

A PUBLIC POLICY PRACTICE NOTE

## **Exposure Draft**

# **Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act for 2015 and Beyond**

*September 2014*

Developed by the Rate Review Practice Note Work Group  
of the American Academy of Actuaries



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**EXPOSURE DRAFT**  
**Practice Note on Actuarial Practices Relating to**  
**Preparing, Reviewing, and Commenting on Rate**  
**Filings Prepared in Accordance with the Affordable Care Act for 2015 and Beyond**

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This is a new practice note based on Affordable Care Act (ACA) requirements in place as of April 1, 2014, meant for use in rate filings and review for calendar year 2015 and later. 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 practice note replaces the addendum released for exposure in April 2013 entitled, *Addendum to Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act*. This document is intended to provide updated information to actuaries preparing, reviewing, or commenting on rate filings in accordance with Section 2794 of the Public Health Service Act, as amended, for regulatory filings submitted in 2014 for rates effective on or after Jan. 1, 2015.

This practice note reflects instructions released by the U.S. Department of Health and Human Services (HHS) for the Part I Unified Rate Review Template (URRT) instructions and for the Part III Actuarial Memorandum and Certification instructions dated April 30, 2014. These instructions are available via the Centers for Medicare & Medicaid Services' (CMS) Health Insurance Oversight System (HIOS) portal. It is through this system that actuaries can access updated instructions related to rate filings and review under the ACA. When this practice note references "instructions," the instructions being referred to can be found via HIOS.<sup>3</sup>

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. However, this practice note does address a number of issues that were not addressed in the original practice note because official HHS guidance had yet to be finalized (e.g., essential health benefits, actuarial value, reinsurance, risk adjustment, etc.). The actuary should review state and federal regulations and related material continuously as 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 is unclear. For example, potential changes to the reinsurance program are described in HHS's final rule on exchange and insurance market standards for 2015 and beyond, but that regulation does not actually change the program.<sup>4</sup>

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>

<sup>3</sup> <https://portal.cms.gov/wps/portal/unauthportal/home/>

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

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## **Introduction**

Since the original practice note was published in October 2012, the Preliminary Justification Parts I, II, and III that were created by the U.S. Department of Health and Human Services (HHS) regulation implementing Section 2794 of the Public Health Service Act, as amended by the Affordable Care Act (ACA), have been replaced with a new set of requirements to be used for filing with states and HHS when applying for qualified health plan (QHP) status and when a plan or product has a rate increase.<sup>5</sup>

This practice note essentially replaces the section, *Recommendations for Completing HHS Required Documentation*, in the October 2012 practice note for non-transitional plans. The other sections in the original October 2012 practice note are still relevant and may give readers additional insight in filing rate information. For example, there are sections that discuss the review of “subject to review” rate increases, state reporting requirements to HHS, and considerations for developing rate increases for health plans subject to the ACA.

## **General**

Any mention of the effect of the ACA in this document refers to the requirements that affect products, plans, and rating requirements beginning in 2014. There are many other ACA regulations that were effective prior to 2014 that are not discussed in this note.

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 it is allowed, transitional plans (sometimes referred to as “grandmothered plans”) are not included in the projection period under the new rating requirements affecting ACA-compliant plans, Part I Unified Rate Review Template instructions released April 30, 2014, 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.

Similar to requirements that were newly effective for Jan. 1, 2014 filings, rate review and disclosure requirements for ACA-compliant plans include Parts I, II, and III.

- 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.

There are two worksheets in Part I—Worksheet 1 includes aggregate information across the entire risk pool and Worksheet 2 includes information by product and plan within a product.

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<sup>5</sup> Transitional plans with rate increases must use the previous rating forms and process, referred to as the preliminary justification process, described in the October 2012 practice note.

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- Part II includes a summary description of the rate changes and is filed whenever a rate increase is greater than the threshold for rate review. The description in the original October 2012 practice note related to Part II still applies.
- Part III is the actuarial memorandum and certification that describes and supports the development of the information provided in Part I. Part III includes additional required documentation to show the development of rates from the index rate.

The instructions for Parts I and III can be found on the HIOS website.

Both Parts I and III are filed for all plans and products included in the single risk pool every year. The need for Parts I and III do not apply to grandfathered business. However, if grandfathered business experience is needed for credibility purposes, the actuary can include that experience in the credibility manual columns. In addition, these forms are filed for all federally-facilitated exchange (FFE) qualified health plan (QHP) applications and for compliance with applicable state law.

The URRT (Part I) does not necessarily align with actuarial information, techniques, or computations typically 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. According to the instructions, rate increase percentages for Parts I, II, and III should be determined based on the projected population, which results in the need to determine how projected enrollment and product choices theoretically would affect premium levels one year before the projection period, in addition to the projection period itself. Prior to 2014, state DOI submissions generally did not align with this method for calculating rate increase percentages.

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. This purpose is noted in the instructions published by HHS.

However, 45 CFR Section 154.215(f) requires that Part III, the actuarial memorandum and certification, include reasoning and assumptions supporting the data contained in Part I. Section 154.215(g) continues to state that "Content of rate filing documentation (Part III): (1) The rate filing documentation must be sufficient for CMS to conduct an examination satisfying the requirements of section 154.301(a)(3) and (4) and determine whether the rate increase is an unreasonable increase."

45 CFR Section 154.301(a) lists the items a state must include in its review of rates to be considered as having an "effective rate review program." 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 values, and other market reforms. Subsection (a)(4) includes the itemized list of factors a state must review. Not all of the listed items in Subsections (a)(3) and (4) are included in Parts I and III (see list included below under *Effective Rate Review Information*).

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Information in Parts I and III that is not identified specifically by the issuer and affirmed by HHS as well as state regulators as proprietary will be made publicly available on an HHS web site. State requirements for rate filings may differ from the requirements for Part III. One option to consider is to check applicable state rules and regulations regarding filing requirements and confidentiality to determine what is optional to include in Part III compared to what needs to be included in the state filing memorandum (some states allow Part III to satisfy state filing requirements, as long as specific state requirements are included and addressed). An actuary might choose to file separate actuarial memorandums for state requirements, if the state allows such separate filings.

The actuarial memorandum and certification (Part III), as noted in the instructions, includes documentation that supports the information in Part I along with documentation showing the development of the plan adjusted index rate from the index rate. In addition, information supporting specific elements listed in 45 CFR 154.301(a)(3) and (4) may need to be included in the actuarial memorandum.

If a state does not have an effective rate review program and the rate increase is subject to review (the increase is greater than the threshold), then HHS will use Parts I and III to determine whether the rate increase is “unreasonable.” 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 require one. 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 be requested by state regulators.

Important Actuarial Standards of Practice (ASOPs) to consider are mentioned throughout this practice note and are listed in the instructions to Part III.

The Part III instructions provide information regarding the language to include in the actuarial certification. However, some states have specific language and mandatory references to law that may be required.

Parts I and III must be filed each year to reflect the updated index rate, whether or not a rate increase for any plan is being filed.

## **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 156.180), 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

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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.
- 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 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> Grandfathered plans also are not subject to the federal rate review requirements; however, based on guidance as of April 1, 2014, transitional plans are subject to the federal rate review requirements. These requirements are described in the October 2012 practice note.

Health plans offered both inside and outside of an exchange that are subject to the market reform rules must be included in the single risk pool. Additionally, the final market rules (released in February 2013) include association business sold to individuals (not in connection with a group health plan), which will be considered part of the individual market for purposes of the market reforms.

As described in the instructions, an index rate is developed based on an issuer's total essential health benefits (EHB) allowed claims within the single risk pool of that issuer's state market. A market-adjusted index rate is then determined by incorporating expected market-wide payments and charges under the risk adjustment and reinsurance programs, and exchange user fees, in the state. A plan-adjusted index rate is then determined for each plan by applying permissible plan-level adjustments to the market-adjusted index rate. Permitted actuarially justified plan adjustments include the plan's benefit and cost-sharing structure, network and delivery system characteristics, administrative costs, and eligibility impact on catastrophic plans. Note that for filings effective Jan. 1, 2015 and beyond, HHS and many state regulators may expect Part III to include a table that clearly lays out the transformation from the index rate to the market-adjusted index rate and then to the plan-adjusted index rate.

As noted in the instructions, premium rates for all of the issuer's plans in the relevant state market must be developed using the applicable plan-adjusted index rate. Allowable premium rate variation within a plan is specified under the fair health insurance premiums provision which states rates can vary by: age, family, tobacco, and geography. Factors not explicitly identified,

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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>

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such as health status, claims experience, gender, industry classification or small-group size, are prohibited.

### **Effective Rate Review**

As mentioned earlier, 45 CFR Section 154.301 (released May 23, 2011, and amended Feb. 27, 2013) defines the following criteria by which HHS will evaluate whether a state has an effective rate review program for each of the individual and small-group markets, as well as the types of products within those markets (i.e., association products). Below are important excerpts from 45 CFR Section 154.301 used to evaluate a state's rate review process and procedures:

*(1) The State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3) of this section.*

*(2) The State conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase.*

*(3) The State's rate review process includes an examination of:*

*(i) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions.*

*(ii) The health insurance issuer's data related to past projections and actual experience.*

*(iii) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act.*

*(iv) The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the Affordable Care Act.*

*(4) The examination must take into consideration the following factors to the extent applicable to the filing under review:*

*(i) The impact of medical trend changes by major service categories.*

*(ii) The impact of utilization changes by major service categories.*

*(iii) The impact of cost-sharing changes by major service categories, including actuarial values.*

*(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.*

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*(v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.*

*(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.*

*(vii) The impact of changes in reserve needs;*

*(viii) The impact of changes in administrative costs related to programs that improve health care quality;*

*(ix) The impact of changes in other administrative costs;*

*(x) The impact of changes in applicable taxes, licensing or regulatory fees.*

*(xi) Medical loss ratio.*

*(xii) The health insurance issuer's capital and surplus.*

*(xiii) The impacts of geographic factors and variations.*

*(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.*

*(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.*

*(5) The State's determination of whether a rate increase is unreasonable is made under a standard that is set forth in State statute or regulation.*

It is important to note that some of the criteria noted above, specifically item (3)(iv) with respect to examination of health issuer data related to implementation of essential health benefits and other market reform rules, fall outside of what traditionally was considered part of a state's rate review process.

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 and are also described in the October 2012 practice note.

## **Rate Filing Requirements**

In February 2013, HHS amended the rate increase disclosure and review provisions under 45 CFR Part 154 to reflect the new market reform provisions. The amendments are applicable to non-grandfathered, non-transitional health insurance coverage subject to the market reform rules, for plan years (individual) or policy years (small group) beginning on or after Jan. 1, 2014 (ACA-compliant plans). The new provisions added a reporting threshold for any increase above 0 percent, while maintaining a 10 percent review threshold (or a state-specific threshold) to evaluate the reasonableness of the proposed increase; directed issuers to use a new URRT; and

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updated the requirements of states having an effective rate review program to review the rate impact of federal reinsurance, risk adjustment, and other market reforms (as noted above). Current guidance on the process for state submission of state-specific thresholds is available at: <http://www.cms.gov/CCIIO/Resources/Files/Downloads/rrjsptguidance.pdf>.

Rate filing justifications are applicable to non-grandfathered individual and small group (which includes groups of up to 100 employees starting in 2016) health insurance plans that are not considered excepted benefits.<sup>7</sup>

According to 45 CFR 156.80, all products within a single risk pool from a licensed entity must be included in a single filing. The table below summarizes when each part of the justification must be submitted to both HHS and the state (if applicable):

	<b>Transitional*</b>	<b>Single Risk Pool – issuer applying for any plans to be certified as QHP in exchange</b>	<b>Single Risk Pool – issuer not applying for any plans to be certified as QHP in exchange</b>
Part I (URRT)	Included only in experience period.	Yes, for all rates including new plans	Yes, annual submission is required as issuers submit their index rate.
Part II (Narrative Justification)	Only if rate increase is above state threshold (calculated at product level),* and only as part of the experience period discussion.	Only if rate increase is above state threshold (calculated at product level)*	Only if rate increase is above state threshold (calculated at product level)*
Part III (Actuarial Memorandum)	Included only as part of the experience period.	Yes, for all rates including new plans	Yes, annual submission is required as issuers submit their index rate.

\*Transitional plans with rate increases must use the previous rating forms and processes described in the October 2012 practice note, called the Preliminary Justification process.

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 many states, rate filing requirements and processes have and will likely continue to evolve as new information becomes available and states react to changes in the market.

According to the instructions, issuers are required to establish the index rate annually for each market.

In March 2014, HHS released a proposed rule limiting what would be considered a “new” plan.<sup>8</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:

<sup>7</sup> See the October 2012 practice note for a list of excepted benefits: [http://actuary.org/files/RRPN\\_100512\\_final.pdf](http://actuary.org/files/RRPN_100512_final.pdf).

<sup>8</sup> See <http://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf>

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- Product offered by the same issuer
- Product is offered as the same product type (e.g., PPO or HMO)
- 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>9</sup>

The April 30, 2014 URRT instructions also describe changes to a product on renewal that would be considered the same product if it meets specific criteria.<sup>10</sup> This list essentially reflects the information above. States may provide a broader definition of what would be considered a uniform modification of coverage.

### 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 its website (HIOS). If the state does not have an effective rate review program, HHS will make the determination and post an explanation of its determination on HIOS. The explanation is expected to be publicly available and should 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>.

45 CFR Part 154, as added by the ACA, also requires that the Secretary of HHS work with the states to monitor premium increases inside and outside the exchange. No further information is available at the time of this writing on this provision.

### Unified Rate Review Template (URRT)

There are numerous issues through which actuaries must navigate as they fill out or review the URRT (Part I).

#### Part I, Worksheet 1, Section I

Part I, Worksheet 1, Section I only allows for one year of actual experience for the legal entity, state, and market segment level (i.e., the legal entities' experience in the single risk pool). For the individual or combined market, the instructions state that the effective date must be Jan. 1, and the experience period also must be a calendar year period. The instructions go on to state that the experience period for these markets should be the most recently completed calendar year, and

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<sup>9</sup> Ibid

<sup>10</sup> Page 23 of the April 30, 2014 instructions

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that if not, the actuary would need to include an explanation in the actuarial memorandum. Brand new issuers to these markets will not have any experience and can instead rely on manual rates with 100 percent credibility.

The instructions state, “For the small-group market submissions, the first date of the experience period must be the first date of a calendar quarter (i.e., Jan. 1, April 1, July 1, or Oct. 1).” As also stated in the instructions, “the information in this section (Part I, Worksheet 1, Section I) should reflect historical financial and enrollment information for the identified legal entity only.” Thus, the actual experience for the experience period should be entered in the template, regardless of the credibility level (excluding experience for grandfathered policies, though grandfathered experience might be reflected through the credibility manual if the actuary feels that experience aids in accuracy, which is Section II of Worksheet 1). If the issuer has opted to continue policies under the transitional option, then the experience for these transitional policies would be included in the experience period data. 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,” which is Section II of Worksheet 1. 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). 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. Alternatively, the actuary may choose to use a manual rate to blend with the actual experience from the experience period. Alternatively, an actuary could choose to reflect experience from additional time periods, or adjustments due to pooling of large claims adjustments to experience, in Part I Worksheet 1 through the population risk morbidity adjustment. In any case, as stated in the instructions, the actuary should explain his or her methodology and the data source for the manual rate, or morbidity adjustments, as part of the actuarial memorandum.

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

Part I, Worksheet 1, Section II allows for four types of adjustments to the experience period data—population risk morbidity, other, cost trend, and utilization trend. The “Population Risk Morbidity” adjustment factor is applied to the utilization data while the “Other” adjustment factor is applied to the cost per service data. These two factors are not annualized and are not “trended.” They are applied directly to the experience data. Whereas, the “Utilization” and “Cost” trend factors are entered as annualized trend factors, trended by the calculated number of months from the experience period to the projection period, and then applied to the experience data.

The instructions are specific as to the type of changes that should be included in each of the adjustment factors. For example, the instructions state that changes in mix of services or changes in product mix should be included in the utilization trend, while changes in cost related to a change in the distribution of services across network providers should be included in the cost trend. The instructions also state that utilization trend would include changes in induced demand related to product mix and any effects of selection, and the “Other” factor would include changes in the average utilization of services due to differences in average cost sharing requirements between the experience period and the projection period.

In the small-group market, employers historically have chosen a single issuer (or possibly two) with a handful of plans to offer their employees. Participation and contribution requirements

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helped limit adverse selection across the group's members. The ACA has set a minimum participation rate of 70 percent for federally facilitated SHOPS, but requirements vary for state SHOPS. An issuer still can have a minimum participation and contribution requirement outside of the open enrollment period. Effective 2014, small groups that do not meet the minimum participation or contribution requirements can now enroll during a short open enrollment period from Nov. 15 through Dec. 15, potentially creating additional adverse selection to an issuer's small-group line of business.<sup>11</sup> This selection effect could be included in the "Utilization" trend factor, and would result in it being applied to the entire small-group market products (as is required by ACA). Any adjustment for this issue would need to be described in the actuarial memorandum.

Population risk morbidity is further discussed under the section on *Enrollee Risk Profile Considerations*.

When the experience period claims data is 100 percent credible, zeroes must still be entered in the credibility manual section so as not to produce errors when the template is validated.

Given the standardization built into the federal forms, there will be many instances in which an issuer will have to modify the results of their rate development to fit the data required in these federal forms. Therefore, the issuer can 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 Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers."

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

This section takes the projected allowed experience claims per member, per month (PMPM) and applies several factors and adjustments to arrive at the issuer's estimate of the single risk pool gross premium average rate PMPM. There are some places in which the inputs might differ from the inputs an actuary might use in his or her rate development or how amounts are treated for medical loss ratio (MLR) purposes. In the "Projected Risk Adjustment PMPM" line, the risk adjustment transfer projection should be net of any risk adjustment user fees similar to how the "Projected ACA Reinsurance Recoveries" is net of any contributions made to the federal reinsurance program. Conversely, the "Taxes & Fees" line should not include any contributions to the federal transitional reinsurance program or risk adjustment user fees. Also, the "Profit & Risk Load" entries should reflect after-tax amounts. Further, the single risk pool gross premium is not intended to be a base rate that actuaries historically would develop in their rate filing as a starting point for premium development.

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<sup>11</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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The user is also asked to enter in the “Index Rate for the Projection Period.” Note that the index rate for the projection period should equal the projected allowed experience claims PMPM except in the following cases:

- 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 the index rate for the projection period.
- If, in the small-group market only, the rate filing submissions includes prospective quarterly trend adjustments, then the index rate for the projection period should 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.

### **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 cases, 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 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.

Also note that the expected changes in the payments and charges under the risk adjustment and reinsurance programs must also be included in the taxes and fees. As the reinsurance program results in lower claim recoveries in 2015 from that projected in the rates for 2014, this would result in a large increase in costs to be included in the taxes and fees. This effect also will occur in 2016 and 2017, as the reinsurance program slowly goes away. Depending on how risk adjustment payments and charges were included in the 2014 rates, changes to that program would be included in taxes and fees. If 2014 rates did not include a risk adjustment due to projection of market level rates, and 2015 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 2014 rates did include an adjustment to get to issuer specific rates, the expected change in payments and charges for the 2015 risk adjustment program must be included in taxes and fees. Assumptions on changes to the reinsurance and risk adjustment payments and charges, as well as justification, must be included in the actuarial memorandum.

Part I, Worksheet 2, Section II also requests projected membership by plan within each metal tier. 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 will be weighted by this

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membership and the average current rate PMPM to determine the overall rate increase for the product or plan. Note that in the case of a new plan, there will be no rate change to enter. 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. There is expected to be a continued increase in membership for the individual market. 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 their membership projections, including 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 or not the state will or has adopted Medicaid expansion.
- Whether or not the state is changing its Medicaid eligibility or overall Medicaid delivery strategy in order to move certain classes of enrollees to the individual market.
- Whether or not the state will introduce a Basic Health Plan.
- Whether or not the state allows transitional policies, and timelines for this extension in the state.
- The size and income distribution of the uninsured population in the issuer’s market.
- Whether or not 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.
- Any available information on whether small employer groups are planning to stop offering health plan coverage in the issuer’s market.
- Any 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 2014 rate filings and possibly the 2015 rate filings, many issuers may close current products or plans and offer new products or plans. In the case of a new product or plan, there will be no information completed in Worksheet 2, Section III “Experience Period Information,” but there will be information completed in Worksheet 2, Section IV “Projected Period Information.” In the case of a closed product or plan (i.e., “terminating plan”), it is expected that there will be no information completed in Worksheet 2, Section IV “Projected Period Information,” but there will be information completed in Worksheet 2, Section III “Experience Period Information.”

Transitional plans, which were issued prior to Jan. 1, 2014, do not have fully ACA-compliant benefits, and will continue to be available through 2016, would have information included in

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Section III “Experience Period Information” but not in Section IV “Projected Period Information.”

The experience for both terminating and transitional policies may be combined in a single column in Worksheet 2—2013 experience should be indicated in the plan name and the issuer would need to enter “catastrophic” in the metal row for this column.

Section IV of Worksheet 2 represents projected information. It is expected that the projection period from this section generally will align with the projection period from Worksheet 1, Section II, except in cases in which the small-group market submission includes prospective quarterly trend adjustments. In this case, the projection period will represent a weighted average. Similar to the index rate for the projection period in Section III of Worksheet 1, the information in Section IV of Worksheet II will represent a weighted average for all effective dates in the submission.

Updated instructions issued March 20, 2014, require issuers that apply a tobacco surcharge to a plan’s premium rates to make an adjustment in the plan AV and cost share factor, which is used to calculate 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 should be the same for all plans, although the resulting adjustment may differ slightly by plan as explained later. If the issuer uses different tobacco surcharges for different plans, then the adjustment will vary based on the applicable surcharges but should 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 not reflect tobacco use in rates, the weighted average of the plan adjusted index rates should equal the single risk pool gross premium developed in Part II of Worksheet 1. For a company that does reflect tobacco use in 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.

Sections III and IV, Worksheet 2, 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 are 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 cannot be validated and uploaded into HIOS. In fact, there are specific instances in which a warning message will be generated. One of these is the tobacco adjustment discussed above.

### **Other Technical Issues**

There are other technical issues with the URRT and missing information. In future years, these technical issues may be fixed.

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On Part I, Worksheet 2, if too many products are added, the ones that are not needed cannot be deleted. Due to this technical limitation of the URRT, it is likely that the actuary would need to start over with the input process.

On Part 1, Worksheet 2, Section I, a rate decrease can be input as a value less than 1.0. Hovering over the cell input states the value must be greater than or equal to 1.0. However, inputting a value less than 1.0 still works, although when validating the worksheet, an error message occurs. This error message should not result in a problem uploading the sheet. However, the actuary may wish to consider discussing this error in the actuarial memorandum.

On Worksheet 2, for terminating products, a zero can be used for the metallic AV, and a near-zero value (e.g., 0.0000001) can be used for the AV pricing value.

## **Part II Instructions**

According to the Part II Instructions, for rate increases exceeding the “subject to review threshold,” issuers must provide a consumer friendly narrative description of the rate increase. See the October 2012 practice note for recommendations on completing this component of the rate filing justification.

## **Actuarial Memorandum**

The following provides information for actuaries completing the actuarial memorandum.

### **General Information**

*Company Identifying Information* describes the issuer submitting the memorandum. This would match the information in Worksheet 1 of the URRT, and include company name, state with regulatory authority, HIOS ID, market in which the plans are offered, and effective date of the Index Rate change.

*Company Contact Information* assists the reviewer to contact the company. This includes the name of the primary contact person, telephone number, and email address.

### **Proposed Rate Increase(s)**

This section provides information related to the increases, such as the increase by product. Part of the single risk pool requirement dictates that whenever rates change for any one plan, all plans for a legal entity/market/state must be included in the actuarial memorandum, along with information on any and all rate changes, including those plans’ rates that are not changing.

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

The actuary is required to describe the significant factors driving the proposed rate change. The HHS instructions list several of these factors:

- Single risk pool experience more adverse than assumed in current rates: When filing 2015 rates compared to 2014 rates, the actuary may have little information available to them to determine if the 2014 single risk pool experience is more or less adverse than assumed in the 2014 rates. It is possible that prospective prescription drug risk scores could be used to estimate risk; however, in 2014, membership is continuing to increase

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throughout the open enrollment period, and the risk of the single risk pool population may not be known at the time of the filing for 2015 rates.

- Medical inflation; increased utilization: These are trend factors that would be developed by service category (inpatient, outpatient, professional, other medical, capitations, prescription drug) and rolled up to total factors.
- Benefit changes by product or plan.
- Changes to taxes and regulatory fees.
- Anticipated changes in the average *market-wide* morbidity: If, for example, the average risk score of the entire market is expected to increase, it is possible that the issuer may get no financial relief from risk adjustment, even if it expects its own average risk score to increase. This could occur if the average risk score of the market is greater than the issuer's own average risk score. Estimating this factor will be difficult, considering the lag between rate setting early in the calendar year and release of information about market average risk levels later in the year. If this item is included along with the first item above (experience being more adverse than assumed in the current rates), the actuary would need to be sure that there is no "overlap" between the two items, so that the market-wide morbidity component is not double-counted.
- Anticipate changes in payments from and contributions to the ACA reinsurance program.

In addition to these factors that HHS lists in its instructions, the actuary also may 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.
- Leveraging of trend in plans with deductibles and out-of-pocket maximums that don't change from year to year.
- While a pricing consideration for risk corridors may not have made sense in 2014, for 2015 and beyond, it might be appropriate for the actuary to analyze the effect of the budget neutral risk corridor decision; for example, if applied nationally, this revised policy could be interpreted to mean a subsidization to not only strategically and unintentionally underpriced issuers in the state, but also underpriced issuers nationally. Further, the actuary should consider how an enhanced bias towards underpricing might exist in states that have an active purchaser strategy.

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

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**Experience Period Premium and Claims**

This section of the actuarial memorandum provides support for the experience of the single risk pool during the experience period in Worksheet 1 of the URRT Part I. Per the instructions, the information should include, and the actuary may wish to consider, the following:

- Paid through date for claims incurred during the experience period: This usually would be two months, and preferably three months, after the end of the experience period, if this claims runout is available. The actuary may want to consider ASOPs relating to incurred but not reported (IBNR) claims, reliance on others (if applicable), and actuarial communications, providing enough detail for another actuary to assess the reasonability of the data source, methods, and assumptions.
- Premiums (net of MLR rebate) in experience period: This would need to support the earned premiums for the experience period. The earned premiums would be shown prior to MLR rebates and not be reduced by the allowed MLR reductions, such as taxes and assessments. Also, the actuary would want to include the amount of MLR rebates refunded or expected to be refunded for the market during the experience period. As stated in the instructions, if any portion of the MLR rebate has not been finalized, the actuary would include an estimate of the rebate and describe the methodology used to calculate the estimate. For example, the actuary may include the calculation used to determine the liability for MLR rebates in the issuer's most recent annual statement, updated for any new information after the submission of the statement.
- Allowed and incurred claims: These would be the actuary's best estimates of both the allowed claims and incurred claims during the experience period. Worksheet 1, Section I shows these claim estimates. As stated in the instructions, the actuary also would separately include the amount of claims both processed through and processed outside the issuer's claim system and include an estimate of claims incurred but not paid as of the paid through date. The instructions also state that the incurred but not paid estimates should be provided separately for the incurred claims and for the allowed claims in the experience period.

The instructions state “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 and member cost sharing.” An issuer's allowed claims by service category may also come from a different data source than the net incurred claims. In this situation, the actuary may need to adjust reported allowed claims so that they are consistent with the reported net incurred claims, and should provide an explanation of the adjustment.

- Support for the incurred but not paid claims: The instructions state “describe the methodology used to develop the estimate of claims incurred but not paid for both allowed claims and incurred claims...” and, if the method differs, “describe and support why they are different.” The instructions also direct the actuary to state whether the completion factors were developed from the claims during the experience period or some alternative claims set. For example, to increase the credibility and stability of the factors,

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the actuary may need to base some or all of the completion factors on a combination of large group, small group, and individual experience. If an alternative claims set is used, the source of the alternative claims set and why it was used can be described in the actuarial memorandum.

The instructions state that “if the incurred but not paid claims are unusually high or unusually low relative to the experience period paid claims...explain what is causing them to be unusually high or unusually low.” The Part III instructions mention as possible reasons a new claim system or a significant employee turnover. Other reasons could include known liabilities for members with very high levels of unpaid claims or corporate holidays that affect the number of claim paying days.

### **Benefit categories**

In the filing of benefit categories in Worksheet 1, Section I, the actuary chooses from a drop down list in the URRT the measurement units for each benefit category. It is likely that for “Capitation” the number chosen for “Utilization per 1,000” may be somewhat contrived, such as 12,000, but as long as the resulting PMPM is accurate, then the projection will still work correctly.

### **Projection Factors**

Overall changes in average PMPM claim costs from experience period to projection period for each benefit category are to be disaggregated into four separate components—changes in population risk morbidity, changes in unit costs, changes in utilization, and changes in other factors. If the issuer has transitional policies, this may affect population risk morbidity factors, and demographic changes that appear under “other factor.” (For further details, see also the section on filling URRT, Part I, Worksheet 1, Section 2).

### **Credibility Manual Rate Development**

If the actuary considers the base period claims experience less than fully credible and, thus, decides to use the credibility manual section of the URRT for projecting experience, the actuary can develop and justify “Credibility Manual Rates” that will then be combined with historical experience to produce the unique index rates for the state and market under consideration. The actuary would need to document and explain the methodology used in the development of credibility manual rates.

### **Credibility Experience**

When the base period experience is less than fully credible, the actuary needs to assign a credibility weight to the projected base period experience.

- Description of the credibility methodology used: This could be based on internal company analysis and consideration of ASOP No. 25.
- Resulting credibility level assigned to base period experience when applying the proposed credibility methodology: This value would be calculated based on the methodology outlined above.

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#### Paid-to-Allowed Ratio

As noted in the instructions, the actuarial memorandum should “provide support for the paid to allowed average factor in projection period for the market.” For example, one suggested approach is to weight the AV pricing value for each plan by the associated projected membership as long as the AV pricing values are adjusted so that they can be applied to an allowed amount (which represents no cost sharing). Any approach used should be clearly documented.

#### Risk Adjustment

In the early years, there may be limited emerging experience to estimate the plan level risk level or the market level risk levels. HHS intends to provide information quarterly, but as of the date of this publication, HHS has not been able to make a commitment and no specifics have been announced as to what data will be provided and when it will start.

Until or even after such information from HHS becomes available, the actuary may develop or have access to a model of the overall market that projects the market and plan risk levels. Such models that are currently in use typically make use of filed and publically available premium rates, data on the demographics and health status of insured and uninsured populations, and other issuer data. If the actuary uses a market model to estimate these risk levels, the actuary may wish to describe the general method and assumptions used by the model upon request.

#### Transfer Formula

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 ( $\bar{P}_s$ ) 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, especially in 2014) 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 since risk adjustment methodologies do not entirely reflect morbidity.

While Part I does not require risk adjustment values to be included for 2013 experience or for the projection period in the 2015 form, it will be a challenge to estimate the risk adjustment impact for the 2014 and 2015 experience periods in the 2016 and 2017 forms. The risk adjustment program for small-group and individual markets will still be relatively new. Further, HHS does not plan to release actual market risk scores for 2014 and 2015 until the second half of the following years (2015 and 2016), after rates for the next years must be filed.

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), new versus renewal enrollment of issuers versus competitors (and likely risk level implications), and 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 of \$1 PMPY), 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;
- 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 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

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applying any risk adjustment system, an actuary may wish to consider ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*.

**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 has attempted to estimate the market risk level for the total market in his or her projections, then the actuary may wish to 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 that of 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 mean 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 for the base data to the total market rather than to the issuer's projected population.

Per the actuarial memorandum and certification instructions excerpted below, issuers need to include certain information in their rate justification:

“Under the single risk pool pricing requirements issuers are required to make a market wide adjustment to the pooled market level Index Rate to account for federal risk adjustment and reinsurance payments. Consistent with this adjustment, anticipated risk adjustment revenue must be allocated proportionally based on plan premiums for all plans within a risk pool by applying the risk adjustment transfer adjustment factor as a constant multiplicative factor across all plans. The risk adjustment transfer amount should be net of the risk adjustment fees.

In the Part III Actuarial Memorandum, issuers must explain how they developed their estimated risk adjustment revenue for all of the plans in the risk pool. Issuers are expected to explain all of their market and plan level assumptions related to the inputs of the HHS payment transfer formula (or alternative state payment transfer formula, if applicable). In other words, issuers must explain their assumptions related to plan and market level risk scores and other relevant cost factor adjustments that are used to calculate payment transfers under the risk adjustment program.”

First, 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-

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group markets separately, or combined for states with a merged 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 and new products and consider the morbidity of both the currently insured and newly insured (previously uninsured) populations. The projected average statewide risk score should 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 support 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.

Since 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 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 will have to project which plans will 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 be transfer payments collected by the first issuer from the second issuer but not specifically by metal level. This is an area of uncertainty for an actuary and would need to be articulated in the actuarial memorandum. An actuary may wish to consider including the following items 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 non-grandfathered non-ACA compliant plans and new products and the impact of enrollees phasing into the market.
- How the risk adjustment amount is allocated by plan.

As noted in the instructions to the actuarial memorandum:

“Issuers must also explain how anticipated risk adjustment transfer revenue was allocated to plan premiums in the risk pool (as noted above transfers must be allocated proportionally based on plan premium). Issuers should describe the overall impact of risk adjustment transfers on premiums.”

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

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of the derivation of the anticipated risk adjustment transfer amount by plan that sums to the overall transfer amount, the constant multiplicative factor used for allocation, 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.

The overall risk adjustment transfer amount (and risk adjustment fee of \$1 PMPY) would be entered in the URRT Worksheet 1, Section III, as “Projected Risk Adjustment, PMPM.” The allocated risk adjustment transfer revenue by plan would be entered in the URRT Worksheet 2, Section IV, as “Net Amount of Risk Adjustment.” One way to demonstrate this is to show that the allocations of risk adjustments by plan are the same percentages of total risk adjustment as the premiums by plan are to the total premium.

Lastly, the instructions also state:

“Issuers should explain any potential outlier assumptions that have a significant impact on transfers. Issuers may elect to provide supplemental exhibits detailing their plan level transfer calculations in order to demonstrate that their transfer estimates appropriately track with the HHS payment transfer formula.”

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 should include documentation to support the reasoning behind outlier assumptions.

Other considerations in assessing the risk adjustment transfer amount:

The “Projected Risk Adjusted PMPM” on 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 may lead one to consider the treatment of risk transfer amounts as similar to incurred claims, it is important to note that 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, 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, to understand the reasonable range of resulting risk transfers and rebates.

Sequestration effects on risk adjustment payments (collections) may also be a consideration.

## **Reinsurance**

The ACA reinsurance will be in effect for the individual market for 2014 through 2016. The reinsurance parameter will change every year. The HHS notice of benefit and payment parameters for 2015 stated:

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“Using the methodology set forth in the 2015 Payment Notice, we establish a 2015 uniform reinsurance contribution rate of \$44 annually per capita, and the 2015 uniform reinsurance payment parameters – a \$70,000 attachment point, a \$250,000 reinsurance cap, and a 50 percent coinsurance rate. We are also finalizing our proposal to decrease the attachment point for 2014 from \$60,000 to \$45,000. Additionally, in order to maximize the financial effect of the transitional reinsurance program, we provide that if reinsurance contributions collected for a benefit year exceed total requests for reinsurance payments for the benefit year, we will increase the coinsurance rate on our reinsurance payments for that benefit year up to 100 percent, rolling over any remaining funds for use as reinsurance payments for the subsequent benefit year.”<sup>12</sup>

In the Preamble to the rule, Exchange and Insurance Market Standards for 2015 and Beyond, HHS provided a response to comments in which a lower attachment point was recommended:

“We intend to propose changes to the reinsurance parameters for 2015 generally consistent with these recommendations. Specifically, in the proposed 2016 Payment Notice, we intend to propose to lower the 2015 attachment point from \$70,000 to \$45,000. We may also propose to modify the target 2015 coinsurance rate based on estimates of roll-over of funding from 2014 and estimates of collections and payments for 2015. These proposals will be subject to notice and comment rulemaking.”<sup>13</sup>

The actuary may wish to use his or her judgment in deciding how much weight to give to these stated intentions. Some may consider it appropriate to assume a \$70,000 attachment point since that is what is in current law, while others may assume \$45,000, considering it the most likely outcome. However, some states may not allow the lower assumption.

Per the actuarial memorandum and certification instructions, issuers need to include the following information in their rate justification:

“Under the single risk pool pricing requirements, issuers are required to make a market wide adjustment to the pooled market level Index Rate to account for federal risk adjustment and reinsurance payments. Consistent with this adjustment, anticipated reinsurance revenue must be allocated proportionally based on plan premiums for all plans within a risk pool by applying the reinsurance adjustment factor as a constant multiplicative factor across all plans.”

Reinsurance estimates can have no adjustments for risk adjustment. That is, reinsurance is calculated independent of risk adjustment payments or receivables.

Although the instructions state that the anticipated reinsurance revenue must be allocated proportionally based on plan premiums, there is also an indication that reinsurance payments be estimated at the plan level. For example, different out-of-pocket maximums could affect the anticipated reinsurance recoveries by plan. The instructions indicate that:

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<sup>12</sup> See: <http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf>

<sup>13</sup> See: <http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf>

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“Issuers may provide supplemental exhibits that demonstrate how they estimated plan level reinsurance payments in order to demonstrate that they appropriately track with the Federal methodology for calculating reinsurance payments.”

To estimate the reinsurance recoveries, the actuary may use a claims continuance table that is either derived from the same source as the experience period data in the URRT or normalized to reflect the anticipated trended PMPM allowed costs.

If the overall national reinsurance fees are not sufficient to pay for reinsurance claims, HHS will reduce the reinsurance receivables proportionally. This possibility might affect projections of reinsurance recoveries.

### **Non-Benefit Expenses**

More documentation of non-benefit expenses (NBE) is required now.

The instructions indicate:

“Describe the methodology used for developing the estimate of these non-benefit expenses expected during the projection period for the applicable market, including any allocation of corporate overhead. Discuss how the percentage load varies by product or plan, if applicable. Describe the source data that was used as a basis for the projections and why that data is appropriate.

It is suggested that the issuer maintain documentation of the expense allocation methodology, including expenses identified by function and whether they are fixed or variable, so that it can be made readily available to the regulator upon request.”

These instructions indicate that the actuary should work closely with other areas of the company to understand the projected budgets for the coming year. Corporate business plans should be requested and used as a source of information in developing the projected NBE amounts.

NBE amounts should be broken into categories, and projected cost for quality improvement should be estimated separately, if applicable.

Changes from prior filings either in PMPM or percentage of premium NBE amounts should be explained.

Section 3.4.4 of the exposure draft of the revised ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*, has useful information on non-benefit expense assumptions.

### **Profit & Risk**

The instructions indicate that any risk charge in addition to the profit (underwriting gain or loss margin) should be reported separately, and that changes in profit and risk margins from prior filings should be explained.

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The actuary may consider capital and surplus requirements in determining rate increases. The insuring organization should be considered as a viable ongoing concern that will meet state statutory capital requirements. There may be circumstances when contributions to surplus are necessary to maintain the insuring organizations' financial soundness. If this is the case, the actuary may wish to include contributions to surplus in the rate increase calculations. On the other hand, some states have set limits on rate increases dependent on high levels of capital.

Also, Sections 3.4.5 and 3.4.7 of the exposure draft of the revised ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*, have useful information pertaining to profit margins in rate filing and rate review.

### **Taxes and Fees**

The instructions state, "Describe only the taxes and fees that may be subtracted from premiums for purposes of calculating MLR. However, do not include any contributions to the Federal transitional reinsurance program or risk adjustment user fees in this amount despite their treatment in MLR calculations, since Federal reinsurance and risk adjustment are expressed in the template net of reinsurance premium and risk adjustment user fees."

The instructions also state, "Describe each tax and/or fee and indicate the amount for each, either as a percent of premium or a per member per month amount." Therefore, the development of the level of each tax or fee amount should be documented separately. If the health insurer tax is adjusted for the fact that it is not tax deductible, the actuary should document in a quantitative way how the adjusted tax rate is derived from the nominal tax rate.

If the issuer is offering products on and off of the exchange, the exchange user fee is charged equally to all products and not just to the on-exchange products. The instructions state the actuary should demonstrate how the exchange user fee is adjusted to reflect the expected mix of exchange and non-exchange plans. For example, if the issuer expects that 40 percent of its premium will come from non-exchange plans, and if the exchange user fee is 3.5 percent of premium, then the net fee applied to all products, both on and off the exchange, is 60 percent times 3.5 percent, or 2.1 percent of premium.

### **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, this could be addressed in a separate state actuarial memorandum rather than in the Part III actuarial memorandum, or it 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 should be prepared, corresponding to claims and premium experience, as required by the state.

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The HHS reporting form includes information needed to determine federal MLRs for each market.<sup>14</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 would be included. Per updated MLR instructions,<sup>15</sup> risk adjustment transfers to the issuer and reinsurance 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.

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 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. However, as described earlier, the actuary may wish to monitor policy changes to the risk corridor program, such as budget neutrality, that change this initial assumption.

The actuary may wish to actively review the HHS website for updates and additional information.

It is important to recognize that federal MLRs will be tracked and computed at the market level (in addition to state and legal entity), which may 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.

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

### **Single Risk Pool**

The single risk pool demonstration is only necessary for ACA-compliant plans. As stated in the instructions, the issuer is required to support that the single risk pool is established according to the requirements in 45 CFR 156.80(d). Thus, the actuarial memorandum should include a

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<sup>14</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>15</sup> See: <http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf>

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description of how the content of the base data and all adjustments to arrive at the plan premiums are consistent with the federal requirements for a single risk pool.

The single risk pool includes transitional products/plans in the base experience period and then adjustments are made for differences in benefits, population morbidity, etc. Per the instructions, the projection period is to include members in the transitional products that will purchase fully ACA-compliant plans during the projection period to the extent that they will be covered in the projection period. However, members who remain in transitional policies during the projection period would not be included as part of the projected period single risk pool.

### **Index Rate**

Section 1312(c) of the ACA requires issuers to combine all non-grandfathered business into a single risk pool. The experience period and projected period index rates are the mechanisms that implement the single risk pool. The experience period index rate is developed by combining the allowed claims experience of the enrollees in all non-grandfathered plans (both non-ACA compliant and ACA compliant) of an issuer in the individual or small-group market (or combined, if required by state law). The projected period index rate is developed by combining the allowed claims experience of the projected enrollees in ACA compliant plans only, and not projections for non-ACA compliant plans still in effect until the point at which these members move to an ACA compliant plan. Excepted benefits (e.g., dental, vision, and short-term policies) are not subject to the single risk pool requirement. All rates for an issuer's non-grandfathered ACA compliant plan business effective Jan. 1, 2015, will be developed from the index rate.

As noted in the instructions, the allowed claims experience should include only those essential health benefits that were in existence during the experience period, without any estimation of non-existent benefits. For example, if maternity coverage in the individual market did not exist during the experience period, no adjustment for maternity should be made in the index rate. Such adjustment for newly covered essential health benefits should be made in the projection section of the URRT Worksheet 1. In addition, any benefits that are not considered essential health benefits, but were included in the experience period, must be removed from the calculation of the experience period index rate.

The instructions state, "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." Thus, the projection period index rate only includes projected allowed claims experience for essential health benefits and, by definition, does not include any benefits in excess of the essential health benefits. In addition, it is important to project allowed claims assuming any projected membership for the CSR variations, which may not be at the standard plan level but potentially at a higher projected allowed claims level for those CSR members (reflecting benefit richness), but only to the extent the actuary deems appropriate.

The definition of allowed claims on page 10 of the instructions to Part I URRT states, "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." Since allowed claims may potentially reflect higher utilization assumptions for those low-income CSR members, premium rate development, as part of the AV and cost share factor, may need to adjust out the value of the

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CSR variations in order to develop rates that are appropriate for the standard plan level only. (See discussion of *AV and Cost Share Factor* below.)

In addition, the index rates should not reflect any payments or charges under the reinsurance or risk adjustment programs, nor should it reflect exchange user fees.

Rates are required to be shown to meet the new rating requirement of single risk pool rate development. This requirement identifies the starting point as the projected index rate and then three market-wide adjustments are made. The plan adjusted index rate for any given plan cannot vary from the resulting adjusted market-wide index rate, except for the five plan-specific modifiers that are allowed. The instructions state, “The purpose of the actuarial memorandum is to provide certain information related to the submission, including support of the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases.” The discussion below highlights issues the actuary might need to consider.

Per the instructions, the index rate, the market adjusted index rate, and the plan adjusted index rate calculations should all follow the market reform rating rules,<sup>16</sup> be actuarially justified, and be implemented by issuers in a transparent fashion.

### **Market Adjusted Index Rate**

Once the projection period index rate is set, a market-wide adjustment is made to the index rate based on the total expected market-wide payments and charges under the risk adjustment and transitional reinsurance programs in a state and the issuers’ estimated user exchange fees for projected members expected to purchase on an exchange in the market. In this way, risk adjustment, reinsurance, and exchange user fees are spread across all products and plans in a market. Note that “market-wide” here means the issuer’s market (i.e., individual, small group, or combined). Also note that the risk adjustment fee and the reinsurance assessment (premium) are included in the risk adjustment and reinsurance adjustment here, similar to values reflected in Worksheet 1 and 2 of the URRT.

The exchange user fees expected to be required for the members projected to purchase on an exchange in a market must be spread across all projected members in the market. For example, if an issuer projects that 60 percent of its membership will purchase through an exchange (on-exchange), and 40 percent of its membership will purchase outside of an exchange (off-exchange), then the 3.5 percent exchange user fee would need to be included here as (3.5 percent x 60 percent + \$0 x 40 percent), or 2.1 percent.

The actuary may wish to include a description of how each of these adjustments were developed and applied to the index rate to develop the market adjusted index rate in the actuarial memorandum. Because the index rate and the market adjusted index rate are based on allowed values, in order to get to the paid values, the actuary may also wish to consider the effect of the application of the paid-to-allowed factor being applied after the market adjustment, as part of the plan AV and cost-share factor, and adjust the market adjustments appropriately.

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<sup>16</sup> See: <http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf>

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### **Plan Adjusted Index Rates**

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 user fees.
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for these plans.

Once the plan adjusted index rate has been developed, that value defines the location of the issuer’s projected membership on the age curve. In other words, the plan adjusted index rate reflects the average demographic characteristics of the single risk pool. Once the location on the age curve has been identified, the age curve defines the relationship between the plan adjusted index rate and all the other age rates. In the actuarial memorandum to be filed with HHS supporting the URRT filing, no further adjustments, such as to calculate a base rate for an age 21 year old (where the age factor is 1.0) will be required. Calibration is allowed (discussed below). However, state requirements may include the development of base rates, and the actuary should be aware of any state requirements that may result in a separate actuarial memorandum to meet state requirements.

Each of the following factors must be described and shown how they are applied to the market adjusted index rate to develop the plan adjusted index rate.

#### *Actuarial Value and Cost Sharing Adjustment*

The instructions state, “The actuarial value and cost sharing adjustment (plan adjustment) would take into account the benefit differences, utilization differences due to differences in cost sharing and an adjustment for non-tobacco user status. The utilization difference may reflect the impact higher cost sharing has on utilization but cannot reflect differences due to health status.”

Therefore, that actuary may wish to consider the following items:

- 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 across different plan designs that affect utilization differences due to the benefit richness of each plan design. This adjustment does not include any estimates of variation in costs due to selection of a plan design by members (sometimes called induced utilization due to selection). The actuary should provide discussion on how this value was developed and how it does not include any adjustment due to selection or differences in health status.

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- Cost share reduction component to remove, if the actuary deems appropriate, any projected additional utilization due to benefit richness for those members in cost sharing variations of the standard plan design. Since the allowed PMPMs would include any projected additional utilization for these members, the plan adjusted index rate needs to remove some excess utilization in order to appropriately develop premium rates for standard plan designs, due to the fact that HHS reimburses the issuer for additional utilization through the cost share reduction subsidy, at least for the portion of the benefit for which HHS compensates issuers. This adjustment is a single adjustment applied to all plans, since the market adjusted index rate is an aggregate across all plans.
- The allowed rating factor of tobacco status results in additional revenue being collected for a smoking tobacco status, should an issuer choose to charge a tobacco factor. In order to develop rates that are not excessive, an adjustment needs to be made to remove the effect of the tobacco status rating factor. This adjustment will essentially result in a plan adjusted index rate that removes the higher revenue for smokers. This would then result 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.
- Any additional adjustment that the actuary deems appropriate to reflect the fact that the allowed rating factors for age do not reflect expected costs by age.

This adjustment reflects the issuer's expected underlying cost differentials by plan (other than for selection, as noted above) and is not to be 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. Since 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 are appropriate 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 tighter 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 would be 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 clarify: "If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have

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a separate plan for each network with(in) the rating area.” Note that some states may not allow this, such as for 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 the state’s benchmark plan. Each state has a defined set of essential health benefits from which plans have additional benefits can be determined. It is important for the value included here to be reflective of the average demographics of the projected population, including age, geographic area, and tobacco 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. Should an issuer include prohibited benefits, such as abortion services, 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.

*Impact of Specific Eligibility Categories for the Catastrophic Plan*

It is appropriate 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.

*Adjustment for Distribution and Administrative Costs*

The instructions state, “Note, fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Exchange User fees, which are applied at the market level to the Index Rate.” This adjustment would then include all administrative costs, commissions, contribution to risk, profit, 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.

**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 assuming all members are non-tobacco users. When calculating a consumer adjusted premium rate for a particular member, the calibration for age and geographic area is used 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 and state when developing the consumer adjusted premium rates.

*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.

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The use of the factor related to the weighted average age of the projected population comes from the interpretation of two elements of the final rules:

- 45 CFR 147.102(e) *Uniform age rating curves*. Each state may establish a uniform age rating curve in the individual or small-group market, or both markets, for rating purposes under paragraph (a)(1)(iii) of this section. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with Section 147.103, a default uniform age rating curve specified in guidance by the HHS Secretary will apply in that state that takes into account the rating variation permitted for age under state law.
- 45 CFR 156.80 (d) (2), which states: “(2) Permitted plan-level adjustments to the index rate. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:
  - (i) The actuarial value and cost-sharing design of the plan.
  - (ii) The plan's provider network, delivery system characteristics, and utilization management practices.
  - (iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.
  - (iv) Administrative costs, excluding exchange user fees.
  - (v) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.”

It is important to determine the weighted average age using the weighted average age factors from the curve. Essentially, this process identifies the distribution of the age weighted by the age curve factors to determine the weighted average age. This determines the average age on the age curve the plan adjusted index rate reflects—once that has been completed, all the other rate relationships are defined. This 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, applying a factor of zero (0) for the distribution of members expected to pay no premium (more than three dependent children) can also be done to reflect the limitation on rating for family size.

*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.

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### **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, and then is multiplied by the allowable rating factors (i.e., age, geographic area, and tobacco status) of the individual member and calibrated using the age and geographic calibration reflective of the average demographic characteristics of the projected population.

The consumer adjusted premium rate (the rate for each member charged) would be the plan adjusted index rate multiplied by the tobacco status factor and each person's age factor divided by (or multiplied by, depending on how the actuary applies the calibration factors) the age calibration multiplied by the geographic factor divided by (or multiplied by) the geographic area calibration.

### **AV Pricing Values**

The definition of the AV pricing value for each plan has been changed from the 2014 instructions. The "AV pricing value" is defined on page 25 of the URRT instructions as, "the cumulative effect of adjustments made by the issuer to move from the market adjusted index rate to the plan adjusted index rate." The instructions provide that the portion of the AV pricing value that is attributable to each of the allowable modifiers to the index rate as described in 45 CFR 156.80(d)(2) be indicated.

### **Membership Projections**

A detailed description of the assumptions used in projections of membership contained in Worksheet 2 of the URRT for the projected 12 month period is required. This may include factors such as introduction of the guaranteed issue (GI) requirement in the Individual market, the individual mandate, Medicaid, and the introduction of a BHP. This would be in addition to basic business projections as to sales, termination, internal migration of business, and the like. With the exception of terminated plans, it is expected that no plans will have a projected membership of zero.

An actuary may wish to include a description of the changes in the amount and nature of projected membership compared to existing membership, as appropriate. Similarly, an actuary may wish to include all covered membership even if premium is not to be explicitly collected (i.e., all children should be counted, including those in families with more than three dependent children under age 21).

Silver members with income levels less than 250 percent of the federal poverty level and Native Americans with income less than 300 percent of the federal poverty level are eligible for cost sharing reduction subsidies. The instructions state, "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."

In addition, if the issuer will be requesting prepayment from HHS for cost sharing reduction subsidies for those Native Americans whose income is greater than 300 percent of the federal

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poverty level who use Indian health service providers, an actuary may wish to include the projected membership in the actuarial memorandum.

### **Terminated Products**

An actuary may wish to include a list of each product that will be terminated prior to the effective date, including both business with experience in the single risk pool and those products only made available after the end of the experience period. These products could be made identifiable to the reviewer by cross reference to either contract forms, use of names explicitly included in the current or prior rate filing, etc. and, therefore, avoid internal “marketing” type terminology not elsewhere defined.

### **Plan Type**

If any of the plan types in the drop-down box in Worksheet 2, Section I of the URRT do not exactly describe an issuer’s plan exactly, and, thus, the issuer has chosen the closest plan available, the instructions state, “please describe the differences between the issuer’s plan and the plan type selected.”

### **Warning Alerts**

If the sum of plan level projections in Worksheet 2 does not equal the total projected amounts in Worksheet 1, the instructions state, “Describe any difference between the sum of the plan level projections in Worksheet 2 and the total projected amounts found in Worksheet 1.” The differences are contained in warning alerts in Worksheet 2. Note that if tobacco surcharges are used, the required tobacco adjustment to the plan adjusted index rate will result in warning alerts for both the plan adjusted index rate and the total premium.

### **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, while optional, these items could be included in the actuarial memorandum. The submission could also include any state specific informational or data requirements. This can save the issuer from having to submit materials separately, as well as avoid time consuming correspondence during the review process.

These items noted specifically in 45 CFR 154.215(f) that are listed as “necessary to satisfy requirements of 154.301(a)(3) and (4) and to determine whether the rate increase is an unreasonable rate increase,” which are not included in Part I (URRT) , are as follows:

- Subsection (a)(3)(ii)—The health insurance issuer’s data related to past projections and actual experience.
- Subsection (a)(4)(iii)—The impact of cost-sharing changes by major service categories, including actuarial values. Part I does not have a specific section for cost-sharing changes by service category. This would be included in the “Other” column on Part I, Worksheet 1, along with other items, and explained separately in Part III.
- Subsection (a)(4)(v)—The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use. Part I, Worksheet 1 does include input for population risk morbidity.

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- Subsection (a)(4)(vi)—The impact of any overestimation or underestimation of medical trend for prior year periods related to the rate increase.
- Subsection (a)(4)(vii)—The impact of changes in reserves required.
- Subsection (a)(4)(viii)—The impact of changes in administrative costs related to programs that improve health care quality.
- Subsection (a)(4)(ix)—The impact of changes in other administrative costs. Part I includes input on changes to total administrative costs, but not broken out by health care quality improvement costs and other administrative costs, so these will need to be provided in Part III.
- Subsection (a)(4)(xi)—Medical loss ratio (MLR). Part I does not include input on the ACA MLR; therefore, discussion on MLR will need to be included in Part III.
- Subsection (a)(4)(xii)—Insurer capital and surplus.
- Subsection (a)(4)(xiii)—The impact of geographic factors and variations.

All of these items not included in Part I but required by 45 CFR 154.215(f), which references 45 CFR 154.301(a)(3) and (4), can be included in the actuarial memorandum (Part III), particularly when the state does not have effective review and HHS would be performing the review.

### **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) may be disclosed. Please note that reliance statements do not absolve the actuary signing the memorandum from responsibility to review the data or information for reasonability or consistency, nor of the use of proper professional judgment in the application of such information. Section 3 of ASOP No. 23 in particular contains detailed guidance on use of data, reliability, responsibility, etc.

### **Actuarial Certification**

The instructions list three items for which the actuary must certify:

- The methodology used to calculate the AV metal value for each plan,
- The appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based, and
- The index rate is developed in accordance with federal regulations, and the index rate with allowable modifiers is used in the development of plan specific premium rates.

An actuary also may wish to include specific information or certifications that may be required in a specific state for which rates are being filed. This again would normally make for a more timely and efficient process.

As stated on page 23 of the actuarial memorandum instructions, "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." Reference 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

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develop rates in accordance with the appropriate ASOPs and the Code of Professional Conduct. Applicable ASOPs include, but are not limited to:

- ASOP No. 5, [\*Incurred Health and Disability Claims\*](#)
- ASOP No. 8, [\*Regulatory Filings for Health Plan Entities\*](#)
- ASOP No. 8 (revised, effective Sept. 1, 2014), [\*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\*](#)

Future modifications or additions to applicable ASOPs as well as other materials referenced above may occur.

The instructions require the inclusion of the following (again, it is likely advisable to also include any additional state specific required certifications), which are reproduced below verbatim:

- “1. Identification of the certifying actuary and a statement that he/she is a member of the American Academy of Actuaries
2. A certification that the projected Index Rate is:
  - a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
  - b. Developed in compliance with the applicable Actuarial Standards of Practice
  - c. Reasonable in relation to the benefits provided and the population anticipated to be covered
  - d. Neither excessive nor deficient
3. A certification that the Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
4. A certification that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
5. A certification stating that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template 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 Part 156, §156.135 must be included. The certification must be signed by a member of the American Academy of Actuaries, and must indicate that the values were

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developed in accordance with generally accepted actuarial principles and methodologies.”

For purposes of rate review, the actuary also may wish to include the reason an alternate methodology was used and describe the chosen alternate methodology that was used for each applicable plan. The actuary would need to describe the process that was used to develop the AV metal value.

The instructions explicitly state that the actuary may qualify the opinion, if desired and so applicable, to the effect that the URRT does not necessarily demonstrate the process used to develop rates. This normally would only be the case when a separate memorandum is being prepared for purposes of rate filing submission to a particular state. The actuary also needs to explain how the requirements set forth in 156.80(d) and 147.102 have been satisfied.