DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Unified Rate Review Instructions

Rate Filing Justification: Parts I, II, and III

Effective for Plan Years Starting on or after January 1, 2027

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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Contents

1. Overview

1.1 Purpose

Section 2794 of the Public Health Service Act (PHS Act) 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 & Medicaid Services (CMS). This submission is called the Rate Filing Justification (RFJ). The RFJ must include 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.

A RFJ for single risk pool plans[1] consists of the following three parts:

- **Part I** - Unified Rate Review Template (URRT): The URRT is required for all single risk pool plans in the individual, small group, and combined markets. This includes single risk pool plans that experience no rate changes, rate decreases, as well as new single risk pool plans. It is intended to capture information needed to monitor premium increases for health insurance coverage offered through and outside an Exchange and to ensure compliance with the single risk pool methodology, including allowable market-level Index Rate adjustments to reflect risk adjustment payments and charges, and other federal rating requirements.
- **Part II** - Written Description Justifying the Rate Increase (Consumer Justification Narrative): Part II is required only for rate increases in single risk pool products that are subject to review (i.e., a plan within the product has a rate increase of 15% or greater). Part II is a consumer-friendly narrative that provides justification for the rate increase, describes the relevant Part I data, explains the assumptions used to develop the rate increase, and outlines the most significant factors driving it.
- Part III - Rating Filing Documentation (Actuarial Memorandum): Part III is required for any rate increase in a single risk pool plan. It is also required for any rate filing containing Qualified Health Plans (QHPs) or whenever a state requires it to be submitted. It is required for all plans in states that do not have an Effective Rate Review Program and for which CMS is responsible for reviewing the rate filing. Part III is a memorandum that includes the actuarial reasoning and assumptions, justifications, and methodologies that support the entries in the URRT.

For questions regarding submission of rate filings, please contact the rate review inbox at ratereview@cms.hhs.gov.

1.2 Public Disclosure

CMS will publicly post the Part II written description and the information contained in Parts I and III of the RFJ that do not constitute trade secrets or confidential commercial or financial information as defined in HHS's Freedom of Information Act (FOIA) regulations.[2] The information for all single risk pool coverage proposed rate changes (regardless of whether the increase is subject to review) and all

[1] The phrases "single risk pool plan" and "single risk pool coverage" are used to describe non-grandfathered health insurance coverage in the individual or small group (or combined) market that is subject to all of the single risk pool provisions at 45 CFR 156.80.
[2] 45 CFR 5.31(d)

final rate changes will be posted at https://ratereview.healthcare.gov/ and at http://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html.

A state with an Effective Rate Review Program must post on the state's website at least the information contained in Parts I, II, and III of the RFJ that CMS makes available on its website (or provide a link to CMS's website for such information) for proposed rate increases subject to review.[3] 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 annual individual market annual open enrollment period for the applicable calendar year.[4]

1.3 General Instructions

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

Tip: Issuers may only introduce new plans for sale through the Federally-facilitated Exchanges at the beginning of a calendar year.

Annual Submissions

All health insurance issuers offering single risk pool products in the individual, small group, and/or combined markets must submit the applicable parts of the RFJ via the Unified Rate Review (URR) Submissions Page in MPMS.[5] Issuers should check the Final Bulletin regarding the Timing of Submission and Posting of Rate Filing Justifications for the applicable Filing Year for Single Risk Pool Coverage to determine when annual rate filings must be submitted.[6]

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

Quarterly Submissions

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

Issuers can submit an RFJ for quarterly rate changes in the small group market for single risk pool plans, if allowed by the state regulatory authority. The quarterly submission would contain rate changes beyond

[3] 45 CFR 154.301(b)(1)(i)
[4] 45 CFR 154.301(b)(1)(ii)
[5] For all instances in this document that refer to filing in the URR Submissions Page of MPMS, rate filing documentation that is filed through the NAIC's System for Electronic Rate & Form Filing (SERFF) and automatically uploaded to the URR Submissions Page of MPMS will be considered as filed with CMS. This filing option is not available for states that do not have an Effective Rate Review Program and states that do not participate in SERFF. For information on states with an Effective Rate Review Program, see https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet. For information on state participation in SERFF, see https://www.serff.com/serff_participation_map.htm.
[6] The Final Bulletin is available at https://www.cms.gov/cciio/resources/regulations-and-guidance#Review-of-Insurance-Rates.

any scheduled trend increases included in the annual submission for subsequent quarters in the same calendar year (i.e., second, third, and/or fourth quarters). Issuers are not allowed to file trended rates for effective dates in the subsequent calendar year. An issuer may only have one active quarterly single risk pool submission per market in MPMS.

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

Index Rates

All issuers with single risk pool plans are required to establish an Index Rate with an effective date of January 1 of each year and file it with the applicable regulatory authority. This is the annual submission described above and will be labeled as the annual filing in the URR Submissions Page of MPMS, even if it includes scheduled quarterly small-group trend increases. Subject to state requirements, small group issuers may file subsequent submissions that reset the Index Rate, market-level adjustments, or plan-level adjustments for the remaining quarters of the calendar year. These are the quarterly submissions described above. The Index Rate in the quarterly filings should only reflect remaining quarterly effective dates in the same calendar year (i.e., rates for groups with effective dates in the subsequent calendar year should not be included).

Dental Plans

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

Grandmothered Plans

Issuers of plans subject to the CMS non-enforcement policy[7] (also known as grandmothered plans) must submit a Preliminary Justification for any filing that includes a rate increase of 10% or more into the Health Insurance Oversight System (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 implementing any rate increase subject to review. Instructions for submitting these types of plans can be found at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Rate-Review-Technical-Instructions-for-States-and-Health-Insurance-Issuers.pdf.

[7] Health insurance issuers are required to submit rate filings for coverage that has been renewed under CMS's non-enforcement policy continually since 2014. See Bulletin: Extension of Limited Non-Enforcement Policy through 2023 and Later Benefit Years (March 23, 2022), available at:

Optional Benefits

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

1. The issuer can create a separate product with the required Essential Health Benefits (EHBs) and the "optional" benefit included.
2. The issuer can offer the "optional" benefit as a separate policy in a manner that satisfies the definition of one of the categories of excepted benefits.[8]

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

1.4 Market Reform Rating Rules

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

Single Risk Pool

The single risk pool, as specified in 45 CFR 156.80(a-c), includes ALL non-grandfathered covered persons (lives) an issuer has in a state, within a market (individual, small group, or combined). This includes information on transitional products/plans. However, for reporting purposes and the build-up of the projected Index Rate, an issuer should list only transitional plan experience that actually affects the projected Index Rate. In other words, an issuer is not required to include transitional plan experience from the Experience Period; it is only required to back out that experience when calculating the projected Index Rate. The Projection Period should reflect the experience of transitional policies to the extent that the issuer anticipates the members of those policies will be enrolled in single risk pool plans during the Projection Period.

Index Rate

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

The Index Rate is the allowed claims costs for providing EHBs within the single risk pool of that market, expressed on a PMPM basis. As a result, the Index Rate should be the SAME value for all non-grandfathered plans for an issuer in a state and market. This includes claims and enrollment for transitional products/plans in the Experience Period and in the Projection Period to the extent the issuer anticipates the members in those policies will be enrolled in single risk pool plans during the Projection Period.

If an issuer projects members in transitional policies to migrate to a single risk pool policy, appropriate adjustments should be made in Worksheet 1 – Section II of the URRT to align the costs associated with the transitional policies with the projected costs of the single risk pool policy in the projected experience. Projected member experience should reflect when those members are expected to enter a single risk pool

https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.

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

plan. For example, transitional plan members expected to enroll in a single risk pool plan in October would contribute three months of projected experience.

Market-Wide Adjusted Index Rate

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

Plan Adjusted Index Rate

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

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

- Actuarial value and cost-sharing design of the plan.
- CSR load factor, to account for CSR amounts provided to eligible enrollees if permitted by the applicable State authority, provided the issuer does not otherwise receive reimbursement for such amounts.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- Benefits provided under the plan that are in addition to EHBs.
- Administrative costs, excluding Exchange user fees (which are already accounted for in the MAIR).
- Only catastrophic plans may be adjusted for the expected impact of the special eligibility categories of these plans. If an adjustment is made to catastrophic plans, this adjustment may not be recovered elsewhere in the rating process, as that would be seen as removing the catastrophic plan experience from the single risk pool.

Other adjustments not specified in 45 CFR 156.80(d)(2) are not allowed at this point in the development.

Calibration

The PAIR must be calibrated for plans within the single risk pool to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco use rating factor of 1.0.[9] 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 results in the appropriate consumer-adjusted premium rate for an individual age X living in rating area Y, with the applicable tobacco load factor applied.

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

[9] 45 CFR 156.80(d)(3)

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

Fees

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 to the Index Rate at the market level as instructed by 45 CFR 156.80(d). All other fees must be included in the development of the PAIR before applying member-level rating factors, such as age factors. No additional fees may be charged outside of the development of the PAIR. For example, if it costs an issuer $35 to process an application, that cost must be included in the premium rate development for all policies (new issues and renewals) and be subject to member-level rating factors such as age, geographic rating, and tobacco use factors. The issuer may not, in that example, charge a $35 fee per policy for submission of the application.

Consumer Adjusted Premium Rate

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group after applying the rating and premium adjustments under the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the PAIR to the age curve as described above, calibrating for geography and tobacco use if necessary, and applying the allowable rating factors.[10] Allowable rating factors, found in 45 CFR 147.102(a), are as follows:

- Family Structure: Family structure takes into account family composition and a maximum of three under-age-21 child dependents. The total premium for family coverage is determined by summing the premiums for each individual family. For family members under 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium. This adjustment does not result in a separate rating factor. Family tiering only occurs in states that use pure community rating and is uniformly applied to all plans in the risk pool (tier information available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating#family).
- Rating Area: Geographic rating areas are specific to each state, and all issuers in the state are required to follow them. Issuers may set only one rating factor per rating area, per state, per market, and that factor must apply uniformly to all plans the issuer has in that rating area. If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have a separate plan for each network in the rating area. Geographic factors should reflect only differences in delivery costs (including unit costs and provider practice patterns). Geographic factors may not reflect differences in morbidity by region. State-specific geographic rating areas are available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.

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

- Age Factor: Once the PAIR is calibrated to a 1.0 value on the age curve, the full set of age rates is determined using the standard age factor of each age. The age factors must be the standard age curve set by HHS or a state-specific age curve (if the state requires age factors different from the standard federal age curve).[11]
- Tobacco Use: A tobacco use surcharge (limited to 50% of the Consumer Adjusted Premium Rate) may be applied to individuals who may legally use tobacco under federal and state law.

The following graphic depicts the flow of the Index Rate development process:

Figure 1 Flow of the Index Rate development process

1.5 Guaranteed Renewability and Uniform Modification of Coverage

Issuers should review 45 CFR 147.106(e), 146.152(d) and (f), 148.122(e), and 144.103 when determining if a product or plan is considered to be the same product or plan for rate review purposes. Note that changing the HIOS Product or Plan ID does not necessarily result in the product or plan being considered new for rate review purposes.

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

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

- The product is offered by the same health insurance issuer or a member of the issuer's controlled group.
- The product network type remains the same, for example, a health maintenance organization remains a health maintenance organization, or a preferred provider organization remains a preferred provider organization.
- The product continues to cover the majority of the same service area.
- Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level.

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

- The product provides the same covered benefits (i.e., covered items and services), except for changes in benefits that cumulatively impact the PAIR for any plan within the product within an allowable variation of ±2 percentage points (not including changes pursuant to applicable federal or state requirements).

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

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

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

Issuers that replace an entire portfolio of products in a market with new products may also avoid a 5-year ban under the market withdrawal provision provided the issuer reasonably identifies which newly offered product (or products) is replacing the discontinued product (or products) and subjects the new product (or products) to the federal rate review process, where the process is otherwise applicable to the type of product and market. An issuer's identification of which new product replaces which discontinued product will be considered reasonable if it reflects the issuer's expectations regarding a significant transfer of enrollment from one product to the other (for example, because the products have been cross-walked for that purpose). Issuers should identify which new product replaces which discontinued product in the actuarial memorandum. See *2.2.1 Section I: General Product and Plan Information* for instructions on how to reflect this crosswalk in the URRT. This provides issuers with a way to completely revise their product portfolio without triggering a 5-year ban, provided they are not revising all their products simply to avoid rate review. Issuers that do not adhere to these conditions will be considered to have exited a market and subject to the 5-year ban on market re-entry.

2. Part I: Unified Rate Review Template

Tip: If copying and pasting values into the URRT, make sure pasted values are consistent with decimal place limits and formatting instructions found within the URRT cells. Do not finalize a URRT that has linked formulas in the input cells.

The Unified Rate Review Template (URRT) is intended to help regulators review rates for single risk pool plans for compliance with the Affordable Care Act and determine whether proposed rate increases subject to review are unreasonable. The URRT also collects data from issuers so that CMS can fulfill its duty to monitor premium increases inside and outside of the Exchanges. This includes single risk pool plans that experience no rate changes, rate decreases, as well as rates for new single risk pool plans. The 'Submission Level Rate Increase %' and 'Product Rate Increase %' on Worksheet 2 of the URRT will display on the CMS website, regardless of the size of the change. If a plan within a product has a rate increase of 15 percent or greater (i.e., the product is subject to review), MPMS will require the issuer to enter a written justification for the rate increase. The written justification will also be displayed on the CMS website.

It is critically important that issuers provide accurate and complete information in the URRT. Failure to provide accurate information in the first submission increases the likelihood that state or federal regulators will need to request additional information. Issuers must respond promptly to all questions from the applicable regulator(s). Failure to provide information on a timely basis or failure to provide accurate information slows the review process. It puts issuers at risk for missing critical deadlines to offer products and plans in the individual, small group, 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 after it is uploaded to MPMS. 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.

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

2.1 Worksheet 1 – Market Experience

The purpose of Worksheet 1 of the URRT is to capture information at the market level for non-grandfathered individual and small group (or combined) products, consistent with the requirement to set premium rates using a single risk pool, as defined in 45 CFR 156.80. The worksheet is not intended to prescribe a rate development methodology. Instead, the worksheet captures Experience Period data and key assumptions consistent with those used in developing the MAIR. There are three sections in this worksheet.

1. General Information Section: Captures information about the issuer, state, and the health insurance market to which the proposed rate changes will apply.[12] This information is displayed on Worksheets 1 and 2 of the URRT.
2. Section I (Experience Period Data): Captures summarized historical financial and enrollment information from a recent historical Experience Period.
3. Section II (Projections): Captures projections for factors such as trend, demographics, changes in plan design, and other information for the upcoming plan year.

2.1.1 General Information Section

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

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

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 its allowable markets (i.e., if a state requires issuers to merge the individual and small group markets into a single risk pool with the same plan options, the issuer must choose "Combined").

Effective Date of Rate Change(s): The effective date for the submitted rates. This field is automatically populated based on the latest "Effective Date of Proposed Rates" entered in Row 19 of Worksheet 2. All new and renewing products and plans must have the same effective date.

If the submission is for the individual or combined markets, the effective date must be January 1 of the year for which rates are being submitted. If the submission is for the small group market, enter the effective date for which the Index Rate is being revised. For example, if the small group submission revises the Index Rate for July 1, 2021, and includes a trend increase applicable on October 1, 2021, enter July 1, 2021, as the effective date.

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

2.1.2 Section I: Experience Period Data

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

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

The Experience Period must be twelve months. 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. Therefore, the first date of the Experience Period must be January 1. For small group market submissions, the Experience Period must begin on the first day of the calendar quarter (i.e., January 1, April 1, July 1, or October 1).

The Experience Period reflects a period during which premiums were earned and claims were incurred. For example, if the Experience Period is January 1, 2021, through December 31, 2021, the issuer may include claims payments through a date beyond the end of the Experience Period (e.g., February 28, 2022) for claims with dates of service within the Experience Period when estimating the total claims incurred during the period. The paid-through date is not captured in the template but is requested in the Actuarial Memorandum.

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, cost-sharing paid by HHS on behalf of low-income members, and net payments from any federal or state reinsurance arrangement or program. Consequently, allowed claims should include actual payments made and estimates of claims incurred but not reported during the period. See the Actuarial Memorandum instructions for guidance related to incurred but not reported claim reserve documentation. Allowed Claims also include claims not tied to a specific date of service, such as capitation or risk-sharing payments, provided the services were rendered during the Experience Period. They include claims for both EHBs and non-EHBs. This would not include the amount of billed charges the member must pay in excess of the issuer's contractual allowed amount (often described as "balance billing").

By definition, "Allowed Claims" do not include:

- Ineligible claims, such as duplicate claims, third-party liabilities (e.g., coordination of benefits claims), and any other claims that are denied under the policy terms.

- Payments for services other than medical care provided (e.g., medical management, quality improvement, and fraud detection and recovery expenses), even if these amounts are included in claims for Medical Loss Ratio (MLR) reporting purposes.
- Active life reserves (policy reserves, contract reserves, contingency reserves, or any reserves except traditionally defined reserves for claims incurred but not reported) or change in such reserves.
- Charges or payments from the federal risk adjustment program.

Reinsurance: Enter any claims reimbursement received through a federal or state reinsurance program, net of any reinsurance fees.

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

Incurred claims are defined as Allowed Claims (defined above) less member cost-sharing, cost-sharing paid by HHS on behalf of low-income members, as well as any net payments from a federal or state reinsurance arrangement. Incurred claims include claims for EHBs and non-EHBs.

Member cost sharing is defined as payments made by the member against the Allowed Claims for health care services (e.g., deductibles, 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").

Risk Adjustment: Enter the transfer payments or charges from the federal risk adjustment program.

Transfer amounts should include the high-cost risk pool adjustment to claims and any assessment to pay for those claims. The risk adjustment user fee should not be included here; rather, it should be included in the taxes and fees portion of administrative costs. Payments made to an issuer from the risk adjustment program should be entered as a positive amount, while charges assessed to an issuer should be entered as a negative amount.

Risk adjustment should account for Risk Adjustment Data Validation (RADV) adjustments, including default data validation charges (DDVCs) and allocations, as appropriate.

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.

Experience Period Premium: Enter the amount of premium earned during the Experience Period.

This should be the premium earned and should not reflect any MLR rebates.

Experience Period Member Months: This number is automatically calculated from Worksheet 2 and should reflect the total number of member months from the Experience Period.

2.1.3 Section II: Projections

The section begins with the Index Rate of the Experience Period, broken out by benefit category, and applies trend and other adjustments to arrive at the MAIR. The information entered here should represent the actuary's best estimate.

2.1.3.1 Benefit Category and Manual Rate

Several fields listed below require issuers to enter data by Benefit Category. The preferred definitions for each Benefit Category follow:

- ***Inpatient Hospital:*** Includes non-capitated facility services for medical, surgical, maternity, mental health, and substance abuse disorder, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- ***Outpatient Hospital:*** Includes non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.
- ***Professional:*** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- ***Other Medical:*** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services.
- ***Capitation:*** Includes all services provided under one or more capitated arrangements.
- ***Prescription Drug:*** Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

Experience Period Index Rate PMPM: The Index Rate from the Experience Period should be broken out by the benefit categories listed above.

The Index Rate is the average allowed claims PMPM for providing EHBs within the state market's single risk pool. It is the legal-entity-specific rate for the market being submitted (i.e., the issuer's individual, small group, or combined market). It is the Allowed Claims PMPM for EHBs only.

Year 1 and Year 2 Trend: The Experience Period Index Rate should be trended forward to the Projection Period by benefit category. The trend should be broken out between cost and utilization.

The Experience Period Index Rate is multiplied by the cost and utilization trend factors for years 1 and 2. Trend should be entered as one plus the trend amount (e.g., a 3.5% cost trend for Year 1 should be entered as 1.035). For quarterly small group filings, the terms "Year 1" and "Year 2" are used loosely. Depending upon the Experience Period and Projection Period used, Years 1 and 2 might not cover a 12-month period. The trend rates entered should be the applicable trend that takes the Experience Period Index Rate to the MAIR for the effective date of the filing. For example, if an issuer were to file a third quarter rate increase, the trends entered should lead to a projected Index Rate and MAIR for July 1. Once the permitted plan-level adjustments and calibrations are applied, the Calibrated Plan Adjustment Index Rate should be the effective base rate for July 1. Applying the appropriate age, rating area, and tobacco use factors should generate consumer premium rates effective July 1. The trend calculation should be explained in the actuarial memorandum.

Trended EHB Allowed Claims PMPM: This is automatically calculated in the spreadsheet by applying Years 1 and 2 cost and utilization trends to the Experience Period Index Rate PMPM.

2.1.3.2 Adjustments to EHB Allowed Claims PMPM

Morbidity Adjustment: 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 that will occur under the circumstances where all demographic (e.g., age, gender, and region) and product mix, and 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.

Some of the adjustments issuers might include are:

- Take-up rate of the uninsured (the percent of currently uninsured that purchase coverage during the Projection Period)
- Health status of newly insured
- Induced demand of newly insured
- Pent-up demand of newly insured
- Subsidy effects

A description of the methodology used to develop the adjustment must be included in the actuarial memorandum.

Demographic Shift: Enter the assumed change in allowed claims due to demographic shifts of the covered population from the Experience Period to the Projection Period. Demographics may include things such as age, gender, and geographic area changes in the population.

Similar to the morbidity adjustment, the change in demographics should be entered as 1 plus the total anticipated percent change in allowed claims related to demographic changes from the Experience Period to the Projection Period.

The methodology used to develop the adjustment must be included in the actuarial memorandum.

Plan Design Changes: Enter the assumed change in EHB allowed claims due to plan design changes.

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.

Other: Enter the assumed change in cost related to things other than a change in Morbidity, Demographic Shift, or Plan Design Changes.

The "Other" change must be entered as 1 plus the total anticipated percent change in EHB allowed claims from the Experience Period to the Projection Period.

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

- Legislative changes affecting the market.
- Changes brought about by State Relief and Empowerment Waivers under section 1332 of the Affordable Care Act.

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

Adjusted Trended EHB Allowed Claims PMPM for MM/DD/YYYY: This is automatically calculated in the spreadsheet by applying the morbidity adjustment, demographic shift, plan design changes, and other adjustments to the Total Trended EHB Allowed Claims PMPM.

Manual EHB Allowed Claims PMPM: In cases where the issuer's experience is not credible, a manual rate for EHB allowed claims can be entered here. An explanation of how the manual rate was developed should be included in the actuarial memorandum if an issuer uses a manual rate.

Applied Credibility %: Enter the credibility percentage that should be applied to the Trended EHB Allowed Claims PMPM. For fully credible experience, enter 100% in this field.

2.1.3.3 Adjustments to the Projected Index Rate

Projected Index Rate for MM/DD/YYYY: This field is automatically calculated in the URRT by weighting the Adjusted Trended EHB Allowed Claims PMPM and Manual EHB Allowed Claims PMPM by the Applied Credibility % entered above.

This should be the projected Index Rate, which is the Allowed Claims PMPM for EHBs only.

Reinsurance: Enter any expected net reinsurance recoverables received through a state or federal reinsurance program here on an allowed amount PMPM basis. Since the Projected Index Rate represents EHB-allowed claims, the reinsurance amount entered here should be grossed up by the paid-to-allowed average factor.

While state reinsurance payments are not identified as an allowable adjustment to the Index Rate in 45 CFR 156.80, this is an appropriate place to enter reinsurance amounts for reporting purposes. Amounts an issuer receives as reinsurance payments should be entered as a positive number. For example, if an issuer expects to receive $10.75 PMPM in net reinsurance payments on an allowed basis, then $10.75 should be entered in this field.

Risk Adjustment Payment/Charge: Enter the projected PMPM amount of risk adjustment transfers for the Projection Period. The value should reflect the actual PMPM amounts expected in the Projection Period. However, the net risk adjustment transfer amount applied in the calculation of the MAIR should be grossed up by the paid-to-allowed average factor as the Index Rate and MAIR reflect claim costs on an allowed basis.

Transfer amounts should include the high-cost risk pool adjustment to claims and any assessment to pay for those claims. The risk adjustment user fee should not be included here; rather, it should be included in the taxes and fees portion of administrative costs. If the issuer expects to receive a projected risk adjustment payment, then the entry should be a positive value. If the issuer expects to owe a projected risk adjustment charge, the entry should be negative.

As previously mentioned, risk adjustment should account for RADV adjustments, including DDVCs and allocations, as appropriate.

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

Exchange User Fees: Enter the expected exchange user fees as a percentage charge.

Remember, we are dealing with claims on an allowed basis at this point. A description of the process the issuer used to calculate the adjustment should be provided, along with a narrative that demonstrates that the Exchange user fees are applied as an adjustment to the Index Rate at the market level. The value should reflect the expected mix of Exchange and non-Exchange enrollees.

Market Adjusted Index Rate: The template calculates a MAIR by subtracting the amounts entered for reinsurance and risk adjustment (so a negative risk adjustment entry increases the MAIR) and dividing by 1 minus the exchange user fee percentage.

The MAIR calculation is carried forward to Worksheet 2, where the allowable plan adjustment factors are applied to determine the PAIR. For annual filings, this should be the Index Rate that applies for the first quarter. For quarterly small group filings, the Index Rate should represent the Index Rate applicable to the initial quarter being changed. For instance, a small group rate filing applicable to the third and fourth quarter rates should reflect the third quarter Index Rate.

Projected Member Months: This field is automatically pulled from Worksheet 2.

Section 2.2 Worksheet 2 – Plan Product Information

The purpose of Worksheet 2 is to capture information at the product and plan level. The worksheet captures information on Experience Period data, Plan Adjustment Factors, Projection Period data, and other information for each product or plan. There are four sections in this worksheet.

- Section I (General Product and Plan Information) captures information about each product and plan. This includes general information, such as the plan and product IDs, as well as more specific details, such as the effective date, Actuarial Value (AV), and rate change.
- Section II (Experience Period and Current Plan Level Information) captures current and historical information, such as premium and claims, in a more detailed manner than in Worksheet 1. Information related to risk adjustment transfer charges and payments, reinsurance, and current membership is also collected.
- Section III (Plan Adjustment Factors) collects the allowable plan level adjustments found in 45 CFR 156.80(d)(2) and the calibration factors discussed in 45 CFR 156.80(d)(3).
- Section IV (Projected Plan Level Information) captures similar information collected in Section II, for the Projection Period.

2.2.1 Section I: General Product and Plan Information

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 whether the plan is new or renewing, along with an appropriate rate change entered in the Cumulative Rate Change % (over 12 months prior) field (Field 1.11) of the URRT. Each plan offered in the experience period, but terminated prior to the effective date of the filing, should also have its own column indicating that the plan will be terminated. Transitional plan experience included in Worksheet 2 may be combined and entered under a single plan. Terminated plans should have Experience Period information entered in Section II of the URRT, but Sections III and IV will be populated with 0. Issuers that replace an entire portfolio of products in a market with new products may avoid a five (5)-year ban if each terminated plan is cross-walked to a newly offered plan. To do so, each "new plan" and "terminated plan" must each have their own column in the URRT. Select "renewing" as the Plan Category for the "new plan" because it must be treated as the "renewing" terminated plan, rather than a truly new plan, for rate review purposes. Enter the "terminating plan's" current enrollment and current premium Per Member Per Month (PMPM) in the "new plan's" (marked as "renewing") column rather than in the "terminating plan's" column. Enter "0" for the current enrollment and current premium PMPM in the "terminating plan's" column.

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

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

Tip: The product name in the URRT must match the name in HIOS.

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 must be identified in Worksheet 2 of the template.

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

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

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

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

Generally, if a plan is the "same plan" as the previous year, it should maintain the same HIOS Standard Component (plan) ID. There are exceptions to this, such as when a plan changes metal tiers from one plan year to the next. Even though this plan may be defined as the same plan under 45 CFR 144.103, risk adjustment reporting requires this plan to receive a new Plan ID. Note that in this situation, an issuer should still identify the plan as "renewing" even though it has a new Plan ID.

Metal: For each plan within a product, choose the corresponding metal level from the drop-down menu in the template. Plans included in a QHP certification application must match the Metal shown in the QHP application.

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

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

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

Table 1: Metal Level

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

*Catastrophic level – a plan offered in the individual market only that is available only to individuals who are below the age of 30 before the beginning of the plan year, over 30 and don't qualify for savings on a Marketplace plan, or others who qualify for a hardship exemption or affordability exemption.[13]

For single-risk pool plans terminated before the Projection Period, enter the plan's metal level just before termination.

The "Not Applicable" selection should be made in the case of non-single risk pool products or plans that are reported in the Experience Period.

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

For non-single risk pool products that are reported in the Experience Period, enter zero.

For single-risk pool plans terminated before the Projection Period, enter the prior metal AV value for each plan.

[13] https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans/

For catastrophic plans, enter an approximate AV Metal Value for the plan (e.g., 0.580). Since there is no catastrophic continuance table within the AV Calculator, actuaries should use their best judgment in estimating the AV Metal Value.

Plan Category: Use the dropdown box to identify plans as New, Renewing, or Terminated.

Remember, selecting "Renewing" for a plan with an annual increase of 15% or greater will result in MPMS identifying the product as subject to review and requiring the issuer to enter a Consumer Justification Narrative for that product.

An existing issuer must have at least one "Renewing" plan; otherwise, the issuer may be considered to have exited the market. Revisit Section 1.6 above for more information.

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

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

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

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

Exchange Plan?: 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 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. If an application for QHP status is pending, enter "Yes." This indicator should not be used to identify whether a plan is offered on a private Exchange. If you indicate "Yes" for a plan offering full EHB, the plan will automatically be considered as available on and off the Exchange, due to guaranteed availability. Exchange issuers are required to make all full EHB plans available upon request from consumers who meet the guaranteed availability and EHB requirements but are not required to market or actively sell Exchange plans outside the Exchange.

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

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

All non-terminating products and plans must have the same effective date.

If the submission is for the small group market, enter the effective date on which the products' rates will change due to the Index Rate being revised. For example, if the small group quarterly submission revises the Index Rate for July 1, 2020, effective date, and includes a trend increase applicable on October 1, 2020, enter July 1, 2020.

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

This should be measured as the change in premium rates tables over the 12 month prior rate table, using the plan's current distribution of enrollment by age, geographic area, and tobacco status. For small group quarterly rate filings, this should reflect the weighted rate change across all remaining quarters in the year.

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

Issuers should enter 0% in this field for terminating plans.

Tip: Make sure information entered into the URRT is correct. Information submitted in the URRT will determine the requested rate increase shown on the CMS website.

Product Rate Increase %: The template calculates the average rate increase for each product by weighting the Cumulative Rate Change Percent (over the 12 months prior) for each renewing plan within the product, using Current Enrollment and the Current Premium PMPM.

If a plan is identified as New or Terminated in the Plan Category field or has a Metal designation of "Not Applicable," that plan's Cumulative Rate Change will not be counted toward the Product Rate Increase Percent. This is the product rate change that will appear when proposed and final rate changes (regardless of whether the increase is subject to review) are released at https://ratereview.healthcare.gov/.

Submission Level Rate Increase %: The template calculates the submission-level rate increase by weighting each renewing plan in the submission using Current Enrollment and the Current Premium PMPM.

Similar to the Product Rate Increase % above, if a plan is identified as New or Terminated in the Plan Category field or has a Metal designation of "Not Applicable," that plan's Cumulative Rate Change will not be counted toward the Submission Level Rate Increase Percent.

This is the submission level rate increase that will appear when proposed and final rate changes (regardless of whether the increase is subject to review) are released at https://ratereview.healthcare.gov/. Rate changes of zero will not be posted.

2.2.2 Section II: Experience Period and Current Plan Level Information

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

For small group submissions, the information in this section, except where noted, should reflect the Experience Period data on Worksheet 1. For example, if the Experience Period on Worksheet 1 is calendar year 2022, the information in this section should be for calendar year 2022.

2.2.2.1 Experience Period and Current Data

Issuers enter data for the Experience Period as well as current enrollment and premium in this section. The experience period entries are then used to calculate a loss ratio and PMPM amounts.

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

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

Reinsurance: Enter any claims reimbursement received through a federal or state reinsurance program, net of any reinsurance fees.

If the reinsurance recoveries during the Experience Period are not available at the time of the filing, issuers should enter their best estimate of the expected recoveries.

Member Cost Sharing: Enter any cost sharing (i.e., deductible, coinsurance, copayments) paid by the members. This should not include any cost sharing paid on behalf of the member through federal cost-sharing reductions.

Federal Cost-Sharing Reduction (CSR) Payments: Enter cost sharing paid by the federal government on behalf of members eligible for federal cost-sharing reduction subsidies.

If the federal government does not pay cost-sharing reduction subsidies, the amount entered here should be $0.

Issuer CSR Payments: Enter cost sharing paid by the issuer on behalf of members eligible for federal cost-sharing reduction subsidies for which the issuer does not otherwise receive reimbursement as a positive value. Note the amount entered here does not affect the incurred claims calculation in line 2.8.

To calculate Issuer CSR Payments:

- Determine the value of cost-sharing reductions provided for each enrollee using the CMS standard methodology..[14]
- Subtract CSRs reimbursed by other entities, such as payments from state-based subsidy programs.

Recoveries from CSR Load: Enter additional revenue collected as a result of CSR loading. This applies only to issuers that made permitted plan-level adjustments to account for CSR amounts provided to eligible enrollees for which the issuer does not otherwise receive reimbursement.

To calculate CSR Load Recoveries,

- Divide the experience period premium revenue by the CSR load factor applied when developing rates for the experience period benefit year.
- Subtract that amount from the experience period premium revenue.

CMS acknowledges this methodology may need to be adjusted to obtain a more precise estimate of CSR recoveries.

Incurred Claims: This is a calculated field that displays the incurred claims that the issuer is responsible for paying.

[14] See Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2017 (March 29, 2018) at https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/final-csr-reconciliation-guidance-by2017.pdf.

This field is automatically calculated by subtracting reinsurance, member cost sharing, and federal CSR payments from allowed claims. Please check to make sure this amount reflects the incurred claims that are the issuer's responsibility.

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

Transfer amounts should include the high-cost risk pool adjustment to claims and any assessment to pay for those claims. The risk adjustment user fee should not be included here; rather, it should be included in the taxes and fees portion of administrative costs. Payments made to an issuer from the risk adjustment program should be entered as a positive amount, while charges assessed to an issuer should be entered as a negative amount.

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.

Premium: Enter the total premium earned in the Experience Period for each plan. See the instructions for Worksheet 1 for the definition of Experience Period Premium.

Experience Period Member Months: Enter the total number of months of coverage during the Experience Period for all members that had single risk pool 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, and counting the member month if the member is active on the 15th of the month.

Current Enrollment: Enter a snapshot of 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).

Depending upon when the filing is due and the data available to an issuer at that time, we recognize that the date of current enrollment will vary by issuer. Some states may wish to establish a uniform date for issuers to use when reporting current enrollment.

Current Premium PMPM: Enter the current premium PMPM amount for each plan. This should reflect the current population enrolled in the plan.

For small group quarterly rate filings, this should reflect the current premium of members affected by the rate filing. If the filing were effective October 1, the current premium would reflect the current premium for groups that will be renewing in the fourth quarter.

As with the current enrollment, the date used should be indicated in the actuarial memorandum. Again, some states may wish to establish a uniform date issuers should use.

Loss Ratio: This is a calculated field in the template that divides incurred claims by premium plus the risk adjustment transfer amount. This is not the federal MLR for determining rebates.

2.2.2.2 Per Member Per Month (PMPM) Calculations

This section of Worksheet 2 automatically calculates PMPM amounts for many of the Experience Period Data fields described above. Issuers should check the calculated PMPM amounts for reasonability, as an odd PMPM could indicate a data entry error.

Allowed Claims: This is a PMPM amount calculated by dividing allowed claims by Experience Period member months.

Reinsurance: This is a PMPM amount calculated by dividing reinsurance amounts by Experience Period member months.

Member Cost Sharing: This is a PMPM amount calculated by dividing member cost-sharing amounts by Experience Period member months.

Federal CSR Payments: This is a PMPM amount calculated by dividing federal CSR payments by Experience Period member months.

Issuer CSR Payments: This is a PMPM amount calculated by dividing Issuer CSR Payments by Experience Period member months.

Recoveries from CSR Load: This is a PMPM amount calculated by dividing CSR load recoveries by Experience Period member months.

Incurred Claims: This is a PMPM amount calculated by dividing incurred claim amounts by Experience Period member months.

Risk Adjustment Transfer Amount: This is a PMPM amount calculated by dividing risk adjustment amounts by Experience Period member months.

Premium: This is a PMPM amount calculated by dividing premium amounts by Experience Period member months.

2.2.3 Section III: Plan Adjustment Factors

The Plan Adjustment Factor section pulls the MAIR rate for the Projection Period from Worksheet 1 and applies the permitted plan-level adjustments to the Index Rate[15] to calculate the PAIR. This section also collects the allowable calibration factors[16] to calculate a Calibrated Plan Adjusted Index Rate. The Calibrated Plan Adjusted Index Rate can be thought of as a base rate where an individual's premium could be calculated by applying the appropriate age rating factor, geographic rating factor, and tobacco use rating factor.

AV and Cost-Sharing Design of Plan: Enter the allowable adjustment to the MAIR accounting for the actuarial value and cost-sharing design of the plan. Do not include CSR-loading adjustments; enter those amounts in the CSR Load Factor line item instead.

> This factor should not include adjustments that take into account the morbidity of the population expected to enroll in the plan.

[15] 45 CFR 156.80(d)(2)
[16] 45 CFR 156.80(d)(3)

CSR Load Factor: Enter the allowable adjustment for CSR amounts provided to eligible enrollees for which the issuer does not otherwise receive reimbursement. For example, if an issuer determines a 16% load to its silver plan is appropriate to recover unpaid CSRs, enter 1.16 in this field for the applicable silver plan.

Enter 1.0 for plans for which no CSR load adjustment is made.

Provider Network Adjustment: Enter the allowable adjustment to account for a plan's provider network, delivery system characteristics, and utilization management practices.

This factor should reflect only differences between the plan's network characteristics and the average network characteristics of all plans. The weighted average of the network factors for all plans should be 1.0.

Benefits in Addition to EHB: Enter the adjustment to the MAIR accounting for the benefits the plan offers in addition to EHBs.

As the MAIR reflects only allowed claims for EHBs, this adjustment accounts for benefits provided in addition to EHBs. 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 & Benefits Template when rounded to the fourth decimal point (i.e., 1 divided by "EHB Percent of Total Premium"). As part of the data integrity review, CMS will identify any mismatch between "Benefits in Addition to EHB" in the URRT and the reciprocal "EHB Percent of Total Premium" in the Plans & Benefits Template and prompt you to confirm that the submitted values are correct.

Certain benefits, including routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, and specified sex-trait modification procedures (as defined at 45 CFR 156.400) should not be considered EHB, even if the State EHB Benchmark plan covers such benefits.[17]

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.[18] 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 issuer or to the enrollee:

In a state that defrays the cost of a state-required benefit in addition to EHB directly to the QHP issuer:

- The issuer should **exclude** 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.
- 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 details regarding the amount the QHP issuer expects to receive from the state for defrayal of the state-required benefit.

[17] 45 CFR 156.115(d)
[18] 45 CFR 155.170

- The issuer **should not** factor the state-required benefit into the calculation of "Benefits in Addition to EHB" (the multiplicative inverse of the "EHB Percent of Total Premium" field in the Plans & Benefits Template). Including this information would result in the QHP issuer being paid for the state-required benefit twice. However, the QHP issuer should still indicate in the "Benefit Information" field in the Plans & Benefits Template that it covers the state-required benefit in question as "Not EHB - Defrayed to Issuer."
- If a state is defraying to the QHP issuer the cost of a state-required benefit for the coverage of abortion for which public funding is prohibited (also known as non-Hyde abortion services),[19] the issuer should follow the above steps. If all remaining benefits are EHB, enter "1.0" in the "Benefits in Addition to EHB" field in the URRT, which will result in the plan's "EHB Percent of Total Premium" in the Plans & Benefits Template equaling 100%.

In a state that defrays the cost of a state-required benefit in addition to EHB directly to the enrollee:

- The QHP issuer should **include** 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 the Rates Table Template.
- 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.
- The QHP issuer **should** factor the state-required benefit into the calculation of "Benefits in Addition to EHB" (the multiplicative inverse of the "EHB Percent of Total Premium" field in the Plans & Benefits Template). The QHP issuer should indicate in the "Benefit Information" field in the Plans & Benefits Template that the QHP covers the state-required benefit in question as "Not EHB - Defrayed to Enrollee."
- If a state is defraying the cost of abortion for which public funding is prohibited directly to the enrollee, the QHP issuer should follow the above steps. If the state is defraying the cost of a state-required benefit in addition to EHB directly to the enrollee, the value entered in the "Benefits in Addition to EHB" field in the URRT must be greater than "1.0," and the "EHB Percent of Total Premium" in the Plans & Benefits Template must be less than 100%.

For plans that include coverage of abortion services for which public funding is prohibited offered in states where the benefits package of the EHB benchmark plan includes such abortion services, you must handle the portion of the premium related to these services using one of the two methods described below:

- If the plan is a QHP offered on an SBE, SBE-FP, or an FFE, the issuer should **include** such benefits in the calculation of the "Benefits in Addition to EHB" field in the URRT (even though these services are in the EHB benchmark package). The percentage of the premium associated with such abortion services **should be not be included** in the "EHB Percent of Total Premium field" in the Plans & Benefits Template because the "EHB Percent of Total Premium" is used to calculate subsidy amounts, and subsidy payments may not be provided for costs associated with such abortion services.

[19] 45 CFR 156.280(d)

    - If the state is defraying the cost of abortion for which public funding is prohibited, follow the applicable above steps relevant to defrayal.
- If the plan is not a QHP offered on an SBE, SBE-FP, or an FFE, the issuer should **not include** the percentage of the premium associated with such abortion services in the "Benefits in Addition to EHB" field in the URRT and should instead include it in the "EHB Percent of Total Premium" field in the Plans & Benefits Template.

Plans that cover abortion services that are not included in the benefits package of the EHB benchmark (regardless of whether public funding for such abortion services is permitted or prohibited) must factor such benefits into the calculation of the "Benefits in Addition to EHB" field in the URRT and, if relevant, follow the applicable above steps relevant to defrayal.

Plans that cover abortion services for which public funding is permitted should include the percentage of premium associated with such services in the "EHB Percent of Total Premium" field in the Plans & Benefits Template if such services are included in the benefits package of the EHB benchmark plan.

Administrative Expense: Enter the administrative expense portion of total administrative costs as a percent of the PAIR.

Taxes and Fees: Enter the taxes and fees portion of total administrative costs as a percent of the PAIR.

Exchange user fees should not be included in this percent, as those are already accounted for in the MAIR.

Profit & Risk Load: Enter the profit and risk load portion of total administrative expense as a percent of the PAIR.

Catastrophic Adjustment: For catastrophic plans only, enter the allowable adjustment for the expected eligibility categories for the plans. For non-catastrophic plans, enter a value of 1.0.

Issuers may consider the expected impact of specific eligibility categories for catastrophic plans. No adjustment is allowed to the metal plans (platinum, gold, silver, or bronze) or to the single risk pool index rate to account for a catastrophic plan adjustment. In other words, an issuer may not lower the rates of catastrophic plans due to an expectation that healthier members will choose these plans, then make up the revenue shortfall for this adjustment by increasing rates on the metal tier plans. While a separate plan-level adjustment is permitted for catastrophic members, catastrophic plan experience must be included in the single risk pool. Allowing an adjustment to metal plans to account for catastrophic plan experience effectively excludes catastrophic plan experience from the single risk pool, which is inconsistent with the single risk pool provision. In addition, the catastrophic adjustment should not duplicate the impact of age that is reflected by the application of the standard age curve to the Calibrated Plan Adjusted Index Rate.

Plan Adjusted Index Rate: This field is automatically calculated in the spreadsheet by applying the permitted plan-level adjustments to the MAIR.

Age Calibration Factor: Enter the appropriate age calibration factor to calibrate the issuer's actual population to an age rating factor of 1.0 so that multiplying by the appropriate age rating factor will result in the correct premium rate for a member of that age.

Note that the URRT multiplies the PAIR by the age calibration factors, so issuers should ensure the calibration is entered as a multiplicative factor.

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

Some states have established their own age curves that are different from the standard CMS age curve. In this case, issuers should check with their state regulators to determine whether applying a factor of zero (0) for the distribution of members expected to pay no premium is an appropriate and allowable adjustment for the three under-age-21 child-dependent cap.

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

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

Geographic Calibration Factor: Enter the appropriate geographic calibration factor to calibrate the issuer's actual population to a geographic rating factor of 1.0 so that multiplying by the appropriate geographic area rating factor will result in the correct premium rate for a member (individual or enrolled with a group) located in that rating area.

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

The Actuarial Memorandum should explain how the geographic rating 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) and not differences in population morbidity by geographic area.

Note that the geographic calibration adjustment is not plan-specific. In other words, the same geographic calibration would be applied to all plans in the projected single risk pool.

Tobacco Calibration Factor: Enter the tobacco calibration factor that calibrates the issuer's actual population to a tobacco rating factor of 1.0 so that multiplying by the tobacco rating factor will result in the correct premium rate for a tobacco-using member.

Issuers using tobacco rating factors must calibrate the PAIR to remove the portion of the cost expected to be recouped through the tobacco surcharge. This adjustment should reflect only the expected surcharge collected from tobacco users. In the event that tobacco users enter a wellness program that reduces the tobacco user load applied, only the net impact on revenue should be accounted for in the adjustment factor.

Calibrated Plan Adjusted Index Rate: This field is automatically calculated in the template by multiplying the PAIR by the age, geographic, and tobacco calibration.

The Calibrated Plan Adjusted Index Rate can be thought of as a base rate. Applying the appropriate age factor, geographic area factor, and tobacco use factor should result in the correct premium for a member or group enrolling on the effective date of the proposed rates.

It is understood that this may not match exactly the rates submitted in the Rates Table Template document due to rounding and truncation of variables in the URRT; however, it is expected that the rates will be reasonably close to each other.

2.2.4 Section IV: Projected Plan Level Information

The information shown in this section captures the projected data for the twelve-month period following the effective date for each plan. It is expected that in general, the Projection Period found in this section should be the same as the Projection Period found in Section II of Worksheet 1.

2.2.4.1 Projection Period Data

Issuers enter expected data for the Projection Period in this section. The entries are then used to calculate a loss ratio and PMPM amounts.

Allowed Claims: Enter the expected allowed claims for each benefit plan with service dates within the Projection Period.

Reinsurance: Enter any claims reimbursement expected to be received through a federal or state reinsurance program, net of any reinsurance fees.

Member Cost Sharing: Enter any cost sharing (i.e., deductible, coinsurance, copayments) expected to be paid by the members. This should not include any cost sharing paid on behalf of the member through federal cost-sharing reductions.

Federal CSR Payments.: Enter cost sharing expected to be paid by the federal government on behalf of members eligible for federal cost-sharing reduction subsidies.

If the federal government does not pay cost-sharing reduction subsidies, the amount entered here should be $0.

Issuer CSR Payments: Enter cost sharing expected to be paid by the issuer on behalf of members eligible for federal cost-sharing reduction subsidies for which the issuer does not otherwise receive reimbursement as a positive value.

Recoveries from CSR Load: Enter additional revenue expected to be collected as a result of CSR loading. To calculate CSR load recoveries:

- Divide the projection period premium revenue by the CSR load factor.
- Subtract that amount from the projection period premium revenue.

CMS acknowledges this methodology may need to be adjusted to obtain a more precise estimate of CSR recoveries.

Incurred claims: This is an automatically calculated field that displays the projected incurred claims that the issuer is responsible for paying.

This field is calculated by subtracting reinsurance, member cost-sharing, and federal CSR payments from allowed claims. Please check to make sure this amount reflects the incurred claims that are the issuer's responsibility.

Risk Adjustment Transfer Amount: Enter the risk adjustment transfer payment or charge expected to be paid for the Projection Period for each plan.

Transfer amounts should include the high-cost risk pool adjustment to claims and any assessment to pay for those claims. The risk adjustment user fee should not be included here; rather, it should be included in the taxes and fees portion of administrative costs. If the issuer expects to receive a projected risk adjustment payment, then the entry should be a positive value. If the issuer expects to owe a projected risk adjustment charge, the entry should be negative.

Note that the reported risk adjustment transfer amounts should account for RADV adjustments, including DDVCs and allocations, as appropriate.

Premium: Enter the expected total premium earned in the Projection Period for each plan.

Projected Member Months: Enter the expected member months for each single risk pool plan in the Projection Period.

Loss Ratio: This is an automatically calculated field in the template that divides incurred claims by premium plus the risk adjustment transfer amount. This is not the federal MLR for determining rebates.

2.2.4.2 Per Member Per Month (PMPM) Calculations

This section of Worksheet 2 automatically calculates PMPM amounts for many of the Projection Period Data fields found above. Issuers should check the calculated PMPM amounts for reasonability, as an odd PMPM could indicate a data entry error.

Allowed Claims: This is a PMPM amount calculated by dividing allowed claims by projected member months.

Reinsurance: This is a PMPM amount calculated by dividing reinsurance amounts by projected member months.

Member Cost Sharing: This is a PMPM amount calculated by dividing member cost-sharing amounts by projected member months.

Federal CSR Payments: This is a PMPM amount calculated by dividing federal CSR payments by Projected Member Months.

Issuer CSR Payments: This is a PMPM amount calculated by dividing Issuer CSR Payments by projected member months.

Recoveries from CSR Load: This is a PMPM amount calculated by dividing CSR load recoveries by projected member months.

Incurred Claims: This is a PMPM amount calculated by dividing incurred claim amounts by Projected Member Months.

Risk Adjustment Transfer Amount: This is a PMPM amount calculated by dividing risk adjustment amounts by Projected Member Months.

Premium: This is a PMPM amount calculated by dividing premium amounts by Projected Member Months.

Section 2.3 Worksheet 3 – Rating Areas

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 total number of rating areas that are in the state, regardless of the number of rating areas where coverage will actually be offered. Beginning in Row 6, the issuer can identify the rating areas where coverage will be offered in Column A and enter the corresponding area rate factor in Column B.

For example, if a state had 8 rating areas and the issuer were to offer coverage in all of rating areas 1 and 3 and offer coverage in one county of rating area 5, the issuer would select 8 for the number of rating areas in the state. Beginning in cell A6, the issuer would select rating areas 1, 3, and 5 from the dropdown list in column A (select Rating Area 1 in cell A6, Rating Area 3 in cell A7, and Rating Area 5 in cell A8) and enter the appropriate rating factor in column B next to the corresponding rating area in column A. The issuer would not need to select the other rating areas in the state where it is not offering coverage.

3. Part II: Written Description Justifying the Rate Increase

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

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

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

- Scope and range of the rate increase: Provide the number of individuals impacted by the rate increase. Explain any variation in the increase among affected individuals (e.g., describe how any changes to the rating structure impact premium).
- Financial experience of the product: Describe the overall financial experience of the product, including historical summary-level information on historical premium revenue, claims expenses, and profit. Discuss how the rate increase will affect the projected financial experience of the product.
- Changes in Medical Service Costs: Describe how changes in medical service costs are contributing to the overall rate increase. Discuss cost and utilization changes, as well as any other relevant factors that impact overall service costs.
- Changes in benefits: Describe any changes in benefits and explain how benefit changes affect the rate increase. Issuers should explain whether the applicable benefit changes are required by law.
- Administrative costs and anticipated margins: Identify the main drivers of changes in administrative costs. Discuss how changes in anticipated administrative costs and underwriting gain/loss are impacting the rate increase.

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

4. Part III: Actuarial Memorandum and Certification Instructions

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

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

- The methodology used to calculate the AV Metal Value for each plan.
- The development of the Index Rate in accordance with federal regulations, and the development of plan-specific premium rates using allowable modifiers to the Index Rate.
- The geographic rating factors, which should reflect differences only in the costs of delivery (which can include unit cost and provider practice pattern differences) and not differences in population morbidity by geographic area.

State-specific required information or certifications may also be included at the actuary's discretion to avoid the need to create a separate state actuarial memorandum.

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

4.1 Redacted Actuarial Memorandum

As required by 45 CFR 154.215(h)(2), CMS will make available to the public the information contained in Part III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information, consistent with HHS FOIA regulations, 45 CFR 5.31(d). To facilitate the release of Part III to the public, health insurance issuers must upload two versions of Part III: (1) 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. **Redacted Actuarial Memorandums will be reviewed for compliance with 45 CFR 5.31(d) to ensure that issuers are not redacting more information than permitted under the regulation.**

The MPMS system requires issuers to upload the Redacted Actuarial Memorandum , or check a box may be checked to indicate that CMS should use the non-redacted Actuarial Memorandum uploaded for CMS review. If an issuer selects this box, the non-redacted version will appear on the HHS website (RateReview.Healthcare.gov).

4.2 General Information Section

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

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

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

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

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

4.3 Proposed Rate Changes

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

Reason for Rate Increase(s): Provide the quantitative impact and a narrative description of all significant factors driving a proposed rate increase. As an example, these factors could include:

- Single risk pool experience, which is more adverse than that assumed in the current rates
- Medical inflation
- Increased utilization
- Prospective changes to benefits covered by the product or successor products
- New taxes and fees imposed on the issuer
- Anticipated changes in the average morbidity of the covered population that is market-wide, as opposed to issuer-specific morbidity that is reflected in risk adjustment

If the requested rate increase is not the same across all products and plans, explain why the rate changes vary by product or plan, given that they are based on the same single risk pool of experience for the market. Explain how the impact of morbidity was removed from impacting the variance in rate changes across products or plans.

4.4 Market Experience

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

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

4.4.1 Experience and Current Period Premium, Claims, and Enrollment

This section of the Actuarial Memorandum should include information related to the actuary's best estimate of premium, claims, and enrollment for the single risk pool during the Experience and Current Periods reported in Worksheet 1, Section I, and Worksheet 2, Section II of the URRT.

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

Current Date: Provide the applicable date for which the current enrollment and premium are reported.

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

- Worksheet 1, Section I shows the actuary's best estimate of the amount of claims that were incurred during the 12-month Experience Period. Separately indicate the amount of claims which were processed through the issuer's claim system, processed outside of the issuer's claims system, and the amount that represents the actuary's best estimate of claims incurred but not reported as of the Paid Through Date stated above. This should be provided separately for Incurred Claims in the Experience Period and Allowed Claims.
- Describe the method used for determining Allowed Claims. For example, Allowed Claims could come directly from an issuer's claim records or alternatively could be developed by combining paid claims or capitation payments with member cost-sharing.
- Provide support for the estimate of incurred but not reported claims.
    - Describe the methodology used to develop the estimate of claims incurred but not reported 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 reported claims on an allowed basis differs from the methodology or completion factors used to estimate incurred claims, describe and support why they are different.
    - Indicate whether the claims used to develop any completion factors reflect the Experience Period claims for the information submitted or some alternate claims set, such as a larger block of the issuer's experience. If an alternate claims set was used, please provide support for why it is appropriate.

- If the incurred but not reported claims are unusually high or unusually low relative to the Experience Period claims paid as of the Paid Through Date, explain what is causing them to be unusually high or unusually low (e.g., introduction of a new claims system, significant employee turnover, etc.).

4.4.2 Benefit Categories

For each of the Benefit Categories in Worksheet 1, Section II, describe the methodology used to determine which category each claim in the Experience Period falls.

4.4.3 Projection Factors

This section should include a description of each factor used to project the Experience Period Index Rate to the Projection Period and supporting information related to the development of those factors. For each factor, the actuary should include a description of the source data or assumptions used, why they are appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for issuer-specific experience, industry, or internal studies, benefit design, and credibility of the source data.

4.4.3.1 Trend Factors

Trend Factors (cost/utilization): Trend factors reported in the URRT are broken out by Year 1 and Year 2, as well as between cost and utilization. To calculate the Trended EHB Allowed Claims PMPM, the spreadsheet multiplies the Experience Period Index Rate PMPM by the trend factors entered.

For quarterly small group filings, the terms "Year 1" and "Year 2" are used loosely. Depending on the Experience Period and Projection Period used, Years 1 and 2 might not cover a 12-month period. The trend rates entered should be the applicable trend that takes the Experience Period Index Rate to the MAIR for the effective date of the filing. For example, if an issuer were to file a third-quarter rate increase, the trends entered should lead to a projected Index Rate and MAIR for July 1. Once the permitted plan-level adjustments and calibrations are applied, the Calibrated Plan Adjustment Index Rate should be the effective base rate for July 1. Applying the appropriate age, rating area, and tobacco use factors should generate consumer premium rates effective July 1.

As the trend factors entered into the URRT may not represent the annual trend number, the issuer should specify the annual trends and the months of trend applied to Year 1 and Year 2 in the Actuarial Memorandum.

Demonstrate and describe the trend calculation, including the source claims data used and the methodology for developing the cost and utilization projection factors, including all adjustments made to the data. Explain why the adjusted source data applies to the single risk pool. Some examples of such adjustments include, but are not limited to, the following:

- Normalization for changes in age.
- Normalization for benefit changes that occurred during the period (even if allowed claims are used to project trend, a normalization adjustment may be warranted to account for the influence that changes in benefits have on utilization).
- Adjustments for seasonality patterns underlying the claims that may skew calculated trends.
- Normalization for any one-time events which are not anticipated to recur during the Projection Period.

- Adjustments for anticipated changes in provider contracts that differ from those underlying the experience used.
- For prescription drugs, any adjustments are made to account for changes in the formulary, expiration of patents, or introduction of new drugs.

4.4.3.2 Adjustments to Trended EHB Allowed Claims PMPM

This section should explain adjustments other than trend that are made to the Experience Period claims in order to develop the projected Index Rate.

Morbidity Adjustment: Describe any adjustment factors applied to the projected claims to account for anticipated differences in the average morbidity of the pooled population underlying the Experience Period and the issuer's population anticipated to be insured in the Projection Period. These adjustments are shown in the "Morbidity Adjustment" entry on Worksheet 1, Section II. The population's morbidity could be affected by factors such as guaranteed availability, an individual mandate to maintain coverage, expansion of Medicaid programs, and the introduction of a Basic Health Program.

Demographic Shift: Describe the development of the demographic shift factor used to adjust the projected claims to reflect differences between the average mix of the population by age, gender, and region underlying the base period experience and the average mix anticipated to underlie the Projection Period. Describe and support the age/gender factors underlying the development of these claims-based demographic adjustment factors.

Plan Design Changes: Describe the development of factors used to adjust the Experience Period claims to reflect the average benefits that will be covered during the Projection Period, including any newly mandated benefits (if any). The factors could adjust for items including but not limited to the following:

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

Other Adjustments: Describe any other adjustments, in addition to morbidity, demographics, and plan design changes which are specifically addressed above, that are reflected in the "Other" adjustments entry on Worksheet 1, Section II. Also, describe how these factors were developed. Some examples might include legislative changes affecting the market other than mandated benefits or changes brought about by State Relief and Empowerment Waivers under section 1332 of the ACA.

4.4.3.3 Manual Rate Adjustments

For issuers with Experience Period claims that are not deemed fully credible, other credible claims experience must be used to develop a Manual EHB Allowed Claims PMPM for the Projection Period. The actuary must provide information on the other experience and the general methodology used to develop the manual rate.

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

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

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

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

4.4.3.4 Credibility of Experience

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

- A description of the credibility methodology used.
- The resulting credibility level assigned to the base period experience when applying the proposed credibility methodology.

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

When determining credibility, the actuary should consider Actuarial Standard of Practice #25, *"Credibility Procedures."*

4.4.3.5 Establishing the Index Rate

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

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

Small Group Quarterly Trend Increases: State any scheduled small group quarterly trend adjustments to the index rate.

Small Group Quarterly Rate Filings: Rate adjustments for the small group market may be filed every quarter if permitted by the state. These quarterly filings may include adjustments for other items, such as new products, more recent Experience Period claims, and so on. However, the rate development for these interim filings must be based on the single risk pool. The change in the Index Rate is permitted only for the remainder of the calendar year, and a subsequent submission is required at the beginning of the following calendar year.

For example, if a small group issuer submits the URRT for January 1, they may submit a subsequent URRT that resets the Index Rate to an effective date of July 1 of that same year. The URRT, effective July 1 in this example, is only allowed to include 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 following calendar year.

4.4.3.6 Development of the Market-wide Adjusted Index Rate

Issuers are required to provide support for the development of the MAIR, including an explanation of the risk adjustment and exchange user fees entered into Worksheet 1 of the URRT. If state-based reinsurance information is entered in Worksheet 1 of the URRT, support for the development of the net reinsurance amount should also be provided.

The MAIR is calculated as the Index Rate, adjusted for all allowable market-wide modifiers defined in the market rating rules at 45 CFR 156.80(d)(1). Since the Index Rate is on an allowed-claims basis, the market-level adjustments should be on an allowed basis.

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

Reinsurance: Explain any expected reinsurance recoveries from federal or state reinsurance programs, net of the costs of the reinsurance, and the anticipated impact to claims in the Projection Period.

Risk Adjustment Payment/Charge: 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 to all plans within a risk pool based on plan premiums, using the risk adjustment transfer adjustment factor as a market-level adjustment. As previously mentioned, reported risk adjustment payment and charge amounts should account for RADV adjustments, including DDVCs and allocations, as appropriate.

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

Issuers must also explain how the anticipated risk adjustment transfer amount was applied to the Index Rate in the development of the MAIR. Issuers should describe the overall impact of risk adjustment transfers on premiums.

Please note that the risk adjustment transfer amounts shown on Worksheet 1 of the URRT should reflect the actual PMPM amounts expected during the Projection Period. However, the risk adjustment transfer amount applied to the Index Rate in developing the MAIR is on an allowed claims basis (i.e., before the application of the expected paid-to-allowed ratio), as the Index Rate is on an allowed claims basis.

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

4.4.4 Plan Adjusted Index Rate

The Plan Adjusted Index Rates for the Projection Period are included in Worksheet 2, Section III of the URRT.

The PAIR is calculated as the issuer's MAIR adjusted for all allowable plan-level modifiers defined in the market rating rules, 45 CFR 156.80(d)(2), and also entered in Section III of Worksheet 2 of the URRT. Only the following adjustments are allowable under these rules:

- Actuarial value and cost-sharing design of the plan.
- CSR load factor, to account for CSR amounts provided to eligible enrollees if permitted by the applicable State authority, provided the issuer does not otherwise receive reimbursement for such amounts.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- Benefits provided under the plan that are in addition to EHBs.
- Administrative costs, excluding Exchange user fees and federal or state reinsurance fees (which are already accounted for in the MAIR). Section III of Worksheet 2 asks for the administrative costs broken out by Administrative Expense, Taxes and Fees, and Profit and Risk Load.
- Only catastrophic plans may adjust for the expected impact of the specific eligibility categories for these plans. If an adjustment is made to catastrophic plans, this adjustment may not be recovered elsewhere in the rating process, as that would be seen as removing the catastrophic plan experience from the single risk pool.

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

The issuer is required to explain how these modifiers are developed and applied to the MAIR to derive the PAIR.

The AV and cost-sharing design of the plan may take into account the cost shares and the resultant impact on utilization. The utilization may reflect the impact higher cost-sharing has on utilization, but it cannot reflect differences due to health status. If the cost-sharing impact on utilization is reflected, describe in detail how the methodology ensures that differences due to health status are not included in the adjustment.

If the issuer is applying a CSR load factor, specify the load factor and provide an explanation of the methodology used to determine it. Additionally, specify the additional revenue expected to be collected from the applied CSR load factor and the expected amount of CSRs that will be paid on behalf of eligible enrollees for the upcoming plan year. Provide a detailed explanation that compares these amounts and demonstrates that the CSR load factor is calibrated on actual market experience that accounts only for the projected revenue loss of unreimbursed CSR payments without materially exceeding that amount. As noted in the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Final Rule,

[20] CSR loading is meant to recover lost CSR reimbursement and should not be seen as a premium adjustment factor to achieve a desired subsidy level. Specifically, silver-plan premiums should not be loaded in a way that purposefully collects more in premium than the expected amount of unreimbursed CSRs to increase subsidy amounts and lower premiums at other metal levels. This practice goes beyond CSR loading and is an inappropriate use of the CSR load factor.

If benefits in addition to EHB are being provided, please describe the additional benefits.

Specifically, for the catastrophic plan rate, describe the methodology used to estimate the adjustment reflecting the expected impact of the specific eligibility categories for these plans as compared to the single risk pool.

Similar to the Index Rate and MAIR, the PAIR reflects the average demographic characteristics of the single risk pool. In other words, the PAIR is not calibrated.

4.4.5 Calibration

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

Age Curve Calibration

Issuers must provide a detailed explanation of the methodology used to calibrate the age curve. Specifically, issuers should describe the factors used to determine the calibration factor, the data used to weight those factors, and a description of the exact calculation. Issuers will need to provide actuarial justification that the methodology used to calculate the calibration to the age curve complies with the standard age curve methodology.

[20] https://www.federalregister.gov/documents/2026/05/20/2026-10050/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2027-and

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

Some states have established their own age curves that are different from the standard CMS age curve. In this case, issuers should check with their state regulators to determine whether applying a factor of zero (0) for the distribution of members expected to pay no premium is an appropriate and allowable adjustment for the three under-age-21 child-dependent cap.

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

Geographic Factor Calibration

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

The Actuarial Memorandum must include a comprehensive explanation of the development of the geographic rating factors. This includes detailing the methodology used to ensure that the factors reflect only delivery cost differences, or how they are adjusted for variations in population morbidity. Additionally, it must demonstrate how these factors are applied to the PAIR. For example, if the weighted average of the geographic factors does not equal 1.0, the calibration adjustment that is applied should be included in the Actuarial Memorandum, along with documentation of its calculation. Note that the geographic calibration adjustment is not plan-specific. In other words, the same geographic calibration would be applied to all plans in the projected single risk pool. If an issuer has multiple networks within a given rating area and wants to develop premiums specific to each network, the issuer must have a separate plan for each network within the rating area.

Tobacco Use Rating Factor Calibration

Issuers using tobacco rating factors must calibrate the PAIR to remove the portion of the cost expected to be recouped through the tobacco surcharge. This adjustment should reflect only the expected surcharge collected from tobacco users. If tobacco users enter a wellness program that reduces the tobacco user load applied, only the net impact on revenue should be accounted for in the adjustment factor.

Once the PAIR is calibrated to the 1.0 factor on the age curve and calibrated to the geographic rating area and tobacco use rating factors, the complete set of age rates is determined using the standard age factor for each age. The age factors must be the standard age curve set by HHS or a state-specific age curve (if the state requires age factors different from the standard federal age curve).

4.4.6 Consumer Adjusted Premium Rate Development

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

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

4.5 Projected Loss Ratio

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

If the state requires a projected loss ratio demonstration, it should be included as well.

4.6 Plan Product Information

4.6.1 AV Metal Values

The issuer must describe whether the plan AV Metal Values included in Worksheet 2 of the URRT were calculated using only the AV Calculator or, if any plan designs are not compatible with the AV calculator, describe the acceptable alternative methodology used to generate the AV Metal Value. If an alternate method was used to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR 156.135. A member of the American Academy of Actuaries must sign the certification. It must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.

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

4.6.2 Membership Projections

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

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

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

4.6.3 Terminated Plans and Products

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

4.6.4 Plan Type

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

4.7 Miscellaneous Instructions

4.7.1 Effective Rate Review Information (Optional)

45 CFR 154.301 describes the elements of an Effective Rate Review Program. There are elements of an effective rate review for which the data needed to perform the review are not explicitly shown on the URRT (e.g., the health insurance issuer's capital and surplus). Issuers may optionally provide additional information to facilitate an effective review of the submitted rate increase(s). While this information is optional, providing it with the initial submission reduces the likelihood that the reviewer will request supplemental information during the rate review. In addition, states may have additional data requirements. Additional state-specific required data may be submitted with the URR submission.

4.7.2 Reliance

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

4.7.3 Actuarial Certification

An actuarial certification must be provided for the following:

- The methodology used to calculate the AV Metal Value for each plan.
- The Index Rate is developed in accordance with federal regulations, and the Index Rate, along with allowable modifiers, is used in the development of plan-specific premium rates.
- The geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

State-specific required information or certifications may also be included at the actuary's discretion to prevent the need for creating multiple Actuarial Memorandums for the same filing. If an actuary chooses to exclude state-specific required information from the Actuarial Memorandum, this information will need to be provided to the state regulatory agency under separate cover.

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

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*
- ASOP No. 12, *Risk Classification*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures*
- ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*
- ASOP No. 41, *Actuarial Communications*
- ASOP No. 50, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*

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

1) Identification of the certifying actuary and a statement that they are a member of the American Academy of Actuaries.
2) A certification that the projected Index Rate is:
    a. In compliance with all applicable state and federal statutes and regulations (45 CFR 156.80 and 147.102)
    b. Developed in compliance with the applicable Actuarial Standards of Practice
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered
    d. Neither excessive nor deficient
3) A certification that the Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 156.80(d)(2) were used to generate plan-level rates.
4) A certification that the geographic rating factors reflect only differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.
5) A certification stating that the AV Calculator was used to determine the AV Metal Values shown in Part I of Worksheet 2 in the URRT for all plans except those specified in the certification. If an alternate methodology was used to calculate the AV Metal Value for at least one plan offered, a copy of the actuarial certification required by 45 CFR 156.135 must be included. A member of the American Academy of Actuaries must sign the certification. It must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.
6) For purposes of rate review, also include the reason an alternate methodology was used and the chosen alternate methodology that was used for each applicable plan. Describe the process that was used to develop the AV Metal Value.

The actuary may, if desired, qualify the opinion by stating that the URRT does not demonstrate the issuer's process for developing the rates. Instead, it represents information required by federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-facilitated Exchanges, and for certification that the Index Rate is developed in accordance with federal regulation, used consistently, and adjusted only by the allowable modifiers.

5. MPMS Submission

5.1 Submission Status

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

Table 2 MPMS Submission Statuses

Submission Status	Meaning
In Progress	The submission has been created but has not yet been sent to CMS for review.
Submitted – Under Review	The submission has been sent to CMS and is currently under review.
Update Required	CMS has reviewed the submission and determined that updates or additional information from the issuer are needed.
Submission Complete	CMS has fully reviewed the submission, and no further updates are required.

5.2 Unlocking a Submission

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

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

6. SERFF Submission

Tip: 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.

The CCIIO and National Association of Insurance Commissioners (NAIC) teams built a system connection between the NAIC's System for Electronic Rates & Forms Filing (SERFF) and CMS's MPMS module. Rate filings submitted in the URRT tab in SERFF will automatically be transferred to the CMS MPMS module for validation. SERFF will display a message when the validation is complete. 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[21] 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.

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

[21] For information on states with an Effective Rate Review Program, see https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet. For information on state participation in SERFF, see https://www.serff.com/serff_participation_map.htm

(or earlier State deadline).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.

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.

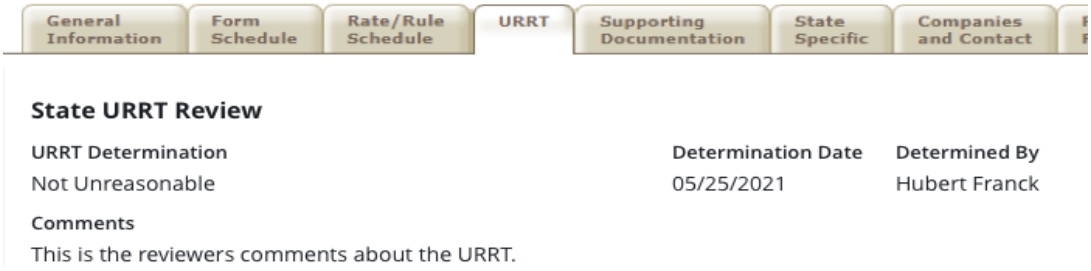
Issuers can upload the Consumer Justification Narrative (CJN) in the URRT tab regardless of if the filing meets the threshold making it subject to review, but if the filing is above threshold, upload of the CJN becomes a requirement.

An "Additional Supporting Documentation" section is available on the URRT tab in which up to 30 files can be uploaded.

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:

- Request Confidentiality
- Objections/Objections Letters
- Change Schedule Items
- Response Letters
- Amendment Letters
- State Public Access

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 ratereview.healthcare.gov. Once a determination has been sent to CMS, there can be no further action on the URRT tab from the issuer or the state.



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.[22] 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.

[22] A member of the rate review team at CCIIO can be reached by emailing ratereview@cms.hhs.gov.