DEPARTMENT OF HEALTH & HUMAN SERVICES
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Part I Unified Rate Review Template Instructions

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Part I Unified Rate Review Template v2.0.1

The Part I Unified Rate Review template is required to be submitted by all issuers in the individual, small group and/or combined markets that are proposing a rate increase on any single risk pool compliant products. In addition, all issuers applying to offer at least one QHP in the state must submit the template for the market in which the QHP would be offered. The template may also be required by regulatory authority for products in the single risk pool. Issuers are required to submit the annual rate change (i.e. January rate changes). In addition, quarterly rate increases for the small group market are allowed if allowed by the state regulatory authority. See the Appendix for additional detail on the timeframe for submission.

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.

The Part I Unified Rate Review template is intended to:

- Demonstrate compliance with the Single Risk Pool requirement of 45 CFR Part 156.80,
- Provide support for the development of the Index Rate which is defined in 45 CFR Part 156.80(d),
- Identify product level rate increases to determine whether a rate increase is subject to review under 45 CFR Part 154, and
- Provide supporting information to State or Federal regulators for product level rate increases

Additional information about how CCIIO uses or discloses information from the template is described in the Appendix.

Specific instructions for the treatment of dental plans within the Part I Unified Rate Review template have been developed for plans offered in 2015 and beyond.

- Only embedded pediatric dental benefits within a medical plan should be reflected in the Part I Unified Rate Review Template. Further, in order for the dental costs to be included in the Part I Unified Rate Review Template 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 Part I Unified Rate Review Template.

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

Beginning with plans effective in 2015 and beyond, ALL benefits to be offered in a plan must be included in that plan. So if an issuer wants to offer an "optional" benefit, there are two options an issuer can use to meet this goal.

- The issuer can create a separate plan with the required EHBs and the "optional" benefit included.

- The issuer can offer a separate policy which is a supplemental policy providing non-EHB benefits.

The concept of "optional riders" is incongruent with federal rating rules and the single risk pool requirements.

It is critically important that information be entered into the template as accurately as possible with the information available to the issuer at the time of submission. Failure to provide accurate information in the first submission increases the likelihood of the need to provide additional data to the State or Federal regulators reviewing the template. Failure to provide accurate information also slows the speed of any required approvals or certification and puts the products and plans at risk for missing critical deadlines to be offered in the markets.

Beware, 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 the data entered in the Part I Unified Rate Review Template 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.

The following should be considered an instructional tool in developing issuer pricing, as allowed under the market and rating rules for the single risk pool.

ACA & MARKET RATING RULES - ALLOWABLE RATING & PRICING

Allowable rating methods and factors

- The Single Risk Pool should include ALL (non-grandfathered) covered persons (lives) an issuer has in a state, within a market (individual, small group or combined). This includes transitional products/plans for purposes of base period 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 fully ACA-compliant plans during the projection period.

- The Index Rate is defined as the EHB portion of projected allowed claims divided by all projected 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 fully ACA-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 2013 experience for developing rates for the 2015 year. Appropriate adjustments should be made in Worksheet 1 – Section II of the Unified Rate Review Template to bring these policies in line with all requirements of non-grandfathered policies projected in the Single Risk Pool in 2015. For example, in the projection period, include projected experience and membership at the point when these products become ACA-compliant and the membership renews to the ACA-compliant plan, or at the point when the members in these plans move to an ACA-compliant plan, if the plans are closed to new membership in 2015.

- The Market Adjusted Index Rate is the Index Rate adjusted for Risk Adjustment, Reinsurance and Exchange 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.

- The Plan Adjusted Index Rate is the Market Adjusted Index Rate further adjusted for plan specific factors allowed by 45 CFR Part 156.80(d)(2) such as provider network, utilization management, benefits in addition to Essential Health Benefits (EHBs), actuarial value and cost sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.

- Note, 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 Exchange 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.

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

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

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

- 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 and tobacco if

necessary, and applying the allowable rating factors. Allowable rating factors are Age (3:1 standard age curve or state specific age curve), Tobacco, Geography and Family tiering/structure, unless otherwise prohibited by state law.

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).

The tobacco factors can be issuer specific but cannot vary by product/plan for an issuer (i.e. an issuer must use the same tobacco factors across all products/plans within a state and market).

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 to all plans the issuer has in that rating area uniformly. 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 with the rating area.

Family structure takes into account family composition and the maximum of 3 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 are uniformly applied to all plans in the risk pool (and published to the cciio.cms.gov website).

Worksheet 1 – Market Experience

The purpose of Worksheet 1 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 Part 156, §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.

- The 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 Part I Unified Rate Review Template.

- 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.

General Information

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, 2015

effective dates and includes a trend increase applicable on October 1, 2015, enter July 1, 2015. See the Appendix for further guidance on trend increases in the small group market.

All issuers are required to file the Part I Unified Rate Review Template and Part III Actuarial Memorandum 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. However, the change in the Index Rate 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 Part I Unified Rate Review Template for January 1, they may submit a subsequent Part I Unified Rate Review Template that resets the Index Rate effective July 1 of that same year. The Part I Unified Rate Review Template 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" is defined as a unique combination of benefits, various cost sharing options and a network design(s) to a particular service area. "Product" has the same meaning as included in 45 CFR Part 154. The term "plan" is defined as a unique combination of benefits to a specific set of cost sharing options and network design(s) to a particular service area. Most products will be made up of multiple plans produce an actuarial value equal to one of the metal levels permitted under Title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA).

Section I

The financial and enrollment information entered in this section should reflect the experience of all non-grandfathered 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.

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 Part III 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 Part III 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 with dates of service within the Experience Period (e.g., February 28, 2013) when estimating the total claims incurred during the period. The paid through date is not captured in the template, but is requested in the Part III Actuarial Memorandum.

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

Start with premiums earned during the experience period. 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 Part III 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 Part III of 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 essential health benefits (EHB) 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.

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 Part I Unified Rate Review Template 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 essential health benefits. It is the legal entity-specific rate for the market that is being submitted – i.e., the issuer's individual market, small group market or combined market. It should not be adjusted for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply allowed claims PMPM for essential health benefits.
>
> 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 essential health benefits, but should not be adjusted to include essential health benefits that were not covered during the experience period, such as, in some cases, maternity coverage in the individual market.

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.

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.

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 Part III 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.

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 Part III 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 Part III 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.

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:

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

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

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

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 Part III 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.

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.

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 Part III 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 Part III 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.

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 Part III 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 (w/ 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 rein & Risk Adj't, PMPM: The template calculates this value by multiplying the Projected Allowed Experience Claims PMPM (w/ 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 federal 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 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 Part III Actuarial Memorandum.

Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM: The template calculates this value by subtracting the Projected Risk Adjustments, PMPM from the Projected Incurred Claims, before ACA rein & Risk Adj't, 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).

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 rein & Risk Adj't, 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 and 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 Part 156, §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 Part 156, §156.80(d). It is shown separately on the template to facilitate rate review.

Single Risk Pool Gross Premium Avg. 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 essential health benefits. 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 Exchange user fees. It is simply projected allowed claims PMPM for essential health benefits. 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.

% 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.

% increase, annualized: The template calculates this value by annualizing the % increase over Experience Period. Like the % 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 Part III 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 for 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.

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, actuarial values 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.

Plan level data is required because it could be used in calculating the advance premium tax credits and cost sharing subsidy advance payments. If the plan level data is not provided for each plan, the calculation of the advance premium tax credit and cost sharing subsidy advance payments may be incorrect for an issuer which may result in significant over or under advance payments.

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 Part I Unified Rate Review Template 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 the Part I Unified Rate Review

Template, an issuer may be required to resubmit the template which may cause delays in the rate review and approval process.

Section I

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

The term "product" is defined as a unique combination of benefits, various cost sharing options and a network design(s) to a particular service area. "Product" has the same meaning as included in 45 CFR Part 154.

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 but were made available thereafter.

If multiple products will be closed prior to January 1, 2015, 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 Part III Actuarial Memorandum.

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

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

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

If multiple products will be closed prior to January 1, 2015, 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 Part III Actuarial Memorandum.

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 actuarial value as prescribed in 45 CFR Part 156, §156.20. AV Pricing Value is defined below.

The ACA requires that all plans offered in the market must have an actuarial value 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 actuarial values are defined as "the percentage paid by a health plan of the percentage of the total allowed costs of benefits."[1] There are five levels of coverage that can be offered: Platinum, Gold, Silver, Bronze and Catastrophic. The actuarial values for each of these metal levels are shown in the table below. The actuarial value used in determining the metal level must be based on the Actuarial Value Calculator (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 Part III Actuarial Memorandum.

The actuarial value used to determine the metal level must be within a de minimis variation from the actuarial values 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 products that are reported on a combined basis as terminated products prior to January 1, 2015, enter "Catastrophic".

[1] 45 CFR Part 156, §156.20

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 Part 156 §156.135(b).

For products that are reported on a combined basis as terminated products prior to January 1, 2015, enter zero.

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, the actuary should use their best judgment in estimating the AV Metal Value.

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

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. 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.

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

- Plan benefits in addition to the essential health benefits. The additional benefits must be pooled with similar benefits provided in other plans to determine the allowable rate variation for plans that offer those benefits.

- Administrative costs, excluding Exchange user fees.

- For catastrophic plans, the expected impact of specific eligibility categories for these plans.

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 Part III 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" is defined as a unique combination of benefits to a specific set of cost sharing options and network design(s) to a particular service area. Most products will be made up of multiple plans that produce an actuarial value equal to one of the metal levels permitted under the ACA. 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.

For products that are closed to new entrants prior to January 1, 2015, the issuer should indicate that there is one plan in the product when completing the template. The Plan Name for the product or grouping of terminated products should be entered as "Terminated Products."

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. "20Percent Coinsurance Plan" for "20% Coinsurance Plan."

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

The Plan ID is a unique identifier for the set of benefits and cost sharing values offered within a product by the HIOS issuer, or in other words, a unique identifier of each plan. Plan IDs contain three digits. This field must be entered as a text input and must include any leading zeros (e.g. 001).

For products that are closed to new entrants prior to January 1, 2015, 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.

Exchange Plan: For each plan, enter an indicator (yes or no) as to whether the plan will be offered inside a State-based or Federally Facilitated Exchange or Small Business Health Options Program (SHOP), regardless of whether or not it will also be offered in the outside market. If an application for qualified health plan status is pending, enter "yes." This indicator should not be used to identify whether a plan is offered on a private exchange.

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 -999% 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 -999% 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, 2015 effective dates and includes a trend increase applicable on October 1, 2015, enter July 1, 2015.

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

For new plans enter 0.00% in this field.

Cum'tive Rate Change % (over 12 mos 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.

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

Proj'd Per Rate Change % (over Exper. Period): For each plan, the percentage change in rates between the Experience Period and the Projection Period is shown. This is a calculated field.

Product Threshold Rate Increase %: 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 Part 154 §154.200.

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

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

> 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 Part I Unified Rate Review Template 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 the Part I Unified Rate Review Template, 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 need to 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 Rate PMPM 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 projected membership, not the currently enrolled membership.
>
> 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 Cum'tive Rate Change % (over 12 mos prior) entered as -999.00% as instructed above), enter the projected average rate PMPM for each plan in this field. It is understood that these new plans do not actually have current rates. However, it is necessary to populate this field with the projected average rate so that the projected Average Rate PMPM in Section IV is calculated correctly by the template. It is also understood that the calculated Average Current Rate PMPM across all plans will not reflect the true current average in the event that there are new plans or very recently offered plans with Projected Member Months (which are used to calculated the overall average) but whose current rate reflects a rate for a later effective date than the remaining plans that are not new. 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 criteria, issuers may be required to resubmit the Part I Unified Rate Review Template which may cause delays in the rate review and approval process.

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.

Average Rate PMPM: Enter the average premium rate PMPM for each plan during the experience period. The average should be generated using membership consistent with the Experience Period for each plan.

> It is anticipated that the overall Average Rate PMPM during the Experience Period should be similar to the average premium rate found in Section I 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 Part III Actuarial Memorandum that explains the differential.

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 Part III Actuarial Memorandum.

Total Premium (TP): The total premium earned in the Experience Period for each plan is calculated as the Average Rate PMPM multiplied by the Member Months in a given plan.

> The Total Premium (TP) in the experience period should be consistent with the total premium found in Section I 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 Part III Actuarial Memorandum that explains the cause.

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). Note these fields are optional for submissions with an experience period that ends prior to January 1, 2014.

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

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

If abortion services are not included in the 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 exchange.

State mandated benefits portion of TP that are other than EHB: Enter the percentage of the total premium for each plan that is associated with state mandated benefits that are not part of the EHB package. Note these fields are optional for submissions with an experience period that ends prior to January 1, 2014.

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.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured as to whether or not to purchase the benefits) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The premium associated with these types of benefits should be included in the Other benefits portion of the premium, which is defined below.

The percentages in these fields are required (except for the optional treatment described above) 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 Part III 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. Note these fields are optional for submissions with an Effective Date, as shown on Worksheet 1, in calendar year 2015.

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 Exchange or State-Based Exchange, the percentage of the allowed claims associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB package).

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

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

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. Note these fields are optional for submissions with an experience period ending prior to January 1, 2014.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The allowed claims associated with these types of benefits should be included in the Other benefits portion, which is defined below.

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 Part III 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 Part III 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 Part III 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 %: 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 Amt 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.

For time periods prior to 2014, the value should be zero, as the program was not operational until 2014.

Net Amt of Risk Adj: 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.

For time periods prior to 2014, the value should be zero, as the program was not operational until 2014.

Section IV : Projected (12 months following effective date)

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.

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 Part 156.80(d)(2) such as provider network, utilization management, benefits in addition to Essential Health Benefits (EHBs), actuarial value and cost sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.

The overall weighted average of the Plan Adjusted Index Rates should be similar to the Single Risk Pool Gross Premium Avg. Rate, PMPM found in Section III of Worksheet 1. 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 Part III Actuarial Memorandum that explains the differential. One explanation that may apply is that the small group Plan Adjusted Index Rates reflect 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.

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 Average 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 Part III Actuarial Memorandum that explains the cause.

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 CCIIO 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 ACA 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 Exchange or State-Based Exchange, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Since subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.

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

If abortion services are not included in the 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 exchange.

Submission of the Part I Unified Rate Review Template and corresponding Part III Actuarial Memorandum satisfies the requirements of 45 CFR 154.215 and 156.470.

State mandated benefits portion of TP that are other than EHB: Enter the percentage of the total premium for each plan that is associated with state mandated benefits that are not 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.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The premium associated with these types of benefits should be included in the Other benefits portion of the premium, which is defined below.

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 Part III 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 Exchange or State-Based Exchange, the percentage of the allowed claims associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB package).

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

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

Submission of the Part I Unified Rate Review Template 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.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The allowed claims associated with these types of benefits should be included in the Other benefits portion, which is defined below.

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 Part III 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 Part III Actuarial Memorandum.

- Other claims that are not described above but included in this cell should be described in detail in the Part III 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 Part III 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 Amt 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 Amt of Risk Adj: 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.

Validation and Finalization of Part I Unified Rate Review Template (URRT) in HIOS

An issuer must validate the URRT submission in order to complete the upload process within HIOS. The following steps are to be taken in order to complete the process.

1. The issuer creates the initial submission and uploads the required documentation. At this point the submission is in the Pre-Validation status.
2. The issuer must check the validation box on the submission summary. Once the issuer checks this box, the submission is in the Record Validated status.

Appendix

Single Risk Pool and Index Rate Requirements

The Single Risk Pool and Index Rate Requirements are specified in 45 CFR Part 156.80.

45 CFR Part 156.80(a), (b), and (c) require that health insurance issuers consider the claims experience of all enrollees in all non-grandfathered health plans subject to section 2701 of the Public Health Services Act and offered by the issuer in the state to be members of a single risk pool for each of the individual, small group, and combined markets.

45 CFR Part 156.80(d) requires that a health insurance issuer establish an Index Rate for each of the individual, small group, or combined markets annually. The Index Rate for each market is based on the total combined claims costs for providing Essential Health Benefits within the Single Risk Pool for that state market.

Timeframe for Part 1 Unified Rate Review Template Submissions

The following table provides the guidelines for the submission of the Part 1 Unified Rate Review Template for rates associated with the different types of public exchanges (i.e. FFM/SPM), and non-QHPs. This applies to filings for January 1 effective dates in all markets.

Type of Filing	Issuer Submission Date for 2015 Rates
QHP Filing – FFM/SPM	[TBD]
QHP Filing – SBM	Based on state regulatory agency requirements
Non-QHP Filing	Based on state regulatory agency requirements

In addition, issuers may file revised rates for small group plans on a quarterly basis, subject to other state requirements. For example, a state may not allow issuers to submit revised rates for fourth quarter. The table below shows suggested guidance for a timeline of submission of these plans. However, the specific submission dates may vary from these guidelines depending upon specific requirements for individual states.

Small Group Quarterly Submission Schedule (Non-Grandfathered Single Risk Pool Plans)

Type of Filing	Issuer Submission Date	Finalization Date for 2015 Rates
QHP Filing – FFM/SPM	At least 90 days prior to effective date	At least 45 days prior to effective date
QHP Filing – SBM	At least 90 days prior to effective date	At least 45 days prior to effective date
Non-QHP Filing	Based on state regulatory agency requirements	At least 45 days prior to effective date

Use of the Data Submitted in the URRT

CCIIO uses the data submitted in the URRT in a variety of ways.

In states where CCIIO performs the Market Reform Rules compliance reviews, CCIIO uses the URRT in conjunction with other information to perform the compliance reviews.

CCIIO's Financial Management may use certain fields in the calculation of Advance Premium Tax Credit (APTC) payments and Cost Sharing Reduction (CSR) advance payments.

Disclosure of the URRT data

Upon completion of the Freedom of Information Act review that is underway, CCIIO will disclose the data included in the URRT on its website.

URRT Submission Statuses

URRT submissions are in the following statuses under various circumstances.

The URRT contains no rate increases that are subject to review

Pre-validation – the issuer has successfully created the URRT submission

Record Validated – this issuer has validated the URRT submission. Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission.

Pending Resubmission – the URRT submission has been "unlocked" to allow the issuer to upload a revision to one or more of the documents. The URRT submission needs to be re-validated after the revised documents have been uploaded.

Rate Filing Accepted – review of the URRT submission has been completed. If any revisions are necessary after the submission is put into this status, the submission will need to be deactivated and the issuer will need to create a new URRT submission

The URRT contains one or more rate increases that are subject to review

Pre-validation – the issuer has successfully created the URRT submission

Record Validated – this issuer has validated the URRT submission. Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission.

Pending Resubmission – the URRT submission has been "unlocked" to allow the issuer to upload a revision to one or more of the documents. The URRT submission needs to be re-validated after the revised documents have been uploaded.

Submission Filed – preliminary review of the submission has been completed by the appropriate regulator.

Review in Progress – submission is pending final determination.

Review Complete – final determination has been entered by the appropriate regulator.

How to Request a Revision to a URRT Submission

While a submission is in the "Pre Validation" status, the issuer may revise the submission at will.

Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission. To request authorization to revise the submission, send an email to ratereview@cms.hhs.gov with the following information:

- Submission tracking number.
- Description of the specific changes you are requesting. Include any necessary explanation of the revisions and the reasons the revisions are required.
- An indication that the appropriate regulator has authorized the requested revision.
- An indication of whether the submission contains any Exchange plans.
- An indication of whether the Index Rate will change as a result of the revisions to the submission.

If the requested revision is authorized, the issuer needs to re-validate the submission after the revised documents have been uploaded.

Guidance for Quarterly Rate Increases

This appendix provides guidance on a methodology for the completion of the Part I Unified Rate Review template 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 Unified Rate Review template.

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.