

## **Crosswalk of Changes to the Unified Rate Review Template and Instructions (CMS 10379)**

### **A. Changes to Unified Rate Review Template**

1. The only visible change between the templates is the movement of Worksheet 1 cells I3:J4 in version 5.0 to cells D4:E5 in version 6.1. This was done to avoid having to scroll over on the worksheet to enter the state and market information.
2. Additionally, some cells in v5.0 limited the number of decimal places that could be entered, sometimes causing a loss of precision in calculating some field values. Version 6.1 no longer caps the number of decimal places outside of the limits that already exist in Excel.
3. The calculations of Fields 1.12 and 1.13 on Worksheet 2 were updated so the rate change calculation is rounded rather than truncated. While the difference is minor, rounding is the more correct display.

### **B. Changes to URR Instructions**

Changes made to the URR Instructions are driven by three major factors: changes to the submission process, clarification of information being requested, and removal of specific references that would require the instructions to be updated annually simply to update those specific references.

At the time of the last major update to these instructions, all issuers were required to submit information to CMS through the Health Insurance Oversight System (HIOS). Most issuers had to submit information here, as well as to their state regulators through the System for Electronic Rates & Forms Filing (SERFF). CMS has worked with the National Association of Insurance Commissioners (NAIC) to allow importing of the appropriate rate review documents into HIOS through SERFF for most issuers. This change has decreased burden for both issuers and participating state regulators. These instructions have been updated to explain the SERFF to HIOS transfer.

Additional changes to the instructions have been made in some cases to add clarity around data elements collected and how to input that information. Areas that needed clarification were identified based on questions, comments, and conversations with stakeholders. Stakeholders include issuers filling out the template, state regulators reviewing the template, and consultants working with both issuers and regulators.

The final changes were made to remove references to specific documents and information that can change over time. For example, instead of listing out the states where CMS is responsible for federal rate review, we include a link to a webpage with information on rate review, including which states fall under federal review. There were also references to specific annual bulletins that have been updated to direct users to reference the bulletins for exact dates, as well as provide a

link to the regulations and guidance webpage where the final bulletin can be found. These changes should prevent us from having to update the instructions annually just to reference the specific final bulletin.

The following table contains the list of changes made to the 2016 URRT Instructions as a result of internal review and in response to comments received from stakeholders.

Changes to the URRT Instructions		
	Section Edited	Revision (Red indicates modified language)
1	Title Page	<del>2023</del> Unified Rate Review Instructions Removed <del>2023</del> Added Effective for Plan Years Starting on or after January 1, 2024
2	Page 2	Removed <del>The revised Unified Rate Review Template (version 5.0) and instructions are currently under review by the Office of Management and Budget (OMB) (CMS-10379/OMB-0938-1141, expiring 8/31/19). The template is therefore subject to change. An issuer who uses the template published in HIOS' URR module on March 11, 2019 for purposes of submitting quarterly filings for 2019 or the template published in HIOS' URR module on May 3, 2019 for purposes of submitting quarterly or annual filings for 2020 will be deemed to be in compliance with the requirement to file its rate justification data on a form prescribed by the Secretary even if that form differs from what is ultimately approved.</del>
3	Page 5 Footnote	<sup>2</sup> See 45 CFR 154.301. The <del>current list of</del> states that do not have an Effective Rate Review Program <del>is available at</del> <a href="https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet">https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet</a> for plan year 2023 are Oklahoma and Wyoming.
4	Page 6	<del><sup>2</sup> See, e.g., Centers for Medicare &amp; Medicaid Services, "Letters to the State Insurance Commissioners" (Nov.14, 2013), available at <a href="https://www.cms.gov/cciio/resources/letters/downloads/commissioner_letter_11-14-2013.pdf">https://www.cms.gov/cciio/resources/letters/downloads/commissioner_letter_11-14-2013.pdf</a>. Also see Centers for Medicare &amp; Medicaid Services, Bulletin: Extension of Limited Non-Enforcement Policy through 2023 and Later Benefit Years (March 23, 2022), available at: <a href="https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf">https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf</a></del>

5	Pages 6 & 7	Struck through <b>pages 6 &amp; 7</b> because they were updated on pages 3 & 4.
6	Page 7	<sup>8</sup> The Final Bulletin is available at <a href="https://www.cms.gov/ccio/resources/regulations-and-guidance#Review-of-Insurance-Rates">https://www.cms.gov/ccio/resources/regulations-and-guidance#Review-of-Insurance-Rates</a> <del><a href="https://www.cms.gov/CCHO/Resources/Regulations_and_Guidance/Downloads/Final-Rate-Review-Bulletin-forCY2022.pdf">https://www.cms.gov/CCHO/Resources/Regulations_and_Guidance/Downloads/Final-Rate-Review-Bulletin-forCY2022.pdf</a></del>
7	Page 8	<p>Section 2794 of the Public Health Service Act (<b>PHSAPHS Act</b>) and the implementing regulations, 45 CFR Part 154, establish requirements for issuers offering non-grandfathered health insurance coverage in the small group and/or individual markets to submit rate filing information on rate increases to the Centers for Medicare &amp; Medicaid Services (CMS). Rate Filing Justification (<b>RFJ</b>) submissions must provide sufficient information for state or federal regulators to review rate filings for compliance with 45 CFR 154.215, 154.225, 147.102, and 156.80.</p> <p><del>The</del> <b>A</b> Rate Filing Justification (RFJ) for single risk pool plans<sup>1</sup> consists of the following three parts:</p> <p><b>Part I</b> - Unified Rate Review Template (URRT): The URRT is required for all single risk pool plans in the individual <del>and</del>, small group, <del>and combined</del> markets.</p>
5	Page 8	<p><b><del>1.2—Changes to the Instructions</del></b></p> <p><del>The URRT has undergone significant changes from prior years; the instructions and the information requested in the Actuarial Memorandum have changed significantly. The URRT Version 5.0 has been updated to more closely follow the build-up from the Index Rate to the Plan-Adjusted Index Rate. The URRT Version 5.0 also collects calibration factor information and geographic area rating factors. We believe these changes will facilitate the rate review process, as well as reduce burden on issuers completing the template.</del></p>
6	Page 10	<del>Updated 1.3 Public Disclosure</del> to 1.2 Public Disclosure

7	Page 10	<p>CMS will <b>publicly</b> post the Part II written description and the information contained in Parts I and III <b>of the RFJ</b> that do not constitute trade <del>secret</del> <b>secrets</b> or confidential commercial or financial information as defined in HHS’s Freedom of Information Act (FOIA) regulations</p> <p>A state with an Effective Rate Review Program must post on the state’s website at least the information contained in Parts I, II, and III of the RFJ that CMS makes available on its website (or provide <b>a link to</b> CMS’s web address for such information) for proposed rate increases subject to review.<sup>4</sup> That information must be posted on a uniform date no later than the date specified by the Secretary in guidance. The deadline for a state with an Effective Rate Review Program to post the same information on all final rate increases (not just those subject to review) is no later than the first day of the <b>annual</b> individual market, annual open enrollment period <b>for the applicable calendar year</b>.<sup>5</sup></p> <p><b>Tip:</b> Issuers may only introduce new plans for sale through the Federally-facilitated Exchanges at the beginning of a calendar year.</p> <p><del><b>Tip:</b> An “Annual Submission” has an effective date of January 1. “Quarterly Submissions” have an effective date of April 1, July 1, or October 1.</del></p> <p>All health insurance issuers offering single risk pool products in the individual, small group, and/or <del>merged-combined</del> markets must submit the applicable parts of the RFJ via the Unified Rate Review (URR) module in HIOS.<sup>6</sup> Issuers should check the Final Bulletin regarding the <del>Revised</del> Timing of Submission and Posting of Rate Filing Justifications for the <b>2019 applicable</b> Filing Year for Single Risk Pool Coverage <del>once published</del> to determine when annual rate filings must be submitted.<sup>7</sup></p> <p><del><b>Tip:</b> An “Annual Submission” has an effective date of January 1. “Quarterly Submissions” have an effective date of April 1, July 1, or October 1.</del></p> <p>Updated web link in Footnote #7 -  <a href="https://www.cms.gov/ccio/resources/regulations-and-guidance#Review-of-Insurance-Rates">https://www.cms.gov/ccio/resources/regulations-and-guidance#Review-of-Insurance-Rates</a></p>
8	Page 11	<p><b>Under Quarterly Submissions</b></p> <p>Issuers can submit <del>an</del> RFJ for quarterly rate changes in the small group market for single risk pool plans</p> <p><del><b>Tip:</b> When submitting quarterly rate changes in the small group market,</del></p>

		<p><del>make sure you file early enough to allow for regulatory review in time to submit new rates to the SHOP.</del></p> <p>Added <b>Tip:</b> An “Annual Submission” has an effective date of January 1. “Quarterly Submissions” have an effective date of April 1, July 1, or October 1.</p> <p>Added <b>Tip:</b> When submitting quarterly rate changes in the small group market, make sure you file early enough to allow for regulatory review in time to submit new rates to the SHOP.</p>
9	Page 12	<p>Added <b>Grandmothered Plans</b></p> <p>Issuers of plans subject to the CMS non-enforcement policy<sup>2</sup> (also known as grandmothered plans) must submit a Preliminary Justification for any filing which includes a rate increase of 10% or more into the HIOS Rate Review Justification (RRJ) Module, which generally consists of Part I – Rate Increase Summary Form, Part II – Written Explanation of the Rate Increase, and Part III – Rate Filing Documentation. In states that do not have an Effective Rate Review Program, issuers are encouraged to submit the Preliminary Justification at least 60 days in advance of implementation of any rate increase which is subject to review. Instructions for submitting these types of plans can be found at: <a href="https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Rate-Review-Technical-Instructions-for-States-and-Health-Insurance-Issuers.pdf">https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Rate-Review-Technical-Instructions-for-States-and-Health-Insurance-Issuers.pdf</a>.</p>
10	Page 12	<p>The issuer can create a separate <del>plan</del> <b>product</b> with the required Essential Health Benefits (EHBs) and the “optional” benefit included.</p> <p>Updated <del>1.5</del> <b>Market Reform Rating Rules</b> to 1.4</p> <p><b>Added Tip:</b> The Index Rate is the allowed claims PMPM for providing EHBs during the applicable period.</p> <p><b>Under Index Rate</b></p> <p>The Index Rate is the allowed claims costs for providing <del>Essential Health Benefits</del> (EHBs) within the single risk pool of that market expressed on a <b>per member per month PMPM</b> basis. As a result, the Index Rate should be the SAME value for all non-grandfathered plans for an issuer in a state and market.</p>

11	Page 13	<p>Removed <b>Tip:</b> The Index Rate is the allowed claims PMPM for providing EHBs during the applicable period.</p> <p>Removed footnote <sup>5</sup> <del>For more information on excepted benefits, see 45 CFR 146.145 and 148.220</del></p>
12	14	<p>If an issuer projects members in transitional policies to migrate to a single risk pool policy, appropriate adjustments should be made in Worksheet 1 – Section II of the URRT to bring the costs associated with the transitional policies in line with projected costs of the <del>singe</del> <b>single</b> risk pool policy in the projected experience.</p> <p>Added <b>Tip:</b> The only allowable plan adjustments are found in 45 CFR 156.80(d)(2). “Other” is not an allowable plan adjustment.</p> <p>Under <b>Plan Adjusted Index Rate</b></p> <p>Only <del>Catastrophic</del> <b>catastrophic</b> plans may be adjusted for the expected impact of the special eligibility categories of these plans.</p> <p>Removed <b>Tip:</b> <del>The only allowable plan adjustments are found in 45 CFR 156.80(d)(2). “Other” is not an allowable plan adjustment.</del></p> <p>Under <b>Calibration</b> The intent of the calibration factors is to reset the PAIR so that applying the age factor, geographic rating area factor, and tobacco use factor will result in the appropriate consumer adjusted premium rate for an individual age <b>X</b>, living in rating area <b>Y</b>, with the applicable tobacco load factor applied.</p>
13	16	<p>Under <b>Fees</b>, The issuer may not, in that example, charge a <b>\$35 fee per policy for submission of the application.</b></p> <ul style="list-style-type: none"> <li>Under <b>Family Structure</b>, added <u>Family Structure</u>: Family structure takes into account family composition and the maximum of three under-age-21 child dependents. The <b>total</b> premium for family coverage is determined by summing the premiums for each individual family member. <del>provided at most.</del> With respect to family members under the age of 21, the premiums for no more than the three oldest <del>child dependents under age 21 are covered</del> <b>children must be taken into account; this in determining the total family premium.</b> This adjustment does not result in a separate rating factor. Family tiering only occurs in states that use pure community rating and <b>is uniformly applied to all plans in the risk pool</b> (tier information available at: <a href="https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating#family">https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating#family</a>).</li> </ul>

14	16	<p>Removed <del>7-Approved state-specific rating variations are published on the CCHIO website at <a href="https://www.cms.gov/CCHIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html">https://www.cms.gov/CCHIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html</a></del></p> <p>Updated with <del>Approved state-specific rating variations are published on the CCHIO website at <a href="https://www.cms.gov/CCHIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html">https://www.cms.gov/CCHIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html</a></del></p>
15	12	<p>Removed <del>1.6</del> and updated to <b>1.5</b></p> <p><b>Under Guaranteed Renewability and Uniform Modification of Coverage</b></p> <p>In the individual <del>and</del>, small group, <del>and combined</del> markets, product modifications made uniformly at the time of coverage renewal and solely pursuant to applicable federal or state requirements are considered a uniform modification of coverage if the modification is made within a reasonable time period after the imposition or modification of a federal or state requirement,</p>
16	19	<p>modification made uniformly at the time of coverage renewal in the individual<del>-or</del>, small group, <del>or combined</del> market is also considered to be a uniform modification of coverage if the resulting health insurance coverage for the product meets the following criteria:</p>
17	20	<p>Removed <del><b>Tip:</b> At least one plan must be marked as “renewing”; otherwise an issuer may be considered as having exited the market.</del></p>
18	14	<p><b>Under Part 1: Unified Rate Review Template</b>, added <del><b>Tip:</b> If copying and pasting values into the URRT, make sure pasted values are consistent with decimal place limits and formatting instructions found within the URRT cells. Do not finalize a URRT that has linked formulas in the input cells.</del></p>
19	13	<p><del>individual, small group markets. Note that if an issuer copies and pastes values into cells that exceed the correct number of decimal places for those cells, the mismatch may cause validation or submission errors resulting in either rejected submissions or requiring resubmissions at a later date., and combined markets. Issuers should verify that the data entered in the URRT is consistent with decimal place limits and instructions to avoid delays in the review process. Issuers should not finalize a URRT containing input cells with formula links, as this can cause problems with the file once it has been uploaded into HIOS. If formula links are used to bring input data into the URRT, be sure to copy and paste values in the input cells before clicking “Finalize” in the template.</del></p> <p>Removed</p>



		<del><b>Tip:</b> If copying and pasting values into the URRT, make sure pasted values are consistent with decimal place limits and formatting instructions found within the URRT cells.</del>
20	15	<p><b>Under 2.1.1 General Information Section</b></p> <p><b>Effective Date of Rate Change</b>  For example, if the small group submission revises the Index Rate for July 1, <del>2020</del> <b>2021</b> and includes a trend increase applicable on October 1, <del>2020</del> <b>2021</b>, enter July 1, <del>2020</del> <b>2021</b> as the effective date.</p>
21	22	<p><b>Under Experience Period</b></p> <p>It should be the most recently completed calendar year. <del>if not, include an explanation in the Actuarial Memorandum.</del></p> <p>The Experience Period reflects a period during which premiums were earned and claims were incurred. For example, if the Experience Period is January 1, <del>2018</del> <b>2021</b> through December 31, <del>2018</del> <b>2021</b>, the issuer may include claims payments through a date beyond the end of the Experience Period (e.g., February 28, <del>2019</del> <b>2022</b>) for claims with dates of service within the Experience Period when estimating the total claims incurred during the period.</p>
22	22	<p><b>Under Allowed Claims</b></p> <p>Consequently, allowed claims <b>should</b> include actual payments made <del>or</del> <b>and</b> estimates of <del>costs</del> <b>claims</b> incurred but not <del>yet paid</del> <b>reported</b> during the period. See the Actuarial Memorandum instructions for guidance related to incurred but not <del>paid, reported</del> claim reserve documentation</p>
23	23	<ul style="list-style-type: none"> <li>Active life reserves (policy reserves, contract reserves, contingency reserves, or any kind of reserves except traditionally defined reserves for claims incurred but not <del>paid</del> <b>reported</b>) or change in such reserves.</li> </ul> <p>Under Risk Adjustment</p> <p>Edited: <del>In some cases the risk</del> <b>Risk</b> adjustment <del>payment or charge from the Experience Period may not be final. Issuers should provide their best estimate in these cases.</del></p> <p><del>The risk adjustment amount entered may also</del> <b>account for Risk Adjustment Data</b></p>

		<p>Validation (RADV) adjustments, including default data validation charges (DDVCs) and allocations, <del>to the extent a state allows. A state may instead allow issuers to consider payments and charges related to RADV adjustments, including DDVCs and allocations, for the time period those payments and charges are collected and paid (e.g., 2017 RADV adjustments and DDVCs will be collected and distributed in the 2021 calendar year). The intent of this flexibility is to mitigate the need for issuers to build in additional margin when projecting risk adjustment transfers to account for the uncertainty of estimating RADV adjustments and DDVCs and allocations as appropriate.</del></p>
24	25	<p><b>Under Plan Design Changes:</b> Enter the assumed change in EHB allowed claims due to plan design changes.</p> <p>The change should be entered as 1 plus the total anticipated percent change in EHB allowed claims. For example, if plan design changes are expected to decrease allowed EHB claims by 3.5%, enter 0.965 in the field.</p>
25	26	<p>Added (in green)</p> <ul style="list-style-type: none"> <li>Changes brought about by State Relief and Empowerment Waivers under section 1332 of the Affordable Care Act.</li> </ul>
26	26 to 27	<p><b>Under Risk Adjustment Payment/Charge</b></p> <p><del>The risk adjustment amount entered may also account for Risk Adjustment Data Validation (RADV), including default data validation charges (DDVCs) and allocations, to the extent a state allows. A state may instead allow issuers to consider payments and charges related to RADV adjustments, including DDVCs and allocations, for the time period those payments and charges are collected and paid (e.g., 2017 RADV adjustments and DDVCs will be collected and distributed in the 2021 calendar year). The intent of this flexibility is to mitigate the need for issuers to build in additional margin when projecting risk adjustment transfers to account for the uncertainty of estimating RADV adjustments and DDVCs and allocations.</del></p> <p>Added</p> <p>As previously mentioned, risk adjustment should account for RADV adjustments, including DDVCs and allocations, as appropriate.</p>

27	28	<p><b>Section I: General Product and Plan Information</b></p> <p>All products and plans included in the single risk pool must be accounted for on Worksheet 2 of the URRT. Each non-transitional plan that will be offered for sale must have its own column in the URRT indicating if the plan is new or renewing, along with an appropriate rate change entered in the Cumulative Rate Change % (over 12 <del>mos-months</del> prior) field (Field 1.11) of the URRT.</p> <p>Moved to <b>Section I General Product and Plan Information</b></p> <p><b>Tip:</b> HIOS does not report product or plan names containing special characters. Consider spelling out name of special characters (e.g., “20Percent Coinsurance” rather than “20% Coinsurance”).</p>
28	30	<p><b>AV Metal Value:</b> For each plan, enter the corresponding AV value that results from the AV Calculator or a permissible alternative method that complies with 45 CFR 156.135(b).</p> <p>For non-single risk pool products that are reported in the Experience Period, enter zero.</p> <p>For single risk pool plans that are terminated prior to the Projection Period, enter the prior metal AV value for the plans.</p> <p>For <del>Catastrophic</del> catastrophic plans, enter an approximate AV Metal Value for the plan (e.g., 0.580). Since there is not a <del>Catastrophic</del> catastrophic continuance table within the AV Calculator, actuaries should use their best judgment in estimating the AV Metal Value.</p> <p><b>Plan Type:</b> Select the applicable plan type from the drop-down box. Valid Plan Types are Indemnity, PPO, POS, HMO or EPO.</p> <p>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 <b>Actuarial Memorandum</b>.</p>
29	31	<p><b>Exchange Plan?:</b> For each plan, select an indicator (Yes or No) from the drop-down box as to whether the plan will be offered inside a State-based-<del>or</del> Exchange (SBE), Federally-facilitated Exchange (FFE), or Small Business Health Options Program (SHOP), regardless of whether or not it will also be offered or marketed outside the Exchange.</p> <p>Moved from <b>Cumulative Rate Change % (over 12 months prior)</b> to <b>Effective Date of Proposed Rates</b></p> <p><b>Tip:</b> A Product should have only one Plan Type listed under it. A single product may not contain both HMO and PPO network types.</p>
30	32	<p>Moved <b>TIP</b> from <b>Plan Level Information</b> to <b>Submission Level Rate Increase %</b></p> <p><b>Tip:</b> Make sure information entered into the URRT is correct. Information submitted</p>

		<p>in the URRT will determine the requested rate increase shown on the CMS website.</p> <p><b>Under Plan Level Information</b></p> <p>For small group submissions, the information in this section, except where noted, should reflect the Experience Period data on Worksheet 1. For example, if the Experience Period on Worksheet 1 is calendar year <del>2018</del> 2022, the information on this section should be for calendar year <del>2018</del> 2022.</p>
31	33	<p><b>Reinsurance:</b> Enter any <del>reinsurance amount claims reimbursement received or expected to be received for each plan during the Experience Period, net of any reinsurance fees.:</del>  <del>This value is not limited to</del> through a federal <del>reinsurance program and may also include any type of reinsurance from a</del> or state reinsurance program, net of any reinsurance fees.</p> <p>Removed</p> <p><del>In some cases the risk adjustment payment or charge from the Experience Period may not be final. Issuers should provide their best estimate in these cases.</del></p> <p><del>The risk adjustment amount entered may also account for Risk Adjustment Data Validation (RADV), including default data validation charges (DDVCs) and allocations, to the extent a state allows. A state may instead allow issuers to consider payments and charges related to RADV adjustments, including DDVCs and allocations, for the time period those payments and charges are collected and paid (e.g., 2017 RADV adjustments and DDVCs will be collected and distributed in the 2021 calendar year). The intent of this flexibility is to mitigate the need for issuers to build in additional margin when projecting risk adjustment transfers to account for the uncertainty of estimating RADV adjustments and DDVCs and allocations.</del></p> <p>Added</p> <p>In some cases the risk adjustment payment or charge from the Experience Period may not be final. Issuers should provide their best estimate in these cases. As previously mentioned, risk adjustment should account for RADV adjustments, including DDVCs and allocations, as appropriate.</p>

32	34	<p>Edited sentence to read :</p> <p><b>Current Enrollment:</b> Enter a <b>snapshot of</b> the number of members currently enrolled in the plan as of a recent date. The date should be indicated in the actuarial memorandum (e.g., enrolled lives as of March 31, 20XX).</p> <p>Under <b>Loss Ratio</b> , added:</p> <p><b>Tip:</b> Current Enrollment should be a recent snapshot of enrolled lives as of a particular date in time (e.g., enrolled lives as of March 31, 20XX).</p> <p>Under <b>Benefits in Addition to EHB Added</b></p>
33	35	<p>Under <b>Benefits in Addition to EHB Added</b></p> <p>For individual market QHPs, CMS expects that “Benefits in Addition to EHB” is the multiplicative inverse of the “EHB Percent of Total Premium” field in the Plans &amp; Benefits Template when rounded to the fourth decimal point (i.e., 1 divided by “EHB Percent of Total Premium”). As part of data integrity review, CMS will identify any mismatch between “Benefits in Addition to EHB” in the URRT and the reciprocal of “EHB Percent of Total Premium” in the Plans &amp; Benefits Template and prompt you to confirm that the submitted values are correct.</p> <p>Certain benefits, including routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia should not be considered EHB, even if the State EHB Benchmark plan covers such benefits.<sup>17</sup></p> <p>A state may require a QHP to offer benefits in addition to the EHB, but the state is required to defray the cost of such state-required benefits to the enrollee or to the QHP issuer on behalf of the enrollee..<sup>18</sup> How an individual market QHP issuer should handle the portion of premium related to these services depends on whether the state makes these defrayal payments to the enrollee or to the issuer:</p> <p>In a state that defrays the cost of a state-required benefit in addition to EHB directly to the QHP issuer:</p> <ul style="list-style-type: none"> <li>• The issuer should <b>exclude</b> the amount the state will defray (or that the state will begin defraying in the plan year for which the rates apply) from the rates submitted on both the URRT and the Rates Table Template.</li> </ul>

		<ul style="list-style-type: none"> <li>• The issuer should indicate in the Actuarial Memorandum that accompanies the URRT that the issuer anticipates the state will defray to the issuer the cost of any state-required benefit that is in addition to EHB and that, therefore, the cost of the state-required benefit is not included in the issuer’s rates in the URRT. QHP issuers should provide additional detail regarding the amount the QHP issuer expects to receive from the state for defrayal of the state-required benefit.</li> <li>• The issuer <b>should not</b> factor the state-required benefit into the calculation of “Benefits in Addition to EHB” (the multiplicative inverse the “EHB Percent of Total Premium” field in the Plans &amp; Benefits Template). <ul style="list-style-type: none"> <li>○ This is because the QHP issuers should treat the state-required benefit as if it does not exist for purposes of the “EHB Percent of Total Premium” field, such that the state-required benefit is excluded from both the EHB percent of premium and the total premium from which the EHB percent of premium is calculated.</li> <li>○ However, the QHP issuer should still indicate in the Benefits Information field on the Plans and Benefits template that it covers the state-required benefit in question as a non-EHB.</li> </ul> </li> </ul> <p>In a state that defrays the cost of a state-required benefit in addition to EHB directly to the enrollee:</p> <ul style="list-style-type: none"> <li>• The QHP issuer should <b>include</b> the amount the state defrays (or that the state will begin defraying in the plan year for which the rates apply) in the rates submitted on both the URRT as well as in the Rates Table Template.</li> <li>• The QHP issuer should indicate in the Actuarial Memorandum the amount that the issuer anticipates the state will defray directly to the enrollee for the cost of any state-required benefit that is in addition to EHB.</li> <li>• The QHP issuer <b>should</b> factor the state-required benefit into the calculation of “Benefits in Addition to EHB” (the multiplicative inverse the “EHB Percent of Total Premium” field in the Plans &amp; Benefits Template). <ul style="list-style-type: none"> <li>○ This is because, although the QHP issuer should not include the state-required benefit in the EHB Percent of Total Premium on the Plans &amp; Benefits Template, it should include the cost of the state-required benefit in the total premium from which the EHB Percent of Total Premium is calculated (therefore treating it as non-EHB for purposes of the total premium).</li> <li>○ The QHP issuer should indicate in the Benefits Information field on the Plans and Benefits template that the QHP covers the state-required benefit in question as a non-EHB.</li> </ul> </li> </ul>
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34	38 & 39	<p>Under <b>Profit and Risk Load</b></p> <p>Enter the profit and risk load portion of total administrative expense as a percent of the PAIR.</p> <p>Moved</p> <p><b>Tip:</b> The age curve is not linear. Attempts to treat it as such when performing the age curve calibration will likely result in unexpected results.</p> <p>To: <b>Age Calibration Factor</b></p>
35	39	<p>Under <b>Geographic Calibration Factor</b></p> <p>Edited:</p>

		<p>The Actuarial Memorandum <del>must include a detailed description of the development of the</del> should explain how the geographic rating factors (including a description of how the methodology results in factors that reflect factor is calculated and state the rating factor only reflects differences in the costs of delivery (which can include unit cost and provider practice pattern differences <del>only, or are otherwise adjusted for</del>) and not differences in population morbidity by geographic area.</p>
36	40 & 41	<p><b>Under Projection Period Data:</b></p> <p><b>Reinsurance:</b> Enter any <del>expected net reinsurance amount to be</del> claims reimbursement received for each plan during the Projection Period.  <del>This value is not limited to the</del> through a federal reinsurance program and may also include any type of reinsurance from a or-state reinsurance program, net of any reinsurance fees.</p> <p><b>Under Risk Adjustment Transfer Amount:</b></p> <p><del>The</del>Note that the reported risk adjustment <del>amount entered may also</del> transfer amounts should account for <del>Risk Adjustment Data Validation (RADV), including default data validation charges (DDVCs) and allocations, to the extent a state allows. A state may instead allow issuers to consider payments and charges related to RADV adjustments, including DDVCs and allocations, for the time period those payments and charges are collected and paid (e.g., 2017 RADV adjustments and DDVCs will be collected and distributed in the 2021 calendar year). The intent of this flexibility is to mitigate the need for issuers to build in additional margin when projecting risk adjustment transfers to account for the uncertainty of estimating RADV adjustments and DDVCs and allocations as appropriate.</del></p> <p><b>Section 2.3 Worksheet 3 – Rating Areas</b></p> <p>Worksheet 3 captures an issuer’s rating area factors for rating areas in which the issuer offers plans. Click on the “Create Rating Areas” button, then enter the <b>total</b> number of rating areas that are in the state, regardless of the number of rating areas where coverage will actually be offered.</p>
37	42	Edited



		<p>The written statement must be <del>entered</del> uploaded in HIOS <del>via a text box in one of the accepted document types</del>. Such information posted by the issuer will be clearly displayed as the statements of the issuer. CMS will not edit the statements provided by issuers for Part II.</p> <p><del>Note HIOS can now display rich text and allow for bullet point outline formats in the description. Note characters of “&lt;”, “&gt;”, and “/” are still not allowed with the rich text upgrade.</del></p>
38	43 & 44	<p>Under Part III: <b>Actuarial Memorandum and Certification Instructions</b>  Failure to provide information on a timely basis or failure to provide accurate information slows the review process and puts the issuer at risk for missing critical deadlines to offer products and plans in the individual <del>and</del>, small group, <del>and</del> combined markets.</p> <p><b>4.1 Redacted Actuarial Memorandum</b>  As required by 45 CFR 154.215(h)(2), CMS will make available to the public the information contained in Part III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information, consistent with HHS FOIA regulations, 45 CFR 5.31(d). To facilitate release of Part III to the public, health insurance issuers must upload two versions of Part III: (1) <del>an</del> <del>un</del> a non-redacted version for CMS review (“CMS version”) and (2) a redacted version that will be made available to the public (“public version”). The CMS version should contain all data elements and information required in this manual with no redactions. The public version should redact only information that is a trade secret or confidential commercial or financial information. <b>Redacted Actuarial Memorandums will be reviewed for compliance with 45 CFR 5.31(d) to ensure that issuers are not redacting more information than is allowable according to the regulation.</b></p> <p>The HIOS system requires the Redacted Actuarial Memorandum to be uploaded to a particular field, or a box may be checked indicating CMS should use the <del>Un</del> non-redacted Actuarial Memorandum uploaded for CMS review. If an issuer selects this box, the <del>un</del> non-redacted version will appear on the HHS website (RateReview.Healthcare.gov).</p>
39	45	<p>Under <b>Allowed and Incurred Claims Incurred During the Experience Period:</b></p> <p>Separately indicate the amount of claims which were processed through the issuer's</p>

		<p>claim system, processed outside of the issuer's claims system, and the amount that represents the actuary's best estimate of claims incurred but not <b>paid reported</b> as of the Paid Through Date stated above.</p> <ul style="list-style-type: none"> <li>• Provide support for the estimate of incurred but not <b>paid reported</b> claims. <ul style="list-style-type: none"> <li>○ Describe the methodology used to develop the estimate of claims incurred but not <b>paid reported</b> for both Allowed Claims and Incurred Claims in the Experience Period. To the extent that the methodology or completion factors used to estimate incurred but not <b>paid-reported</b> claims on an allowed basis differs from the methodology or completion factors used to estimate incurred claims, describe and support why they are different.</li> <li>○ Indicate whether the claims used to develop any completion factors reflect the Experience Period claims for the information submitted or some alternate claims set, such as a larger block of the issuer's experience. If an alternate claims set was used, please provide support for why it is appropriate.</li> <li>○ If the incurred but not <b>paid-reported</b> claims are unusually high or unusually low relative to the Experience Period claims paid as of the Paid Through Date, explain what is causing them to be unusually high or unusually low (e.g., introduction of a new claims system, significant employee turnover, etc.).</li> </ul> </li> </ul>
40	49	<p><b>Under Trend Factors</b></p> <ul style="list-style-type: none"> <li>• For prescription drugs, any adjustments made to account for changes in the formulary, <b>expiration of patents, or introduction of new drugs.</b></li> </ul> <p><b>Under Risk Adjustment Payment/Charge:</b></p> <p>Added</p> <p>Under the single risk pool pricing requirements, issuers are required to make a market-wide adjustment to the pooled market-level Index Rate to account for federal risk adjustment payments and charges (including the high cost risk pool adjustment and any assessment to pay for those claims, but not risk adjustment user fees). Consistent with this adjustment, anticipated risk adjustment revenue must be allocated proportionally based on plan premiums for all plans within a risk pool by applying the risk adjustment transfer adjustment factor as a market-level adjustment. <b>As previously mentioned, reported risk adjustment payment and charge amounts should account for RADV adjustments, including DDVCs and allocations, as appropriate.</b></p> <p>Removed</p> <p><del>If a state allows and an issuer opts to consider payments and charges related to RADV adjustments, including DDVCs and allocations, the amount for the projection period and the amount for RADV adjustments should each be stated specifically.</del></p>

41	51	<del><b>Tip:</b> The only allowable plan adjustments are found in 45 CFR 156.80(d)(2). “Other” is not an allowable plan adjustment.</del>
42	52	<p><b>Under Tobacco Use Rating Factor Calibration</b> Removed</p> <p><del>The calibration adjustments are to be applied uniformly to all plans; plan specific calibration is not allowed.</del></p>
43	53	<p><b>Under AV Metal Values</b> The issuer must describe whether the plan AV Metal Values included in Worksheet 2 of the URRT <del>were entirely based on</del> calculated using only the AV Calculator or <del>whether an</del>, if any plan designs are not compatible with the AV calculator, describe the acceptable alternative methodology <del>was</del> used to generate the AV Metal Value <del>of one or more plans</del>. If an alternate methodology was <del>employed</del> used to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR 156.135. The certification must be signed by a member of the American Academy of Actuaries and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.</p> <p>The actuary must indicate the reason an alternate methodology was used, explain why the benefits for those plans for which an acceptable alternative methodology was used are not compatible with the AV Calculator, and state the chosen alternate methodology that was used for each applicable plan. <del>The actuary must describe the process that was used to develop the AV Metal Value.</del></p>
44	58	<p><b>For Table 2 HIOS Submission Statuses</b> <b>Under Record Validated – Next Step</b></p> <p><del>If all plans within the submission have rate increase is changes</del></p> <p><u>Rate increases subject to review:</u> If any plan within the submission has a rate increase that is <math>\geq 15\%</math>,</p> <p>Added footnotes This submission status also applies to SERFF submissions. In states with an Effective Rate Review Program, the applicable state regulatory authority is the regulator. In states without an Effective Rate Review program, CCIIO is the regulator. State regulators in states with an Effective Rate Review Program must notify</p>

		CCIIO when a submission passes the compliance review.
45	59 - 64	<p><b>Supplemental Materials Received</b></p> <p><b>Definition</b> - The issuer has revised a submission that was previously in the Pending Supplemental Materials status.</p> <p><b>Additional Information</b></p> <p>The issuer can revise the submission during the Materials Received phase</p> <p><b>Next Step</b></p> <p><u>The issuer must re-validate their submission.</u></p> <p><b><u>Rate Filing Accepted</u></b></p> <p><b><u>Definition</u></b></p> <p>A submission not subject to rate review has passed the compliance review, and CCIIO has checked the “Web Content Assessment” box in HIOS.</p> <p><b>Additional Information</b></p> <p>Only applicable to submissions where all plans have rate changes of &lt; 15%.</p> <p><b>Next Step</b></p> <p><u>None. This is the final status for submissions not subject to rate review.</u></p> <p><b><u>Submission Filed</u></b></p> <p><b><u>Definition</u></b></p> <p>CCIIO has checked the “Web Content Assessment” box in HIOS for a submission subject to rate review.</p> <p><b>Additional Information</b></p> <p>Only applicable to submissions that contain a plan with a rate increase of <math>\geq 15\%</math>.</p> <p><b>Next Step</b></p> <p><u>The regulator must select “Review in Progress” in the dropdown menu in HIOS and then click Save.</u></p> <p><b><u>Review in Progress</u></b></p> <p><b><u>Definition</u></b></p> <p>A submission subject to rate review is being reviewed by the regulator.</p> <p><b>Additional Information</b></p> <p>Only applicable to submissions that contain a plan with a rate increase of <math>\geq 15\%</math>.</p> <p><b>Next Step</b></p> <p><u>The regulator must enter a Final Determination of Unreasonable or Not Unreasonable in HIOS.</u></p> <p><b><u>Review Complete</u></b></p> <p><b>Definition</b></p>


		<p>The regulator has finished reviewing a submission subject to rate review and has entered a final determination of Not Unreasonable in HIOS.</p> <p><b>Additional Information</b></p> <p>Only applicable to submissions that contain a plan with a rate increase of <math>\geq 15\%</math> that have been deemed Not Unreasonable</p> <p><b>Next Step</b></p> <p><u>None. This is the final status for submissions with rate increases that are subject to rate review and have been determined by the regulator to be Not Unreasonable.</u></p> <p><b><u>Pending Final Justification</u></b></p> <p><b><u>Definition</u></b></p> <p>The regulator has finished reviewing a submission subject to rate review and has entered a final determination of Unreasonable in HIOS.</p> <p><b>Additional Information</b></p> <p>Only applicable to submissions that contain a plan with a rate increase of <math>\geq 15\%</math> that have been deemed Unreasonable.</p> <p><b>Next Step</b></p> <p><u>If the issuer decides to implement the Unreasonable rate increase, then the issuer must enter a Final Justification in HIOS.</u></p> <p><u>If the issuer decides to modify the Unreasonable rate increase, the issuer should request a submission unlock and resubmit.</u></p> <p><u>If the issuer decides not to implement the unreasonable rate increase, then the issuer should contact CCHIO to request a submission deactivation.</u></p> <p><b><u>Final Justification Comments Submitted</u></b></p> <p><b>Definition</b></p> <p>The issuer has entered a Final Justification in HIOS.</p> <p><b>Additional Information</b></p> <p>Only applicable to submissions that contain a plan with a rate increase of <math>\geq 15\%</math> that have been deemed Not Unreasonable.</p> <p><b>Next Step</b></p> <p><u>None. This is the final status for submissions with rate increases that are subject to rate review, have been determined by the regulator to be Unreasonable, and will be implemented by the issuer.</u></p> <p><b><u>Submission Failed</u></b></p> <p><b><u>Definition</u></b></p> <p>The issuer unsuccessfully attempted to create a submission in HIOS.</p> <p><b>Additional Information</b></p> <p>Submission failures occur when the issuer enters invalid data or fails to enter</p>
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		<p>required data.</p> <p><b>Next Step</b>  <u>HIOS generates an email to the issuer indicating the submission failure. The issuer should create a new submission.</u></p> <p><b>Submission Deactivated</b>  <b>Definition</b>  CCIO has deactivated the submission.</p> <p><i>Note:</i> In states with an Effective Rate Review Program, the state regulator must first contact CCIO to request the deactivation.</p> <p><b>Additional Information</b>  Only submissions with a status of Record Validated, Review Complete, or Rate Filing Accepted can be deactivated.</p> <p><b>Next Step</b>  <u>The issuer should create a new submission.</u></p> <p><b>Pending Resubmission</b>  <b>Definition</b>  State Reviewer can request resubmission which puts the submission in “Pending Resubmission” status.</p> <p><b>Additional Information</b>  Only applicable to submissions that contain a plan with a rate increase of <math>\geq 15\%</math></p> <p><b>Next Step</b>  <i>The issuer must revalidate submission and requires new content assessment by CMS.</i></p> <p><b>Pre-Validation Pending Part 2 Consumer Justification Narratives</b>  <b>Definition</b>  Issuer submitted a plan with a 15% or greater annual increase will result in HIOS identifying the product as subject to review and will require the issuer to enter a Consumer Justification Narrative for that product.</p> <p><b>Additional Information</b>  Only applicable to submissions that contain a plan with a rate increase of <math>\geq 15\%</math>.</p> <p><b>Next Step</b>  <i>The issuer must submit a Consumer Justification document on the Submit/Edit Consumer Justification Narratives section.</i></p> <p><b>Contractor Review in Progress</b>  <b>Definition</b>  CCIO has assigned a submission to a Contractor to review</p> <p><b>Additional Information</b>  Only applicable to submissions that contain a plan with a rate increase of <math>\geq 15\%</math>.</p>
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46	65	<p><del>According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1141. The time required to complete this information collection is estimated to average [21 minutes] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security</del></p> <p><b>The CCHIO and NAIC teams have built a system connection between the NAIC's System for Electronic</b></p> <p><b>Tip:</b> The new system connection is Not Applicable to States without an Effective Rate Review Program, or states that do not participate in SERFF. Issuers in these states should continue to submit filings directly into the HIOS URR module.</p> <p>Rates &amp; Forms Filing (SERFF) and CMS's Health Insurance Oversight System Unified Rate Review (HIOS URR) module. This connection allows automatic data and file transfers between the two systems to reduce duplicative manual entry work for</p>

	<p><b><u>Tip:</u></b> Grandmothered plans, student health insurance coverage, and excepted benefit products, such as stand-alone dental products, should not be submitted through the SERFF transfer system connection.</p> <p>both Issuers and State reviewers. All rate filing information for the non-grandfathered single-risk pool coverage in the individual and small group (or merged) markets will be entered directly into SERFF where there will be a new “URRT” tab. Issuers in states with an Effective Rate Review Program that participate in SERFF<sup>4</sup> are required to file the applicable plan year Rate Filing Justification for non-grandfathered single-risk pool coverage in the new URRT tab of SERFF</p>
	<p><b><u>Tip:</u></b> <del>The new system connection is Not Applicable to States without an Effective Rate Review Program, or states that do not participate in SERFF. Issuers in these states should continue to submit filings directly into the HIOS URR module.</del></p>
	<div><div>General Information</div><div>Form Schedule</div><div>Rate/Rule Schedule</div><div>Supporting Documentation</div><div>URRT</div><div>Companies and Contact</div><div>Filing Fees</div></div> <p>Once the user navigates to the URRT tab, they will be asked if URRT is applicable to the rate filing. The Unified Rate Review Template is required to be submitted by Issuers (for both QHPs and non-QHPs) for non-grandfathered single risk pool coverage in the individual or small group (or merged) market. Issuers can submit quarterly rate changes for the small group market if allowed by the State regulatory authority. Quarterly rate changes must be submitted at least 105 days prior to the effective date of the rate change (or earlier State deadline).</p> <p>Once the URRT has been uploaded, it will be automatically sent to CMS for validation and a message appears to the issuer in SERFF. Once the validation request has been processed, the message will update accordingly. If the validation is successful, SERFF will display the regenerated Excel file.</p> <p>Issuers will be required to upload the Actuarial Memorandum and Redacted Actuarial Memorandum in the URRT tab. These two files must have different file names.</p> <p>For information on states with an Effective Rate Review Program, see <a href="https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet">https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet</a>. For information on state participation in SERFF, see <a href="https://www.serff.com/serff_participation_map.htm">https://www.serff.com/serff_participation_map.htm</a></p> <p>Issuers can upload the Consumer Justification Narrative (CJN) in the URRT tab regardless of if the filing meets the threshold making it subject to review, but if the filing is above threshold, upload of the CJN becomes a requirement.</p>



		<p>An “Additional Supporting Documentation” section is available on the URRT tab in which up to 30 files can be uploaded.</p> <p>The template and supporting URR items may also have the following SERFF functions applied, but these functions will not be transferred to the URR module of HIOS:</p> <ul style="list-style-type: none"> <li>• Request Confidentiality</li> <li>• Objections/Objections Letters</li> <li>• Change Schedule Items</li> <li>• Response Letters</li> <li>• Amendment Letters</li> <li>• State Public Access</li> </ul> <p>Once the state review is complete, the state will need to close out the filing in SERFF. If the filing contains only plans below the threshold, the state regulator will mark the filing as “complete.” If the filing contains at least one plan above the threshold, the state regulator will enter a final determination. The state’s final determination and associated comments will be sent to the URR Module of HIOS and displayed on <a href="http://ratereview.healthcare.gov">ratereview.healthcare.gov</a>. Once a determination has been sent to CMS, there can be no further action on the URRT tab from the issuer or the state.</p> <p>If changes need to be made to a filing after it has been put into a final status, the state must contact a member of the Rate Review team at CCIIO to have the submission deactivated in HIOS.<sup>5</sup> The issuer must then start from scratch and create a new submission in SERFF. We strongly recommend that state regulators do not close out filings until they are certain that no further changes are necessary.</p> 
47	66	Added

		<div> <div>General Information</div> <div>Form Schedule</div> <div>Rate/Rule Schedule</div> <div>URRT</div> <div>Supporting Documentation</div> <div>State Specific</div> <div>Companies and Contact</div> </div> <div> <p><b>State URRT Review</b></p> <p>URRT Determination Not Unreasonable</p> <p>Determination Date 05/25/2021</p> <p>Determined By Hubert Franck</p> <p>Comments This is the reviewers comments about the URRT.</p> </div>
48	66	<p><b>Added</b></p> <p>A member of the rate review team at CCIIO can be reached by emailing <a href="mailto:ratereview@cms.hhs.gov">ratereview@cms.hhs.gov</a>.</p>