

A PUBLIC POLICY PRACTICE NOTE

# Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act

*December 2015*

Developed by the Premium Review Work Group  
of the American Academy of Actuaries



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This practice note supports rate filings based on Affordable Care Act (ACA) requirements. It does not replace the original 2012 practice note, [\*Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act\*](#).<sup>1</sup> That practice note is still helpful (for issues described later in this practice note) when filing rate changes for transitional plans, which are non-grandfathered, non-ACA-compliant plans that have been allowed to renew through Oct. 1, 2016, effective dates in some states.<sup>2</sup> This document is intended to provide information to actuaries preparing, reviewing, or commenting on rate filings in accordance with Section 2794 of the Public Health Service Act. Specific changes from one year to the next are not considered in this practice note. Rather, it is meant to provide information on the main issues related to filing ACA-compliant plan rates, reflecting the requirements under the ACA.

This practice note is intended for use as a reference tool only and is not a substitute for any legal analysis or interpretation of the regulations or statutes. This practice note is not a promulgation of the Actuarial Standards Board, is not an actuarial standard of practice, is not binding upon any actuary, and is not a definitive statement as to what constitutes appropriate practice or generally accepted practice in the area under discussion. Events occurring subsequent to this publication of this practice note may make the practices described in this practice note irrelevant or obsolete.

This practice note is not an official or comprehensive interpretation of the ACA. The actuary should review state and federal regulations and related material regularly as the Department of Health and Human Services (HHS) and states may revise regulations and interpretations periodically. The actuary may need to rely on judgment to determine how best to use revised regulations and interpretations in rating, as sometimes material may be unclear or regulations may not be finalized in a timely manner.

We welcome comments and questions. Please send comments to [healthanalyst@actuary.org](mailto:healthanalyst@actuary.org).

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<sup>1</sup> [http://actuary.org/files/rrpn\\_100512\\_final.pdf](http://actuary.org/files/rrpn_100512_final.pdf)

<sup>2</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>

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## **General Rate Filing Requirements**

This practice note addresses ACA-compliant plans only. The term “ACA-compliant plans” refers to those plans that are regulated under the single risk pool requirements in the ACA, and which must follow the ACA health reform rating rules. This excludes grandfathered and transitional plans. Student health plans are not required to be filed as ACA-compliant, single risk pool plans.

In November 2013 and in March 2014, HHS allowed the temporary continuation of non-grandfathered, non-ACA-compliant plans (commonly referred to as “transitional plans”) that were sold prior to Dec. 31, 2013. For states in which transitional plans are allowed, they are not included in the projection period under the new rating requirements affecting ACA-compliant plans, a factor that may affect rates and rate filings in these states for several years. Rate increases for these transitional plans would need to follow the previous requirements described in the October 2012 practice note, using the preliminary justification forms and process.

This practice note is not a substitute for reading the Unified Rate Review Instructions.

The rating requirements for ACA-compliant plans include the following components:<sup>3</sup>

- Part I is the Unified Rate Review Template (URRT). The URRT is an Excel spreadsheet that includes experience period and projected data and information for all products and plans from an issuer in a market (i.e., individual, small group, or combined), which is essentially the single risk pool of products and plans.
- Part II is only filed when a rate increase is greater than the threshold for rate review.
- Part III is the actuarial memorandum and certification that describes and supports the development of the information provided in Part I.

Both parts I and III are filed for all plans and products included in the single risk pool every year and, potentially, quarterly for small-group insurers. They are filed whether or not a plan or product has a rate increase, rate pass, or rate decrease.

The table below summarizes when each part of the justification must be submitted to both HHS and the state (if applicable) and what plan data is included in each part, for an ACA-compliant filing:

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<sup>3</sup> The instructions for parts I, II, and III can be found on the CCIIO website: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2016-Unified-Rate-Review-Instructions-20150222-Final.pdf>.

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	<b>Transitional</b>	<b>Single Risk Pool – ACA-compliant plans offered on or off exchange</b>
Part I (URRT)	Included only in experience period	Included in experience period (if exists) and projection period, as appropriate. Includes new plans in projection period.
Part II (Narrative Justification)		Only if rate increase is above state threshold.
Part III (Actuarial Memorandum)	Included only as part of the experience period	Included in experience period (if exists) and projection period, as appropriate. Includes new plans in projection period.

States may have additional rate filing requirements, including state-specific templates or actuarial memorandum requirements. The actuary is expected to become familiar with specific state laws and requirements related to rate development and filing.

In May 2014, HHS released a final rule limiting what would be considered a “new” plan.<sup>4</sup> Changes that will be considered “modifications” to an existing plan based on the proposed rule include modifications made solely pursuant to applicable federal or state law, and modifications that meet the following criteria:

- Product offered by the same issuer
- Product covers a majority of the same provider network (as applicable)
- Product covers a majority of the same counties in its service area
- Product has the same cost-sharing structure, except for changes made related to cost and utilization of medical care or to maintain the same metal level
- Product covers the same benefits or includes cumulative benefit changes impacting the rates by no more than 2 percent (not including changes required by federal or state law)<sup>5</sup>

States may provide a broader definition of what would be considered a uniform modification of coverage. The actuary should monitor any changes to these rules.

## **2014 Market Reforms**

As noted above, this practice note focuses on health insurance policies compliant with the 2014 ACA market reforms applicable to the individual and small-group markets (ACA-compliant plans), including but not limited to the following requirements relating to rating:

- Single risk pool (45 CFR 156. 80), requiring issuers to maintain a single risk pool in the individual market, and a single risk pool in the small-group market, or a merged individual and small-group pool if required by the state, by licensed entity, by state. Issuers can no longer segment enrollees into separate rating pools.
- Fair health insurance premiums (45 CFR 147.102), requiring that health insurance premiums for a given plan vary only by (1) family composition; (2) rating area as defined for the given state; (3) age, by no more than 3:1 for adults; and (4) tobacco use by a factor of up to 1.5. Group health plans can only apply the tobacco surcharge if they offer a wellness program compliant with federal regulations.

<sup>4</sup> <http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf>

<sup>5</sup> <http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf>

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- Guaranteed availability (45 CFR 147.104).
- Guaranteed renewability (45 CFR 147.106).
- Prohibition against discrimination based on health status (45 CFR 146.121).
- Essential health benefits (EHB) and actuarial value requirements (45 CFR Part 156), requiring issuers to cover a minimum set of services within standardized levels of cost sharing.

Grandfathered plans, or plans available prior to March 23, 2010, that have been subject to limited changes and fulfilled the participant and regulatory disclosure requirements on time, are not subject to the requirements above, nor are plans that fall under the transitional policy allowing for the renewal of certain plans (as allowed by the state) offered in 2013 not in compliance with the above requirements for policy years beginning on or before Oct. 1, 2016.<sup>6</sup>

### **Effective Rate Review**

45 CFR Section 154.301 (released May 23, 2011, and amended Feb. 27, 2013) defines the criteria by which HHS will evaluate whether a state has an effective rate review program for each of the individual and small-group markets, or the merged market, if applicable. Subsection (a)(3) includes reasonableness, past projections versus actual experience, reinsurance and risk adjustment program effects, the market-wide single risk pool, essential health benefits, actuarial value, and other market reforms. Subsection (a)(4) includes the itemized list of factors a state must review. If a state does not have effective rate review, and HHS performs the review, the actuary may want to include all of the elements in subsections (a)(3) and (a)(4) in his or her actuarial memorandum.

For states without an effective rate review program, HHS reviews the rate filing justifications and makes a determination as to the reasonableness of the rate increase based on whether or not it is excessive, unjustified, or unfairly discriminatory. These standards are further defined in 45 CFR 154.205 as described below:

- An **excessive** rate increase is one that results in rates that are unreasonably high in relation to the benefits provided. A rate increase could be deemed excessive if it results in future loss ratios below the federal medical loss ratio (MLR) standard under PHSA Section 2718 (for the applicable market), one or more of the assumptions on which the increase is based is not supported by substantial evidence,<sup>7</sup> or the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.
- An **unjustified** rate increase is one for which the insurer provides data or documentation to HHS that is incomplete, inadequate, or inconclusive.
- An **unfairly discriminatory** rate increase is one that results in premium differences, that are not permissible under state law, for a particular product between insureds within

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<sup>6</sup> See <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

<sup>7</sup> The phrase **substantial evidence** is not common in actuarial literature. The actuary might want to provide sound actuarial reasoning, data, and analyses supporting each assumption employed. This holds for the combination of all assumptions and results of the actuarial methodology employed in developing the proposed rate increases.



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similar risk categories, or, if no state law applies, do not reasonably correspond to differences in expected costs.

If the information in parts I and III is not sufficient for HHS to determine whether the rate increase is “unreasonable,” HHS may ask for more information.

If a state has an effective rate review program, it also may have its own requirements for filing information to support the rate increase requested. A separate actuarial memorandum supporting the rate filing is appropriate to use in states that have additional or separate requirements. The actuarial memorandum and certification (Part III) supporting the information included in Part I and information addressing 45 CFR 154.301(a)(3) and (4) may also be requested by state regulators.

### **State Requirements**

For a rate increase that is subject to a required review for reasonableness (i.e., the rate increase is above the threshold), 45 CFR 154.210 requires that states with an effective rate review program provide a brief explanation of their determination of whether the rate increase is unreasonable. HHS will post this explanation on the Centers for Medicare & Medicaid Services (CMS) website. If the state does not have an effective rate review program, HHS will make the determination and post an explanation of its determination on the Health Insurance Oversight System (HIOS) portal. The explanation is expected to be publicly available and could be written in a way that is understandable to consumers.

States receiving premium review grants also are required to provide information about trends in premium increases in health insurance coverage in premium rating areas to the secretary of HHS, and make recommendations to the state (or federal) exchange about whether an issuer should be excluded from participation due to a history of excessive or unjustified premium increases.

Information on states awarded rate review grants is available at <http://www.cms.gov/CCIIO/Resources/Rate-Review-Grants/index.html>.

### **Unified Rate Review Template (URRT)**

It is important to note that the URRT (Part I) does not necessarily align with actuarial information, techniques, or computations traditionally used in the development of rates or rate table increases that, in turn, form the basis of states’ departments of insurance (DOI) rate submissions. As an example, in Worksheet 2 of Part I, the rate change percent and the cumulative rate change percent over the 12 months prior are inputs and not derived directly from other information on the form. Prior to 2014, state DOI submissions generally did not follow this method for calculating rate increase percentages.

Furthermore, Part I has a different purpose from a typical rate review objective; namely, that the information provided will track items over time such as experience data and rate increases, as well as actual and expected index rates to meet certain ACA reporting requirements.

Therefore, it is important to refer to and to follow the instructions. The following provides additional considerations when completing the URRT and the actuarial memorandum.

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**Part I, Worksheet 1, Section II**

In the small-group market, there is at least one additional consideration actuaries are aware of that is not mentioned in the instructions. Employers historically have chosen a single issuer (or possibly two) with a handful of plans to offer their employees. Participation and contribution requirements helped limit adverse selection across the group's members. The ACA has set a minimum participation rate of 70 percent for federally facilitated Small Business Health Options Programs (SHOPs), but requirements vary for state SHOPs. An issuer still can apply a minimum participation and contribution requirement outside of a prescribed annual enrollment period. Effective 2014, small groups that do not meet the minimum participation or contribution requirements can now enroll during a short annual enrollment period from Nov. 15 through Dec. 15, potentially creating additional adverse selection to an issuer's small-group line of business.<sup>8</sup> If applicable, any selection effect not included in the base period experience could be included in the "Utilization" trend factor, and would result in it being applied to all small-group market products (as is required by the ACA). Any adjustment for this issue would need to be described in the actuarial memorandum. Changes in the market such as the ones described above eventually will not be needed when the base period experience includes claims that conform to the new market rules.

If an issuer would like to use more than one year of data in its projection, then this could be handled in the "Credibility Manual." For example, smaller issuers with less credible experience may choose to use two years of data and perhaps weight the more recent annual period (Year N) more heavily than the less recent year (Year N-1). Here, Year N is the experience period 2 years prior to the projection period (Year N+2), and Year N-1 is the period 3 years prior to the projection period. In this case, an actuary may enter the experience for Year N in Section I and enter the projected Year N-1 experience as the "Credibility Manual" in Section II.

The actuary may want to consider additional alternatives as well. Examples of some possible alternatives are as follows; however, this is not intended to be an exhaustive list:

- The actuary might use a manual rate to blend with the actual experience from the experience period.
- The actuary might reflect experience from additional time periods.
- The actuary might make adjustments due to pooling of large claims adjustments to experience, in Part I, Worksheet 1 through the population risk morbidity adjustment.

The actuary needs to explain his or her methodology and the data source for the manual rate and all adjustments made to the manual rate source data as part of the actuarial memorandum.

**Part I, Worksheet 1, Section III**

The single risk pool gross premium is not intended to be a base rate of the type that actuaries historically would develop in their rate filing as a starting point for premium development.

The user is asked to enter the "Index Rate for the Projection Period." The index rate for the projection period is likely to equal the projected allowed experience claims per member, per month (PMPM) except in the following cases:

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<sup>8</sup> See CFR 147.104: <http://www.ecfr.gov/cgi-bin/retrieveECFR?n=45y1.0.1.2.62.0.27.4>.

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- If the issuer is covering benefits in excess of EHB, then this amount will be included in the projected allowed experience claims PMPM but not in the index rate for the projection period.
- If, in the small-group market only, the rate filing submission includes prospective quarterly trend adjustments, then the index rate for the projection period would reflect a member weighted average of the projected index rates for each applicable period while the projected allowed experience claims PMPM will reflect only the date of the index rate change. The actuary may want to consider documenting in Part III the reconciliation of the quarterly small-group index rates to the projected allowed experience PMPM.

### **Part I, Worksheet 2, Section II**

Part I, Worksheet 2, Section II requests the components of the premium increase separated by type of service categories in addition to administrative costs, taxes and fees, and risk and profit charges. Many actuaries typically do not develop rates using a “bottom-up” approach that would allow them to detail the premium increase by these types of service categories. In these situations, one approach would be to determine the amount of total premium rate increase related to medical claims and to then allocate by type of service category using a projected distribution of claims by type of service. It is expected that an issuer will be able to isolate the component of the premium increase related to administrative costs, taxes and fees, and risk and profit charges.

Note that taxes and fees on Worksheet 2, Section II would include the portion of the rate change that is due to a change in the transitional reinsurance assessment or the risk adjustment fee. These are not in the taxes and fees on Part I, Worksheet 1, Section III because the reinsurance assessment is netted out of reinsurance recoveries and the risk adjustment fee is netted out of the risk adjustment value.

The expected changes in the payments and charges under the risk adjustment and reinsurance programs are expected to be included in the taxes and fees on Worksheet 2, Section II. When the reinsurance program results in lower claim recoveries year-over-year as the program phases out, this could result in a large increase in costs to be included in the taxes and fees reported in this section. Depending on how risk adjustment payments and charges were included in the current year’s rates, changes to that program would be included in taxes and fees. If current year’s rates did not include a risk adjustment payment or charge due to projection of market level rates, and the rating year’s rates are also projected at market level (rather than issuer-specific), then the changes in payments and charges for the risk adjustment program may not need to be included in taxes and fees. However, if the current year’s rates did include an adjustment to get to issuer specific rates, the expected change in payments and charges for the rating year’s risk adjustment program are to be included in taxes and fees. Assumptions on changes to the reinsurance and risk adjustment payments and charges, as well as justification, are included in the actuarial memorandum.

Part I, Worksheet 2, Section II also requests projected membership by plan. There is an option to provide membership at the product level. This will be an important assumption, as the weighted average components of the rate increase are weighted by this membership and the average current rate PMPM to determine the overall rate increase for the product or plan. Starting with 2017 rate filings, rate increases will be calculated at the plan level based on changes in the plan

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adjusted index rate. Note that in the case of a new plan that is not replacing a terminating single risk pool-compliant plan, there will be no rate change to enter. (If the terminating single risk pool-compliant plan is “mapped” into the new plan, the rate increase would be measured from the terminated plan to the new plan.) It may be very difficult for an issuer to project membership by plan with precision for issuers that are intending to file new plans or products. However, the instructions state, “With the exception of terminated plans, the projected member months for a plan should not be zero.” A regulator reviewing a filing may question the validity of projecting 0 membership for a plan, given the guaranteed availability requirements. Also, entering a 0 value for projected membership may cause errors in subsequent calculated values that may be referenced by other systems. Actuaries need to be aware that there are many aspects an issuer may want to consider in its membership projections, including but not limited to the following:

- Enrollment experience data, including metal level and plan choices, network preferences, income levels, and the timing of enrollments and disenrollments. This includes a review of small-group enrollments as compared to prior years to determine likely timing of potential new entrants.
- Competitors’ enrollment experience, to the extent publicly available.
- Whether the state will or has adopted Medicaid expansion or is changing its Medicaid eligibility or overall Medicaid delivery strategy in order to move certain classes of enrollees to the individual market.
- Whether the state will or has introduced a Basic Health Plan.
- The size and income distribution of the uninsured population in the issuer’s market.
- Whether the state is maintaining its high-risk pool, and the timeline for closing such possible plans.
- Enforcement of the individual shared responsibility penalty.
- Changes to tax credits available to small employers, or simply changing awareness of tax credits.
- Available information on whether small employer groups are planning to stop offering, or self-fund, health plan coverage in the issuer’s market.
- Any publicly available competitor information on new products being marketed and potential price points for these products.

**Part 1, Worksheet 2, Sections III and IV**

In the case of single risk pool-compliant plans terminated prior to the projection period that are closed to new entrants and are mapped to a new plan ID, the instructions state that “the issuer should include information related to the Experience Period of the terminated plans in the column of the new Plan ID.” Otherwise, a new product or plan will have no information completed in Worksheet 2, Section III “Experience Period Information,” and a closed product or plan (i.e., “terminating plan”) will have no information completed in Worksheet 2, Section IV “Projected Period Information.” If a closed product or plan was only available in the current year and will be closed, then there would be no experience in the experience period, and no experience to be projected.

Transitional plans that were issued prior to Jan. 1, 2014, do not have fully ACA-compliant benefits. Transitional plans will continue to be available through 2016 and would have information included in Section III “Experience Period Information” through the 2018 filing, but would not have information in Section IV “Projected Period Information.”

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The experience for both terminating non-single risk pool (non-ACA-compliant) plans and transitional plans not mapped to ACA-compliant plans may be combined in a single column in Worksheet 2. Refer to the instructions on how to populate this column.

The instructions require issuers that apply a tobacco surcharge to a plan's premium rates to make an adjustment as part of the calculation of the plan adjusted index rate to remove the portion of the cost that is expected to be recouped through the tobacco surcharge. If the tobacco surcharges are the same for all plans, then the weighted average tobacco rating factor used to determine this adjustment also would be the same for all plans, although the resulting adjustment may differ slightly by plan, as explained later. Per comments from CCIIO, however, if the issuer uses different tobacco surcharges for different plans, then the adjustment will vary based on the applicable surcharges but would not vary based on expected enrollment. This is because the market adjusted index rate (the starting point) reflects the average demographics across all plans.

For an issuer that does reflect tobacco use in its premium rates, the weighted average of the plan adjusted index rates will be less than the single risk pool gross premium because the plan adjusted index rates must reflect an adjustment to remove the portion of the revenue that is expected to be recouped through the tobacco surcharge. In addition, because the composite premium on Part I, Worksheet 1, Section III is on an effective year basis, and the Plan Adjusted Index Rate for the small-group market is based on a weighted average membership distribution, the presence of quarterly trend factors in the small-group market can cause these two items to vary from Worksheet I to Worksheet II.

Worksheet 2, Sections III and IV, Column B calculates or references values from Worksheet 1 that are meant to be compared to comparable values from Worksheet 2. "Warning" messages are generated in Column A if the difference between these values is outside of a +/-2 percent range. HHS has indicated that these warnings are to provide guidance to the actuary completing Part I and should be noted in the actuarial memorandum, but a warning does not necessarily mean that the Part I is incorrect and cannot be validated and uploaded into HIOS. In fact, there are specific instances in which a warning message could be generated when no error is actually present (e.g., tobacco adjustment).

### **Part III: Actuarial Memorandum**

The actuary needs to be aware of ASOP No. 41 on actuarial communications, as the instructions require the actuarial certification include a statement that the actuary is complying with ASOP No. 41. The detail needs to be sufficient enough that another actuary can form an opinion based on the information provided.

#### **Reason for Rate Increase(s)**

The actuary is required to describe the significant factors driving the proposed rate change. In addition to the factors that HHS lists in its instructions, the actuary may also wish to consider:

- Changes in the issuer's contracted provider reimbursement rates that may impact the unit costs beyond the level of trend alone.
- Changes in the issuer's risk sharing arrangements with providers.

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- Leveraging of trend in plans with deductibles and out-of-pocket maximums that don't change from year to year.
- Pricing consideration for risk corridors: A pricing consideration for risk corridors may not make sense for future filings, as any assumption implies overpricing or underpricing of future rates, except in situations where the issuer's non-claims expenses and/or after-tax profit assumptions trigger the cap on administrative costs or the floor on profit. If data is available for prior experience, an adjustment could be made to that data but the actuary needs to make sure they are not duplicating any other experience adjustments. The risk corridor provisions apply through 2016.

All of these factors, in addition to benefit changes by product, can impact the size of the rate change by plan.

### **Risk Adjustment**

The actuarial memorandum needs to describe how anticipated federal risk adjustment transfers are developed and explain how transfers are applied to the index rate when developing the market adjusted index rate. Plan level risk and market level risk may be difficult to estimate, especially in the early years, due to limited emerging experience and lack of market data. The actuary may use a variety of methods to model and estimate risk adjustment transfer amounts. With any method used, the actuarial memorandum instructions state that issuers must explain how they developed their estimated risk adjustment transfer revenue amount.

The HHS risk adjustment transfer formula is as follows:

**HHS Transfer formula:**  $T_i$

$$= \left[ \frac{PLRS_i \times IDF_i \times GCF_i}{\sum_i (s_i \times PLRS_i \times IDF_i \times GCF_i)} - \frac{AV_i \times ARF_i \times IDF_i \times GCF_i}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times GCF_i)} \right] \bar{P}_s$$

Where:

$T_i$  = Transfer for plan  $i$

$\bar{P}_s$  = State Average Premium

$PLRS_i$  = Plan  $i$ 's plan liability risk score

$IDF_i$  = Plan  $i$ 's allowable rating factor

$AV_i$  = Plan  $i$ 's metal level AV (metallic AV)

$ARF_i$  = Plan  $i$ 's allowable rating factor (age)

$GCF_i$  = Plan  $i$ 's geographic cost factor

$s_i$  = Plan  $i$ 's share of State enrollment, and the denominator is summed across all plans in the risk pool in the market in the state

The two summary level terms in the formula are identical except the first term uses plan liability risk score (PLRS), which reflects both morbidity based risk scores and the actuarial value of the enrolled members, while the second term uses allowable rating factor (ARF), or age factor, and a separate actuarial value term (AV metal level). Other variables are included and are present to capture the interaction between variables.

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The state average premium ( $\overline{P}_s$ ) in the formula above is an important component of the formula but may be difficult to estimate. Different sources of information may be available to estimate this value.

Estimating the plan liability risk score and the allowable rating factor for the issuer relative to the state/market will usually include an estimate in the experience period (if feasible) and an estimate of changes between the experience period and the rating period. These analyses may parallel the estimates of an issuer's morbidity in the experience period and changes in an issuer's morbidity, although differences may exist because risk adjustment methodologies may not entirely reflect morbidity.

The URRT requires risk adjustment transfer payment amounts to be included for the experience period. Because final risk adjustment transfers for the experience period will likely be unknown at the time of the projected period filing, issuers could explain the method used to estimate the experience period transfer amounts.

Factors that could aid in analyzing risk adjustment transfers include: metal level and cost-sharing reduction (CSR) enrollment, differences between the issuer and the statewide market (and correlations that metal level selection has to risk levels), publicly available information on new versus renewal enrollment of issuers versus competitors (and likely risk level implications), and publicly available information on geographical enrollment differences between the issuer and competitors (and correlations that geography may have with risk levels).

Without any credible information or modeling of the market level risk, an actuary could assume no risk adjustment payments or charges (other than the risk adjustment fee), and explain this in the actuarial memorandum.

### **Risk Score**

Factors to consider in assessing enrollees' risk score changes for the issuer relative to the statewide market:

- The major reasons driving a change in relativities from the experience period;
- The reasonable range of the risk relativity to the statewide market for the projection period and the financial effect on rate sufficiency when outcomes deviate from the chosen single point estimate; and
- The possibility of changes in coding intensity for the market versus an issuer's own pool. Consistent changes in both likely would not affect rates materially, but differences between the market and the issuer likely would.

A major purpose of risk adjustment is to protect issuers against potential adverse selection effects that are not already handled by permitted rating variations. Transfers reflect health risk only. In applying any risk adjustment system, an actuary may wish to consider the guidance in ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*.

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**Justification of Risk Adjustment Transfer Amount**

The issuer will have to report and document the development of:

- Estimated market risk level for the total market;
- Estimated issuer risk level at the market and plan level;
- Overall risk adjustment impact on premiums; and
- Estimated risk adjustment fee.

If an actuary estimates that the issuer will enroll members with average market risk level, then the actuary would likely assume no risk transfer to or from the issuer. For example, if the issuer offers a variety of plans at different metal levels and uses a provider network similar in size to its competitors, then lacking any other information about the risk levels of issuer's own business or publicly available information on its competitors in the market, the actuary might assume that the issuer will not experience any risk transfers. If the issuer is large and has a current membership that is close to that of the total market, then it is unlikely that its future membership risk level will be significantly different than the market, and in this situation, without other information, the actuary may wish to assume no risk transfers.

The issuer could potentially project allowed claims PMPM to be at the state market level rather than the issuer-specific allowed claims PMPM. This would indicate that no further adjustment would be made for risk transfer in the URRT except to the risk adjustment fee. If an issuer takes this approach, the morbidity change factor in the projection of the allowed claims would be an adjustment from the experience period morbidity level to the projected total market level for the rating period.

Actuaries may wish to estimate the risk score for their own book of business as well as a risk score for the overall statewide business for all issuers, for the individual market and small-group markets separately, or combined for states with a merged market risk pool. Projection of the average (all issuers) *statewide* risk score is paramount in setting all non-grandfathered ACA-compliant premiums. The projection needs to take into consideration all current non-grandfathered plans whose membership will be expected to move to the ACA-compliant plans, non-grandfathered ACA-compliant plans, and new ACA-compliant plans/products, and to consider the morbidity of both the currently insured and newly insured (previously uninsured) populations. The projected average statewide risk score needs to be used consistently when estimating transfer amounts for each plan. Because the statewide average enrollee risk score will impact significantly a given plan's risk transfer, the issuer may want to provide as much justification for its estimate of the anticipated statewide average enrollee risk score as possible, particularly when little experience data is available or when enrollee composition in plans might not be stable.

Because risk scores will be assigned to enrollees only for the period they are covered by plans under the single risk pool rule, the timing of when enrollees will be phased in to the market over time might be considered. This consideration would affect both the number of enrollees in the market as well as the enrollee's risk score.

While risk adjustment transfer calculations are presented at the plan/rating area level, both the actual payment transfers and the anticipated risk adjustment transfers that are built into the index rate are performed at the issuer level. In practice, issuers may elect to project which plans will



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receive payments and which plans will be assessed charges, and then sum them all up at the issuer level for the index rating and input an aggregate in Worksheet 1. Although calculations are performed at the plan level, final payments and charges are based on relativities issuer to issuer, and will be made on an aggregate basis. For example, if two issuers are in a market, and one issuer is selling primarily gold and platinum plans, and the second issuer is selling primarily silver and bronze plans, there would likely be transfer payments collected by the first issuer from the second issuer but not specifically by metal level. This area of uncertainty for an actuary would need to be articulated in the actuarial memorandum. An actuary may wish to consider including the following information in the actuarial memorandum:

- The assumptions behind each of the factors shown in the above risk adjustment transfer formula.
- The assumptions behind the derivation of the statewide average premium, taking into consideration current ACA-compliant plans, new products, and the impact of enrollees phasing into the market.
- How the risk adjustment amount is allocated by plan.

The actuarial memorandum instructions state that issuers must explain how expected risk adjustment transfers were applied to the index rate to develop the market adjusted index rate. Note that the risk adjustment transfers shown in Worksheet I of the URRT reflect the actual transfers paid or received by the issuer. However, the adjustment applied to the Index Rate would be on an allowed claims basis.

The estimated risk adjustment revenue needs to be first developed for *all* of the plans in the risk pool, and allocated to individual plans. The actuarial memorandum might include an explanation of the derivation of the anticipated risk adjustment transfer amount by plan that sums to the overall transfer amount, the market level adjustment, and how anticipated risk adjustment transfer revenue is allocated to plan premiums in the risk pool. Note that the anticipated risk adjustment transfer amount by plan would most likely not be the same as the allocated risk adjustment transfer amount used for rating purposes, due to the allocation requirement. Note again that the actual results are calculated issuer-wide, and not plan-by-plan.

Lastly, the instructions also state that issuers should explain any potential outlier assumptions that could significantly impact transfer payment estimates.

An example of an outlier assumption could include an assumption or set of assumptions that implies that the issuer is expected to receive (or pay) a significant transfer of funds. The issuer would include documentation to support the reasoning behind outlier assumptions.

Other considerations in assessing the risk adjustment transfer amount:

- The “Projected Risk Adjusted PMPM” on URRT Worksheet 1, Section III is incorporated into the definition of “Projected Incurred Claims.” Similarly, risk adjustment transfer payments and charges are reflected in the numerator of the adjusted MLR. While this inclusion in claims for the URRT purpose may lead one to consider the treatment of risk transfer amounts as similar to incurred claims, it is important to note that

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the value of actual risk adjustment payments is calibrated on premiums, not incurred claims. This calibration by premiums rather than incurred claims may play a role in pricing.

- The actuary might wish to consider the reasonable range of adjusted MLRs, as well as the possibility of its owing rebate payments due to incorrectly estimating the issuer's own risk profile and the statewide risk profile, as well as the relativity between the two. One approach is to contemplate the reasonable range of issuer versus statewide anticipated risk profiles, incurred claims, and premiums, in order to understand the reasonable range of resulting risk transfers and rebates.
- Sequestration effects on risk adjustment payments to issuers also may be a consideration, because they affect timing of receipt of such payments.

### **Non-Benefit Expenses**

ASOP No. 8 has information for considerations of non-benefit expenses to which an actuary can refer.

### **Projected Loss Ratio**

For individual business, the cumulative historical loss ratio and the projected future lifetime loss ratio are common state requirements. Depending on state requirements, the reporting of cumulative historical loss ratio and projected future lifetime loss ratio could be addressed in a separate state actuarial memorandum rather than in the Part III actuarial memorandum, or this reporting could be included in a separate section of the Part III memorandum. If the state does not have cumulative or lifetime loss ratio requirements, this information does not need to be included in the Part III actuarial memorandum.

The actuary would likely need to describe how the loss ratios were calculated and the assumptions and methodology used. This information would need to be provided in a manner that allows for testing associated with any applicable state lifetime loss ratio calculations. In addition, claims activity and member data would be prepared, corresponding to claims and premium experience, as required by the state.

The HHS reporting form includes information needed to determine federal MLRs for each market.<sup>9</sup> The MLR generally can be expressed as:

$$\text{MLR} = \frac{[\text{Incurred Claims} + \text{Quality Improvement Expenses}]}{[\text{Earned Premiums} - \text{Taxes} - \text{Fees}]}$$

When determining the projected MLR using the federally prescribed methodology, the projected risk adjustment transfer to or from the issuer, any reinsurance recovery due under the ACA temporary reinsurance program, and any cost-sharing reduction payments from HHS are to be included. Per updated MLR instructions,<sup>10</sup> risk adjustment transfers to the issuer and reinsurance

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<sup>9</sup> The federal MLR reporting requirements and regulations can be found on the HHS website: <http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html#Medical Loss Ratio>.

<sup>10</sup> See: <http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf>.

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recoveries are treated as reductions to incurred claims in the numerator of the MLR formula, and risk adjustment transfers from the issuer are considered as additions to the incurred claims in the MLR formula. The ACA reinsurance fee and other ACA fees and taxes are allowed as reductions to earned premiums in the denominator of the MLR formula. If the projected MLR is less than 80 percent, the instructions require the actuary to explain any plans to comply with the 80 percent MLR requirement.

There are allowed MLR adjustments for blocks of business with less than 100 percent credibility and for issuance of high deductible plans. Also, to the extent that the issuer includes corporate federal income tax (FIT) as a reduction to earned premium in the denominator of the MLR formula, the actuary needs to recognize that the insurer fee is not tax-deductible. Thus, the effective corporate FIT rate will be higher than the nominal corporate FIT rate, presently 35 percent.

Risk corridor payments and charges also are part of the calculation of the MLR. For rating purposes, it is likely that projected risk corridor payments and charges would be \$0, due to the rate setting assuming that experience costs will be very close to expected costs in the target calculation for risk corridor, except in situations where the issuer's administrative costs and/or profit are sufficient to trigger the administrative costs cap or the profit floor. Note that MLR regulations in 45 CFR 158.130(b)(5) require that these caps and floors be calculated with an adjustment percentage of 0 percent, regardless of any adjustment percentage expected.

It is important to recognize that federal MLRs will be tracked and computed at the market level including grandfathered policies (in addition to state and legal entity), which may not coincide with product groupings used for rate increases. It would be the responsibility of the actuary to reconcile experience used in the rate filing to that used to determine federal MLRs and provide support for any differences when required. Additionally, the federal MLR used for determining consumer rebates is calculated based on three years of experience.

Note that the projected loss ratio is not to be included on Part I, the URRT.

### **Index Rate**

The index rate demonstrates compliance with the single risk pool concept, and is defined as allowed claims for essential health benefits divided by all single risk pool lives. The instructions state, "Allowed claims are defined as the total payments made under the policy to healthcare providers on behalf of covered members, and include payments made by the issuer, member cost sharing, and cost sharing paid by HHS on behalf of low income members."

### **Market Adjusted Index Rate**

The market adjusted index rate is calculated from the index rate. There are expected to be three allowable adjustments to the index rate to arrive at the market adjusted index rate: risk adjustment, reinsurance, and exchange user fees. It is recommended that the actuary include a description of how each of these adjustments was developed and applied to the index rate to develop the market adjusted index in the actuarial memorandum.

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**Plan Adjusted Index Rate**

Once the market adjusted index rate is set, the plan adjusted index rate is then developed using only the following factors:

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network and delivery system characteristics, as well as utilization management practices.
- Plan benefits in addition to the essential health benefits—the additional benefits must be pooled with similar benefits provided in other plans to determine the allowable rate variation for plans that offer these benefits.
- Distribution and administrative costs, excluding exchange user fees, reinsurance assessments, and risk adjustment fees, as they have already been reflected in the market-wide adjustments.
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for these plans.

The plan adjusted index rate reflects the average demographic characteristics of the single risk pool (i.e., it is not calibrated).

According to the instructions, each of the following factors must be described and shown how it is applied to the market adjusted index rate to develop the plan adjusted index rate.

*Actuarial Value and Cost Sharing Adjustment*

The actuary considers the following items with respect to the AV and cost-sharing adjustments:

- Paid-to-allowed adjustment to reflect the fact that the market adjusted index rate reflects allowed PMPM values, and ultimate premium rates need to reflect the value of the cost-sharing component of the plan design.
- Benefit richness adjustment to reflect variation in utilization across different plan designs. This adjustment does not include any estimates of variation in costs due to selection of a plan design by members (sometimes called utilization due to selection). The actuary provides discussion on how this value was developed and how it does not include any adjustment due to selection or differences in health status.
- Cost share reduction component to remove, if appropriate, any projected additional utilization due to benefit richness for those members in cost-sharing variations of the standard plan design. Because the allowed PMPMs would include any projected additional utilization for these members, the plan adjusted index rate removes that portion of the excess utilization that HHS reimburses to the issuer through the cost-share reduction subsidy. This adjustment is a single adjustment applied to all plans, because the market adjusted index rate is an aggregate across all plans. This adjustment can be included in the paid to allowed factor.
- If an issuer chooses to charge a tobacco factor, the allowed rating factor of tobacco status results in additional revenue being collected for a smoking tobacco status. In order to develop rates that are not excessive, an adjustment is made to remove the effect of the

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tobacco status rating factor. This adjustment essentially results in a plan adjusted index rate that removes the higher revenue and costs for smokers. This then results in a plan adjusted index rate that, when developing consumer adjusted premium rates for non-smokers or smokers, would be appropriate for both. As explained below, an interim step for weighting purposes must be performed before the correct tobacco adjustment can be calculated.

This plan level adjustment reflects the issuer's expected underlying cost differentials by plan (other than for selection, as noted above) and is not necessarily based on the AV calculator used to determine metal levels for each plan design.

*Provider Network, Delivery System, and Utilization Management Adjustment*

Certain plan designs may be based on different networks or delivery systems, and these could also contain different utilization management requirements or capabilities. Because the market adjusted index rate is an average value across all plans and projected members in an issuer's market in the single risk pool, adjustments can occur for any variation in network reimbursement, delivery system variations that affect cost, and different utilization management techniques by plan.

For example, an issuer may offer an HMO product with a closed network requiring strict managed care protocols alongside a PPO product with a much larger network with few managed care protocols. The HMO is likely to have a different average reimbursement rate for providers due to the closed network than the PPO. The HMO may have lower utilization in some service categories (e.g., inpatient hospital) and higher utilization in other service categories (e.g., primary care provider visits) as compared to the PPO. These variations are reflected in this adjustment factor.

Note that the instructions make clear that issuers may only use one rating factor per rating area per state per market and that the factor is applied to all plans the issuer has in that rating area uniformly. However, the instructions also state: "If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have a separate plan for each network within the rating area." Note that some states may not allow this, such as states that require statewide PPO networks.

*Adjustment for Benefits in Addition to EHBs*

Issuers may choose to include in some or all of their plans benefits that are in addition to the essential health benefits defined by each state's benchmark plan. It is important for the value included here to be reflective of the average demographics of the projected population, including age and geographic area, and a non-tobacco user status, as the value reflected in the plan adjusted index rate will be multiplied by each of the allowed rating factors (i.e., age, geographic area, tobacco status) relative to each of the calibration values allowed. One way to reflect this value is as a multiple. Another way to reflect this is as a flat PMPM value, if the flat PMPM value has been determined with the allowable rating factors in mind. If an issuer includes prohibited benefits, even if a state's benchmark plan includes these benefits, they must be shown under this section, and considered as benefits in addition to EHBs.<sup>11</sup>

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<sup>11</sup> Note that the minimum chargeable for prohibited abortion services is \$1 PMPM.

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*Impact of Specific Eligibility Categories for the Catastrophic Plan*

It is permitted to project the membership of the population allowed to purchase a catastrophic plan, develop projected costs for that population, and reflect the differential in the impact of specific eligibility categories for the catastrophic plan. Although the catastrophic plan is part of the single risk pool, this is an allowed adjustment to reflect this special group of eligible individuals. This adjustment would specifically include “expected average enrollee gross spending and expected average risk adjustment payments and transfers” per the final Market Rule (page 13422-13423 of 78 FR 39). This adjustment would be the same for all catastrophic plans and would not apply to any non-catastrophic plans.

*Adjustment for Distribution and Administrative Costs*

The instructions state, “Fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Risk Adjustment user fees, Reinsurance contributions, and Marketplace (Exchange) User fees, which are applied at the market level to the Index Rate.” This adjustment would then include all administrative costs, commissions, contribution to risk, profit, Patient-Centered Outcomes Research Institute (PCORI) fees, health insurer fee, premium tax, and other licenses, fees and taxes, but not the exchange user fees, reinsurance assessments, or risk adjustment fees.

- Any additional adjustment that the actuary uses to reflect the fact that the allowed rating factors for age do not reflect expected costs by age could be included in the contribution to risk and profit load. This adjustment, if used, would be a single adjustment across all plans.

**Calibration**

The plan adjusted index rate is reflective of the expected demographic characteristics of an issuer, including the mix of member ages and geographic areas, but assumes all members are non-tobacco users. When calculating a consumer adjusted premium rate for a particular member, the calibration for age and geographic area used is relative to the member’s actual age and geographic area to calculate the appropriate consumer adjusted premium rate. As stated in the instructions, once calibration is determined, it is applied uniformly to all plans in a market/state when developing the consumer adjusted premium rates. The actuary may want to show some examples of how the Consumer Adjusted Premium Rate is calculated, as is required by some states.

*Age Curve Calibration*

The instructions to the actuarial memorandum state that issuers must provide the approximate weighted average age, rounded to a whole number, associated with the projected single risk pool. It goes on to state that issuers should describe the factors used in the determination of the risk pool weighted average age, a description of data used to weight the factors, and a description of the exact calculation.

It is important to determine the weighted average age using the weighted average age factors from the age curve. Essentially, this process uses the membership distribution of the projected population by age, weighted by the age curve factors to determine the weighted average age.

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Once the weighted average age factor is determined, the weighted average age of the projected membership of the single risk pool is identified as the rounded age associated with the weighted average age factor. This process determines the weighted average age associated with the projected single risk pool and the plan adjusted index rate. Once this process has been completed, all the other rate relationships are defined. This practice ensures that the age curve is maintained.

One way to determine the age calibration is to use the weighted average of all the age factors, weighted only by the membership distribution of the projected population reflected in the index rate. If this method is used, one option an actuary might use is applying a factor of zero (0) for the distribution of members expected to pay no premium (more than three dependent children), because the rates, as required by the rules, for dependent children more than three, must be zero (0).

### *Geographic Factor Calibration*

One way to determine the geographic factor calibration is to use the weighted average of the geographic factors weighted by the projected membership distribution by area that is reflected in the index rate. The geographic factors may not reflect differences in population morbidity. In other words, geographic factors cannot be determined based solely on claim experience or utilization differences, but could be derived from provider reimbursement and practice pattern differences. If another method is used, the actuary documents how the methodology adjusts for differences in population morbidity.

### **Consumer Adjusted Premium Rate Development**

The consumer adjusted premium rate is the rate that would be charged to an individual member based on his/her actual age, geographic area, and tobacco status. The calculation starts with the plan adjusted index rate, calibrating it (as described above), and then applying the allowable rating factors (i.e., age, geographic area, and tobacco status) of the individual member.

### **Small-Group Composite Rating**

Federal regulations define a default methodology for determining small-group composite premiums. Under this methodology, an average premium is developed (1) for all covered individuals age 21 and over and (2) for all covered individuals under age 21, both based on the non-tobacco user consumer adjusted premium amounts. The premium for a given family is then calculated by adding up the applicable average for each individual in the family (including up to three covered children under age 21). The tobacco surcharge is calculated based on the individual rate that would have been applicable to each family member. The average amounts used for composite rating must be calculated using the enrolled individuals in the group at the beginning of the plan year and cannot vary throughout the plan year.<sup>12</sup> Some states have approval from CMS to require an alternative composite rating methodology. Issuers need to work with state regulators to ensure understanding of any state specific requirements.

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<sup>12</sup> <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html>

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### **Effective Rate Review Information**

Certain items are not required in the URRT but are contained in Section 154.301 describing the elements of an effective rate review. To facilitate the actual rate review process, an option is to include these items in the actuarial memorandum. The submission could also include any state-specific informational or data requirements. This inclusion can save the issuer from having to submit materials separately, as well as avoid time-consuming correspondence during the review process.

### **Reliance**

As stated in the instructions, if the actuary relies on information or underlying assumptions in preparing the URRT, this should be indicated and the name of the supplying individual(s) be disclosed. Reliance statements do not eliminate responsibility of the actuary signing the memorandum to review the data or information for reasonability or consistency and to use proper professional judgment in the application of such information. Section 3 of ASOP No. 23 in particular includes guidance on use of data, reliability, responsibility, etc.

### **Actuarial Certification**

Note that the actuary is required to certify certain items. Please refer to the instructions to get the most up to date information. Reference in the certification in particular should be made to the Academy's "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States" as well as Precept 2 of the Code of Professional Conduct. The actuary must develop rates in accordance with the appropriate ASOPs and the Code of Professional Conduct. Relevant ASOPs may include, but are not limited to:

- ASOP No. 5, [\*Incurred Health and Disability Claims\*](#)
- ASOP No. 8, [\*Regulator 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\*](#)

Always check online for the current version of relevant ASOPs as well as other materials referenced above, as modification or additions may occur.

Given the standardization built into the federal forms, there will be many instances in which an issuer will have to modify the results of its rate development to fit the data requirements of these federal forms. Therefore, the issuer may want to use the actuarial memorandum to clearly state the assumptions that were needed to "cross-walk" an issuer's rate development to the federal forms. The actuarial memorandum instructions also state the following:

"The actuary may qualify the opinion, if desired, to state that the URRT does not demonstrate the process used by the issuer to develop the rates."

This may be the case when a separate memorandum is being prepared for purposes of a rate filing submission to a particular state. The actuary also needs to explain how the requirements set



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forth in 156.80(d) and 147.102 have been satisfied. Including this qualification in the certification does not, however, eliminate any of the requirements set forth in federal regulation or in the Part I and Part III instructions.