipated loss ratio filed in the actuarial certification. In addition, Mercer verified that the supporting information represented time periods under review which included the entire period for which rates are computed to provide coverage. In some filings there was an expressed projected rate period for the future rates. In other filings, the future rate period was not specified, which conveyed that

the rates filed did not have an end date and were to be effective until another rate adjustment filing was made. The review period also applied to the historical period for rate revisions based from the original effective date of the form or the effective date of the regulation.

Based on the criteria above, several filings were not in compliance with the anticipated loss ratio requirement due to a lack of specific support for the anticipated loss ratio calculation. This observation is based on Mercer's interpretation that explicit premiums and claim losses and/or annual loss ratios should be reported in support of meeting anticipated loss ratio requirements. Eleven of the 32 rate filings either showed some inaccuracy in reporting anticipated loss ratio data or lacked one or more data elements to sufficiently support the anticipated loss ratio outcomes. For form/rate filings, 21 of the 38 either showed some inaccuracy in reporting anticipated loss ratio data or lacked one or more data elements to sufficiently support the anticipated loss ratio outcomes.

Rate filing checklists

DOI Review Requirements Checklists

"The DOI Review Requirements Checklists are intended to aid insurers in preparing filings that comply with regulatory requirements. The checklists identify the specific standards that the DOI analysts will apply to form, advertising and rate filings to determine whether filings comply with applicable Arizona law.… All insurers are required to submit the appropriate Review Requirement Checklist with all product filings. If the appropriate checklist does not accompany the submission, the filing will be regarded as incomplete and will be returned."

The checklists include the following items:

- *Complete rate history, including dates filed*
- *Schedule of current and requested rates*
- *Arizona and nationwide specific loss experience, including earned premium, losses paid and losses incurred*
- *Exhibit demonstrating how rate revision was calculated*
- *A trend worksheet exhibiting development and calculation of annual trend*
- *Number of Arizona and nationwide policyholders affected by filing*
- *Scope and reason for rate revision*
- *Expected average effect of premiums*
- *Does rate revision apply to new business only, inforce policies only or both?*
- *Is this a closed block of business?*
- *Accreditation of actuary (Form P-124*)

Variation

The Health Insurance Rate Filing Review Requirements Checklist is required to be submitted for all filings, and an additional forms checklist is required to be submitted for form/rate filings. Mercer observed variation in the way responses were made for the Rate Filing Review Requirements Checklist and the forms checklist. The review covered checklist reference inputs and documentation support for the listed checklist item.

The checklists have a space for the filer to identify where in the form the element relating to those requirements can be found. Responses were to be made based on referencing the name of the form, page and paragraph that the reviewer could use to find the reply to the checklist reference. Many checklist responses to individual items did not have specific form, page and paragraph identification, but used some other form of response such as “We comply,” “In compliance” or “Yes” as responses. In other instances, a specific response was lacking for some checklist cells. The occasions in which a lack of a response was noted was primarily attributed to rate checklist item #1 in which documentation confirmation of certification to the reasonableness of benefits in relation to premium charged (Arizona Administrative Code Section R 20-6-607) was requested. Though a given checklist did not have a response for this checklist element, a further review found that in all non-response checklist occurrences, the P-124 form filed with the checklist did include this certification. Checklist comment on “applies to individual disability insurance policy forms and rates” may have been responsible for this lack of response for this checklist item, with filers misinterpreting “disability insurance” as “disability income insurance” instead of understanding that it included other forms of health insurance.

Other additional variations observed for checklist items are listed below:

- Not all filings included a schedule of current and requested rates (rate checklist #2).
- Not all filings demonstrated how the rate revision was calculated (rate checklist #5).
- Not all filings included a trend worksheet exhibiting development and calculation of annual trend (rate checklist #6).
  - A trend factor was provided in some filings without trend support documentation.
- Not all filings included a scope and reason for the rate revision (rate checklist #9).
- Not all filings included Arizona and nationwide specific loss experience for earned premium, losses paid and losses incurred (rate checklist #3 and #4)
- Not all filings included explanation for the rating factors used and the effect they have on rates.

Statutory requirements

For the purposes of this review, Mercer determined if the statutory requirements were satisfied with the rates checklists to include the following description of each of the types of documentation that are required to be included with all rate filings. Mercer utilized these definitions based on the rate filing instruction parameters provided below as the basis for rate filing checklist details.

Development of rates for new form: *A description of the formulation of new rates and an actuarial validation of the methodology and assumptions used is required for all rate filings relating to new forms. An explanation of all factors that affected the development of those rates must also be included.*

Development of rate revision: *A justification for any rate revision, a demonstration of how the rate changes were calculated and an actuarial validation of the methodology used must be included with all rate renewals. If no change of the rates is requested, justification of that conclusion is required.*

Trend development worksheet: *A trend worksheet exhibiting the development and calculation of the annual trend from the different factors, such as inflation, utilization, change in medical costs, etc., must be included with each filing. Each of the factors that were involved in the annual trend computation must also be described and supported.*

Rate history: *A complete rate history, including dates of rate changes and the percentage of each change. The rate history may also include the ratio of actual claims to the claims expected.*

Explanation of load factors: *All load factors, such as age/sex, area factors, weight, etc., that apply to the new or revised rates must be substantiated by an explanation of the purpose of its use and the effect they have on rates.*

Explanation of expense increases: *If premiums are increased, any proportionate increase in any expense category, such as administrative, agent commissions, reserves, etc., must be justified. Any such justification must identify which expenses are fixed and which are variable. Also, the trend used for computing expenses must be appropriate. The trend percentage that is used in the benefit calculation is not considered appropriate for expenses.*

Schedule of rates:
A rate schedule must be submitted which shows the amount to be charged to the insured persons. For rate revisions, the current rates must be submitted along with the proposed rates, showing how the change was applied. In addition, if a company chooses to file a rate formula, a sample calculation showing how the current rate and the proposed rate are each determined for a typical renewing enrollee should be demonstrated.

In summary, 59 of the total 64 rate filings had one or more elements missing and could be interpreted as not being in compliance based on all requirements of the administrative law code, rate filing instructions, checklists, certification of a qualified actuary and actuarial standards of practice. This includes elements that were only partially submitted or not submitted at all. Checklists and health care rate development factors lacked proper disclosure for many filings. Mercer found this to be the primary reason many of the filings did not pass. Deficiencies in properly completing the review requirement checklists were noted in the review details previously provided; however, a filing failing the checklist submission portion could have submitted proper substantiation when other documentation was reviewed. As previously noted, this happened frequently when the non-response to the reasonableness of benefits checklist item #1 was actually found to have a response confirmed and fulfilled in the P-124 certification document. Checklist non-disclosure for the reasonableness of benefits certification is a reason a filing may not pass, though the certification may have been contained in the P-124 document.

Certification/additional results

Additional review items

Other compliance items examined in the substantive review process include the following elements either as a component of the P-124 form or other document as listed:

- A history of the most recent five years' contiguous experience under existing rates for each plan number.
- The number of members (including number of Arizona-covered lives) enrolled for each form and the combined enrollment for all forms in the filing.
- Any other additional data, including earned premium and incurred claims used as base data, benefit/deductible/coinsurance factors, lapse rates and trend factors.
- Signed certification.
- 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).
- Other ASOPs as applicable to rate-filing work, including data quality, measurement of claims liabilities and actuarial communications.

Variation

Arizona Administrative Code R20-6-607 requires a signed certification verifying that the filing is in compliance with the applicable laws and regulations of the State of Arizona and that the rates are reasonable in relation to the benefits provided. To be "qualified" as an actuary for this purpose, a person must be listed in the Actuarial Memberships of the American Academy of Actuaries. Mercer noted additional observations in the Actuarial Certification (P-124) form. These additional observations are listed below:

- Several P-124 forms were signed by a non-actuary.
  - Individual signing the certification was the person responsible for the rate-filing submission.
  - In such cases, certification in the actuarial memorandum was usually noted to be signed by an actuary.
- Actuary's first name shown on the signed actuarial certification was different from the listed first name in the online Directory of Actuarial Memberships of the American Academy of Actuaries. Also, the actuary's employer shown in the Directory was a sister company to the company for which the rate filing was made. The combination of these made confirmation of the actuary's credentials more difficult than for the typical actuarial certification.
- Form's first issue date as part of a rate-revision filing was listed as unknown.
- Rate revision did not list the last rate submission date for the form filed and approved in Arizona.
- Filings did not include number of members enrolled for each form and the combined enrollment for all forms in the filing.

Statutory requirements

A review of the actuarial memoranda and support documents for rate form/rate filings was also made. The Arizona Administrative Code requires that each rate submission include an actuarial memorandum describing the basis on which rates were determined. No further detailed description pertaining to the actuarial memorandum content is provided by the administrative code.

Mercer observed additional variation in the actuarial support for individual rate filing certifications. These observations are not explicitly identified in regulation and, therefore, would not be used to determine compliance with the law. These other issues noted in the substantive review process include the following:

- Not all filings included a description of the formulation of new rates.
- Not all filings identified the sources of the information used for rate development.
- Some filings were deficient in the explanation of rating factors (age/gender, area, tobacco use smoking, persistency factors, health discounts/loads, credibility). Not all filings contained supporting material and/or descriptions for rate factors. All load factors that apply to rates must be substantiated by an explanation of the purpose of its use and the effect they have on rates.
- Some filings did not report historical data underlying the existing rates, including premiums, paid losses and incurred losses.
- Some filings had an Anticipated Loss Ratio that did not match the standard for the coverage type.
- Some filings had a coverage type in the Actuarial Certification that did not match the coverage type in the Actuarial Memorandum.
- Not all filings had certifications that explicitly identified the annual time period covered by the certification.

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Summary

The summarized information and observations described in the previous sections are based on Mercer's review of individual form/rate and rate filings submitted between November 1, 2010 and April 30, 2011. The substantive review encompassed evaluation of submitted information for form rate and rate filing checklists, P-124 Actuarial Certification forms and actuarial memoranda as submissions provided by ADOI. The filings provided to Mercer are assumed to reflect complete filings as submitted by the sponsoring insurer. If, through additional review, it is discovered that supporting documents were filed with ADOI, but were not included as a part of this review, the results and observations as stated in this report may be amended to reflect any new information relevant to this review. Mercer also utilized its understanding and interpretation of Arizona Administrative Code in developing the results and observations identified in this report. These reviews are not explicitly identified in regulation and therefore would not be used to determine compliance with the law. The guide for the substantive review process was based on the ADOI rate filing requested information as part of rate filing instructions, checklists and forms as well as generally accepted actuarial standard of practice

The findings and observations detailed in this report identify significant variation in how the insurers in the individual health insurance market submit actuarial certifications and documentation in support of individual insurance rate filings. A more detailed tracking of Mercer's findings for each individual filing reviewed was provided to ADOI on May 4, 2011.

Most of the individual filings complied with the vast majority of reporting measures currently requested. There were many instances in which a filing was not in compliance with all measures simply because the filing failed to disclose a proper response on the checklist form or the P-124 form. 42 of the 64 total filings did not include proper responses to the checklists and 40 of the 64 filings contained inappropriate information for the P-124 form. Only in a few instances were filings deemed to not be in compliance because the filing failed to meet anticipated loss ratio standards as set forth in Arizona's Administrative Code 20-607.

Mercer's conclusion based on its completion of the substantive review process, is improvement in the rate-filing submissions can easily be achieved for individual filings based on TOI, using the specific evaluation of the criteria currently used. Mercer intends to review these findings under the current process with ADOI and discuss recommendations for potential improvements that could be adopted for enhancement standardization in the forms and filings. Mercer will also recommend additions or changes to the existing forms and filings to improve efficiency and dependability to generate reliable evaluation outcomes for meeting the specific section of the law for individual insurance. This would include use of these documents in determining whether individual filing consistency can be centered on current and future regulatory environment for individual health insurance marketplace. These additional tasks will be conducted as a part of milestone task 1.B.iv-a.

Appendix A

TOI REPORT

Date Range: 11/01/10 - 04/30/11

TOI	RATE FILINGS*	FORMRATE FILINGS*	TOTAL FILINGS*	RATE REVIEWS COMPLETED	FORMRATE REVIEWS COMPLETED	TOTAL REVIEWS COMPLETED	% RATE REVIEWS COMPLETED	% FORMRATE REVIEWS COMPLETED	% TOTAL REVIEWS COMPLETED
H07I Individual Health - Specified Disease - Limited Benefit	10	13	**23**	9	13	**22**	90.0%	100.0%	**95.7%**
H08I Individual Health - Intensive Care - Limited Benefit	0	0	**0**	0	0	**0**	0.0%	0.0%	**0.0%**
H10I Individual Health - Dental	3	9	**12**	1	9	**10**	33.3%	100.0%	**83.3%**
H13I Individual Health - Short Term Care	1	2	**3**	1	2	**3**	100.0%	100.0%	**100.0%**
H14I Individual Health - Hospital Indemnity	1	13	**14**	1	13	**14**	100.0%	100.0%	**100.0%**
H15I Individual Health - Hospital/Surgical/Medical Expense	1	1	**2**	1	1	**2**	100.0%	100.0%	**100.0%**
H16I Individual Health - Major Medical	16	0	**16**	13	0	**13**	81.3%	0.0%	**81.3%**
TOTAL	**32**	**38**	**70**	**26**	**38**	**64**	**81.3%**	**100.0%**	**91.4%**

* These filings reflect Form/Rate and Rate filings that could be reviewed as part of the substantive review process. They exclude advertising and form type filings.

* In some instances, ADOI SERFF filings were split into multiple reviews based on the number of actuarial certifications/memorandums submitted.

Appendix B

Arizona Administrative Code

CHAPTER 6. DEPARTMENT OF INSURANCE R20-6-607 Reasonableness of Benefits in Relation to Premium Charged

A. Applicability. This rule shall apply to individual disability insurance (as defined in A.R.S. § 20-253) policy forms and rates.

B. When rate filing is required. Every individual policy form, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement form shall also be filed.

C. General contents of all rate filings. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of 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. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the rate filing is in compliance with applicable laws and regulations of this state and that the benefits are reasonable in relation to the premiums.

D. Previously approved forms. Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

1. A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums including the anticipated loss ratio for the form.
2. A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons therefore.
3. A history of the experience under existing rates, including at least the data indicated in subsection (D). The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim run-offs for claim reserves and liabilities; determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data.
4. The date and magnitude of each previous rate change, if any.

E. Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit to the NAIC annual statement convention blank. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except the data for calendar years prior to the most recent five years may be combined.

F. Evaluation experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

1. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.
2. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.
3. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.
4. The mix of business by risk classification.

G. Anticipated loss ratio standard. With respect to a new form or a currently approved form, except currently approved noncancelable policy forms, under which the average annual premium (as defined below) is expected to be at least $200, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table: For a policy form including riders and endorsements, under which the expected average annual premium per policy is $100 or more but less than $200, subtract 5 percentage points from the numbers in the table above, or if less than $100, subtract 10 percentage points. The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation). The above anticipated loss ratio standards do not apply to a class of business which is regulated by specific statutes or regulations mandating loss ratios for such business, e.g., Medicare Supplement and Credit Life and Disability.

Definitions of Renewal Clause

OR – Optionally Renewable: renewal is at the option of the insurance company.

CR – Conditionally Renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR – Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC – Non-Cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

H. Rate revisions. With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in subsection (F) above.

1. The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;

2. The anticipated loss ratio derived by dividing (a) by (b) where a. Is the sum of the accumulated benefits, from the original effective date of the form or the effective date of this regulation, whichever is later, to the effective date of the revision, and the present value of future benefits, and b. Is the sum of the accumulated premiums from the original effective date of the form or the effective date of the regulation, whichever is later, to the effective date of the revision, and the present value of future premiums. Such present values shall be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

Appendix C

Arizona Revised Statutes – Title 20 Insurance –20-1110. Approval of forms

A. Any life or disability insurance policy form, life or disability insurance application form where written application is required and is to be made a part of the policy and printed rider or endorsement form, shall not be delivered or issued for delivery in this state by a life or disability insurer unless it has been filed with and approved by the director. The director may also require that proof of death or loss forms shall be filed with and approved by the director.

B. This section shall not apply to policies, riders, endorsements or forms of unique character designed and used for insurance on a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies, and are used at the request of the individual policyholder, contract holder or certificate holder.

C. Every filing shall be made not less than thirty days in advance of any delivery. The form is approved thirty days after filing unless the director has, within the thirty day period, issued an order affirmatively approving or disapproving the form. The director may extend by not more than an additional fifteen days the period for review of the form, by giving notice of the extension before expiration of the initial thirty day period. The director may at any time, after notice and for cause shown, withdraw the director's approval.

D. Any order of the director disapproving the form or withdrawing a previous approval shall state the reasons for the action.

E. A life or disability insurer shall not issue or deliver any advertising matter or sales material to any person in this state until the life or disability insurer files the advertising matter or sales material with the director. This subsection does not require a life or disability insurer to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the life or disability insurer to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At least five days before issuing an order pursuant to this subsection, the director shall provide the life or disability insurer with a written notice of the basis of the order to provide the life or disability insurer with an opportunity to cure the alleged deficiency in the advertising matter or sales material within a single five day period for the particular advertising matter or sales material at issue. The life or disability insurer may appeal the director's order pursuant to title 41, chapter 6, article 10. Except as otherwise provided in this subsection, a life or disability insurer may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

F. The director may, by order, exempt from the requirements of this section for so long as the director deems proper any insurance document or form as specified in the order, to which, in the director's opinion, this section may not practicably be applied, or the filing and approval of which are, in the director's opinion, not desirable or necessary for the protection of the public.

G. This section shall apply also to any form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of that jurisdiction informs the director that the form is not subject to approval or disapproval by that official, and on the director's order requiring the form to be submitted to the director for the purpose. The applicable same standards shall apply to these forms as apply to forms for domestic use.

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