DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

2019 Unified Rate Review Instructions

Rate Filing Justification: Parts I, II, and III

As of March 2018

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1 Overview

1.1 Purpose

Section 2794 of the Public Health Service Act (PHSA) and the implementing regulations, 45 CFR 154, establish requirements for issuers offering non-grandfathered health insurance coverage in the small group and/or individual markets to submit rate filing information on rate increases to the Centers for Medicare & Medicaid Services (CMS). Rate Filing Justification (RFJ) submissions must provide sufficient information for State or Federal regulators to review rate filings for compliance with 45 CFR 154.215, 154.225, 147.102, and 156.80.

The Rate Filing Justification (RFJ) for single risk pool plans[1] consists of the following three parts:

- **Part I** - Unified Rate Review Template (URRT): The URRT is required for all single risk pool plans in the individual and small group markets. This includes single risk pool plans that experience no rate changes, rate decreases, as well as new single risk pool plans. It is intended to capture information needed to monitor premium increases of health insurance coverage offered through and outside an Exchange and ensure compliance with the single risk pool methodology, including allowable market level index rate adjustments to reflect risk adjustment payments and charges, and other Federal rating requirements.

- **Part II** - Written Description Justifying the Rate Increase (Consumer Justification Narrative): Part II is required only for rate increases in single risk pool products that are subject to review (i.e., a plan within the product has a rate increase of 15% or greater). Part II is a consumer-friendly narrative that provides the justification for the rate increase, describes the relevant Part I data, the assumptions used to develop the rate increase, and an explanation of the most significant factors causing the rate increase.

  Part III - Rating Filing Documentation (Actuarial Memorandum): Part III is required for any rate increase in a single risk pool plan. It is also required for any rate filing containing Qualified Health Plans (QHPs) or whenever a State requires it to be submitted. It is required for all States that do not have an Effective Rate Review Program and CMS is responsible for reviewing the rate filing. Part III is a memorandum that includes the actuarial reasoning and assumptions, justifications, and methodologies that support the entries in the URRT.

1.2 Changes to the Instructions

Changes in the 2019 Unified Rate Review (URR) Instructions include:

[1] The phrases "single risk pool plan" and "single risk pool coverage" are used to describe non-grandfathered health insurance coverage in the individual or small group (or merged) market that is subject to all of the single risk pool provisions at 45 CFR 156.80.

- Risk adjustment charges should no longer be reflected in claims on Worksheet 2 of the URRT.
- Rows 71 and 97 of Worksheet 2 in the URRT have been renamed from "Net Amt of Risk Adj" to "Risk Adjustment Transfer Amount." Risk adjustment transfer charges should be reflected here as a negative, while risk adjustment transfer payments made to a plan should be entered as a positive amount.
- URRT Worksheet 2 warnings for Total Incurred claims, payable with issuer funds and Incurred Claims PMPM (Rows 94 and 99) have been removed.
- Certain fields in Section II of Worksheet 2 of the URRT have been designated as "Optional." Issuers will still need to enter "0" in these cells if not reporting the information in order for the template to successfully validate.
- References to the rate review default threshold have been updated from 10% to 15%.
- Plan mapping exhibits have been updated to reflect more appropriate calendar year information.
- Dates from prior year URR instructions have been updated.

1.3 Public Disclosure

CMS will post the Part II written description and the information contained in Parts I and III that do not constitute trade secret or confidential commercial or financial information as defined in HHS's Freedom of Information Act (FOIA) regulations[2]. The information for all single risk pool coverage proposed rate changes (regardless of whether the increase is subject to review) and all final rate changes will be posted at https://ratereview.healthcare.gov/ and at http://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html.

A State with an Effective Rate Review Program must post on the State's website at least the information contained in Parts I, II, and III of the RFJ that CMS makes available on its website (or provide CMS's web address for such information) for proposed rate increases subject to review on a uniform date no later than the date specified by the Secretary in guidance[3]. The deadline for a State with an Effective Rate Review Program to post the same information on all final rate increases (not just those subject to review) is no later than the first day of the individual market annual open enrollment period[4].

1.4 General Instructions

Annual Submissions

[2] 45 CFR 5.31(d)
[3] 45 CFR 154.301(b)(1)(i)
[4] 45 CFR 154.301(b)(1)(ii)

All health insurance issuers offering single risk pool products in the individual, small group, and/or merged markets must submit the applicable parts of the RFJ via the Unified Rate Review (URR) module in HIOS. Issuers should check the Final Bulletin regarding the Revised Timing of Submission and Posting of Rate Filing Justifications for the 2018 Filing Year for Single Risk Pool Coverage to determine when annual rate filings must be submitted[5].

> **Tip:** When submitting quarterly rate changes in the small group market, make sure you file early enough to allow for regulatory review in time to submit new rates to the SHOP.

Small group issuers may include scheduled quarterly trend increases within the annual filing (i.e., the January 1, XXXX rate submission). An issuer may only have one active annual single risk pool submission per market in HIOS.

Quarterly Submissions

Issuers can submit a RFJ for quarterly rate changes in the small group market for single risk pool plans, if allowed by the State regulatory authority. The quarterly submission would contain rate changes beyond any scheduled trend increases included in the annual submission for subsequent quarters in the same calendar year (i.e., second, third, and/or fourth quarters). Issuers are not allowed to file trended rates for effective dates in the subsequent calendar year. An issuer may only have one active quarterly single risk pool submission per market in HIOS.

> **Tip:** An "Annual Submission" has an effective date of January 1. "Quarterly Submissions" have effective dates of April 1, July 1, or October 1.

Quarterly rate changes must be submitted at least 105 days prior to the effective date of the rate change, or such earlier deadline as established by the State. Quarterly submissions must be finalized at least 45 days prior to the effective date. Issuers offering QHPs in a Federally-facilitated Small Business Health Options Program (SHOP) should also be mindful of the data correction windows when a new Rates Table Template must be submitted. Rate filings should be submitted to allow for sufficient time for the review to be completed prior to submitting the Rates Table Template in the Plan Management module of HIOS during the data correction window.

> **Tip:** Issuers may only introduce new plans for sale through the FFMs at the beginning of a calendar year.

Index Rates

All issuers with single risk pool plans are required to set the Index Rate for an effective date of January 1 of each year and file the Index Rate with the applicable regulatory authority. This is the annual

[5] As of the date of publication of these Instructions, the FINAL Bulletin has not yet been released. Once published, it will be available at: https://www.cms.gov/CCIIO/. The DRAFT Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2018 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2019 is available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-2018-filing-timeline-bulletin.pdf

submission described above and will be labeled as the annual filing in the URR module of HIOS, even if the filing includes scheduled quarterly small group trend increases. Subject to State requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate, the market level adjustments, or the plan level adjustments for the remaining quarters of the calendar year. These are the quarterly submissions described above. The Index Rate in the quarterly filings should only reflect remaining quarterly effective dates in the same calendar year (i.e., rates for groups with effective dates in the subsequent calendar year should not be included).

Dental Plans

Only embedded pediatric dental benefits within a medical plan should be reflected in the URRT. Further, in order for the dental costs to be included in the URRT, the dental costs must be spread across the entire single risk pool in accordance with the market rating rules in calculating the projected Index Rate. Stand-alone dental plans should never be reflected in the URRT.

Optional Benefits

ALL benefits offered in a plan must be embedded in that plan. If an issuer wants to offer an "optional" benefit, there are two options:

1. The issuer can create a separate plan with the required Essential Health Benefits (EHBs) and the "optional" benefit included.

2. The issuer can offer the "optional" benefit as a separate policy in a manner that satisfies the definition of one of the categories of excepted benefits[6].

The concept of "optional riders" is incongruent with Federal rules, including the single risk pool requirements.

1.5 Market Reform Rating Rules

Issuers must comply with the Market Reform Rating Rules specified in 45 CFR 156.80 and 147.102. The following is a description of allowable rating methods and factors issuers may use when establishing their rates:

Single Risk Pool

The single risk pool, as specified in 45 CFR 156.80(a-c), must include ALL non-grandfathered covered persons (lives) an issuer has in a State, within a market (individual, small group, or combined). The experience period data includes information for transitional products/plans[7] in order to demonstrate

[6] For more information on excepted benefits, see 45 CFR 146.145 and 148.220.

[7] A transitional plan is health insurance coverage in the individual or small group market that is renewed for a policy year starting after January 1, 2014 that is, under certain conditions, not considered to be out of compliance with specified

the single risk pool. The projection period should reflect experience of transitional policies to the extent the issuer anticipates the members of those policies will be enrolled in single risk pool plans during the projection period.

Tip: The only allowable plan adjustments are found in 45 CFR 156.80(d)(2). "Other" is not an allowable plan adjustment.

Index Rate

The Index Rate is the allowed claims costs for providing Essential Health Benefits (EHBs) within the single risk pool of that market expressed on a per member per month basis. As a result, the Index Rate should be the SAME value for all non-grandfathered plans for an issuer in a State and market. This includes claims and enrollment for transitional products/plans in the experience period and in the projection period to the extent the issuer anticipates the members in those policies will be enrolled in single risk pool plans during the projection period. If an issuer projects members in transitional policies to migrate to a single risk pool policy, appropriate adjustments should be made in Worksheet 1 – Section II of the URRT to bring the costs associated with the transitional policies in line with projected costs of the singe risk pool policy in the projected experience. Projected member experience should reflect when those members are expected to enter a single risk pool plan. For example, transitional plan members expected to enroll in a single risk pool plan in October would contribute three months of projected experience.

Tip: The Index Rate is the allowed claims PMPM for providing EHBs during the applicable period.

Market-Wide Adjusted Index Rate

The Market-Wide Adjusted Index Rate is the Index Rate adjusted for Risk Adjustment and Exchange Fees (with impacts and costs spread across the whole risk pool). As a result, the Market-Wide Adjusted Index Rate should be the same value for ALL non-grandfathered plans for an issuer in a State and market.

Plan Adjusted Index Rate

The Plan Adjusted Index Rate is the Market-Wide Adjusted Index Rate further adjusted for ONLY the plan specific factors allowed by 45 CFR 156.80(d)(2) which are:

- Actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- Benefits provided under the plan that are in addition to EHBs.
- Administrative costs, excluding Exchange user fees and Risk Adjustment user fees (which are

market reforms in accordance with the CMS Transitional Policy. See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-Transitional-Policy-CY2018.pdf.

already accounted for in the Market-Wide Adjusted Index Rate).

- Only Catastrophic plans may be adjusted for the expected impact of the special eligibility categories of these plans. If an adjustment is made to catastrophic plans, this adjustment may not be recovered elsewhere in the rating process, as that would be seen as removing the catastrophic plan experience from the single risk pool.

Other adjustments not specified in 45 CFR 156.80(d)(2) are not allowed at this point in the development, such as an adjustment to recoup revenue related to the three under age 21 child dependent cap.

Calibration

The Plan Adjusted Index Rate must be calibrated for plans within the single risk pool to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco use rating factor of 1.0[8]. The intent of the calibration factors is to reset the Plan Adjusted Index Rate so that applying the age factor, geographic rating area factor, and tobacco use factor will result in the appropriate consumer adjusted premium rate for an individual age X, living in rating area Y, with the applicable tobacco load factor applied.

For each of the allowable rating factors of age, geography, and tobacco use; there is ONLY ONE calibration allowed. That is, the calibration from the single risk pool to the allowable rating factors may not vary by plan; it must be a common adjustment for all plans in a State and market. The ONLY allowable consumer level premium rate modifiers that can be calibrated are age, geography, and tobacco use.

The calibration with respect to the age curve is allowed and identifies the value on the age curve associated with the weighted average age on the standard age curve. The Plan Adjusted Index Rate and the age curve can then be used to generate the schedule of premium rates for all ages for each plan.

Calibration may be required for the geographic factors and tobacco use factors. More detailed instructions are provided later in this document regarding the requirements for these calibrations.

It is important to note that the calibration process (described above) should ONLY occur after the Plan Adjusted Index Rate has been determined, not at any point before. The cost of all benefits (EHB and non-EHB) and other expenses may not be charged to the consumer using a flat dollar amount. All components under the plan must be part of the premium charged. All components of the premium are subject to the consumer level rating adjustments, and therefore, all components of the premium should likewise have the calibration applied to them.

Fees

[8] 45 CFR 156.80(d)(3)

Fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Risk Adjustment user fees and Exchange user fees, which are applied to the Index Rate at the market level as instructed by 45 CFR 156.80(d). All other fees must be included in the development of the Plan Adjusted Index Rate, prior to the application of member level rating factors, such as age factors. No additional fees may be charged outside of the development of the Plan Adjusted Index Rate. For example, if it costs an issuer $35 to process an application, that cost must be included in the premium rate development of all policies (new issues and renewals) and subject to the member level rating factors such as age, geographic rating, and tobacco use factors. The issuer may not, in that example, charge a $35 fee per policy for submission of the application.

Consumer Adjusted Premium Rate

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group after applying the rating and premium adjustments in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography and tobacco use if necessary, and applying the allowable rating factors[9]. Allowable rating factors, found in 45 CFR 147.102(a), are as follows:

- Family Structure: Family structure takes into account family composition and the maximum of three under age 21 child dependents. The premium for family coverage is determined by summing the premiums for each individual family member, provided at most the three oldest child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor. Family tiering only occurs in States that use pure community rating and is uniformly applied to all plans in the risk pool (and published on the cciio.cms.gov website).
- Rating Area: Geographic rating areas are specific to each State, and all issuers in the State are required to follow them. Issuers may only set one rating factor per rating area, per State, per market, and that factor must apply uniformly to all plans the issuer has in that rating area. If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have a separate plan for each network in the rating area. Geographic factors should only reflect differences in the cost of delivery (which can include both unit cost and provider practice pattern differences). Geographic factors may not reflect differences in morbidity by region.
- Age Factor: Once the Plan Adjusted Index Rate is calibrated to the age curve using the weighted average age, the entire set of age rates is determined using the standard age factor of each age relative to the standard age factor for the rounded weighted average age. The age factors must be the standard age curve set by HHS or a State specific age curve (if the State requires different age factors than the standard Federal age curve)[10].

[9] Approved State specific rating variations are published on the CCIIO website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html

[10] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html

- Tobacco Use: A tobacco use surcharge (limited to 50% of the Consumer Adjusted Premium Rate) may be applied to individuals who may legally use tobacco under Federal and State law.

The following graphic depicts the flow of the index rate development process:

2 Part I: Unified Rate Review Template

The Unified Rate Review Template (URRT) is intended to help regulators review rates for single risk pool plans for compliance with the Affordable Care Act and determine whether proposed rate increases subject to review are unreasonable. The URRT also collects data from issuers so that CMS can fulfill its duty to monitor premium increases in health insurance coverage. This includes single risk pool plans that experience no rate changes, rate decreases, as well as rates for new single risk pool plans. The weighted average product rate change in the URRT will display on the CMS website, regardless of the size of the change. If a plan within a product has a rate increase of 15 percent or greater (i.e., the product is subject to review), HIOS will require the issuer to enter a written description justifying the product rate increase. The written justification will also be displayed on the CMS website.

Tip: If copying and pasting values into the URRT, make sure pasted values are consistent with decimal place limits and formatting instructions found within the URRT cells.

It is critically important that issuers provide accurate and complete information in the URRT. Failure to provide accurate information in the first submission increases the likelihood that State or Federal regulators will need to request additional information. Issuers must respond promptly to all questions from the applicable regulator(s). Failure to provide information on a timely basis or failure to provide accurate information slows the review process and puts issuers at risk for missing critical deadlines to offer products and plans in the individual and small group markets. Note that if an issuer copies and pastes values into cells that exceed the correct number of decimal places for those cells, the mismatch may cause validation or submission errors resulting in either rejected submissions or requiring resubmissions at a later date. Issuers should verify that the data entered in the URRT is consistent with decimal place limits and instructions to avoid delays in the review process.

Tip: Make sure information entered into the URRT is correct.

Information submitted in the URRT will determine the requested rate increase shown on the CMS website.

Under no circumstance should issuers attempt to overwrite protected cells. For example, the totals in column F of Worksheet 2 are protected and calculated by formula. Issuers should not attempt to overwrite the values calculated by the template. Any overwriting of the workbook's protection is likely to result in delays and resubmissions.

2.1 Worksheet 1 – Market Experience

The purpose of Worksheet 1 of the URRT is to capture information at the market level for non-grandfathered individual and small group (or combined) products, consistent with the requirement to set premium rates using a single risk pool, as defined in 45 CFR 156.80. The worksheet is not intended to prescribe a rate development methodology. Rather, the worksheet captures experience period data and key assumptions consistent with those used in the development of the proposed premium rate increases. The worksheet uses the data to show that the average gross premium rate complies with the requirements of the single risk pool and reports the total and annualized change in the gross premium relative to the experience period. These calculated changes in the average premium are not equal to the average rate increase of the pool, but rather provide information on how the average gross premiums have changed over time. There are four sections in this worksheet.

1. General Information Section: Captures information about the issuer, State, and the health insurance market to which the proposed rate changes will apply[11]. This information is displayed on both worksheets of the URRT.
2. Section I: Captures summarized historical financial and enrollment information from a recent historical experience period.
3. Section II: Captures historical claims experience on a more granular level, along with the key assumptions employed to project the experience period information forward to the projection period of the effective date.
4. Section III: Displays the assumptions used to adjust the projected allowed claims to incurred claims at the average anticipated benefit level. Administrative expense loads and risk/profit charge loads are also captured. Using this information, the average gross premium for the single risk pool is generated.

2.1.1 General Information Section

Company Legal Name: Enter the organization's legal entity name. The name entered in this cell must be the name that is associated with the HIOS Issuer ID.

State: Enter the State that has regulatory authority over the policies. A separate template must be completed for each State in which the issuer is offering single risk pool products in the individual or small group (or combined) market.

[11] The URRT is required for single risk pool plans that experience rate increases (of any size), no rate changes, rate decreases, as well as new single risk pool plans.

HIOS Issuer ID: Enter the HIOS ID assigned to the legal entity.

Market: Select the applicable market from the drop-down box. Valid markets are Individual, Small Group, or Combined.

> The market chosen must be consistent with the State's determination of their allowable markets (i.e., if a State requires issuers to merge the individual and small group markets into a single risk pool with the same plan options, the issuer must choose "Combined").

Effective Date: This is the effective date for which rates are being submitted. This field is automatically populated based on the Effective Date entered in Row 25 of Worksheet 2. All new and renewing products and plans must have the same effective date.

> If the submission is for the individual or combined markets, the effective date must be January 1 of the year for which rates are being submitted. If the submission is for the small group market, enter the effective date for which the Index Rate is being revised. For example, if the small group submission revises the Index Rate for July 1, 2018 and includes a trend increase applicable on October 1, 2018, enter July 1, 2018 as the effective date.

2.1.2 Section 1 Experience Period Data

The financial and enrollment information entered in this section should reflect the experience of all non-grandfathered (single risk pool and transitional) policies for the specified market and State. The information is intended to reflect the single risk pool for the market as required by 45 CFR 156.80. The information in this section should reflect historical financial and enrollment information for the identified legal entity only, except in cases where legal entities combine to provide coverage as a "joint" policy. A "joint" policy in this case refers to an arrangement between licensed entities where each entity covers a part of the total benefits (e.g., a Point of Service type plan where an HMO entity offers in-network benefits, while a licensed insurance company offers out-of-network benefits). In order to be considered a "joint" policy, the coverage from both licensed entities must be purchased together, and the "joint" policy cannot be offered as stand-alone coverage.

Experience Period: Enter the first date of the experience period.

> The Experience Period must be a twelve-month period. The template calculates the end date of the experience period such that the period is twelve months long.
>
> For individual and combined market submissions, the Experience Period must be a calendar-year period. It should be the most recently completed calendar year; if not, include an explanation in the Actuarial Memorandum. Therefore, the first date of the Experience Period must be January 1. For small group market submissions, the first date of the Experience Period must be the first date of a calendar quarter (i.e., January 1, April 1, July 1, or October 1).
>
> If an experience period other than that required to be shown is used in the derivation of the Index Rate, then the credibility manual rate section should be used to show the Index Rate development, and the Index Rate development should be described in the Actuarial Memorandum.
>
> The Experience Period reflects a period during which premiums were earned and claims were

incurred. For example, if the Experience Period is January 1, 2017 through December 31, 2017, the issuer may include claims payments through a date beyond the end of the Experience Period (e.g., February 28, 2018) for claims with dates of service within the Experience Period when estimating the total claims incurred during the period. The paid through date is not captured in the template, but is requested in the Actuarial Memorandum.

Premiums (net of MLR Rebate) in Experience Period: Enter the amount of premium earned during the Experience Period, net of rebates to policyholders on an incurred basis due to the medical loss ratio (MLR) requirements as defined in 45 CFR part 158.

Start with premiums earned during the experience period, and subtract the actual or estimated MLR rebates incurred during the experience period. Enter the aggregate net premium dollars earned. The template will calculate the per member per month (PMPM) premium amount and the percent of premium. Do not subtract amounts from the net earned premium that would be subtracted from earned premium in the denominator of the MLR calculation, such as taxes and fees. For portions of the experience period for which the MLR rebate has not been finalized, include a best estimate of the rebates in the reported net premium. See section 4.4.1 of the instructions for required documentation of the method used to estimate rebates.

Do not include expected risk adjustment receivables or payables in the experience period premium. This will allow premiums in Worksheet 1 to tie more closely with premiums reported in Worksheet 2 of the URRT.

Incurred Claims in Experience Period: Enter total claims incurred in the Experience Period.

Enter the aggregate incurred claims. The template calculates the PMPM incurred claims amount and the incurred claims as a percent of premium. The calculated percent of premium attributable to claims is not equivalent to the MLR, and therefore may be less than 80%.

Incurred claims are defined as allowed claims (defined immediately below) less member cost-sharing and cost-sharing paid by HHS on behalf of low-income members. Incurred claims includes claims for EHBs and non-EHBs.

Member cost-sharing is defined as payments made against the allowed claims by the member for health care services (e.g., deductible, coinsurance, and copayments). This does not include premium or the amount of billed charges the member must pay in excess of the issuer's contractual allowed amount (often described as "balance billing").

Allowed Claims: Enter total allowed claims with dates of service during the Experience Period.

Allowed Claims are defined as the total payments made under the policy to healthcare providers on behalf of covered members and include payments made by the issuer, member cost-sharing, and cost-sharing paid by HHS on behalf of low-income members. Consequently, they include actual payments made or estimates of costs incurred but not yet paid during the period. See the Actuarial Memorandum instructions for guidance related to incurred but not paid claim reserve documentation. Allowed claims also include claims not tied to a specific date of service, such as capitation or risk sharing payments, if the payments were for services provided during the Experience Period. They include claims for EHBs as well as non-EHBs. This would not include the amount of billed charges the member must pay in excess of the issuer's contractual allowed

amount (often described as "balance billing")

By definition, "Allowed Claims" do not include:

- Ineligible claims, such as duplicate claims, third party liabilities (e.g., coordination of benefits claims), and any other claims that are denied under the policy terms.
- Payments for services other than medical care provided, (e.g., medical management, quality improvement, and fraud detection and recovery expenses) even if these amounts are included in claims for MLR reporting purposes.
- Recovery payments the issuer may receive from private reinsurance or internal large claim pooling mechanisms. These types of adjustments should be handled in the Other adjustment factor found in Section II of Worksheet 1.
- Active life reserves (policy reserves, contract reserves, contingency reserves, or any kind of reserves except traditionally defined reserves for claims incurred but not paid) or change in such reserves.
- Recovery payments the issuer may receive from the Federal Transitional Reinsurance program.
- Charges or payments from the Federal risk adjustment program.
- Charges or payments from the Federal risk corridor program.

Index Rate of Experience Period: Enter the Index Rate underlying the Experience Period. The value entered in this field must be a dollar value containing up to two decimal places.

The Index Rate is the average allowed claims PMPM for providing EHBs within the single risk pool of the State market. It is the legal entity-specific rate for the market that is being submitted – i.e., the issuer's individual market, small group market, or combined market. It should not be adjusted for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply allowed claims PMPM for EHBs only.

The Index Rate should be developed using all covered members, even if premium was not explicitly collected for all members. For example, if the number of members in a given family or policy was capped for premium setting purposes either voluntarily by the issuer or as required by law, all family members covered by the policy should be included.

The experience period Index Rate should be adjusted to exclude benefits that are not EHBs, but should not be adjusted to include EHBs that were not covered during the experience period.

Experience Period Member Months: Enter the total number of months of coverage in the Experience Period for all members that had coverage during any portion of the Experience Period.

For example, if a given member had coverage for five months during the Experience Period, that member would contribute five member months to the total member months for the period. The number entered must be an integer. For partial months, issuers should define a methodology for counting partial months and apply the methodology consistently to all members. Possible methodologies include but are not limited to rounding up, rounding down, rounding to nearest, counting the member month if the member is active on the 15th of the month, etc.

Include all covered members even if premium was not explicitly collected for all members. For

example, if the number of members in a given family or policy was capped for premium setting purposes either voluntarily by the issuer or as required by law.

2.1.3 Section II: Allowed Claims, PMPM basis

Projection Period: The Projection Period start date is auto-populated with the effective date of the rate change from the General Information section of the template. The Projection Period end date is calculated such that the Projection Period is a twelve-month period. The template also calculates the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period.

2.1.3.1 Benefit Category

Several fields listed below require issuers to enter data by Benefit Category. Issuers are required to describe the Benefit Category definitions in the Actuarial Memorandum. The preferred definitions for each Benefit Category follow:

- ***Inpatient Hospital:*** Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse disorder, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

- ***Outpatient Hospital:*** Includes non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

- ***Professional:*** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

- ***Other Medical:*** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services.

- ***Capitation:*** Includes all services provided under one or more capitated arrangements.

- ***Prescription Drug:*** Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

2.1.3.2 Experience Period on Actual Experience Allowed

The experience entered in this section needs to reflect the State and market identified in the General Information section and the Experience Period identified in Section I of this worksheet. The actual experience for this period, State, and market should be entered in the template, regardless of the credibility level.

Utilization Description: For each Benefit Category, choose the appropriate measurement unit that reflects the utilization per 1,000 covered members per year from the drop down menu.

Valid entries are shown below.

- Admits (for Inpatient service category only)
- Days (for Inpatient service category only)
- Benefit Period (for Capitation service category only)
- Visits
- Services
- Prescriptions (for Prescription Drug service category only)
- Other

In cases where "Other" is selected provide additional descriptions of the measurement units in the Actuarial Memorandum.

Utilization per 1,000: Enter the total utilization per 1,000 covered members per year for claims incurred during the Experience Period.

The utilization must be entered on an annualized basis. Include any necessary estimates of utilization related to claims incurred but not yet paid.

Average Cost/Service: Enter the average allowed cost per unit of service for claims incurred during the Experience Period.

While not required, issuers may adjust the average cost per service for claims incurred but not yet paid if the issuer estimates the claims not yet paid to have a different average cost per service than those already paid. If an adjustment is made it should be described in the Actuarial Memorandum.

PMPM: The Allowed Claims PMPM is calculated by the template and is equal to utilization per 1,000 times average cost per service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM. The calculated PMPM must equal the Allowed Claims PMPM calculated by the template in Section I of Worksheet 1.

2.1.3.3 Adjustments from Experience to Projection Period

Population Risk Morbidity: Enter the assumed change in morbidity of the covered population from the Experience Period to the Projection Period.

"Change in morbidity" means that component of the change in average allowed claims PMPM (as described earlier in these instructions) that will occur under the circumstances where all demographic (e.g., age, gender, and region) and product mix, all provider network contracts and time parameters (i.e., trends = 0) are held constant on the population that exists in the Experience Period.

The change in morbidity must be entered as 1 plus the total anticipated percent change in morbidity from the Experience Period to the Projection Period. For example, if in a 24-month period from the Experience Period to the Projection period the morbidity is expected to increase by 10%, enter 1.100. Similarly, if the morbidity is expected to decrease by 10% over the 24-month period, enter 0.900.

This category may include a number of adjustments since the applicable market rules during the

Projection Period may be significantly different from those in the Experience Period. In addition, the impact of new market rules is expected to vary significantly State to State. Some of the adjustments issuers might include are:

- Guaranteed Availability
- Take-up rate of the uninsured (the percent of currently uninsured that purchase coverage during the projection period)
- Health status of newly insured
- Enrollment from prior high risk pools
- Induced demand of newly insured
- Pent-up demand of newly insured
- Subsidy effects

Expected changes in the demographic mix (e.g., age, gender, and region) and tobacco status should not be included in this factor. These factors can be included in the "Other" factor.

A description of the methodology used to develop the adjustment must be included in the Actuarial Memorandum.

Other: Enter the assumed change in cost related to things other than a change in Population Morbidity, Cost Trend, and Utilization Trend. Cost Trend and Utilization Trend are defined in the section immediately following.

The "Other" change must be entered as 1 plus the total anticipated percent change in cost from the Experience Period to the Projection Period, similar to the Population Risk Morbidity Adjustment.

Some of the adjustments an issuer might include in this section are:

- Changes in covered services.
- Significant changes in the provider network, such as adding or removing a provider system, or introducing a limited network option. Note that shifts in the distribution of services across existing network providers should not be reflected here, as they should be reflected in the Cost Trend described below.
- Projected changes in cost related to demographics of the projected covered population.
- Projected changes in pharmacy rebates relative to the pre-rebate prescription drug allowed claims.

In the event an issuer has capitation in the Experience Period, but does not expect to have capitation in the Projection Period, the issuer should enter a near-zero value (such as 0.001) in the "Other" projection factor to remove the costs. It is not anticipated that other EHB categories would need to remove the experience for the entire benefit category.

A description of the methodology used to develop the adjustment must be included in the Actuarial Memorandum.

2.1.3.4 Annualized Trend Factors

Cost Trend: Enter the assumed change in cost per service from the Experience Period to the Projection Period.

The Cost Trend must be entered as 1 plus the annualized trend assumption. For example, if the period from the midpoint of the Experience Period to the midpoint of the Projection Period is 24 months, and if costs in the Projection Period are expected to be 10.25% higher than the Experience Period, then the annual trend is 5.0% (calculated as: √1.1025 -1 = 0.05). In this example, the user should enter 1.050 (which is √1.1025).

Include only the increase in cost for a fixed basket of services. Changes in cost related to changes in mix of services should not be reflected here (they will be reflected in Utilization Trend described below). Changes in cost related to a change in the distribution of services across network providers should be included.

Significant changes in network, such as adding or removing a provider system, or introducing a limited network option should be reflected in the "Other" adjustment and described in the Actuarial Memorandum. Projected changes in prescription drug cost related to manufacturer rebates should also be reflected in the "Other" adjustment.

Utilization Trend: Enter the assumed change in utilization per 1,000 members from the Experience Period to the Projection Period.

The Utilization Trend must be entered as 1 plus the annualized trend assumption, in the same manner as the Cost Trend.

Utilization Trend should include the change in the number of units per 1,000 members for a fixed level of illness burden. If utilization is expected to increase/decrease due to a change in the average health status of the population, that change should be reflected in the Population Risk Morbidity adjustment described above.

Utilization Trend should include assumed changes in the mix or intensity of services provided for a fixed level of illness burden.

Utilization Trend should also reflect changes related to shifts in product mix. This includes changes in induced demand related to product shifts. It also includes any effects of selection since this cannot be reflected in the relative cost of the various products and plans offered.

2.1.3.5 Projections, before Credibility Adjustment

Projections before credibility adjustment are calculated by the template.

Utilization per 1,000: The template calculates projected utilization per 1,000 by multiplying the experience period utilization per 1,000 by the Population Risk Morbidity Adjustment and the Utilization Trend assumption. The Utilization Trend assumption in this calculation is raised to the power of the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period (calculated previously by the template), divided by 12.

Average Cost/Service: The template calculates the projected average cost per service by multiplying the experience period average cost per service by the "Other" adjustment and the Cost Trend assumption. The Cost Trend assumption in this calculation is raised to the power of the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period (calculated previously by the template), divided by 12.

PMPM: The projected allowed claims PMPM is calculated by the template and is equal to projected Utilization per 1,000 times projected Average Cost/Service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM.

2.1.3.6 Credibility Manual

The credibility manual Utilization per 1,000 and Average Cost /Service need only be populated with values greater than zero if the Experience Period claims data is less than 100% credible for projecting future premium rates. When the Experience Period claims data is 100% credible, zeroes must still be entered in the credibility manual section so as not to produce errors when the template is validated. While credibility may not be applied in this manner in rate development, it must be shown in this manner for reporting purposes.

Utilization per 1,000: Enter the assumed utilization per 1,000 for the data underlying the credibility manual.

> The Utilization per 1,000 must reflect the population and covered services for which rates are being submitted. If the issuer uses another credible block of business as the credibility manual, for example, the utilization of that population should be adjusted to reflect morbidity consistent with the projected population. Other adjustments may be necessary. The source of the credibility manual Utilization per 1,000 and the adjustments applied to it should be described in the Actuarial Memorandum.

Average Cost/Service: Enter the assumed average cost per service for the data underlying the credibility manual.

> The cost per service must reflect the projected cost for the population and covered services for which rates are being submitted. If the issuer uses another credible block of business from a different geographic region as the credibility manual, for example, the cost for that population should be adjusted to reflect differences in provider contracting of the two regions. The source of the credibility manual average cost per service and the adjustments applied to it should be described in the Actuarial Memorandum.

PMPM: The projected credibility manual PMPM is calculated by the template and is equal to the credibility manual Utilization per 1,000 times the credibility manual Average Cost/Service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM.

2.1.4 Section III: Projected Experience

Projected Amounts After Credibility Percentage: Enter the assumed level of credibility to be applied to the Experience Period claims that have been projected to the rating period.

> The percentage must be between 0% and 100%. Describe the methodology used to determine

the Credibility Percentage in the Actuarial Memorandum.

The template calculates the credibility to be assigned to the credibility manual and is equal to 1 minus the credibility assigned to the projected experience claims.

Projected Allowed Claims PMPM (with applied credibility if applicable): The template calculates this value as the sum of the projected experience PMPM multiplied by its credibility, and the credibility manual PMPM multiplied by the complement of the credibility (calculated previously by the template).

Paid to Allowed Average Factor in the Projection Period: Enter the average paid to allowed factor for the Projection Period.

This amount is not from the AV Calculator. It should equal the total expected paid claims that are the liability of the issuer divided by the total expected allowed claims for the Projection Period, for the population anticipated to be covered in the Projection Period. Allowed claims have the same definition as in Section I. Paid claims are analogous to the Incurred Claims defined in Section I. Paid claims are net of member cost-sharing and cost-sharing paid by HHS on behalf of low-income members. The Paid to Allowed Average Factor in the Projection Period should reflect the average benefit level anticipated during the Projection Period. For example, if the issuer's members were enrolled primarily in Silver plans in the experience period, but are anticipated to shift to Bronze, then the Paid to Allowed Average Factor in the Projection Period should reflect Bronze cost-sharing levels.

Since the paid claims in the numerator are the trended amounts for the Projection Period, they should reflect any leveraging of fixed dollar cost-sharing inherent in the benefit plans. That is, if no change in benefit mix is anticipated relative to the Experience Period, the paid to allowed ratio should be higher in the projection period than what was realized in the Experience Period due to the leveraging of cost-sharing.

Projected Incurred Claims, before ACA Reinsurance & Risk Adjustment, PMPM: The template calculates this value by multiplying the Projected Allowed Experience Claims PMPM (with applied credibility if applicable) by the Paid to Allowed Average Factor in the Projection Period.

Projected Risk Adjustments PMPM: Enter the projected PMPM amount of net risk adjustment transfers (i.e., net effect of risk adjustment payments and charges) for the Projection Period and net of risk adjustment user fees. The value should reflect the actual PMPM amounts expected in the Projection Period. However, the net risk adjustment transfer amount applied in the calculation of the Market Adjusted Index Rate should be grossed up by the paid to allowed average factor as the Index Rate and Market Adjusted Index Rate reflect claim costs on an allowed basis.

The risk transfers should reflect the projected morbidity, including any projected Population Risk Morbidity changes in column J in Section II.

If the issuer expects to receive a projected risk adjustment payment, then the entry should be a positive value. If the issuer expects to make a projected risk adjustment charge, then the entry should be a negative value.

Risk adjustment user fees should be reflected here and not in the Taxes & Fees.

The calculation of the projected risk adjustments should consider the appropriate published transfer equation. Please describe the methodology for estimating the PMPM amount in the Actuarial Memorandum.

Projected Incurred Claims, before reinsurance recoveries, net of reinsurance premium, PMPM: The template calculates this value by subtracting the Projected Risk Adjustments PMPM from the Projected Incurred Claims, before ACA reinsurance & Risk Adjustment, PMPM.

Projected ACA Reinsurance Recoveries, net of reinsurance premium, PMPM: This is a holdover from prior years. It is expected this field will be populated with "0" for 2019.

Projected Incurred Claims: The template calculates this value by subtracting Projected Risk Adjustments, PMPM and Projected ACA Reinsurance Recoveries, net of reinsurance premium, PMPM from Projected Incurred Claims, before ACA reinsurance & Risk Adjustment, PMPM.

Administrative Expense Load: Enter the administrative expense load included in the premiums being filed for the effective date.

Enter the load as a percentage of premium. The template uses the percentage to calculate the PMPM administrative expense load.

If the Administrative Expense Load varies by product or plan, enter the average expense load for the single risk pool, using a premium-weighted average.

The Administrative Expense Load should include expense loads related to quality improvement and fraud detection/recovery, even if those expenses are considered part of incurred claims for purposes of MLR rebate calculations. It should also include loads for taxes and fees that may not be subtracted from premium in the MLR rebate calculation. For reporting purposes, it should not include the profit and risk load or the taxes and fees load, both described below, even though they are considered administrative expenses for purposes of adjusting the Index Rate to arrive at premium in the pricing process.

Profit & Risk Load: Enter the profit and risk load included in the premiums being filed for the effective date.

Enter the load as a percentage of premium. Not-for-profit issuers should enter the load for contribution to surplus in this entry. The template uses the percentage to calculate the PMPM profit and risk load.

If the Profit & Risk Load varies by product or plan, enter the average profit and risk load for the single risk pool, using a premium-weighted average.

Since taxes (including any Federal income tax) are captured separately in the Taxes & Fees input, the Profit & Risk Load should reflect after-tax amounts.

Note that for pricing purposes, profit and risk load is considered part of administrative expenses, per 45 CFR § 156.80(d). It is shown separately on the template to facilitate rate review.

Taxes & Fees: Enter the taxes and fees included in the premiums being filed for the effective date.

Enter only the portion of any load that is for taxes and fees that may be subtracted from premiums for purposes of calculating MLR. This includes Federal income tax. However, do not include any contributions for Risk Adjustment user fees in this amount despite their treatment in MLR calculations, since Risk Adjustment is expressed in the template net of reinsurance premium and risk adjustment user fees. Any additional load for taxes and fees should be reflected in the Administrative Expense Load. The template uses the percentage to calculate the PMPM Taxes & Fees.

If the Taxes & Fees percentage varies by product or plan, enter the average Taxes & Fees percentage for the single risk pool, using a premium-weighted average.

Note that for pricing purposes, taxes and fees are considered part of administrative expenses, per 45 CFR 156.80(d). It is shown separately on the template to facilitate rate review.

Single Risk Pool Gross Premium Average Rate, PMPM: The template calculates this value by dividing the Projected Incurred Claims by 1 minus the Administrative Expense Load percentage less the Profit & Risk Load percentage less Taxes & Fees percentage.

Index Rate for Projection Period: Enter the projected Index Rate.

As noted in Section I, the Index Rate represents the average allowed claims PMPM for EHBs. This legal entity-specific rate for the Projection Period should not reflect any adjustments for payments and charges under the risk adjustment program or for user fees. It is simply projected allowed claims PMPM for EHBs only. If the submission is for the individual or combined market, the projected Index Rate should reflect the twelve-month projection period, or rating period. For the individual or combined market, if the issuer will not be covering any non-EHBs, the Index Rate for the projection period will be equal to the Projected Allowed Experience Claims PMPM (w/ applied credibility if applicable). If the submission is for the small group market and includes prospective trend adjustments (only if permitted by the State), then the Index Rate for Projection Period should reflect the member weighted average of the projected trended Index Rates applicable for each effective date in the submission. See Section I for additional information about the Index Rate. See the Appendix for further guidance on calculation of the small group weighted average projected Index Rate.

The projected Index Rate should reflect the allowed claim costs and member months for all covered members, including those members for which premium is not expected to be explicitly collected. For example, if the number of dependent child members under age 21 in a given family exceeds three and must be capped for premium setting purposes as required by law, the claim costs for any dependent children excluded from the premium setting by the cap should still be reflected in the projected Index Rate.

Percent Increase Over Experience Period: The template calculates this value which represents the percent increase in the projected average gross premium PMPM over the average gross premium PMPM in the experience period. The average gross premium PMPM for the experience period is calculated by the template in Section I (Premiums (net of MLR Rebate) in Experience Period).

The calculated increase is not the proposed rate increase. The calculated increase may include changes in premium PMPM related to shifts in the covered benefit, age, geographic area, or tobacco status of the population, some of which may be charged to the consumer through

allowable rating factors.

The period of time over which the increase is calculated is dependent upon the Experience Period entered by the issuer. For example, if the length of time between the Experience Period and the Projection Period is two years, the increase calculated will represent a two-year increase.

Percent Increase, Annualized: The template calculates this value by annualizing the percent increase over Experience Period. Like the percent increase over Experience Period, the calculated increase may include changes in premium PMPM related to shifts in the covered benefits, age, geographic area, or tobacco status of the population, some of which may be charged to the consumer through allowable rating factors.

Projected Member Months: Enter the number of member months expected to be covered during the Projection Period.

See "Experience Period Member Months" in Section I for more information on how to calculate member months. Since the Projection Period must be a one-year period, the projected member months might be equal to 12 times the projected enrollment in the first month of the Projection Period, for example. Issuers should describe how the member months were projected in the Actuarial Memorandum.

Include all covered members even if premium is not expected to be explicitly collected for all members, for example if the number of dependent child members under age 21 in a given family exceeds three and must be capped for premium setting purposes as required by law.

Projected Period Totals: The template calculates aggregate dollar amounts from Section III PMPM values entered into or calculated by the template. The amounts are calculated by multiplying the Projected Member Months by the applicable PMPM value.

Section 2.2 Worksheet 2 – Plan Product Information

The purpose of Worksheet 2 is to capture information at the product and plan level. The worksheet captures information on experience period data, the projection period data, and other information related to each product or plan. There are four sections in this worksheet.

- Section I captures information about each product and plan. This includes general information such as the plan and product IDs, along with more specific information such as the effective date, AV, and proposed rate change.
- Section II displays the proposed rate change by major service category and the expected increase in cost-sharing on a per member per month basis for each product and plan.
- Section III captures historical information such as premium and claims in a more detailed manner than in Worksheet 1. Information regarding the portion of the premium and claims related to the EHBs and non-EHBs is required, as well as information related to risk transfer charges and payments, Federal reinsurance payments, and cost-sharing reduction amounts.
- Section IV contains the same information collected in Section III, but for the twelve-month period following the effective date shown in the rate filing for each product.

If a product contains both grandfathered and non-grandfathered insurance policies, the experience of grandfathered policies may be included on Worksheet 2 if the grandfathered policies share the same rating practices as non-grandfathered policies, including pooling of risks and common rate increases or as permitted by the governing State regulatory body. If experience of grandfathered policies is included, then the total experience on Worksheet 2 will exceed that shown on Worksheet 1 which includes only non-grandfathered experience.

In all cases, reasonable projected values are to be entered for all plans directly. All information input into the URRT for each plan must reflect experience or best estimate projections for each specific plan. For example, projected member months must reflect the issuer's best estimate of expected enrollment in each plan. An explanation for any non-terminating plans with zero projected membership should be included in the actuarial memorandum.

2.2.1 Guaranteed Renewability and Uniform Modification of Coverage

Issuers should review 45 CFR 147.106(e), 146.152(d) and (f), 148.122(e), and 144.103 when determining if a product or plan is considered to be the same product or plan for rate review purposes. Note that changing the HIOS Product or Plan ID does not necessarily result in the product or plan being considered new for rate review purposes. Additionally, the HHS Notice of Benefit and Payment Parameters for 2018[12] changed Guaranteed Renewability of Coverage requirements in an effort to help issuers avoid unintended market withdrawals and the associated 5-year prohibition on market re-entry where continuity of coverage is effectively provided.

In the individual and small group markets, product modifications made uniformly at the time of coverage renewal and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if the modification is made within a reasonable time period after the imposition or modification of a Federal or State requirement, and the modification is directly related to the imposition or modification of the Federal or State requirement. For example, if the Federal or State government mandates coverage of a new benefit, existing products may be altered to include coverage of the mandated benefit without being considered "new" products.

A modification made uniformly at the time of coverage renewal in the individual or small group market is also considered to be a uniform modification of coverage if the resulting health insurance coverage for the product meets the following criteria:

- The product is offered by the same health insurance issuer or a member of the issuer's controlled group.
- The product network type remains the same, for example a health maintenance organization remains a health maintenance organization, or a preferred provider organization remains a preferred provider organization.
- The product continues to cover a majority of the same service area.
- Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level.
- The product provides the same covered benefits (i.e., covered items and services), except for changes in benefits that cumulatively impact the plan-adjusted index rate (or for non-single

[12] The 2018 Payment Notice Final Rule, 81 Fed. Reg. 94058 at 94066 (December 22, 2016).

risk pool coverage, the rate) for any plan within the product within an allowable variation of ±2 percentage points (not including changes pursuant to applicable Federal or State requirements).

A State may broaden the standards mentioned in the third and fourth bullet points, so an issuer may need to check with the State to determine if a change to a product's service area or cost-sharing structure is considered to be a uniform modification of coverage.

In addition, an issuer is not considered to have discontinued offering all health insurance coverage in a market if the issuer or a member of the issuer's controlled group continues to offer and make available for enrollment in the applicable market in the State at least one product of the original issuer that is considered to be the same product, meaning that any change to the product is within the scope of uniform modification. For this purpose, ''controlled group'' means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code, 26 U.S.C. 1, et seq.

States that interpret or apply market withdrawal provisions differently under State law are not prohibited from considering the transfer of all products in a market to a different issuer within a controlled group to be new products and the scenario a market withdrawal. A controlled group may be defined more narrowly under State law—that is, a controlled group may be defined to not include all of the entities that would be included under the Federal definition.

Issuers that replace an entire portfolio of products in market with new products may also avoid a 5-year ban under the market withdrawal provision provided the issuer reasonably identifies which newly offered product (or products) is replacing the discontinued product (or products) and subjects the new product (or products) to the Federal rate review process, where the process is otherwise applicable to the type of product and market. An issuer's identification of which new product replaces which discontinued product will be considered reasonable if it reflects the issuer's expectations regarding significant transfer of enrollment from one product to the other (for example, because the products have been cross-walked for that purpose). Issuers should identify which new product replaces which discontinued product in the actuarial memorandum. This provides a way for issuers to completely revise their product portfolio offerings without triggering a 5-year ban, provided they are not revising all of their products simply to avoid rate review. Issuers that do not adhere to these conditions will be considered to have effectuated a market withdrawal subject to the 5-year ban on market re-entry.

2.2.2 Plan Mapping Instructions

A dropdown box on row 17 of Worksheet 2 of the URRT allows issuers to identify a plan's status as New, Renewing, or Terminated. It is very important that issuers enter this information correctly according to Uniform Modification Guidelines outlined above. If a plan is considered the "same plan" for purposes of rate review or is otherwise being subjected to Federal rate review in the context of a discontinuance of an entire product portfolio to avoid triggering a 5-year ban, the plan must be identified as Renewing, even if that plan has a new HIOS Plan ID. Failure to correctly identify plan status will require resubmission of the URRT and slow down the review process.

Issuers are required to handle New, Renewing, or Terminated plans/products in the following manner.

2.2.2.1 New Plans

A plan status of New should only be selected when the issuer is introducing a new plan that is not replacing another plan.

a) If a plan is new and no existing members are being mapped (auto-enrolled) into the new plan:
   i) Section I Rate Change Information should be entered as 0%.
   ii) Section II Components of Premium Increase and the Average Current Rate PMPM should be entered as $0.00.
   iii) Section III Experience Period Information should be entered as 0 or other appropriate value to reflect no experience.
   iv) Section IV Projected information should be filled out with expected projections.

Year	Plans Available
2017	
2018	
2019	A

Section I: General Product and Plan Information

Plan Name	Plan A
Plan Category	New
Effective Date of Proposed Rates	01/01/2019
Rate Change % (over prior filing)	0
Cum'tive Rate Change % (over 12 mos prior)	0

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	0
Section III: Experience Period Information	0
Section IV: Projected (12 months following effective date)	Plan A

Plan A is an entirely new plan with no existing members being mapped into the plan.

b) If a plan has a status of New, but existing members from terminating plans are being mapped (auto-enrolled) into the new plan, and the new plan is not being subjected to rate review in order to avoid triggering a market withdrawal (note: this scenario assumes the issuer has other renewing plans that prevent this from being a market withdrawal):
   i) Section I Rate Change information should reflect the Plan ID effective in the experience period. The rate increase information should be measured from the terminating Plan ID to the new Plan ID. If multiple plans are being mapped into a single new plan, provide the weighted average rate change of the mapped members into the new plan. Note even if these increases are 15% or greater, the product threshold increase review will not be triggered, and HIOS will not require submission of Part II (written description justifying the rate increase) as long as the issuer appropriately identifies the plan as New in the dropdown box. Even though mapping terminating members into truly new plans falls outside of a threshold increase review, entering the rate change information mapped members will receive will assist reviewers in understanding average premium changes members will be experiencing.

ii) Section II Components of Premium Increase should reflect the change from the terminating Plan ID to the new Plan ID. In cases where multiple terminating plans are being mapped to a single new plan, the weighted average of the changes should be entered.

iii) Section III Experience Period Information should show the experience of the terminating Plan ID being mapped to the new Plan ID. In cases where multiple terminating plans are being mapped to a single new plan, enter the experience of the largest terminating Plan ID being mapped to the new plan. The largest terminating plan should be determined based on the experience period member months.

iv) Section IV Projected information should be filled out with expected projections.

Year	Plans Available		
2017	A	B	C
2018	A	B	C
2019	D	D	D

Plan Name	Plan D	Terminated Plan B	Terminated Plan C
Plan Category	New	Terminated	Terminated
Effective Date of Proposed Rates	01/01/2019	01/01/2018	01/01/2018
Rate Change % (over prior filing)	Plans A,B,C => Plan D	0	0
Cum'tive Rate Change % (over 12 mos prior)	Plans A,B,C => Plan D	0	0
Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	Plan A,B,C => Plan D	0	0
Section III: Experience Period Information	Plan A	Plan B	Plan C
Section IV: Projected (12 months following effective date)	Plan D	0	0

Plan A is shown as mapped to Plan D because Plan A has the highest enrollment of plans mapped to Plan D.

Rate Change is based on weighted average of Plans A,B,C to Plan D; but will not trigger a product threshold increase review because Plan D is new.

2.2.2.2 Renewing Plans

A plan status of Renewing should be selected for renewing plans. This includes all plans defined as the same plan under 45 CFR 144.103 and any new plans being subjected to Federal rate review in the context of a discontinuance of an entire product portfolio to avoid triggering a 5-year ban. Note that under 45 CFR 154.200, a product is subject to review if any renewing plan within the product has a rate increase of 15% or more.

a) If a plan available in the experience period is being renewed with no mapping into or out of the plan from or to other plans:
   i) Section I Rate Change information should reflect the rate change for the renewing plan.
   ii) Section II Components of Premium Increase should reflect the change for the renewing plan.
   iii) Section III Experience Period Information should reflect experience of the renewing plan.
   iv) Section IV Projection Information should be filled out with expected projections.

Year	Plans Available
2017	A

2018	A
2019	A

Section I: General Product and Plan Information

Plan Name	Plan A
Plan Category	Renewing
Effective Date of Proposed Rates	01/01/2019
Rate Change % (over prior filing)	Plan A => Plan A
Cum'tive Rate Change % (over 12 mos prior)	Plan A => Plan A

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	Plan A => Plan A
Section III: Experience Period Information	Plan A
Section IV: Projected (12 months following effective date)	Plan A

Plan A is a renewing plan under Uniform Modification Guidelines (45 CFR 147.106).

b) If a plan with a larger service area is divided into multiple smaller service area plans, but maintains all of other characteristics of the plan above, then the issuer should choose the plan with the largest existing enrollment in its service area to remain as the "same plan," and the other plans covering the remaining portions of the previous service area should be "new plans" with new HIOS Standard Component (plan) IDs. The "new plans" would have a status of New or Renewing, depending upon whether they meet uniform modification criteria under 45 CFR 144.103.

Year	Plans Available
2017	A
2018	A
2019	A B C

Section I: General Product and Plan Information

Plan Name	Plan A	New Plan B	New Plan C
Plan Category	Renewing	Renewing*	New*
Effective Date of Proposed Rates	01/01/2019	01/01/2019	01/01/2019
Rate Change % (over prior filing)	Plan A => Plan A	Plan A => Plan B	Plan A => Plan C
Cum'tive Rate Change % (over 12 mos prior)	Plan A => Plan A	Plan A => Plan B	Plan A => Plan C

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	Plan A => Plan A	Plan A => Plan B	Plan A => Plan C
Section III: Experience Period Information	Plan A	0	0
Section IV: Projected (12 months following effective date)	Plan A	Plan B	Plan C

* Plans B and C may be New or Renewing, depending upon whether they meet uniform modification criteria under 45 CFR 144.103.

2.2.2.3 Terminating Plans

A plan status of Terminating should be selected for plans effective during the experience period that will no longer be offered and will not be mapped into new or renewing plans during the projection period.

a) Non-single risk pool plans/products that were effective during the experience period and are terminated prior to the projection period may be combined for reporting purposes. See the instructions under "Product" in section 2.2.3 for further details.

b) Each single risk pool plan that was effective during the experience period, terminated prior to the rating period, and not mapped into another single risk pool plan should be included in Worksheet 2 in its own column. Information associated with the experience period should be included in Section III but Section IV should be entered as 0 or other appropriate value. See the Actuarial Memorandum instructions under "Terminated Plans and Products" for more information.

Year	Plans Available
2017	A
2018	A
2019	

Section I: General Product and Plan Information

Plan Name	Terminated Plan A
Plan Category	Terminated
Effective Date of Proposed Rates	01/01/2018
Rate Change % (over prior filing)	0
Cum'tive Rate Change % (over 12 mos prior)	0

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	0
Section III: Experience Period Information	Plan A
Section IV: Projected (12 months following effective date)	0

Plan A is being terminated and members are not mapped to other plans.

c) Each single risk pool plan that was effective during the experience period and is terminated prior to the rating period and mapped to a new plan should be handled as follows:

i) If members from the terminating plan are being mapped to a plan with a status of New, follow the instructions for new plans given in scenario 1b above that address this situation.

ii) If members from the terminating plan are being mapped to a plan with a status of Renewing, the terminating plan should be listed separately with the terminating plan's experience listed in Sections I, II, and III. Expected projection experience should be listed in Section IV of the renewing plan into which members are being mapped. Historical rate increase information should be filled out with appropriate historical increases, while 0% should be entered into the Rate Change % fields. Projected membership should be 0 under the terminating plan, but included in the projected membership of the renewing plan into which these members are being mapped.

Year	Plans Available		
2017	A	B	C
2018	A	B	C

2019	C	C	C

Section I: General Product and Plan Information

Plan Name	Terminated Plan A	Terminated Plan B	Plan C
Plan Category	Terminated	Terminated	Renewing
Effective Date of Proposed Rates	01/01/2018	01/01/2018	01/01/2019
Rate Change % (over prior filing)	0	0	C => C
Cum'tive Rate Change % (over 12 mos prior)	0	0	C => C

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	0	0	C => C
Section III: Experience Period Information	Plan A	Plan B	Plan C
Section IV: Projected (12 months following effective date)	0	0	Plan C*

Plan C* projection information would include mapped members from Plans A and B.

d) A single risk pool plan that was not effective during the experience period and is terminated prior to the rating period and mapped to a renewing plan should only have projected experience included in Section IV of the plan into which members are being mapped. In this case, the terminating HIOS Plan ID would not appear in the URRT for the upcoming plan year. The terminating plan should still be listed in the Terminated Plans and Products section of the Actuarial Memorandum.

Year	Plans Available	
2017		B
2018	A	B
2019	B	B

Section I: General Product and Plan Information

Plan Name	Plan B
Plan Category	Renewing
Effective Date of Proposed Rates	01/01/2019
Rate Change % (over prior filing)	B => B
Cum'tive Rate Change % (over 12 mos prior)	B => B

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	B => B
Section III: Experience Period Information	Plan B
Section IV: Projected (12 months following effective date)	Plan B*

Plan B* projection information would include mapped members from Plan A.

e) Terminating Pre-2014 Plans and all transitional plans initially issued prior to January 1, 2014 are not required to comply with the single risk pool requirement. Issuers should enter information for these plans in the Experience Period only, as neither of these plan types will contribute to the single risk pool during the Projection Period. The experience information for these plans may be combined and entered in a single column. The column that reflects Terminating pre- ACA and

Transitional Plans should indicate "2016 experience" in the Plan Name. The issuer should enter "Not Applicable" in the Metal row for these plans.

2.2.2.4 Controlled Group Mapping Guidance

When the same product (i.e., any change of the product is within the scope of uniform modification) is mapped from one member of a controlled group to another member within that controlled group, and the product is being made subject to review to avoid the issuer triggering a 5-year market ban, product information should be entered similarly to a renewing plan. If Issuer A and Issuer B are part of the same controlled group, and Issuer A's only product offering contains a single plan that will be offered by Issuer B in the upcoming plan year, then Issuer A's product information would be included in Issuer B's URRT with a plan status of Renewing.

Year	Plans Available
2017	Issuer A Plan 1
2018	Issuer A Plan 1
2019	Issuer B Plan 1

Section I: General Product and Plan Information

Plan Name	Issuer B Plan 1
Plan Category	Renewing
Effective Date of Proposed Rates	01/01/2019
Rate Change % (over prior filing)	Issuer A Plan 1 => Issuer B Plan 1
Cum'tive Rate Change % (over 12 mos prior)	Issuer A Plan 1 => Issuer B Plan 1

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)	Issuer A Plan 1 => Issuer B Plan 1
Section III: Experience Period Information	Issuer A Plan 1
Section IV: Projected (12 months following effective date)	Issuer B Plan 1

Issuer A and Issuer B are part of the same issuer's "Controlled Group."

2.2.3 Section I: General Product and Plan Information

Product: Enter the product name in the corresponding column(s).

The term "product" means a discrete package of health insurance benefits a health insurance issuer offers using a particular product network type (e.g., HMO, PPO, EPO, POS, etc.) within a service area. "Product" has the same meaning as included in 45 CFR 154.102 and 144.103.

All products included in the single risk pool experience shown on Worksheet 1 must be entered in this section of Worksheet 2. This includes any products that are terminated but have experience included in the single risk pool during the Experience Period. It also includes any products that were not in effect during the Experience Period but were made available thereafter. If multiple non-single risk pool products will be terminated prior to the Projection Period, these products may be combined for reporting purposes and shown as a single product in the template. The term "Terminated Products" should be entered as the plan name in this case. The list of product names for the terminated products should be included in the Actuarial Memorandum.

Those single risk pool products that were effective during the Experience Period and are terminated prior to the Projection Period must be shown in Worksheet 2 in a separate column with the plan name and plan ID. The projected membership for these plans should be zero, and no projected experience in the Section IV should be entered. The list of single risk pool plans that are terminated prior to the projection period should be included in the Actuarial Memorandum.

Currently, HIOS does not report product names containing special characters (e.g., "%"). It is recommended that products containing special characters spell out the name of the special character (e.g., "20Percent Coinsurance" instead of "20% Coinsurance").

Product ID: Enter the product ID that corresponds with each product. The two-letter State code portion of the Product ID must be entered using capital letters.

The "Product ID" should be the product number assigned by HIOS. Each product included in the single risk pool during the Experience Period, as well as new products that are part of the rate filing, must be identified in Worksheet 2 of the template.

If multiple non-single risk pool products will be terminated prior to the Projection Period, these products may be combined for reporting purposes and shown as a single product in the template. Enter the Product ID for the largest product (measured by member months during the Experience Period) being terminated. A list of Product IDs for the terminated products should be included in the Actuarial Memorandum.

> **Tip:** HIOS does not report product names containing special characters. Consider spelling out name of special characters (e.g., "20Percent Coinsurance" rather than "20% Coinsurance").

Terminated single risk pool plans and/or products cannot be combined for reporting purposes. All single risk pool plan IDs effective in the Experience Period must be shown as a separate column in Worksheet 2, except in cases where a terminated plan is mapped to a new plan. Refer to the Plan Mapping instructions for this scenario in Section 2.2.2 above.

Metal: For each plan within a product, choose the corresponding metal level from the drop down menu in the template. Plans that are included in a QHP certification application must show the same Metal as is shown in the QHP application.

A "Not Applicable" selection should be made when the AV metal level does not apply to a plan such as a non-single risk pool plan.

In these instructions, the term "actuarial value" is used to describe a manner of estimating the value of a plan, but not a specific manner. AV Metal Value refers to the Federal definition of AV found in 45 CFR 156.20. AV Pricing Value is defined below.

The ACA requires that non-grandfathered plans offered in the individual or small group (or combined) market must have an AV that corresponds to a defined metal level. The metal AVs are defined in 45 CFR 156.20 as "the percentage paid by a health plan of the percentage of the total allowed costs of benefits." There are five levels of coverage that can be offered: Platinum, Gold, Silver, Bronze, and Catastrophic. The AVs for each of these metal levels are shown in the table below. The AV used in determining the metal level must be based on the AV Calculator or an acceptable alternative if a health plan's design is not compatible with the AV Calculator. For further guidance on the calculation of the AV Metal Value in the determination of the metal level, please see the instructions for the Actuarial Memorandum.

The AV used to determine the metal level must be within a de minimis variation from the AVs defined in the ACA.

Metal Level	AV Requirements
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%
Catastrophic	Not specified by law*

**Catastrophic level* – a plan offered in the individual market only that is only available to individuals who are below the age of 30 before the beginning of the plan year or who have received a certificate of exemption based on affordability or hardship.

For non-single risk pool products that are reported on a combined basis as terminated products prior to the projection period, enter "Not Applicable".

For single risk pool plans that are terminated prior to the Projection Period, enter the metal level of the plan just prior to termination.

AV Metal Value: For each plan, enter the corresponding AV value that results from the AV Calculator or a permissible alternative method that complies with 45 CFR 156.135(b).

For non-single risk pool products that are reported on a combined basis as terminated products prior to the projection period, enter zero.

For single risk pool plans that are terminated prior to the Projection Period, enter the prior metal AV value for the plans.

For Catastrophic plans, enter an approximate AV Metal Value for the plan (e.g., 0.580). Since there is not a Catastrophic continuance table within the AV Calculator, actuaries should use their best judgment in estimating the AV Metal Value.

AV Pricing Value: For each plan enter the corresponding AV Pricing Value.

For non-single risk pool products that are reported on a combined basis as terminated products prior to the Projection Period, enter a value of 0.01.

For single risk pool products/plans that are terminated prior to the projection period, enter a value of 0.01.

It is important to note that the AV Pricing Value may be different from the AV Metal Value for several reasons. The AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate which includes the administrative expense load incorporated in the rate development. It is likely to have a spread from one plan to another that emulates the spread in the Plan Adjusted Index Rates of the same plans.

The AV Metal Value compares the amount paid by a health plan to total allowed costs of benefits for the given plan (e.g., the estimated paid costs for a gold plan is compared to estimated allowed costs for a gold plan to generate a ratio between 0.76 and 0.82).

Another difference between the AV Pricing Value and the AV Metal Value is the data used to generate the ratios. The AV Pricing Value is determined from the issuer's own experience rather than the experience of the standard population or standard tables that are used in the calculation of the AV Metal Value. In addition the AV Pricing Value should reflect all of the allowable plan level adjustments to the Index Rate that are used by the issuer. This may include some or all of the following adjustments, so long as the adjustments do not include any assumptions related to the morbidity of the members assumed to select a given plan:

- The cost-sharing design of the plan. This adjustment may include expected differences in utilization of services based on differences in cost-sharing. For example, lower cost-sharing is generally associated with higher utilization of services, independent of health status. This adjustment must not include any differences in utilization due to differing health status of people with different cost-sharing designs.

- The plan's provider network and delivery system characteristics, as well as utilization management practices.

- Plan benefits that are not EHBs. The additional benefits must be pooled with similar benefits provided in other plans to determine the allowable rate variation for plans that offer those benefits.

- Administrative costs, excluding Exchange user fees. Note that this should reflect all applicable administrative costs for the plan, not simply a differential from the average administrative costs across all plans.

- For catastrophic plans only, issuers may consider the expected impact of specific eligibility categories for these plans. No adjustment is allowed on metal plans (platinum, gold, silver, or bronze) to account for a catastrophic plan adjustment. In other words, an issuer may not lower the rates of catastrophic plans due to an expectation that healthier members will choose these plans, then make up the revenue shortfall for this adjustment by increasing rates on the metal tier plans. While a separate plan-level

adjustment is permitted for catastrophic members, catastrophic plan experience must be included in the single risk pool. Permitting an adjustment to metal plans to account for the catastrophic plan adjustment would be seen as effectively excluding catastrophic plan experience from the single risk pool, which is not consistent with the single risk pool provision. In addition, the catastrophic adjustment should not duplicate the impact of age that is reflected by application of the standard age curve to the calibrated Plan Adjusted Index Rate.

Plan Category: Use the dropdown box to identify plans as New, Renewing, or Terminated. Please see Plan Mapping Instructions in Section 2.2.2 above for more information on the appropriate selection for this field. Remember a selection of "Renewing" for a plan with a 15% or greater annual increase will result in HIOS identifying the product as subject to review and will require the issuer to enter a Consumer Justification Narrative for that product.

Plan Type: Select the applicable plan type from the drop-down box. Valid Plan Types are Indemnity, PPO, POS, HMO or EPO.

In the event that the list of plan types does not describe an issuer's plan exactly, the issuer should select the closest plan available and provide further explanation of the Plan Type in the Actuarial Memorandum.

Definitions of each of these categories can be found on the HealthCare.gov website in the glossary. However, each State may have its own definition of these terms which would dictate the plan type.

TIP: A Product should have only one Plan Type listed under it. A single product may not contain both HMO and PPO network types.

Plan Name: Enter the name of each plan within a product.

The term "plan" means, with respect to an issuer and a product, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area. Most products will consist of multiple plans where each plan must have an AV equal to one of the permitted metal levels or catastrophic coverage, and most products will have multiple metal levels represented under a single product. The Plan Name is the marketing name used when referring to the specific set of benefits and cost-sharing values. The Plan Name shown should be consistent across submissions (e.g., QHP application, State filings). All plans included in the single risk pool experience shown on Worksheet 1 must be entered in this section of Worksheet 2. This includes any plans that are terminated but have experience included in the single risk pool during the Experience Period. It also includes any plans that were not in effect during the Experience Period but were made available thereafter. Issuers should not enter cost-sharing reduction plan variations separately, since as described in 45 CFR 156.400 through 156.420, plan variations are not separate plans, but rather variations of the corresponding standard plans, with the same premium, benefits, and network as the standard plan. Further instructions are provided in Sections III and IV, below, on how to account for cost-sharing reductions in this template

Currently, HIOS does not report plan names containing special characters (e.g., "%"). It is recommended that plans containing special characters spell out the name of the special character (e.g., "20 Percent Coinsurance Plan" should be entered instead of "20% Coinsurance

Plan").

Plan ID: Enter each assigned Plan ID. The two-letter State code portion of the Plan ID must be entered using capital letters.

The Plan ID is a unique identifier for the set of benefits and cost-sharing values offered within a product by the HIOS issuer, or in other words, a unique identifier of each plan. Plan IDs include multiple digits. The first ten digits are the Product ID, and the next four identify the unique plan within the product. This field must be entered as a text input and must include any leading zeroes (e.g., 0030).

For non-single risk pool products that are closed to new entrants prior to the Projection Period, the issuer should indicate that there is one plan in the product when completing the template. The Plan ID for the product or grouping of terminated products should be populated with the Plan ID of the largest plan within the largest product (measured by member months during the experience period) being terminated, as discussed above.

Generally, if a plan is the "same plan" as the previous year, it should maintain the same HIOS Standard Component (plan) ID.

Exchange Plan: For each plan, enter an indicator (yes or no) as to whether the plan will be offered inside a State-based or Federally-facilitated Exchange or Small Business Health Options Program (SHOP), regardless of whether or not it will also be offered or marketed outside the Exchange. If an application for qualified health plan status is pending, enter "yes." This indicator should not be used to identify whether a plan is offered on a private Exchange. If you indicate "yes" for a plan offering full EHB, the plan will automatically be considered as available on and off the Exchange, due to guaranteed availability. Exchange issuers are required to make all full EHB plans available upon request from consumers who meet the guaranteed availability and EHB requirements, but are not required to market or actively sell Exchange plans outside the Exchange.

For terminated plans, the issuer should enter "No" in this field, even if the plan was offered on the Exchange just prior to its termination.

Historical Rate Increases: For each product, enter the historical rate increase for the period two years prior to the current calendar year, one year prior to the current calendar year, and the current calendar year.

For example, if the template is submitted in 2018 for an Effective Date of January 1, 2019, the current calendar year is 2018. Rate increases are therefore required to be entered for 2016, 2017, and 2018.

Rate increases must reflect the full rate increase that is applied to a policy during the applicable year. For example, if rate tables in the market change quarterly but each policyholder's premium rates change annually, then the rate increase for policies renewing during the year must reflect the total rate change that applies to each policyholder during that year, which is the cumulative effect of the four quarterly rate changes.

If multiple rate increases were implemented during the calendar year period being reported, enter the premium weighted average rate increase across the entire calendar year. For example,

assume the submission is for the small group market in which 50% of groups (representing 50% of the annual revenue) renew in January, 25% renew in April, and 25% renew in October. The calendar year increases are 7% in January, 6% in April, and 5% in October; then the calendar year average rate increase is 6.25% (=7%*50% + 6%*25% + 5%*25%).

For the current calendar year, include all rate changes that have been approved, are currently under review by the applicable regulatory agency, or are anticipated to be submitted. For example, if the template is being submitted in June 2018 for an effective date of January 1, 2019 for a market in which rates change quarterly, include in the average rate increase for 2018 any rate increases that have already been approved or are intended to be implemented in 2018 including those implemented after the submission (e.g., effective July 2018 and October 2018).

For new plans, enter a value of 0.00% in the Historical Rate Increases. If a plan was recently offered for the first time, and therefore does not have experience in the Experience Period, enter the actual Historical Rate Increases in the same manner as other existing plans. If an existing plan has not previously had a rate increase, enter 0.00%.

For terminated products, the historical rate increase fields are optional. However, since the template expects an entry, enter 0.00% to avoid validation warnings.

Effective Date of Proposed Rates: For each plan, enter the corresponding effective date of the proposed rate increases.

See Worksheet 1 instructions for Effective Date. All non-terminating products and plans must have the same effective date. If some products or plans will have a rate change and others will not, then a 0% rate change may be entered in the "Rate Change % (over prior filing)" field described immediately below for those plans that will not have a rate change on the product's effective date.

As on Worksheet 1, if the submission is for the small group market, enter the effective date on which the products' rates will change due to the Index Rate being revised. For example, if the small group quarterly submission revises the Index Rate for July 1, 2019 effective date and includes a trend increase applicable on October 1, 2019, enter July 1, 2019.

Rate Change Percent (over prior filing): Enter the average change in premium rates over the rates included in the prior filing for each plan.

This should be measured as the change in premium rate tables over the rate tables of the previous filing using the current distribution of enrollment by age, geographic area, and tobacco status.

For new plans without mapped enrollment, enter 0.00% in this field.

Cumulative Rate Change Percent (over 12 months prior): Enter the average change in premium rates over the twelve month period prior to the effective date for each plan. This should be the premium-weighted average of the 12-month increases that apply at renewal.

This should be measured as the change in premium rates tables over the 12 month prior rate table using the plan's current distribution of enrollment by age, geographic area, and tobacco

status.

This is the rate increase that determines whether the renewing product is subject to review, per 45 CFR 154.200. This field is also the HIOS trigger to identify a rate increase subject to review. If any renewing plan within a product has a rate increase of 15% or greater, HIOS will require submission of Part II, the written description justifying the rate increase for that product.

For terminating plans, the rate change fields should be 0%.

Projected Per Rate Change Percent (over Experience Period): For each plan, the percentage change in Plan Adjusted Index Rates between the Experience Period and the Projection Period is shown. This field is automatically calculated by the template.

Product Rate Increase Percent: The template calculates the average rate increase for each product by weighting the Cumulative Rate Change Percent (over 12 months prior) for each renewing plan. If a plan is identified as New or Terminated in the Plan Category field, that plan's Cumulative Rate Change will not be counted toward the Product Rate Increase Percent. This is the product rate change that will appear when proposed and final rate changes (regardless of whether the increase is subject to review) are released at https://ratereview.healthcare.gov/.

2.2.4 Section II: Components of Premium Increase

The information shown in this section should reflect the increase in each of the components based on the change in rates in the current rate tables by the issuer and the rates in the proposed rate tables using the age, geographic area, and tobacco status distribution of the current enrollment.

Note that some fields in Section II will now be optional for the 2019 plan year, although issuers will still need to enter "0" in order for the template to successfully validate. See below for the fields that will be optional. As plan rate increases should be based on changes to the overall single risk pool, asking issuers to break out the information for each plan by category increases burden while providing information of limited value.

The proposed rate increase for each plan can vary for items allowable by State and Federal laws and regulations. All information input into the URRT for each plan must reflect experience or best estimate projections for each specific plan. For example, projected member months must reflect the issuer's best estimate of expected enrollment in each plan.

Inpatient (Optional): Enter the portion of the increase in the premium rate that corresponds to benefits provided for inpatient services for each plan. See the instructions for Worksheet 1, Section II for the definition of Inpatient Hospital services.

Outpatient (Optional): Enter the portion of the increase in the premium rate that corresponds to benefits provided for outpatient services for each plan. See the instructions for Worksheet 1, Section II for the definition of Outpatient Hospital services.

Professional (Optional): Enter the portion of the increase in the premium rate that corresponds to benefits provided for professional services for each plan. See the instructions for Worksheet 1, Section II for the definition of Professional services.

Prescription Drug (Optional): Enter the portion of the increase in the premium rate that corresponds to benefits provided for prescription drugs for each plan. See the instructions for Worksheet 1, Section II for the definition of Prescription Drug services.

Other (Optional): Enter the portion of the increase in the premium rate that corresponds to benefits provided for services defined in the "other" benefit category for each plan. See the instructions for Worksheet 1, Section II for the definition of Other Medical services.

Capitation (Optional): Enter the portion of the increase in the premium rate that corresponds to benefits provided for services defined under capitation for each plan. See the instructions for Worksheet 1, Section II for the definition of Capitation.

Administration (Optional): Enter the portion of the increase in the premium rate that corresponds to administrative expenses incorporated in the premium rates for each plan. See the instructions for Worksheet 1, Section III for the definition of Administrative Expense Load.

Taxes & Fees (Optional): Enter the portion of the increase in the premium rate that corresponds to the taxes and fees incorporated in the premium rates for each plan. Also include expected changes in the payments and charges under the risk adjustment and reinsurance programs, in addition to the administrative costs associated with these programs. Since the total rate increase is affected by changes in anticipated transfer payments, these must be reflected in order for the total to be calculated correctly.

Risk & Profit Charge (Optional): Enter the portion of the increase in the premium rate that corresponds to the risk and profit charges incorporated in the premium rates for each plan. See the instructions for Worksheet 1, Section III for the definition of Profit & Risk Load.

Total Rate Increase: This is a calculated field and equals the sum of the benefit categories, administrative expenses, and the risk and profit charges for each plan. It should equal the difference between the projected Average Current Rate PMPM * (1 + Rate Change % (over prior filing)) and the Average Current Rate PMPM.

Member Cost Share Increase (Optional): Enter the expected increase in the member's cost-sharing portion from the period underlying the current rate for the plan to the projected rating period of the plan. This includes cost-sharing paid by HHS on behalf of low-income members.

> This might reflect the impact of trend on coinsurance, for example. This would not include any increase in the member's cost associated with the increase in premium rates.

Average Current Rate PMPM: Enter the average premium rate on a per member basis for each plan for the most recently approved rates.

> The Average Current Rate PMPM should be generated using the current membership distribution by age, geographic area, and tobacco status.
>
> In the case of small group rates where a trend factor is filed and approved, the Average Current Rate PMPM should reflect the latest approved rate, or the rates that are currently under review by the applicable regulatory agency, or are anticipated to be submitted. For example, assume the current rates were filed for effective dates between January and December with a quarterly

trend factor. The current rates that should be entered in the rate filing would be the rates with effective dates October through December.

For new plans without mapped enrollment, leave this field blank. For new plans with mapped enrollment, enter the Average Current Rate PMPM of the mapped plans. It is understood that the calculated Average Current Rate PMPM across all plans may be understated because the new plans without mapped enrollment will be assigned positive weight based on the projected enrollment and a current rate of zero. In fact, any time the Projected Member Months have a different distribution across plans than the current distribution, the Average Current Rate PMPM will not represent the true current average rate.

Projected Member Months: Enter the projected member months by plan that correspond to the effective period of the rates for each plan. See the instructions for Worksheet 1, Section III for the definition of Projected Member Months. The sum of the Projected Member Months for each of the plans should equal the Projected Member Months on Worksheet 1.

The total Member Months in the Projection Period should be consistent with the Projected Member Months entered in Section III of Worksheet 1. However, the member months may differ if there are different effective dates for the products/plans. The template includes a "Warning" indicator if there is a significant difference between the member months found in Worksheet 1 and in Worksheet 2. In these cases, support for the member months in both worksheets should be documented in the Part III Actuarial Memorandum.

Projected member months entered in the template must reflect an issuer's best estimate of projected enrollment for that specific plan. An explanation for any non-terminating plans with zero projected membership should be included in the actuarial memorandum.

2.2.5 Section III: Experience Period Information

The information shown in this section captures the historical data for the twelve-month period used in the base period experience. This should be the same time period as the Experience Period found in Worksheet 1. See the instructions for Worksheet 1 for the definition of the Experience Period.

For small group submissions, the information in this section, except where noted, should reflect the Experience Period data on Worksheet 1. For example, if the Experience Period on Worksheet 1 is calendar year 2016, the information on this section should be from calendar year 2016.

Plan Adjusted Index Rate PMPM: Enter the Plan Adjusted Index Rate PMPM for each plan during the Experience Period. The average should be generated using membership consistent with the Experience Period for each plan.

The Plan Adjusted Index Rate of the Experience Period is the Market Adjusted Index Rate of the experience period (defined in the introduction of these instructions) further adjusted for plan specific factors allowable by 45 CFR 156.80(d)(2) such as provider network, utilization management, benefits that are not EHB, AV and cost-sharing, distribution and administrative costs (less Exchange fees), and catastrophic plan eligibility variation.

The Plan Adjusted Index Rate entered should be the Plan Adjusted Index Rate that was filed for the Experience Period.

It is anticipated that the overall Plan Adjusted Index Rate PMPM during the Experience Period may not be similar to the average premium rate found in Section I of Worksheet 1 due to differences in the distribution of ages, geography, and benefits that was projected when the issuer was developing rates versus what actually emerged.

For small group filings, the Plan Adjusted Index Rate in the Experience Period should be entered using the following approach:

- Annual rate filings: please enter the Plan Adjusted Index Rate filed during the Experience Period.

- Quarterly rate filings: please enter the Plan Adjusted Index Rate filed for the most recent filing during the Experience Period.

For terminated non-single risk pool plans, enter zero in the template.

Member Months: Enter the total member months during the Experience Period. See the instructions for Worksheet 1 for the definition of Experience Period Member Months.

The total Member Months in the Experience Period should be consistent with the Experience Period Member Months entered in Worksheet 1. The template includes a "Warning" indicator if there is a significant difference between the member months found in Worksheet 1 and in Worksheet 2. In these cases, support for the member months in both worksheets should be documented in the Actuarial Memorandum.

Total Premium (TP): Enter the total premium earned in the Experience Period for each plan. The amount entered here should not reflect Risk Adjustment. See the instructions for Worksheet 1 for the definition of Premiums (net of MLR Rebate) in Experience Period.

The template includes a "Warning" indicator if there is a significant difference between the average premiums on the two worksheets. If the warning is triggered, additional information should be provided in the Actuarial Memorandum that explains the differential.

EHB Percent of TP: Enter the percentage of the total premium that is associated with Essential Health Benefits in each plan (including administrative expenses and profit associated with those services). Certain benefits, including routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia should not be considered EHB, even if the State EHB Benchmark plan covers such benefits[13].

When calculating the EHB Percent of TP, the Administrative Expense Load, Profit & Risk Load, and Taxes & Fees should be allocated to the various categories in this section of the template in proportion to the claims expenses. Those categories include EHB, State mandated benefits that are not EHB, and other non-EHB benefits. For example, if 95% of claims are EHB, and 5% of claims are non-EHBs, then the EHB Percent of TP should be 95%. Similarly, the "Other" benefits portion of TP should be 5% in the example and would be calculated as such by the template.

[13] 45 CFR 156.115(d)

Administrative expenses and profit should not be disproportionately allocated to one benefit over another. The sum of the EHB percentage, the State mandated benefits percentage, and the other benefits percentage should equal 100%.

If abortion services are included in the State EHB Benchmark Plan, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below.

- If the plan is a QHP offered in the Federally-facilitated Exchange or State-based Exchange, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be covered by the State EHB Benchmark Plan). The EHB percentage will be used in the calculation of subsidy amounts. Since subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.

- If the plan is not a QHP offered in the Federally-facilitated Exchange or State-based Exchange, but rather is only offered in the outside market, the percentage of premium associated with abortion services should be included in the EHB percentage.

If abortion services are not covered by the State EHB Benchmark plan, any covered abortion services should be reflected in either the State mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the Exchange.

State Mandated Benefits Portion of TP that are Other Than EHB: Enter the percentage of the total premium for each plan that is associated with State mandated benefits that are not Essential Health Benefits.

Similar to the EHB percentage, the State mandated benefit percentage of the total premium should include the portion of administrative expenses, taxes and fees and risk and profit loads associated with these services.

For purposes of determining EHB, State-required benefits (or mandates) are considered to include only requirements that a health plan cover specific care, treatment, or services. Provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, are not considered to be State-required benefits for purposes of EHB coverage. Similarly, State-required benefits are not considered to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, State anti-discrimination requirements relating to service delivery method (e.g., telemedicine) are not considered to be State-required benefits.

In most cases if the State-required coverage of benefits after December 31, 2011, the benefit in question is considered a non-EHB, even if the benefit is covered by the State EHB Benchmark Plan.

If a State mandates that issuers cover a non-EHB, include the portion of premium associated with the non-EHB in this field. If a State mandates that issuers offer a non-EHB (but the benefit is not required to be included in every plan), do not include that portion of premium in this field;

it should be reflected in the "Other benefits" field.

The percentages in these fields are required as States will need to defray the cost of State mandated benefits that are not EHB, pursuant to 45 CFR 155.170.

Other Benefits Portion of TP: This is a calculated field which generates the remaining percentage of the total premium based on the values entered from the EHB and State mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the State mandated benefit portion for non-EHBs and the other benefits portion should equal 100%.

Total Allowed Claims (TAC): Enter the total allowed claims for each benefit plan with service dates within the Experience Period.

TIP: Allowed claims should not include Risk Adjustment transfer amounts for 2019 filings.

The Total Allowed Claims (TAC) across all benefit plans for the Experience Period should be consistent with the Allowed Claims entered in Section I of Worksheet 1.

The template includes a "Warning" indicator when the allowed claims between Worksheet 1 and Worksheet 2 are significantly different. If a warning is triggered, the issuer should provide additional support for the difference between the total allowed claims between Worksheets 1 and 2 in the Actuarial Memorandum.

EHB Percent of TAC: Enter the percentage of the total allowed claims that are associated with EHBs in each plan during the Experience Period.

If abortion services are included in the State EHB Benchmark Plan, the portion of the allowed claims related to these services is to be handled in two different methods in accordance with the criteria described below.

- If the plan is a QHP offered in the Federally-facilitated Exchange or State-based Exchange, the percentage of the allowed claims associated with abortion services should not be included in the EHB percentage (even though these services may be covered by the State EHB Benchmark Plan).

- If the plan is not a QHP offered in the Federally-facilitated Exchange or State-based Exchange, but rather is only offered in the outside market, the percentage of allowed claims associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the State EHB Benchmark Plan, any covered abortion services should be reflected in either the State mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the Exchange.

State Mandated Benefits Portion of TAC that are other Than EHB: Enter the percentage of the total allowed claims for each plan that are associated with State mandated benefits that are not EHB.

If a State mandates that issuers cover a non-EHB, include the allowed claims associated with the

non-EHB in this field. If a State mandates that issuers offer a non-EHB (but the benefit is not required to be included in every plan), do not include that portion of allowed claims in this field; it should be reflected in the "Other benefits" field.

Other Benefits Portion of TAC: This is a calculated field which generates the remaining percentage of the total allowed claims based on the values entered from the EHB and State mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the State mandated benefit portion for non-EHBs, and the other benefits portion should equal 100%.

Allowed Claims which are not the Issuer's Obligation: Enter the portion of the allowed claims (as defined on Worksheet 2) that were paid by the insured or other funds for each plan separately during the Experience Period. These would include the following types of payments:

- Member cost-sharing (i.e., deductible, coinsurance, and copays). This should be based on the cost-sharing associated with the benefits of each plan. For those plans with reduced cost-sharing subsidies for the member, the cost-sharing amount should reflect both the amount paid by the member and the subsidies. For example, for the silver plan variation with 94% cost-sharing, the value of the cost-sharing included in this field should reflect the approximately 6% cost-sharing expected from the member and the approximately 24% cost- sharing covered by the Federal subsidy for a total cost-sharing value of approximately 30% (6% + 24%).

- Federal reinsurance payments received should be included in this field. The Federal reinsurance payments should be entered by plan. Payments should be entered as positive amounts. The method used to determine these payments by plan should be described in the Actuarial Memorandum. The Federal reinsurance contributions should not be included since they are not part of allowed claims.

- Other claims that are not described above but included in this cell should be described in detail in the Actuarial Memorandum.

TIP: Claims should not include Risk Adjustment transfer amounts for 2019 filings.

Portion of Above Payable by HHS's Fund on Behalf of Insured Person, in Dollars: Enter the portion of the total dollars that are attributable to HHS during the Experience Period. This is the cost-sharing reduction subsidies.

Portion of Above Payable by HHS on Behalf of Insured Person, as Percent: This is a calculated field and displays the percentage of claims covered by HHS over the value of all claims not covered by the issuer.

Total Incurred claims, payable with issuer funds: This is a calculated field that displays the incurred claims which the issuer is responsible for paying.

The Total Incurred claims from all plans should share a relationship with the Incurred Claims in Experience Period from Worksheet 1. A warning is triggered when the incurred claims are significantly different between Worksheet 1 and Worksheet 2. If a warning is triggered, the issuer should provide additional support for the difference between the total incurred claims in Worksheets 1 and 2 in the Actuarial Memorandum.

Net Amount of Rein: Enter the Federal reinsurance amount received for each plan during the Experience Period.

This value should be calculated consistently with the Federal reinsurance amount included in the Allowed Claims which are not the issuer's obligations. However, it will differ from that amount because this field is net of the reinsurance contribution amount.

While the final information on the reinsurance recoveries during the Experience Period may not be available at the time of the filing, issuers should enter their best estimate of the expected recoveries.

Risk Adjustment Transfer Amount: Enter the risk transfer charge or payment during the Experience Period for each plan.

If the transfer amount is a charge (liability payment made to other issuers), the value should be a negative amount. If the transfer amount is a payment received from other issuers, the value should be entered as a positive amount.

While the final information on the risk transfer charges or payments during the Experience Period may not be available at the time of the filing, issuers should enter their best estimate of the expected risk transfer charge or payment.

2.2.6 Section IV: Projected Experience

The information shown in this section captures the projected data for the twelve month period following the effective date for each plan.

It is expected that in general, the projection period found in this section should be the same as the Projection Period found in Section II of Worksheet 1. However, there are circumstances where the projection periods may differ. These circumstances occur in the small group market when prospective trend is included in the submission (if permitted by the State). In this case:

- Similar to the Index Rate for Projection Period on Worksheet 1, the Plan Adjusted Index Rate must reflect the member weighted average of the projected trended Plan Adjusted Index Rates applicable for all effective dates in the submission. See the Appendix for more information on the calculation of the member weighted average Index Rate.

- Member months should be consistent with those reflected on Worksheet 1. Since the single risk pool requires the Index Rate be based on ALL enrollees in the market in the State for that issuer, the member months should reflect all projected member months for the single risk pool in the Projection Period, regardless of the expected renewal month.

All data entered in the Claims Information section (rows 87 through 97) should be consistent with the Projection Period shown on Worksheet 1. Therefore, the amount of trend reflected in the claims section will differ from that reflected in the premium information.

For small group submissions, the information in this section, except where noted, should reflect the Projection Period on Worksheet 1. For example, if the projection period on Worksheet 1 is calendar year 2018, the information on this section should be calendar year 2018.

Plan Adjusted Index Rate: Enter the projected Plan Adjusted Index Rate into these cells for each plan ID for the effective period of the proposed rates.

The Plan Adjusted Index Rate is the Market Adjusted Index Rate (defined in the introduction of these instructions) adjusted for plan specific factors allowable by 45 CFR 156.80(d)(2) such as provider network, utilization management, non-EHBs, AV and cost-sharing, distribution and administrative costs (less Exchange fees), and catastrophic plan eligibility variation.

The overall weighted average of the Plan Adjusted Index Rates should be similar to the Single Risk Pool Gross Premium Avg. Rate, PMPM found in Section III of Worksheet 1.

For small group filings with predefined quarterly trends, the Plan Adjusted Index Rate should reflect the weighted average of the member enrollment. This is consistent with the Index Rate for Projection Period entered on Worksheet 1.

Member Months: The template populates the projected Member Months using the Projected Member Months entered in Section II of the worksheet.

Total Premium (TP): Enter the expected total premium earned in the Projection Period for each plan. The amount entered here should not reflect Risk Adjustment. See the instructions for Worksheet 1 for the definition of Premiums (net of MLR Rebate) in Experience Period.

The Total Premium (TP) in the Projection Period should be similar to the total premium found in Section III of Worksheet 1. The template includes a "Warning" indicator if there is a significant difference between the total premiums shown on both worksheets. If the warning is triggered, additional information should be provided in the Actuarial Memorandum that explains the cause. One explanation that may apply is that the small group Plan Adjusted Index Rates reflects the member weighted average of the rates for all effective dates in the filing, whereas the Worksheet 1 Single Risk Pool Gross Premium Avg. Rate reflects the effective date of the change in the Index Rate.

EHB Percent of TP: Enter the percentage of the total premium that is associated with EHBs in each plan. It is critical that this percentage be entered correctly and consistently with any QHP application. This field may be used by CMS to calculate the advance payments of the premium tax credit for subsidy-eligible enrollees. If the values in this field are not entered correctly, the calculation of the advance payments of the premium tax credit may be incorrect for an issuer.

For non-terminated single risk pool plans, the value entered into the EHB Percent of TP field must be greater than zero. It is critical that this percentage be entered correctly as it may be used to calculate the advance payments of the premium tax credit for subsidy-eligible members.

For pre-ACA plans and terminated plans, the field may be left blank.

When calculating the EHB percentage, the Administrative Expense Load, Profit & Risk Load, and Taxes & Fees should be allocated to the various categories in this section of the template in proportion to the claims expenses. The sum of the EHB percentage, the State mandated benefits percentage, and the other benefits percentage should equal 100%.

If abortion services are included in the State EHB Benefit Plan, the portion of the premium

related to these services is to be handled using two different methods in accordance with the criteria described below.

- If the plan is a QHP offered in the Federally-facilitated Exchange or State-based Exchange, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Since subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.

- If the plan is not a QHP offered in the Federally-facilitated Exchange or State-based Exchange, but rather is only offered in the outside market, the percentage of premium associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the State EHB Benchmark Plan, any covered abortion services should be reflected in either the State mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the Exchange.

Submission of the Part I URRT and corresponding Part III Actuarial Memorandum satisfies the requirements of 45 CFR 154.215 and 156.470.

State Mandated Benefits Portion of TP that are Other Than EHB: Enter the percentage of the total premium for each plan that is associated with State mandated benefits that are not EHB.

Similar to the EHB percentage, the State mandated benefit percentage of the total premium should include the portion of administrative expenses, taxes and fees, and risk and profit loads associated with these services.

If a State mandates that issuers *cover* a non-EHB, include the portion of premium associated with the non-EHB in this field. If a State mandates that issuers *offer* a non-EHB (but the benefit is not required to be included in every plan), do not include that portion of premium in this field; it should be reflected in the "Other benefits" field.

The percentages in these fields are required as States will need to defray the cost of State mandated benefits that are not EHB.

Other Benefits Portion of TP: This is a calculated field which generates the remaining percentage of the total premium based on the values entered from the EHB and State mandated benefits portions, described above.

The sum of the EHB portion, the State mandated benefit portion for non-EHBs, and the other benefits portion should equal 100%.

Total Allowed Claims (TAC): Enter the expected total allowed claims in the Projection Period for each plan.

The Total Allowed Claims (TAC) across all benefit plans for the projection period should be consistent with the total allowed claims entered in Section III

TIP: Claims should not include Risk Adjustment transfer amounts for 2019 filings.

of Worksheet 1. The template includes a "Warning" indicator when the sum of the allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries in Worksheet 1 and the allowed claims in Worksheet 2 are significantly different. If a warning is triggered, the issuer should provide additional support for the difference between these amounts in the Actuarial Memorandum.

EHB Percent of TAC: Enter the percentage of the total allowed claims that are associated with EHB services in each plan during the Projection Period. If abortion services are included in the EHB package, the portion of the allowed claims related to these services is to be handled in two different methods in accordance with the criteria described below. It is critical that this percentage be entered correctly. This field may be used by CCIIO to calculate cost-sharing reduction advance payments for subsidy-eligible enrollees. If the values in this field are not entered correctly, the calculation of the cost-sharing reduction advance payments may be incorrect for an issuer.

- If the plan is a QHP offered in the Federally-facilitated Exchange or State-based Exchange, the percentage of the allowed claims associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB package).

- If the plan is not a QHP offered in the Federally-facilitated Exchange or State-based Exchange, but rather is only offered in the outside market, the percentage of allowed claims associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB package, any covered abortion services should be reflected in either the State mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the Exchange.

Submission of the Part I URRT and corresponding Part III Actuarial Memorandum satisfy the requirements of 45 CFR §§ 154.215 and 156.470.

State Mandated Benefits Portion of TAC that are Other Than EHB: Enter the percentage of the total allowed claims for each plan that are associated with State mandated benefits that are not part of the EHB package.

If a State mandates that issuers cover a non-EHB, include the portion of allowed claims associated with the non-EHB in this field. If a State mandates that an issuers must offer a non-EHB (but the benefit is not required to be included in every plan), do not include that portion of allowed claims in this field; it should be reflected in the "Other benefits" field.

Other Benefits Portion of TAC: This is a calculated field which generates the remaining percentage of the total allowed claims based on the values entered from the EHB and State mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the State mandated benefit portion not associated with EHBs, and the other benefits portion should equal 100%.

Allowed Claims which are not the Issuer's Obligation: Enter the portion of the allowed claims (as defined in Worksheet 2) that were paid by the insured or other funds for each plan separately during the projection period. These would include the following types of payments:

- Member cost-sharing (i.e., deductible, coinsurance, and copays). This should be based on the cost-sharing associated with the benefits of each plan. For those plans with reduced cost-sharing subsidies for the member, the cost-sharing amount included in this value should reflect both the amount paid by the member and the subsidies.

- Other claims that are not described above but included in this cell should be described in detail in the Actuarial Memorandum.

Portion of Above Payable by HHS's Fund on Behalf of Insured Person, in Dollars: Enter the portion of the total dollars that are attributable to HHS during the Projection Period. This is the cost-sharing reduction subsidies.

These estimates should be based on the issuer's expected enrollment of cost-sharing reduction eligible members. The methodology used to estimate these values should be explained in the Actuarial Memorandum.

Since this value is a portion of the payments entered in the Allowed Claims which are not the issuer's obligations (described above), the same methodology to estimate these payments should be employed.

Portion of Above Payable by HHS on Behalf of Insured Person, as a Percentage: This is a calculated field and displays the percentage of claims covered by HHS over the value of claims not covered by the issuer.

Total Incurred claims, payable with issuer funds: This is a calculated field that displays the projected incurred claims which the issuer is responsible for paying.

Net Amount of Rein: This is a holdover from prior years. It is expected issuers will populate this field with "0."

Risk Adjustment Transfer Amount: Enter the amount of any risk transfer payment expected to be received during the projection period for each plan. If a risk transfer charge is anticipated to be assessed, the value entered should be negative.

3 Part II: Written Description Justifying the Rate Increase

Part II is a brief, non-technical consumer-oriented explanation of the rate increase subject to review, intended to provide context for the quantitative information provided in Part I. This data should clearly explain the information given in Part I.

Accordingly, it should identify and explain the key drivers of the rate increase in Part I. For example, if inpatient costs are reported as the main factor of the rate increase, the written explanation should describe why hospital costs are increasing.

The explanation should include information on the following components related to the rate increase:

- Scope and range of the rate increase: Provide the number of individuals impacted by the rate increase. Explain any variation in the increase among affected individuals (e.g., describe how any

changes to the rating structure impact premium).

- Financial experience of the product: Describe the overall financial experience of the product, including historical summary-level information on historical premium revenue, claims expenses, and profit. Discuss how the rate increase will affect the projected financial experience of the product.

- Changes in Medical Service Costs: Describe how changes in medical service costs are contributing to the overall rate increase. Discuss cost and utilization changes as well as any other relevant factors that are impacting overall service costs.

- Changes in benefits: Describe any changes in benefits, and explain how benefit changes affect the rate increase. Issuers should explain whether the applicable benefit changes are required by law.

- Administrative costs and anticipated margins: Identify the main drivers of changes in administrative costs. Discuss how changes in anticipated administrative costs and underwriting gain/loss are impacting the rate increase.

There is no standardized reporting form for Part II, but issuers are expected to cover the items listed above in their submissions. HIOS will require the issuer to enter Part II if any renewing plan within a product has a rate increase of 15% or more. The written statement must be entered in HIOS via a text box. Such information posted by the issuer will be clearly displayed as the statements of the issuer. CMS will not edit the statements provided by issuers for Part II.

Note HIOS can now display rich text and allow for bullet point outline formats in the description. Note characters of "<", ">", and "/" are still not allowed with the rich text upgrade.

4 Part III: Actuarial Memorandum and Certification Instructions

The Part III Actuarial Memorandum instructions below are considered the minimum requirements for a Part III submission. However, issuers are encouraged to provide as much detail and supporting documentation as possible in advance to avoid delaying the review process. If, in the opinion of the regulator, given the facts and circumstances of the submission, additional information is necessary to properly complete the review, issuers are required to respond to all questions in a limited timeframe. Failure to provide information on a timely basis or failure to provide accurate information slows the review process and puts the issuer at risk for missing critical deadlines to offer products and plans in the individual and small group markets.

The Actuarial Memorandum must also capture appropriate actuarial certifications related to:

- The methodology used to calculate the AV Metal Value for each plan.

- The appropriateness of the EHB portion of premium upon which APTCs are based.

- The development of the Index Rate in accordance with Federal regulations, and the development of plan specific premium rates using allowable modifiers to the Index Rate.

- The geographic rating factors, which should reflect differences only in the costs of delivery (which can include unit cost and provider practice pattern differences) and not differences in population morbidity by geographic area.

State specific required information or certifications may also be included at the actuary's discretion. If an actuary chooses to exclude this information from the Actuarial Memorandum, this information would need to be provided to the State regulatory agency, under separate cover.

In any case where information provided is not broadly applicable to all products and plans included in the submission, please clearly indicate to which products and plans the information applies.

4.1 Redacted Actuarial Memorandum

As required by 45 CFR 154.215(h)(2), CMS will make available to the public the information contained in Part III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information, consistent with HHS FOIA regulations, 45 CFR 5.31(d). To facilitate release of Part III to the public, health insurance issuers must upload two versions of Part III: (1) an un-redacted version for CMS review ("CMS version") and (2) a redacted version that will be made available to the public ("public version"). The CMS version should contain all data elements and information required in this manual with no redactions. The public version should redact only information that is a trade secret or confidential commercial or financial information. **Redacted Actuarial Memorandums will be reviewed for compliance with 45 CFR 5.31(d) to ensure that issuers are not redacting more information than is allowable according to the regulation.**

The HIOS system requires the Redacted Actuarial Memorandum to be uploaded to a particular field, or a box may be checked indicating CMS should use the Un-redacted Actuarial Memorandum uploaded for CMS review. If an issuer selects this box, the un-redacted version will appear on the HHS website (RateReview.Healthcare.gov).

4.2 General Information Section

This section of the Actuarial Memorandum should include general information about the issuer and the policies which are the subject of the submission. The information provided in this section should include at least the following:

Company Identifying Information: Provide the following information that uniquely identifies the issuer submitting the memorandum. The information must be the same as the entries in the general information section of Worksheet 1 of the URRT (see the instructions for the URRT for additional definition of these fields):

- Company Legal Name: the organization's legal entity name associated with the HIOS Issuer ID.
- State: the State that has regulatory authority over the policies.
- HIOS Issuer ID: the HIOS ID assigned to the legal entity.
- Market: the market in which the products and plans are offered.

- Effective Date: the effective date of the change of the Index Rate.

Company Contact Information: Provide the following information detailing how the reviewing regulator should contact the company in the case additional information is needed.

- Primary Contact Name: Provide the name of the person at the company who will serve as the primary contact for the submission. The regulator will contact this person if there are questions related to the information submitted, or if additional information is needed.

- Primary Contact Telephone Number: Provide the phone number for the primary contact.

- Primary Contact Email Address: Provide the email address for the primary contact.

4.3 Proposed Rate Increases

In this section the actuary must provide information related to the proposed rate increase(s). If the proposed rate adjustment varies by product, the information provided should clearly identify which proposed adjustments apply to which products. Include all products which are part of the single risk pool, as defined by 45 CFR 156.80, including those products for which no rate adjustment is being proposed. The information that must be provided includes the following items:

Reason for Rate Increase(s): Provide a narrative description of all significant factors driving a proposed rate increase. As an example, these factors could include but are not limited to:

- Single risk pool experience which is more adverse than that assumed in the current rates

- Medical inflation

- Increased utilization

- Prospective changes to benefits covered by the product or successor products

- New taxes and fees imposed on the issuer

- Anticipated changes in the average morbidity of the covered population that is market-wide, as opposed to issuer specific morbidity that is reflected in risk adjustment

If the requested rate increase is not the same across all products and plans, provide a narrative discussion as to why the rate changes vary by product or plan given they are based on the same single risk pool of experience for the market. Large variation in the requested rate change across products and plans will likely require further information for the regulator demonstrating morbidity was not a factor in the varying rate changes.

4.4 Market Experience

4.4.1 Experience Period Premium and Claims

This section of the Actuarial Memorandum should include information related to the actuary's best

estimate of premium and claims for the single risk pool during the experience period reported in Worksheet 1, Section I of the URRT.

Paid Through Date: Indicate the date through which payments have been made on claims incurred during the experience period.

Premiums (net of MLR Rebate) in Experience Period: Provide support for how the amount of premium earned during the experience period, net of MLR rebates to policyholders, was developed.

- Separately indicate the earned premium prior to MLR rebates and the amount of MLR rebates refunded (or expected to be refunded) for the market during the experience period. Earned premium should not be reduced for any reductions prescribed when calculating the issuer's MLR, such as taxes and assessments.

- For portions of the experience premium for which the MLR rebate has not been finalized, a best estimate of the rebates is to be included. Describe the methodology used to estimate such rebates.

Allowed and Incurred Claims Incurred During the Experience Period: Provide support for the development of the actuary's best estimate of allowed and paid claims incurred during the experience period.

- Worksheet 1, Section I shows the actuary's best estimate of the amount of claims that were incurred during the 12-month experience period. Separately indicate the amount of claims which were processed through the issuer's claim system, processed outside of the issuer's claims system, and the amount that represents the actuary's best estimate of claims incurred but not paid as of the Paid Through Date stated above. This should be provided separately for Incurred Claims in Experience Period and Allowed Claims, as defined and reported on Worksheet 1, Section I.

- Describe the method used for determining Allowed Claims. For example, Allowed Claims could come directly from an issuer's claim records or alternatively could be developed by combining paid claims or capitation payments with member cost-sharing.

- Provide support for the estimate of incurred but not paid claims.
    - Describe the methodology used to develop the estimate of claims incurred but not paid for both Allowed Claims and Incurred Claims in the Experience Period. To the extent that the methodology or completion factors used to estimate incurred but not paid claims on an allowed basis differs from the methodology or completion factors used to estimate incurred claims, describe and support why they are different.

    - Indicate whether the claims used to develop any completion factors reflect the experience period claims for the information submitted or some alternate claims set, such as a larger block of the issuer's experience. If an alternate claims set was used, please provide support for why it is appropriate.

    - If the incurred but not paid claims are unusually high or unusually low relative to the experience period claims paid as of the Paid Through Date, explain what is causing them

to be unusually high or unusually low (e.g., introduction of a new claims system, significant employee turnover, etc.).

4.4.2 Benefit Categories

For each of the Benefit Categories in Worksheet 1, Section II, describe the methodology used to determine which category each claim in the experience period falls. For benefit categories where "Other" was selected as the Utilization Description in the URRT, please describe the measurement units that were used.

4.4.3 Projection Factors

This section should include a description of each factor used to project the experience period allowed claims to the projection period and supporting information related to the development of those factors. For each factor, the actuary should include a description of the source data or assumptions used, why they are appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for issuer specific experience, industry or internal studies, benefit design, and credibility of the source data. At a minimum, include support for the following factors:

Changes in the Morbidity of the Population Insured: Describe any adjustment factors applied to the experience period claims to account for anticipated differences in the average morbidity of the pooled population underlying the experience period and the issuer's population anticipated to be insured in the projection period. These adjustments are shown in the "Pop'l risk Morbidity" column on Worksheet 1, Section II and are in addition to the anticipated change in claims cost as a result of changes in the average mix by age and gender of the covered population (which are shown in the "Other" adjustment column). The morbidity of the population could be impacted by items such as guaranteed availability, an individual mandate to maintain coverage, expansion of Medicaid programs, and the introduction of a Basic Health Program.

Changes in Benefits: Describe the development of factors used to adjust the experience period claims to reflect the average benefits that will be covered during the projection period, including any newly mandated benefits. These changes are reflected in the "Other" adjustments column on Worksheet 1, Section II. The factors could adjust for items including but not limited to the following:

- Addition of any benefits covered under the State EHB Benchmark Plan.
- Any newly mandated benefits required under State law that are not reflected in the experience period claims.
- Adjustment for the removal of benefits covered in the experience period claims that will not be covered in the projection period.
- Anticipated changes in the average utilization of services due to differences in average cost-sharing requirements during the experience period and average cost-sharing requirements in the projection period.

Changes in Demographics: Describe the development of factors used to adjust the experience period claims to reflect differences between the average mix of the population by age, gender, and region

underlying the base period experience and the average mix anticipated to underlie the projection period. These changes are reflected in the "Other" adjustments column on Worksheet 1, Section II. Describe and support the age/gender factors underlying the development of these claims-based demographic adjustment factors.

Other Adjustments: Describe any other adjustments, in addition to benefits and demographics which are specifically addressed above, that are reflected in the "Other" adjustments column on Worksheet 1, Section II. Also describe how these factors were developed.

Trend Factors (cost/utilization): Describe the source claims data used and methodology used for developing the cost and utilization projection factors, including all adjustments made to the data. Explain why the adjusted source data is applicable to the single risk pool. Some examples of such adjustments include but are not limited to the following:

- Normalization for changes in age.
- Normalization for benefit changes that occurred during the period (even if allowed claims are used to project trend, a normalization adjustment may be warranted to account for the influence that changes in benefits have on utilization).
- Adjustments for seasonality patterns underlying the claims that may skew calculated trends.
- Normalization for any one-time events which are not anticipated to reoccur during the projection period.
- Adjustments for anticipated changes in provider contracts that differ from those underlying the experience used.
- For prescription drugs, any adjustments made to account for changes in the formulary, expiration of patents, or introduction of new drugs.

4.4.4 Credibility Manual Rate Development

For issuers with experience period claims that are not determined to be fully credible, the use of other credible claims experience must be employed in developing a credibility manual rate for blending with the experience period claims. The actuary must provide information related to the other experience and general methodology used in developing the manual rate.

Source and Appropriateness of Experience Data Used: Describe the source data used to develop the manual rate and why such data is appropriate. Sources considered reasonable for developing manual rates include but are not limited to:

- Multiple years of experience for the market for which rates are being submitted.
- The issuer's experience for similar policies nationwide, including rationale for inclusion/exclusion of various blocks of business.
- A manual rate developed by a consultant with appropriate supporting documentation as to the

underlying source data for development of the manual rate.

Adjustments Made to the Data: The experience upon which the manual rate is based must be adjusted to be reflective of the population, region, provider network, and benefits anticipated under the policies for which rate increases are being submitted. Describe all adjustments made to the data underlying the development of the manual rate to account for differences in demographics, benefits, and morbidity/risk to ensure that the resulting manual rate is appropriate for blending with the adjusted experience period claims.

Inclusion of Capitation Payments: If some of the services in the projection period will be provided under a capitation arrangement, specifically describe how these payments were accounted for in the development of the credibility manual rate.

4.4.5 Credibility of Experience

In this section issuers must provide support for the credibility level assigned to their base period experience, with the complement being applied to a credibility manual rate. The requested information will include items such as:

- Description of the Credibility Methodology Used.
- Resulting Credibility Level Assigned to Base Period Experience when applying the proposed credibility methodology.

When the base period experience is partially credible and included in experience used to develop the manual rate, the actuary must consider the extent to which the manual rate development double counts the base period experience. If the proposed manual rate lacks sufficient independence from the base period experience, the credibility percentage in the template should be adjusted such that the experience is assigned the appropriate credibility (based on the issuer's credibility formula), taking into consideration the proportion of the manual experience that is from the subject base experience. In this case additional documentation should be included in the Actuarial Memorandum to demonstrate that the credibility factor applied in the template is consistent with the issuer's credibility formula.

When determining credibility, the actuary should consider Actuarial Standard of Practice #25, *"Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages."*

4.4.6 Paid to Allowed Ratio

Provide support for the Paid to Allowed Average Factor in Projection Period for the market, shown in Worksheet 1, Section III. Demonstrate that the ratio is consistent with membership projections by plan included in Worksheet 2. The ratio for each plan should be relatively consistent with the metallic AV for the plan to which the actuary is attesting, however it is recognized that they may not be exactly the same due to differences between the issuer's experience and the experience underlying the AV Calculator.

4.4.7 Risk Adjustment and Reinsurance

This section includes information related to the experience and methodology used to estimate risk

transfer payments and charges, and reinsurance amounts that are incorporated in Worksheet 1, Section III and Worksheet 2, Sections III and IV (if applicable).

Experience Period Risk Adjustment and Reinsurance Adjustments PMPM:

Since the final risk adjustment transfers and reinsurance recoveries may not be known at the time of the initial filing, the issuer should explain the methodology that was used to estimate the amounts in the experience period.

Projected Risk Adjustments PMPM:

Under the single risk pool pricing requirements, issuers are required to make a market-wide adjustment to the pooled market level Index Rate to account for Federal risk adjustment and reinsurance payments. Consistent with this adjustment, anticipated risk adjustment revenue must be allocated proportionally based on plan premiums for all plans within a risk pool by applying the risk adjustment transfer adjustment factor as a market level adjustment. The risk adjustment transfer amount should be net of the risk adjustment fees.

Issuers must explain how they developed their estimated risk adjustment revenue for all of the plans in the risk pool. Issuers are expected to explain all of their market and plan level assumptions related to the inputs of the HHS payment transfer formula (or alternative State payment transfer formula, if applicable). In other words, issuers must explain their assumptions related to plan and market level risk scores and other relevant cost factor adjustments that are used to calculate payment transfers under the risk adjustment program. Issuers should explain any potential outlier assumptions that have a significant impact on transfers. Issuers may elect to provide supplemental exhibits detailing their plan level transfer calculations in order to demonstrate that their transfer estimates appropriately track with the HHS payment transfer formula.

Issuers must also explain how anticipated risk adjustment transfer revenue was applied to the Index Rate in the development of the Market Adjusted Index Rate (as noted above, transfers must be applied at the market level). Issuers should describe the overall impact of risk adjustment transfers on premiums.

Please note that the risk adjustment transfer amounts shown on Worksheet 1 of the URRT should take into account the actual PMPM amounts expected in the projection period. However, the risk adjustment transfer amount applied to the Index Rate in the development of the Market Adjusted Index Rate is on an allowed claims basis (i.e., prior to the application of the expected paid to allowed ratio) as the Index Rate is on an allowed claims basis.

Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Merged Markets Only):

This is a holdover from prior years. The reinsurance program ended with the 2016 benefit year. It is expected issuers will populate this field with "0" for the 2018 plan year.

4.4.8 Non-Benefit Expenses and Profit & Risk

Administrative Expense Load: Provide support for all expenses that do not reflect payments made to providers under the contract for covered medical services. Describe the methodology used for

developing the estimate of these non-benefit expenses expected during the projection period for the applicable market, including any allocation of corporate overhead. Discuss how the percentage load varies by product or plan, if applicable. Describe the source data that was used as a basis for the projections and why that data is appropriate.

For reporting purposes, the Administrative Expense Load should not include the Profit & Risk Load or the Taxes & Fees load, both described below, even though they are considered administrative expenses for the purposes of adjusting the Index Rate to arrive at premium in the pricing process.

It is suggested that the issuer maintain documentation of the expense allocation methodology, including expenses identified by function and whether they are fixed or variable, so that it can be made readily available to the regulator upon request.

Profit (or Contribution to Surplus) & Risk Margin: Describe the target underwriting gain/loss margin and any additional risk margin. To the extent that the target as a percent of premium has changed from the prior submission, provide additional support for why the change is warranted. Discuss how the percentage load varies by product or plan, if applicable.

Note that for pricing purposes, Profit & Risk Load is considered part of administrative expenses, per 45 CFR 156.80(d). It is described separately in the Actuarial Memorandum to facilitate rate review.

Taxes and Fees: Describe each tax and/or fee, and indicate the amount for each, either as a percent of premium or a PMPM amount. Describe only the taxes and fees that may be subtracted from premiums for purposes of calculating MLR. However, do not include any contributions to risk adjustment user fees in this amount despite their treatment in MLR calculations, since risk adjustment is expressed in the URRT net of risk adjustment user fees. Any additional taxes and fees should be reflected in the Administrative Expense Load.

Note that for pricing purposes, Taxes & Fees (including Exchange user fees) are considered part of administrative expenses, per 45 CFR 156.80(d). Taxes and fees are described separately in the Actuarial Memorandum to facilitate rate review.

Exchange user fees should be included in the template in Taxes & Fees. The issuer should provide a narrative verifying the Exchange user fees are applied as an adjustment to the Index Rate at the market level. A description of the process the issuer used to calculate the adjustment should be included. The value should reflect the expected mix of Exchange and non-Exchange enrollees.

4.5 Projected Loss Ratio

Indicate the projected loss ratio using the Federally-prescribed MLR methodology. If the projected loss ratio is less than 80%, explain how the issuer plans to comply with the Federal MLR requirement found in Public Health Service Act (PHS Act) section 2718.

If the State requires a projected loss ratio demonstration, then such a demonstration should also be included.

4.6 Application of Market Reform Rating Rules

4.6.1 Single Risk Pool

The issuer is required to provide support that the single risk pool in a particular State and market is established according to the requirements in 45 CFR 156.80. The single risk pool reflects all covered lives for every non-grandfathered product/plan combination for an issuer in a State and market. The single risk pool is specific to the legal entity for the State and market for which it is submitted.

The single risk pool may include transitional products/plans for purposes of base rate experience used to demonstrate the single risk pool. The projection period should reflect experience of transitional policies to the extent the issuer anticipates the members in those policies will be enrolled in single risk pool plans during the projection period.

4.6.2 Index Rate

The issuer is required to provide support for the development of the Index Rate in both the experience period and the projection period. The Index Rate is specific to the legal entity for the State and market for which it is submitted. The Index Rate represents the estimated total combined allowed EHB claims experience PMPM in the single risk pool and should not be adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange user fees.

The Index Rate is to be developed following the specifications of 45 CFR 156.80(d)(1). The Index Rate is based on the total combined claim costs for providing EHBs only for the single risk pool of that State market. The Index Rate is derived by dividing the total combined EHB allowed claims for the single risk pool by all covered lives in the single risk pool of that State market. Issuers must establish a single Index Rate for all product/plan combinations in the single risk pool.

Describe the difference between the total allowed claims PMPM and the Index Rate. For example, describe any covered non-EHBs that are included in allowed claims but excluded from the Index Rate.

The Index Rate of the Experience Period reported in Worksheet 1 should be consistent with the Experience Period Allowed Claims PMPM. While these two amounts may not be identical due to the inclusion of non-EHBs in the Experience Period Allowed Claims PMPM (because of transitional policies or small groups that have not reached their renewal date to move to a single risk pool plan), which would not be included in the Index Rate of the Experience Period, it is anticipated that these amounts would be developed on a consistent basis.

If the experience period contains non-single risk pool plans, provide the methodology used to develop the reported Index Rate of Experience Period. Describe how claims for benefits which were covered during the experience period but are not EHBs were identified and removed.

If the submission is for the individual or combined market, the Index Rate for Projection Period should reflect the twelve month projection period shown on Worksheet 1, Section II. If the submission is for the small group market and includes prospective trend adjustments (only if permitted by the State), then the Index Rate for Projection Period should reflect the member weighted average of the projected Index Rates applicable for each effective date in the submission. Show the projected trended Index Rate for each effective date in the submission.

The projected Index Rate must reflect the anticipated EHB claim level of the projection period with respect to trend, benefit, and demographics. It must reflect the experience of all policies expected to be in the single risk pool (with all necessary adjustments to reflect the benefits, market rules, etc. applicable to policies upon issue or renewal during the projection period). For transitional policies, the issuer should include those policies anticipated to be enrolled in a single risk pool plan during the projection period at a point when the members in these plans move to non-single risk pool plan. If an issuer wants the renewal rates to increase with trend in the small group market as allowed by the State regulatory authority, the issuer may file the quarterly trend amounts for the remainder of the calendar year at one time. The quarterly trend factors applied to the issuer's rates should be included in the Actuarial Memorandum.

The Index Rate may only change at uniform intervals. All issuers are required to set the Index Rate for an effective date of January 1 of each year and file the Index Rate with the applicable regulatory authority. Subject to State requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remaining quarters of the calendar year.

4.6.2.1 Small Group Quarterly Rate Filings

Rate adjustments for the small group market may be filed on a quarterly basis if permitted by the State. These quarterly filings may include adjustments for other items, such as new products, more recent experience period claims, etc. However, the rate development for these interim filings must be based on the single risk pool. For example, take an issuer with two cohorts of small employers that files on an interim quarterly basis. The small employers with young enrollees renew in January, while the small employers with older enrollees renew in April. The issuer's Index Rate in the applicable submissions would be derived as follows (assuming the same experience period is used for the two submissions with no projected changes to the population between the experience period and the projection period):

	January Effective Date	April Effective Date	Total Single Risk Pool
Member Months (2016)	1000	1000	2000
Base Allowed Claims (2016) PMPM	$250	$400	$325
Months of Trend	24	27	
Annual Trend Rate	5%	5%	
Single Risk Pool Projected Allowed Claims (=$325*(1+Annual Trend)^(Months of Trend/12))	$358.31	$362.71	
Index Rate	$358.31	$362.71	

As shown in the table above, the projected Index Rate is based on the weighted average claims, benefit mix, demographic mix, etc. of the entire single risk pool, even if it is only submitted to be effective for a portion of the single risk pool (e.g., one quarter of renewals).

The change in the Index Rate is only allowed to occur for the remainder of the calendar year, and subsequent submission is required at the beginning of the next calendar year.

For example, if a small group issuer submits the URRT for January 1, they may submit a subsequent URRT that resets the Index Rate effective July 1 of that same year. The URRT effective July 1 in this

example is only allowed to contain a trend increase for October 1 of that same year. Quarters after October 1 would be included in the next annual submission effective January 1 of the next calendar year.

See Appendix A for more guidance on quarterly rate filings in the small group market.

4.6.3 Market Adjusted Index Rate

Issuers are required to include the Market Adjusted Index Rate.

The Market Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR 156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Adjustment for the Risk Adjustment program
- Exchange user fee adjustment

Since the Index Rate is on an allowed claims basis, the market level adjustments for the Federal reinsurance program, risk adjustment program, and the Exchange user fees should be on an allowed basis.

The issuer is required to provide an explanation of how these modifiers are developed and applied to the Index Rate to develop the Market Adjusted Index Rate. Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic characteristics of the single risk pool. In other words, the Market Adjusted Index Rate is not calibrated.

4.6.4 Plan Adjusted Index Rate

The Plan Adjusted Index Rates for the projection period are included in Worksheet 2, Section IV of the URRT.

The Plan Adjusted Index Rate is calculated as the issuer's Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR 156.80(d)(2). Only the following adjustments are allowable under these rules:

- Actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- Benefits provided under the plan that are in addition to EHBs.
- Administrative costs, excluding Exchange user fees (which are already accounted for in the Market-Wide Adjusted Index Rate).
- Only catastrophic plans may adjust for the expected impact of the specific eligibility categories for these plans. If an adjustment is made to catastrophic plans, this adjustment may not be

recovered elsewhere in the rating process, as that would be seen as removing the catastrophic plan experience from the single risk pool.

Other adjustments not specified by 45 CFR § 156.80(d)(2) are not allowed at this point in the development, such as adjustments to recoup revenue related to the three under age 21 child dependent cap or a catastrophic adjustment to non-catastrophic plans.

Tip: The only allowable plan adjustments are found in 45 CFR 156.80(d)(2). "Other" is not an allowable plan adjustment.

Tip: The age curve is not linear. Attempts to treat it as such when performing the age curve calibration will likely result in unexpected results.

The issuer is required to provide an explanation of how these modifiers are developed and applied to the Market Adjusted Index Rate to derive the Plan Adjusted Index Rate.

The AV and cost-sharing adjustment (plan level adjustment) would take into account the benefit differences, utilization differences due to differences in cost-sharing and an adjustment for non-tobacco user status. The utilization difference may reflect the impact higher cost-sharing has on utilization but cannot reflect differences due to health status.

Specifically for the catastrophic plan rate, describe the methodology used to estimate the adjustment reflecting differences in anticipated demographics and morbidity of the catastrophic population as compared to the single risk pool.

Similar to the Index Rate and Market Adjusted Index Rate, the Plan Adjusted Index Rates reflect the average demographic characteristics of the single risk pool. In other words, the Plan Adjusted Index Rate is not calibrated.

Issuers must enter the Plan Adjusted Index Rates for the experience period in Worksheet 2 of the URRT. The Plan Adjusted Index Rate entered should be the Plan Adjusted Index Rate that was filed for the experience period.

4.6.5 Calibration

Calibration factors are ONLY allowed for the age, geography, and tobacco factors.

Age Curve Calibration

Issuers must provide the approximate weighted average age, rounded to a whole number, associated with the projected single risk pool.

At this time CMS will allow for the application of a factor of zero (0) for the distribution of members expected to pay no premium when developing the approximate weighted average age in States that follow the standard CMS age curve to account for the lost revenue due to the three under age 21 child dependent cap. While CMS is allowing this methodology, States with an Effective Rate Review Program that follow the standard CMS age curve may choose to allow or disallow this practice.

Some States have established their own age curves that are different from the standard CMS age curve. In this case, issuers should check with their State regulators to determine if applying a factor of zero (0)

for the distribution of members expected to pay no premium is an appropriate and allowable adjustment for the three under age 21 child dependent cap.

Issuers must provide a detailed explanation of the methodology used in the calibration to the age curve. Specifically, issuers should describe the factors used in the determination of the risk pool weighted average age, a description of the data used to weight the factors, and a description of the exact calculation. Issuers will need to provide actuarial justification that the methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology.

Include a demonstration of how the Plan Adjusted Index Rate and the age curve are used to generate the schedule of premium rates for each plan. Note that the age curve calibration adjustment is not plan specific. In other words, the same age curve calibration must be applied to all plans in the projected single risk pool.

Geographic Factor Calibration

The issuer is required to include a listing of all geographic rating factors applied to the Plan Adjusted Index Rate in the Actuarial Memorandum.

The issuer must provide the geographic factor calibration that is applied to the projected single risk pool, if one is necessary. For example, if the weighted average of the geographic factors does not equal 1.0, calibration may be required.

The Actuarial Memorandum must include a detailed description of the development of the geographic rating factors (including a description of how the methodology results in factors that reflect delivery cost differences only, or are otherwise adjusted for differences in population morbidity) and a demonstration of how these factors are applied to the Plan Adjusted Index Rate. For example, if the weighted average of the geographic factors does not equal 1.0, the calibration adjustment that is applied should be included in the Actuarial Memorandum along with documentation of the calculation of the calibration adjustment. Note that the geographic calibration adjustment is not plan specific. In other words, the same geographic calibration would be applied to all plans in the projected single risk pool. If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have a separate plan for each network within the rating area.

Tobacco Use Rating Factor Calibration

Issuers using tobacco rating factors must calibrate the Plan Adjusted Index Rate to remove the portion of the cost expected to be recouped through the tobacco surcharge. This adjustment should only reflect the expected surcharge collected for tobacco users. In the event tobacco users enter a wellness program which reduces the tobacco user load applied, only the net impact on revenue should be taken into account in the adjustment factor.

The calibration adjustments are to be applied uniformly to all plans; plan specific calibration is not allowed.

Calibration adjustments are not displayed in the URRT.

Once the Plan Adjusted Index Rate is calibrated to the age curve using the weighted average age and

calibrated to the geographic rating area and tobacco use rating factors, the entire set of age rates is determined using the standard age factor of each age relative to the standard age factor for the rounded weighted average age. The age factors must be the standard age curve set by HHS or a State specific age curve (if the State requires different age factors than the standard Federal age curve).

Issuers that calibrate the Plan Adjusted Index Rate as described in the previous section must calibrate the plans in the single risk pool consistently; in other words, the calibration cannot vary by plan.

Issuers must apply these member level adjustments as described in 45 CFR 147.102 uniformly to all plans in the single risk pool; these adjustments cannot vary by plan.

4.6.6 Consumer Adjusted Premium Rate Development

The Actuarial Memorandum should describe how each allowable consumer level adjustment is applied to the Plan Adjusted Index Rate so that the reviewing actuary can readily use the information to approximate Consumer Adjusted Premium Rates filed by the issuer.

The Consumer Adjusted Premium Rates are not displayed in the URRT.

Small Group Plan Premium Rates

If an issuer files small group rates with trend, then the Index Rate, the Market Adjusted Index Rate, and the Plan Adjusted Index Rate reflect the member weighted average premium over the calendar year (see example in Appendix A). As such, in the development of the Consumer Adjusted Premium Rates for small group plans in this case, the Plan Adjusted Index Rate must be adjusted to reflect the appropriate quarter when the consumer level modifiers are applied. Issuers should provide the trend factors that apply to the weighted average Plan Adjusted Index Rates to develop the rates for each effective date included in the submission.

4.7 Plan Product Information

4.7.1 AV Metal Values

The issuer must describe whether the AV Metal Values included in Worksheet 2 of the URRT were entirely based on the AV Calculator, or whether an acceptable alternative methodology was used to generate the AV Metal Value of one or more plans. If an alternate methodology was employed to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR 156.135. The certification must be signed by a member of the American Academy of Actuaries and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.

The actuary must indicate the reason an alternate methodology was used, explain why the benefits for those plans for which an acceptable alternative methodology was used are not compatible with the AV Calculator, and state the chosen alternate methodology that was used for each applicable plan. The actuary must describe the process that was used to develop the AV Metal Value.

Actuaries are encouraged to refer to applicable practice note(s) for guidance on alternate methods of calculating AV.

4.7.2 AV Pricing Values

For each plan, indicate the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the Index Rate, as described in 45 CFR 156.80(d)(2). If the adjustment for plan cost-sharing includes any expected differences in utilization due to these differences in cost-sharing, describe in detail how the difference was estimated and how the methodology ensures that differences due to health status are not included in the adjustment.

4.7.3 Membership Projections

Describe how the membership projections found in Worksheet 2 of the URRT were developed. Items impacting these projections could include, but are not limited to, changes in the size of the market due to introduction of guaranteed availability requirements (individual market), the individual mandate, expansion of Medicaid, and the introduction of a Basic Health Program.

Describe how projected member months by plan were developed relative to current membership by plan, and explain any differences.

For Silver level plans in the individual or combined markets, describe the methodology used to estimate the portion of projected enrollment that will be eligible for cost-sharing reduction subsidies at each subsidy level. State the resulting projected enrollment by plan and subsidy level.

4.7.4 Terminated Plans and Products

Include a list of terminated plans and any mappings to existing or new plans. List the name of each plan and product that will be terminated prior to the effective date. Include plans and products that have experience included in the single risk pool during the experience period and any products that were not in effect during the experience but were made available thereafter. If a terminated plan will be mapped to a different plan in the projection period, the issuer must provide a cross-walk between the terminated plan(s) and the new plan(s).

4.7.5 Plan Type

In the event that the plan types listed in the drop-down box in Worksheet 2, Section I of the URRT do not describe an issuer's plan exactly, and the issuer has selected the closest plan available, per the instructions, please describe the differences between the issuer's plan and the plan type selected.

4.7.6 Warning Alerts

Describe any difference between the sum of the plan level projections in Worksheet 2 and the total projected amounts found on Worksheet 1. These differences are indicated by Warning Alerts in Worksheet 2.

4.8 Miscellaneous Instructions

4.8.1 Effective Rate Review Information (Optional)

45 CFR 154.301 describes the elements of an Effective Rate Review Program. There are elements of an effective rate review for which the data needed to perform the review is not explicitly shown on URRT (e.g., the health insurance issuer's capital and surplus). Issuers may optionally provide additional

information to facilitate an effective review of the submitted rate increase(s). While this information is optional, providing the information with the initial submission reduces the likelihood of the reviewer requesting supplemental information during the course of the rate review. In addition, States may have additional data requirements. Additional State specific required data may be submitted with the URR submission.

4.8.2 Reliance

If, in preparing the URRT submission, the certifying actuary relied on any information or underlying assumptions provided by another individual, the information relied upon and the name of the individual providing that information may be disclosed.

4.8.3 Actuarial Certification

An actuarial certification must be provided for the following

- The methodology used to calculate the AV Metal Value for each plan.
- The appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based.
- The Index Rate is developed in accordance with Federal regulations and the Index Rate along with allowable modifiers are used in the development of plan specific premium rates.
- The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

State specific required information or certifications may also be included at the actuary's discretion. If an actuary chooses to exclude this information from the Actuarial Memorandum, this information would need to be provided to the State regulatory agency under separate cover.

The opining actuary must be a member of the American Academy of Actuaries, in good standing, and have the education and experience necessary to perform the work. The actuary must develop rates in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs apply, particular emphasis is placed on the following:

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Plan Entities*
- ASOP No. 12, *Risk Classification*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*

- ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*

- ASOP No. 41, *Actuarial Communications*

- ASOP No. 50, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*

At a minimum, the actuarial certification must include the following:

1) Identification of the certifying actuary and a statement that he/she is a member of the American Academy of Actuaries.

2) A certification that the projected Index Rate is:
    a. In compliance with all applicable State and Federal statutes and regulations (45 CFR 156.80 and 147.102)

    b. Developed in compliance with the applicable Actuarial Standards of Practice

    c. Reasonable in relation to the benefits provided and the population anticipated to be covered

    d. Neither excessive nor deficient

3) A certification that the Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 156.80(d)(2) were used to generate plan level rates.

4) A certification that the percent of total premium that represents EHB included in Worksheet 2, Sections III and IV, was calculated in accordance with actuarial standards of practice.

5) A certification that the geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

6) A certification stating that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I URRT for all plans except those specified in the certification. If an alternate methodology was used to calculate the AV Metal Value for at least one plan offered, a copy of the actuarial certification required by 45 CFR 156.135 must be included. The certification must be signed by a member of the American Academy of Actuaries and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.

7) For purposes of rate review, also include the reason an alternate methodology was used and the chosen alternate methodology that was used for each applicable plan. Describe the process that was used to develop the AV Metal Value.

The actuary may qualify the opinion, if desired, to state that the URRT does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by Federal

regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

5 HIOS Submission

5.1 HIOS Submission Statuses

URR submissions in HIOS undergo several changes in status during the course of the rate review process. The following table describes the various statuses and their associated meanings.

Status	Definition	Additional Information	Next Step
Pre-Validation	An issuer has successfully created a submission in HIOS.	The issuer can revise[14] the submission during the Pre-Validation stage.	The issuer should validate the submission by checking the validation box on the submission summary page in HIOS.

[14] Revising a submission means that the issuer can upload supplemental documents or revise the URRT or Actuarial Memorandum in HIOS.

Status	Definition	Additional Information	Next Step
Record Validated	The issuer has validated the submission. *Note:* The validator (usually a manager at the insurance company) must have "validator" authority within HIOS.	The submission is locked and cannot be revised. *Note:* If the issuer needs to make revisions after validating the submission, the issuer must have the submission unlocked first.	*Rate increases not subject to rate review:* If the rate increase is <15%, the regulator[15] reviews the submission for completeness and for compliance with applicable rating rules. – If the submission passes the compliance review, CCIIO checks the "Web Content Assessment" box in HIOS[16]. – If the submission does not pass the completeness or compliance review, the regulator asks the issuer for more information. *Rate increases subject to review:* If the rate increase is ≥ 15%, the regulator checks that the submission has all the required information. – If there are no obvious errors, CCIIO checks the "Web Content Assessment" box in HIOS. – If the submission has obvious errors, the regulator asks the issuer for more information.
Pending Supplemental Materials	A previously validated submission has been unlocked.	The issuer can revise the submission during the Pending Supplemental Materials phase.	*The issuer should revise the submission.*
Supplemental Materials Received	The issuer has revised a submission that was previously in the Pending Supplemental Materials status.	The issuer can revise the submission during the Materials Received phase.	*The issuer must re-validate their submission.*

[15] In States with an Effective Rate Review Program, the applicable State regulatory authority is the regulator. In States without an Effective Rate Review program, CCIIO is the regulator.

[16] State regulators in States with an Effective Rate Review Program must notify CCIIO when a submission passes the compliance review.

Status	Definition	Additional Information	Next Step
Rate Filing Accepted	A submission not subject to rate review has passed the compliance review, and CCIIO has checked the "Web Content Assessment" box in HIOS.	Only applicable to rate increases of < 15%.	*None. This is the final status for submissions not subject to rate review.*
Submission Filed	CCIIO has checked the "Web Content Assessment" box in HIOS for a submission subject to rate review.	Only applicable to rate increases of ≥ 15%.	*The regulator must select "Review in Progress" in the dropdown menu in HIOS and then click Save.*
Review in Progress	A submission subject to rate review is being reviewed by the regulator.	Only applicable to rate increases ≥ 15%.	*The regulator must enter a Final Determination of Unreasonable or Not Unreasonable in HIOS.*
Review Complete	The regulator has finished reviewing a submission subject to rate review and has entered a final determination of Not Unreasonable in HIOS.	Only applicable to rate increases ≥ 15% that have been deemed Not Unreasonable.	*None. This is the final status for submissions with rate increases that are subject to rate review and have been determined by the regulator to be Not Unreasonable.*
Pending Final Justification	The regulator has finished reviewing a submission subject to rate review and has entered a final determination of Unreasonable in HIOS.	Only applicable to rate increases ≥ 15% that have been deemed Not Unreasonable.	*If the issuer decides to implement the Unreasonable rate increase, then the issuer must enter a Final Justification in HIOS.* *If the issuer decides to modify the Unreasonable rate increase, the issuer should o request a submission unlock and resubmit.*
Final Justification Submitted	The issuer has entered a Final Justification in HIOS.	Only applicable to rate increases ≥ 15% that have been deemed Not Unreasonable.	*None. This is the final status for submissions with rate increases that are subject to rate review, have been determined by the regulator to be Unreasonable, and will be implemented by the issuer.*
Submission Failed	The issuer unsuccessfully attempted to create a submission in HIOS.	Submission failures occur when the issuer enters invalid data or fails to enter required data.	*HIOS generates an email to the issuer indicating the submission failure. The issuer should create a new submission.*

Status	Definition	Additional Information	Next Step
Submission Deactivated	CCIIO has deactivated the submission. *Note:* In States with an Effective Rate Review Program, the State regulator must first contact CCIIO to request the deactivation.	Only submissions with a status of Record Validated, Review Complete, or Rate Filing Accepted can be deactivated.	*The issuer should create a new submission.*

5.2 Unlocking a Submission

If an issuer needs to change a previously validated submission for any reason (e.g. the regulator requests additional documentation, the issuer realizes that a file is missing), the issuer must first have the previous submission unlocked by the State or CCIIO.

The issuer must re-validate the submission after making revisions.

6 Appendix A: Guidance for Quarterly Rate Increases

This appendix provides guidance for the completion of the URRT submission in the small group market when an issuer chooses to file rates with predefined quarterly trend increases. The guidance provided is not the required methodology, but rather an example of how the template could be completed.

Premium rates for products in the small group market may be allowed to change on a quarterly basis for trend, if not prohibited by the State. If an issuer chooses to increase rates on a quarterly basis for trend, the issuer may file for trend increases for a specified period of time. However, the Index Rate for the projection period must be reflective of each of the trended rates effective during the period.

A methodology that could be used to calculate the Index Rate would be to develop a weighted average using each effective premium rate and the expected number of members at the corresponding premium level. This would be performed for each renewal month during the twelve month period. For example, in the template filed for a January effective date, the Index Rate would be calculated for each renewal month (January through December). The December rates in this example would be weighted with the expected enrollment for December renewals for the twelve-month rating period from December of that year through November of the next year. The table below shows an example of this calculation and the Index Rate that could be entered into the Part I URRT.

The example is an issuer that wishes to change their small group rates on a quarterly basis using an annual trend of 5%. The template is submitted for a January 1 effective date.

	Effective Dates				
	January	April	July	October	Total Single Risk
Member Months	1000	500	1000	500	3000
Base Allowed Claims	$ 250.00	$ 250.00	$ 250.00	$ 250.00	$ 250.00

Months of Trend	24	27	30	33	
Annual Trend Rate	5%	5%	5%	5%	
Single Risk Pool Projected Allowed	$ 275.63	$ 279.01	$ 282.43	$ 285.90	$ 280.17
Index Rate Entered in January Template	$ 280.17				
Effective Date Entered in January Template	1/1/xxxx				

The quarterly trend factor for each quarter should be included in the Part III Actuarial Memorandum, and support should be provided. Please see the instructions for the Part III Actuarial Memorandum for further information.