2016 Unified Rate Review Instructions

Rate Filing Justification: Parts I, II, and III

As of February 21, 2015

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1 Overview

1.1 Purpose

Section 2794 of the Public Health Service Act (PHSA) and the implementing regulation, codified at 45 CFR § 154, establish requirements for health insurance issuers (issuers) offering health insurance coverage for non-grandfathered products 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, 45 CFR § 154.225, 45 CFR § 147.102, and 45 CFR § 156.80. In addition, CMS may use data submitted on the RFJ to calculate Advance Premium Tax Credit (APTC) payments and Cost-Sharing Reduction (CSR) advance payments.

As specified in 45 CFR § 154.215, a Rate Filing Justification for single risk pool compliant plans consists of the following three parts:

- **Part I** - Uniform Rate Review Template (URRT): The URRT is required for any rate increase in a single risk pool compliant plan. It is intended to capture information needed to review rate increases and ensure compliance with the single risk pool, allowable market level index rate adjustments to reflect reinsurance and risk adjustment, and other Federal rating requirements.

- **Part II** - Written Description Justifying the Rate Increase: Part II is required only for rate increases that are subject to review (i.e. rate increases of 10% 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 all URR submissions. Part III is an Actuarial 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 to the 2016 Unified Rate Review (URR) Instructions include:

- Combined the instructions for Part I, II, and III (previously issued as separate documents) into a single document and incorporated consistent formatting. Editorial or formatting changes in the instructions are not intended to change current practices and policies.
- Incorporated the uniform rate filing and disclosure timeline provisions of the final rule entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016" (79 FR 03751).
- Provided guidance on the change in the definition of small group from employers with 50 or less employees to employers with 100 or less employees in 2016.

- Clarified the small group market quarterly submission process.

- Clarified the treatment of terminating non-single risk pool plans.
- Provided clarification regarding the adjustment for catastrophic plans.
- Corrected instructions for entering historic rate increases in the URRT.
- On Worksheet II of the URRT, replaced the Average Rate PMPM cells with Plan Adjusted Index Rate cells.
- Required the submission of two versions of the Part III Actuarial Memorandum – an un-redacted version for regulators and a redacted version for public disclosure.

1.3 Public Disclosure

45 CFR § 154.215(h) specifies that CMS will make available on its website the information contained in Part II, and the information contained in Parts I and III that is not a trade secret or confidential commercial or financial information as defined in HHS's Freedom of Information Act (FOIA) regulations at 45 CFR § 5.65.

HHS displays information from Parts I and II on its website at https://ratereview.healthcare.gov/ and at http://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html. Starting in 2015, CMS will also post information from Part III that is not exempt from disclosure under HHS's FOIA regulation.

The deadline for a state with an Effective Rate Review Program to 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 is the 10th business day after receipt of all rate filings (QHP and non-QHP). 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.

1.4 General Instructions

Annual Submissions

All health insurance issuers proposing a rate increase on any plan within a product in the issuer's single risk pool in the individual, small group, and/or merged markets must submit the RFJ via the Unified Rate Review (URR) module of the Health Insurance Oversight System (HIOS). This is true regardless of whether the rate increase meets or exceeds the subject to review threshold. Some state regulatory authorities require issuers to submit the RFJ for all rate filings (not just increases). In addition, all issuers applying to offer at least one Qualified Health Plan (QHP) through the Marketplace must annually submit the RFJ (i.e. the January 1, XXXX rate submission) for the state and market in which the QHP would be offered. All issuers (QHP and non-QHP issuers) are required to submit at least an annual filing to establish their index rate for single risk pool compliant plans. 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.

The deadline for health insurance issuers, regardless of whether the issuer offers a QHP, to submit annual single risk pool rate filings (QHP and non-QHP) is the last day of the QHP application window for the Federally-facilitated Marketplace. If a state has established an earlier deadline for rate filings, then health insurance issuers must comply with the earlier state deadline. The "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016" (79 FR 03751) requires

the uniform submission deadline for annual single risk pool filings starting with the 2015 filing year for the 2016 plan year.

Quarterly Submissions
In addition, issuers can submit a RFJ for quarterly rate changes in the small group market for single risk pool compliant plans if allowed by the state regulatory authority. The quarterly filing would contain rate changes beyond any scheduled trend increases included in the annual submission for subsequent quarters in that calendar year (i.e., second, third, and/or fourth quarters). An issuer may only have one active quarterly single risk pool submission per market in HIOS.

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.

Index Rates
All issuers with plans subject to the single risk pool requirement 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 filing described above, and should be labeled as the annual filing in the URR module even if the filing includes quarterly small group trend increases. 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. These are the quarterly filings described above.

Dental Plans
Specific instructions for the treatment of dental plans offered in 2015 and beyond include the following:

- 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.

- Under no circumstances should stand-alone dental plans be reflected in the URRT

Further details explaining how dental plans should be reflected in the template can be found in the instructions for URRT Worksheet 2 below.

Optional Benefits
Beginning with plans effective in 2015 and beyond, ALL benefits to be offered in a plan must be embedded in that plan. If an issuer wants to offer an "optional" benefit, there are two options:

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

- The issuer can offer the benefit in a manner that satisfies the definition of one of the categories of excepted benefits.

The concept of "optional riders" is incongruent with Federal rating rules and 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 45 CFR § 147.102. The following allowable rating methods and factors are an instructional tool for issuers to 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[1] in order 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 compliant plans during the projection period.

In 2016, the definition of a small employer changes from employers with 50 or fewer employees to employers with 100 or fewer employees. In the small group market experience period, issuers should only include experience for group policies covering employers with 50 or fewer employees (i.e. the experience of group policies covering employers with 51 to 100 employees should not be included in the experience period). However, in the projection period, expected claims experience should reflect group policies for employers with 100 or fewer employees that the issuer expects to be enrolled in single risk pool compliant plans during the projection period. This may be done through the projection factors, use of a manual rate, or combination of the two.

[1] 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 market reforms in accordance with the CMS Transitional Policy. See http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf.

Index Rate

The Index Rate is defined as the EHB portion of allowed claims divided by all single risk pool lives. 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 in 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 compliant plans during the projection period. Note that if an issuer opted to continue policies under the President's transitional memorandum, experience for these policies should be included in the issuer's experience for developing rates for the projected year's costs. To the extent issuers project members in transitional policies to migrate to a single risk pool compliant 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 all requirements of non-grandfathered policies projected in the single risk pool in projected experience. For example, in the projection period, include projected experience and membership at the point when these products become single risk pool compliant and the membership renews to the single risk pool compliant plan, or at the point when the members in these plans move to an single risk pool compliant plan, if the plans are closed to new membership in 2016.

Market Adjusted Index Rate

The Market Adjusted Index Rate is the Index Rate adjusted for Risk Adjustment, Reinsurance and Marketplace Fees (with impacts and costs spread across the whole risk pool). As a result, the Market 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 Adjusted Index Rate further adjusted for **only** the plan specific factors allowed by 45 CFR § 156.80(d)(2) such as provider network, utilization management, benefits in addition to EHBs, actuarial value (AV) and cost-sharing, distribution and administrative costs (less Marketplace fees) and catastrophic plan eligibility variation. Other adjustments not specified by 45 CFR § 156.80(d)(2) are not allowed, such as adjustments to recoup revenue related to the three dependent child limit or a catastrophic adjustment to non-catastrophic plans.

Fees

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, Reinsurance contributions, and Marketplace user fees, which are applied at the market level to the Index Rate. 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 and geographic region factors. The issuer may not, in that example, charge a $35 fee per policy for submission of the application.

Calibration
A calibration may be required to allow the rating factors to be directly applied in order to generate the Consumer Adjusted Premium Rates.

For the allowable rating factors of age and geography, 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. At this time, the **only** allowable consumer level premium rate modifiers that can be calibrated are age and geography.

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. More detailed instructions are provided later in this document regarding the requirements for the calibration.

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.

The result of this calibration process should be that the Plan Adjusted Index Rate calibrated for geography (but not age), multiplied by the geographic factor for a given region should be similar to the Premium Rate for that particular plan for a non-tobacco user in the given geographic region for the weighted average age (rounded to a whole number) of the projected single risk pool.

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 utilizing the rating and premium adjustments as articulated 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 if necessary, and applying the allowable rating factors. Allowable rating factors are Age (3:1 standard age curve or state specific age curve), Tobacco (surcharge limited to 50% of the Plan Adjusted Index Rate), Geography and Family tiering/structure, unless otherwise prohibited by state law.

- 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).

- Geographic Factor: Geographic rating areas are set specific to each state and all issuers in the state are required to follow them and may only set one rating factor per rating area per state

per market and that factor is applied 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.

- Family Structure: Family structure takes into account family composition and the maximum of three child dependents. This is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three 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 sis uniformly applied to all plans in the risk pool (and published to the cciio.cms.gov website).

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

2 Part 1: Unified Rate Review Template

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 do not match the formatting requirements of those cells, the mismatch may cause validation or submission errors resulting in either submissions being rejected or requiring resubmissions at a later date. Issuers should verify that the data entered in the URRT is consistent with formatting requirements and instructions to avoid delays in the approval process.

Under no circumstances 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 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.

- General Information Section - captures information about the issuer, state and the health insurance market to which the proposed rate increases will apply. This information is displayed on all worksheets of the URRT.
- Section I - captures summarized historical financial and enrollment information from a recent historical experience period.
- 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.
- 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 applying for QHP certification or proposing a rate increase on non-grandfathered policies in the individual, small group or combined markets.

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 (e.g. if a state chooses to merge the individual and small group market, the issuer must choose "Combined").

Effective Date: Enter the effective date for which rates are being submitted.

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, 2016 effective date and includes a trend increase applicable on October 1, 2016, enter July 1, 2016.

All issuers are required to file the URRT and Actuarial Memorandum for products subject to the single risk pool requirement annually for an effective date of January 1 of each year. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remainder of the calendar year, these subsequent submissions would be classified as quarterly filings. However, the change in the Index Rate for quarterly submissions is only allowed to occur for the remainder of the calendar year and subsequent submission is required for the beginning of the next calendar year.

For example, if a small group issuer submits the URRT for January 1 (the annual submission); they may submit a subsequent URRT that resets the Index Rate effective July 1 of that same year (quarterly submission). 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.

All products and plans must have the same effective date; however, some products or plans may have a 0% rate change. The term "product" means a discrete package of benefits 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 45 CFR 144.103. The term "plan", as defined by 45 CFR 144.103 and 45 CFR § 154.102 means , with respect to an issuer and a product the pairing of the health insurance coverage benefits under a product and a particular level of cost-sharing structure (as described in sections 1302(d) and (e) of the Affordable Care Act (ACA)), within a service area. The combined service areas of all plans within a product will make up the service area of the product. 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. This definition should be used for products and plans unless it is altered by future Federal rules or statute.

2.1.2 Section I: Experience Period Data

The financial and enrollment information entered in this section should reflect the experience of all non-grandfathered (single risk pool compliant 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 the ACA and 45 CFR § 156.80. The information in this section should reflect historical financial and enrollment information for the identified legal entity only.

For small group submissions, the experience period data should reflect only the experience of small groups that had purchased small group policies that were subject to small group definition during the period, according to the definition of small group in place at that time. For example, if the experience period is calendar year 2014 then a group with 75 employees that purchased a large group policy in 2014 that would be considered a small group under the revised small group definition in 2016 should not have its experience included in the 2014 experience period.

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 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, 2012 through December 31, 2012, the issuer may include claims payments through a date beyond the end of the Experience Period (e.g., February 28, 2013) 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 § 158.

Start with premiums earned during the experience period. 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 the Actuarial Memorandum instructions for required documentation of the method used to estimate rebates.

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.

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. They 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 benefits other than EHB. 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 whole dollar value (i.e. the rate must be rounded to the nearest $1). Please note, if an issuer copies and pastes a value in this cell which contains decimals, the URRT submission could be rejected or an issuer may be required to make a resubmission later in the process which could delay the rate review process and approval.

The Index Rate represents the average allowed claims PMPM for EHBs. 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 Marketplace user fees. It is simply allowed claims PMPM for EHBs.

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 in excess of EHBs, but should not be adjusted to include EHBs that were not covered during the experience period, such as, in some cases, maternity coverage in the individual market.

For the small group market, the Index Rate in the experience period should reflect the experience for those groups with 50 or less employees (i.e. the experience of groups with 51 to 100 employees should not be included in the Index Rate for the experience period at this time).

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 is determined by the template. The Projection Period starts on the effective date entered in 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 that follow require issuers to enter data by Benefit Category. Issuers are required to describe the Benefit Category definitions in the Actuarial Memorandum. The preferred definitions of the Benefit Category follow:

- ***Inpatient Hospital*:** Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, 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 room, 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 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
- Change in definition of the small group market from 2-50 employees to 1-100 employees

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. Shifts in the distribution of services across existing network providers should be reflected in the Cost Trend.
- 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 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% ($\sqrt{1.1025}$ -1). In this example, the user should enter 1.050 ($\sqrt{1.1025}$).

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 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, zeros 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

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 Experience 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 charge, then the entry should be a positive value. If the issuer expects to make a projected risk adjustment payment, 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 Premium: Enter projected reinsurance recoveries, referred to as reinsurance payments in the HHS Notice of Benefit and Payment Parameters, from the Federal reinsurance program, less contributions made to the program (referred to as "Premium" in the template). The value should reflect the actual PMPM amounts expected in the projection period, which are based on incurred claims and not allowed claims. However, the net Federal reinsurance recovery 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.

Recoveries should be entered as positive amounts. For example, in the individual market where recoveries will likely exceed assessments the amount should be positive. In combined markets, the value may be positive or negative depending upon the portion of the market that is expected to be comprised of individuals and small groups. In a combined market, the pooled reinsurance adjustment should be based only on the portion of the issuer's individual market business eligible for reinsurance payments. For the small group market, this amount only reflects the reinsurance assessment and should be entered as a negative number.

Projected Incurred Claims: The template calculates this value by subtracting Projected Risk Adjustments, PMPM and Projected ACA Reinsurance Recoveries, Net of Premium 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 profit 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 to the Federal transitional reinsurance program or risk adjustment user fees in this amount despite their treatment in MLR calculations, since Federal reinsurance and risk adjustment amounts are 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 EHB. This legal entity-specific rate for the Projection Period should not reflect any adjustments for payments and charges under the risk adjustment and reinsurance programs or for Marketplace user fees. It is simply projected allowed claims PMPM for EHB. 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 benefits in excess of EHB, 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 child members under age 21 in a given family exceeds three and must be capped for premium setting purposes as required by law.

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 child members 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.

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 increase.
- Section II displays the proposed rate increase 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, either directly or by using the plan averaging option. For example, if an issuer chooses to enter information separately for each plan, 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. With the exception of terminated plans, no plan should have expected membership of zero, and all membership projections should be supportable and represent the actuary's best estimate of enrollment. If zeros are entered in these cells of the URRT, an issuer may be required to resubmit the template which may cause delays in the rate review and approval process.

Issuers are required to handle terminated plans/products, and new products/plans and uniform benefit modifications in the following manner.

- Non-single risk pool compliant plans/products that were effective during the experience period and are terminated prior to the Projection Period may be combined for reporting purposes and shown as a single product in the template. See under "Product" of the next section for further details.
- Each single risk pool compliant plan that was effective during the experience period and is terminated prior to the rating period and "mapped" (i.e. auto-enrolled) into another single risk

pool compliant plan in the Projection Period must be completed in a separate column with the plan name in the following manner:

- Information in Section I and II should be completed for the plan ID effective in the projection period. The rate increase should be measured from the terminated plan ID to the new Plan ID. Section III should reflect the experience associated with the terminated plan ID.
- Information in Section IV should reflect the expected projections of the new plan ID.

- Each single risk pool compliant plan that was effective during the Experience Period, terminated in the rating period and **not** "mapped" into another single risk pool compliant 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 left blank. See the Actuarial Memorandum instructions under "Terminated Plans and Products" for more information.

2.2.1 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 45 CFR § 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 compliant products will be closed 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 compliant 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 compliant plans that are terminated in the projection period should be included in the Actuarial Memorandum.

Unless regulations change in the future, if an issuer makes changes to the product on renewal, it will be considered the same product for the renewal plan year if all of the following are true per 45 CFR 147.106(e)(3):

- The product is issued by the same issuer; and
- The product is offered as the same product network type; and

- The product covers a majority of the same service area as was covered in the previous index rate submission period; and
- The plans under the product maintain the same cost-sharing options, except for differences to adjust for changes in cost and utilization of medical care, or to maintain the same metal level of coverage (e.g., bronze, silver, gold, platinum or catastrophic); and
- The product provides the same covered benefits, except for differences that impact each plan-adjusted index rate for the plans included in the product by no more than 2 percent (not including changes required by applicable Federal or state law).
- 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 non-single risk pool compliant multiple 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.

Terminated single risk pool compliant plans and/or products cannot be combined for reporting purposes. All single risk pool compliant plan IDs effective in the Experience Period must be shown as a separate column in Worksheet 2.

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.

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 as prescribed in 45 CFR § 156.20. AV Pricing Value is defined below.

The ACA requires that all plans offered in the market must have an AV that corresponds to a defined metal level. For guidance on the definition of "plan" please see the definition of "Plan Name" in these instructions. 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. The Secretary has provided guidance that the de minimis variation standards will be ± 2 percentage points. For example, plans with an AV value between 68% and 72% meet the requirements for a silver level plan.

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 and is only available to individuals below the age of 30 or those for whom premium for minimum essential coverage exceeds 8% of income.

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

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

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

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 compliant products that are reported on a combined basis as terminated products prior to the Projection Period, enter zero.

For single risk pool compliant 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 0.78 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.
- If an issuer chooses to apply tobacco user factors, which is an allowable member-level rating factor, the issuer must make an adjustment so that the resulting Plan Adjusted Index Rate would remove the portion of the cost that is expected to be recouped through the tobacco surcharge. This adjustment should only reflect the expected surcharge collected for tobacco users, as an example, in the event tobacco users enter a wellness program which reduces the tobacco user load applied, only the net impact should be taken into account in the adjustment factor. Issuers that do not charge tobacco surcharges for a plan should not make this adjustment for that plan.
- The plan's provider network and delivery system characteristics, as well as utilization management practices.
- Plan benefits in addition to the 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 Marketplace user fees. Note that this should reflect all applicable administrative costs for the plan, and not simply a differential from the average administrative costs across all plans.
- For catastrophic plans, the expected impact of specific eligibility categories for these plans. The expected impact of the specific eligibility requirement is only allowed on the catastrophic plans. No adjustment for revenue impact of eligibility requirements is

allowed on metal plans (platinum, gold, silver or bronze). 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 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.

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 a product and a particular cost-sharing structure, provider network, within a 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 §§ 156.400-156.420, 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. Non-grandfathered plans are split into five categories and should be reported as follows:

1. New Plans – Plans the issuer offers on January 1, 2016 and after that comply with the single risk pool requirement. The issuer should enter information in the Projection Period for each of the New Plans.

2. Renewing Plans – Plans that were issued in 2014 or later that comply with the single risk pool requirement. The issuer should enter information in the Projection Period for each of the Renewing Plans, as well as the Experience Period if applicable.

3. Terminating Non-Single Risk Pool Compliant Plans and All Transitional Plans – Plans that were issued before January 1, 2014 that do not 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 "2014 experience" in the Plan Name. The issuer should enter "Catastrophic" in the Metal row for these plans.

4. Terminating Single Risk Pool -Compliant Plans, Mapped to New Plan – Plans terminated prior to the Projection Period that are closed to new entrants and are mapped to a new Plan ID. For these plans, the issuer should include information related to the Experience Period of the terminated plans in the column of the new Plan ID.

5. Terminating Single Risk Pool -Compliant Plans, Not Mapped to New Plan - Plans that are terminated prior to the Projection Period must be shown in a separate column. For these plans, the issuer should enter a zero for the projected member months. The information for the Projection Period (Section IV) should be left blank.

If an issuer makes changes to the plan on renewal, it will be considered the same plan for the renewal plan year if the following are true:

(i) The plan has the same cost-sharing structure as before the modification, or any variation in cost sharing is solely related to changes in cost or utilization of medical care, or is to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act;

(ii) The plan continues to cover a majority of the same service area; and

(iii) Continues to cover a majority of the same provider network. For this purpose, the plan's provider network on the first day of the plan year is compared with the plan's provider network on the first day of the preceding plan year (as applicable).

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."

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

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 contain three digits. This field must be entered as a text input and must include any leading zeros (e.g. 001).

For non-single risk pool compliant 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 Product ID discussed above.

Single risk pool compliant plans that are closed to new entrants terminated prior to the Projection Period and not mapped to a new product must be shown in a separate column. For these plans, the issuer should enter a zero for the projected member months. The information for the Projection Period (Section IV) should be left blank. However, if single risk pool compliant plan is terminated and mapped to a new single risk pool compliant plan, the information for the experience period should be included in the column for the new Plan ID.

Marketplace 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 Marketplace or Small Business Health Options Program (SHOP), regardless of whether or not it will also be offered or marketed outside the Marketplace. 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 Marketplace. If you indicate "yes" for a plan, the plan will automatically be considered as available on and off the Marketplace, due to guaranteed availability. Marketplace issuers are required to make all plans available upon request from consumers who meet the guaranteed availability and EHB reasonable assurance requirements, but are not required to market or actively sell Marketplace plans outside the Marketplace.

For terminated plans, the issuer should enter "No" in this field, even if the plan was offered on the Marketplace 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 2013 for an Effective Date of January 1, 2014, the current calendar year is 2013. Rate increases are therefore required to be entered for 2011, 2012, and 2013.

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 April 2013 for an effective date of January 1, 2014 for a market in which rates change quarterly, include in the average rate increase for 2013 any rate increases that have already been approved or are intended to be implemented in 2013 including those implemented after the submission (e.g., effective July 2013 and October 2013).

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 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 submission revises the Index Rate for July 1, 2016 effective dates and includes a trend increase applicable on October 1, 2016, enter July 1, 2016.

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 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 current distribution of enrollment by age, geographic area, and tobacco status.

For new plans enter -999.00% in this field. It is important to enter this negative value in the template in this case so other calculated fields in the template are correctly generated.

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 is a calculated field.

Product Threshold Rate Increase Percent: The template calculates the threshold rate increase for each product. This is the rate increase that determines whether the rate increase is subject to review, per 45 CFR § 154.200. This is a calculated field.

2.2.2 Section II: Components of Premium Increase

This section can be completed with variations only at the product level or variations at each plan level within a product. 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.

If the information is entered with the product level variation, this means the issuer enters the information for the total product spread evenly across all plans within the product. If the issuer chooses this methodology, the proposed rate increase for each plan within the product must be identical.

If the issuer chooses to enter the information separately for each plan within a product rather than use the simplified approach of entering the product averages, the proposed rate increase for each plan can vary for items allowable by state and Federal laws and regulations. If an issuer chooses to enter information separately for each plan, 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. With the exception of terminated plans, no plan should have expected membership of zero. If zeros are entered in these cells of the URRT, an issuer may be required to resubmit the template which may cause delays in the rate review and approval process.

Inpatient: 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: 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: 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 Drugs: 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: 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: 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.

Administrative Expenses: 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: 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 Charges: 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: 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. 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 (i.e., those with Cumulative Rate Change Percent (over 12 months prior), leave this field blank. It is understood that the calculated Average Current Rate PMPM across all plans will be understated because the new plans 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 II 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.

If an issuer chooses to enter information at the plan specific level, projected member months entered in the template must reflect an issuer's best estimate of projected enrollment for that specific plan. With the exception of terminated plans, the projected member months for a plan should not be zero. If the projected membership does not meet this criterion, issuers may be required to resubmit the URRT which may cause delays in the rate review process.

2.2.3 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.

Similar to Section II of this worksheet, the information requested in this section can be entered at the product level or at the plan level. See Section II for a description of these variations.

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 2014, the information on this section should be from calendar year 2014.

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 in addition to EHBs, AV and cost-sharing, distribution and administrative costs (less Marketplace 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. Since issuers were not required to file a Plan Adjusted Index Rate in 2014, the issuer would need to calculate this value based on the Index Rate filed in 2014, the market adjustments filed in 2014 and the allowable plan adjustments for 2014.

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

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. For the2016 annual filing, issuers should enter what would have been the annual 2014 Plan Adjusted Index Rate, if it had been required.
- Quarterly rate filings: please enter the Plan Adjusted Index Rate filed for the most recent filing during the Experience Period. For 2016 quarterly filings, issuers should enter the 2014 Plan Adjusted Index Rate that would have been filed in the most recent 2014 filing, if it had been required.

For terminated non-single risk pool compliant 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): The total premium earned in the Experience Period for each plan is calculated as the Plan Adjusted Index Rate PMPM multiplied by the Member Months in a given plan.

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 were projected when the issuer was developing rates versus what actually emerged. However, the template includes a "Warning" indicator if there is a significant difference between the average premiums on the two worksheets. If the Warning is indicated, 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 EHB services in each plan (including administrative expenses and profit associated with those services).

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 (EHB, state mandated benefits that are not EHB, and other benefits) of the template in proportion to the claims expenses. For example, if 95% of claims are EHB and 5% of claims are other benefits, 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. 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 EHB package, 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 Marketplace or State-based Marketplace, 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 Marketplace or State-based Marketplace, 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 EHB benchmark 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 Marketplace.

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 part of the EHB package.

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 insured gets to choose whether or not to purchase the benefit), 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 fund the portion of the premium for state mandated benefits that are not included in the EHB package.

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 not associated with 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.

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 indicated, the issuer should provide additional support for the difference between the total allowed claims between Worksheet 1 and 2 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 Experience 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.

- If the plan is a QHP offered in the Federally-facilitated Marketplace or State-based Marketplace, 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 Marketplace or State-based Marketplace, 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 Marketplace.

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 allowed claims associated with the non-EHB in this field. If a state mandates that issuers *offer* a non-EHB (but the insured gets to choose whether or not to purchase the benefit), 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 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 included this value 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%).
- Risk transfer charges or payments associated with the risk adjustment program. In this case, risk adjustment charges made to the program should be entered as a negative amount and payments received from the program should be entered as a positive amount. The issuer should estimate the risk transfer charge or payment by plan and provide detailed information in the Actuarial Memorandum on the methodology used to allocate the payments between plans. The risk adjustment user fees should not be included since they are not part of allowed claims.
- 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.

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.

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 in that 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.

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

This value should be calculated consistently with the risk transfer charge or payment included in the Allowed Claims which are not the issuer's obligation. However, it will differ from that amount in that this field is net of the risk adjustment user fees. 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.

2.2.4 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. Similar to Sections II and III of this worksheet, the information requested in this section can be entered at the product level or at the plan level. See Section II for a description of these variations.

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.

Since Total Premium (TP) for the projection period is calculated as the Plan Adjusted Index Rate multiplied by the member months, this will reflect the weighted average Plan Adjusted Index Rates for all effective dates.

All data entered in the Claims Information section (rows 86 through 96) 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 2016, the information on this section should be calendar year 2016.

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) further adjusted for plan specific factors allowable by 45 CFR § 156.80(d)(2) such as provider network, utilization management, benefits in addition to EHBs, AV and cost-sharing, distribution and administrative costs (less Marketplace 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. The template includes a “Warning” indicator if there is a significant difference between the average premiums on the two worksheets. If the Warning is indicated, additional information should be provided in the Actuarial Memorandum that explains the differential. One explanation that may apply is that the small group Plan Adjusted Index Rate 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.

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): The total premium earned in the Projection Period for each plan is calculated as the Plan Adjusted Index Rate PMPM multiplied by the Member Months in a given plan.

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 indicated, 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 EHB services in each plan. It is critical that this percentage be entered correctly and consistently with any QHP application. It is likely that this field will be used by CMS to calculate the advance premium tax credits for subsidy-eligible enrollees. If the values in this field are not entered correctly, the calculation of the advance premium tax credits may be incorrect for an issuer.

For non-terminated single risk pool compliant 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 is likely it will be used to calculate the advance premium tax credits 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 EHB package, 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 Marketplace or State-based Marketplace, 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 Marketplace or State-based Marketplace, 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 EHB benchmark 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 Marketplace.

Submission of the URRT and corresponding 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 part of the EHB package.

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 insured gets to choose whether or not to purchase the benefit), 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 fund the portion of the premium for state mandated benefits that are not included in the EHB package.

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 not associated with 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 projection period. See the instructions for Worksheet 1 for the definition of Allowed Claims.

The Total Allowed Claims (TAC) across all benefit plans for the projection period should be consistent with the total allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries entered in Section III 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 indicated, 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 is 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 Marketplace or State-based Marketplace, 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 Marketplace or State-based Marketplace, 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 Marketplace.

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 insured gets to choose whether or not to purchase the benefit), 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 this value should reflect both the amount paid by the member and the subsidies.

- Risk transfer charges or payments associated with the risk adjustment program. In this case, risk adjustment charges made to the program should be entered as a negative amount and payments received from the program should be entered as a positive amount. The issuer should estimate the risk transfer charge or payment by plan and provide detailed information in the Actuarial Memorandum on the methodology used to allocate the payments between plans.
- Federal reinsurance payments expected to be 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.
- 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 %: This is a calculated field and displays the percentage of claims covered by HHS over the value of claims not covered by the issuer.

Net Amount of Rein: Enter the Federal reinsurance amount expected to be received for each plan during the projection period, net of the reinsurance assessments.

This value should reflect both assessments charged and payments received under the program. The amount entered should be consistent with the amount that reflects payments received or assessments charged under the Federal reinsurance program that is included in the Allowed Claims which are not the issuer's obligations.

Net Amount of Risk Adjustment: 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.

This value should be consistent with the risk transfer payment, if any, included in the Allowed Claims which are not the issuer's obligation. If the transfer amount is expected to be a payment received from other issuers, the value should be entered as a positive amount. If the transfer amount is expected to be a charge (liability payment made to other issuers), a negative value should be entered.

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.

Issuers must provide a brief, non-technical description of why the issuer is requesting this rate increase. This explanation should help consumers interpret the rate summary data provided 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 profits: 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 items listed above in their submissions. The written statement must be submitted 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.

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; and
- 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 as defined in HHS's FOIA regulations, 45 CFR § 5.65. 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 the data elements and information required in this manual with no redactions. The public version should redact any information that is a trade secret or confidential commercial or financial information. Further instructions may be issued regarding submission of the redacted public version of Part III.

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: State 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 Increase(s)

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
- Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program

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.

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 that must be covered under the essential health benefit package
- 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 (if applicable) and IV.

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.

In the Actuarial Memorandum, 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):
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 reinsurance revenue must be applied to the Index Rate for the development of the Market Adjusted Index Rate.

The URRT requires issuers to report reinsurance payments net of reinsurance contributions. Issuers must describe the underlying experience data and assumptions that they used to develop their estimates of both reinsurance contributions and payments. In particular, issuers should provide an explanation of how they developed an estimate of their claims liability between the reinsurance attachment point and cap. Issuers should describe any key aspects of their enrolled population that significantly impacted their claims assumptions.

Issuers must also describe how they allocated their anticipated reinsurance payments net of reinsurance contributions across the plans in their risk pool (as noted above reinsurance revenue should be applied at the market level or to the Index Rate).

As only non-grandfathered reinsurance eligible plans in the individual market may receive payments under the transitional reinsurance program, in a merged market, the pooled reinsurance adjustment should be based only on the portion of the issuer's merged market business eligible for reinsurance payments. Further, the transitional reinsurance program does not apply to non-single risk pool compliant plans

Issuers should state the assumed amount of the assessment as a PMPM amount.

Please note that the reinsurance recovery amounts shown on Worksheet 1 of the URRT should take into account the actual PMPM amounts expected in the projection period, which are based on incurred claims and not allowed claims. However, the net Federal reinsurance recovery amount applied to the Index Rate in the development of the Market Adjusted Index Rate is on an allowed claims basis (i.e. grossed up by the expected paid to allowed ratio) as the Index Rate is on an allowed claims basis.

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 per member per month 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 the Federal transitional reinsurance program or risk adjustment user fees in this amount despite their treatment in MLR calculations, since Federal reinsurance and risk adjustment are expressed in the template net of reinsurance premium and 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 Marketplace user fees) are considered part of administrative expenses, per 45 CFR § 156.80(d). It is described separately in the Actuarial Memorandum to facilitate rate review.

Marketplace user fees should be included in the template in Taxes & Fees. The issuer should provide a narrative verifying the Marketplace 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 Marketplace and non-Marketplace 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 you plan 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(d). 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 should 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 compliant 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 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 Marketplace 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 the EHBs 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 benefits in excess of EHB 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-EHB services in the Experience Period Allowed Claims PMPM (due to transitional policies or small groups that have not reached their renewal date to move to a single risk pool compliant 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 compliant 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 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 compliant plan during the projection period at a point when the members in these plans move to non-single risk pool compliant 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 (2012)	1000	1000	2000
Base Allowed Claims (2012) 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:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Marketplace user fee adjustment (market-wide 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 Marketplace 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.

However, the Market Adjusted Index Rate is not displayed in the URRT..

4.6.4 Plan Adjusted Index Rates

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 Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR § 156.80(d)(2). The following adjustments are allowable under these rules:

- AV and cost-sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)
- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

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 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.

If an issuer chooses to apply tobacco user factors, which is an allowable member-level rating factor, the issuer must make an adjustment so that the resulting Plan Adjusted Index Rate would remove the portion of the cost that is expected to be recouped through the tobacco surcharge. This adjustment should only reflect the expected surcharge collected for tobacco users, as an example, 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. Issuers that do not charge tobacco surcharges for a plan should not make this adjustment for that plan.

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.

Other adjustments not specified by 45 CFR § 156.80(d)(2) are not allowed, such as adjustments to recoup revenue related to the three dependent child limit or a catastrophic adjustment to non-catastrophic plans.

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. Since issuers were not required to file a Plan Adjusted Index Rate in 2014, the issuer would need to calculate this value based on the Index Rate filed in 2014, the market adjustments filed in 2014 and the allowable plan adjustments for 2014. Issuers must include a description in the Actuarial Memorandum explaining how the experience period Plan Adjusted Index Rates were derived in this case.

4.6.5 Calibration

At this time, calibration factors are ONLY allowed for the age and geography factors. Calibration for tobacco-use cannot be applied at this point since it is incorporated in the AV component of the plan level adjustments (see Plan Adjusted Index Rates section).

Age Curve Calibration

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

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 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 and that it conforms with the rating rules specified in 45 CFR § 147.102.

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 should be included in the Actuarial Memorandum. 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.

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 are to be included in the Actuarial Memorandum. 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.

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 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 consumer level adjustments as described in § 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 Info

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 guarantee 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

A list of terminated plans and any mappings to existing plans should be included in the Actuarial Memorandum. List the name of each plan and product that will be terminated prior to the effective date. Include both 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 (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 URRT 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; and,
- 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*

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(d)(1))
    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 45 CFR § 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, were 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.
   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 Marketplaces, 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 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[2] 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.
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 contact CCIIO to have the submission unlocked.[3]	*Rate increases not subject to rate review:* If the rate increase is <10%, the regulator[4] reviews the submission for completeness and for compliance with applicable rating rules. – If the submission passes the compliance review,

[2] Revising a submission means that the issuer can upload supplemental documents or revise the URRT or Actuarial Memorandum in HIOS.
[3] See below for more information on how to request a submission unlock.

Status	Definition	Additional Information	Next Step
			CCIIO checks the "Web Content Assessment" box in HIOS.[5] – If the submission does not pass the completeness or compliance review, the regulator asks the issuer for more information. *Rate increases subject to rate review:* If the rate increase is ≥ 10%, 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 by CCIIO.	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.
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 < 10%.	**None.** This is the final status for submissions not subject to rate review.
Submission	CCIIO has checked the	Only applicable to rate	The regulator must select

[4] In states with effective rate review programs (also known as enforcing states), the applicable state regulatory authority is the regulator. In states without effective rate review programs (also known as Direct Enforcement states), CCIIO is the regulator.

[5] State regulators in enforcing states must notify CCIIO when a submission passes the compliance review.

Status	Definition	Additional Information	Next Step
Filed	"Web Content Assessment" box in HIOS for a submission *subject to rate revie*w.	increases of ≥ 10%.	"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 ≥ 10%.	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 ≥ 10% 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 ≥ 10% 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 contact CCIIO to request a submission unlock. If the issuer decides not to implement the unreasonable rate increase, then the issuer should contact CCIIO to request a submission deactivation.
Final Justification Submitted	The issuer has entered a Final Justification in HIOS.	Only applicable to rate increases ≥ 10% 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 indicate the submission failure. The issuer should create a new submission.
Submission Deactivated	CCIIO has deactivated the submission.	Only submissions with a status of Record	The issuer should create a new submission.

Status	Definition	Additional Information	Next Step
	Note: In enforcing states, the state regulator must first contact CCIIO to request the deactivation.	Validated, Review Complete, or Rate Filing Accepted can be deactivated.	

5.2 Submission Unlock Requests

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 contact CMS to request a submission unlock. To request a submission unlock, send an email to ratereview@cms.hhs.gov with the following information:

- Submission tracking number.
- Description of the specific changes requested; include a detailed explanation of the revisions and the reasons why the revision is required.
- An indication that the appropriate regulator has authorized the revision.
- An indication of whether the submission contains a QHP and, if so, whether the URR revision will impact a QHP template.
- An indication of whether the Index Rate will change as a result of the revision.

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 Pool
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 Claims	$ 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.