



## **Part III Actuarial Memorandum and Certification Instructions**

March 18, 2013

# **Actuarial Memorandum and Certification**

A Part III Actuarial Memorandum, including a corresponding actuarial certification, must be submitted with each Part I Unified Rate Review Template. Please see the instructions for completing the Part I Unified Rate Review Template for circumstances in which the template must be completed and for which products.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for 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. All assumptions should be adequately justified with supporting data, where possible, or other rationale for the use of the chosen assumptions.

While these instructions outline the minimum requirements, issuers are encouraged to provide as much detail and supporting documentation as possible with their original submission to potentially reduce the amount of time in review. Additional information will be required if, given the facts and circumstances of the submission, the regulator determines that it is necessary to properly complete its review of the rate submission.

The actuarial memorandum must also capture appropriate actuarial certifications related to:

- 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,
- the index rate is developed in accordance with federal regulations and the index rate along with allowable modifiers are used in the development of plan specific premium rates

State specific required information or certifications may also be included at the actuary's discretion. If an actuary chooses to exclude this information from the Part III Actuarial Memorandum, this information would need to be provided to the state regulatory agency, under separate cover.

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

## **General Information**

This section of the actuarial memorandum should include general information about the issuer and the policies which are the subject of the submission. The information provided in this section should include at least the following:

**Company Identifying Information:** State the following information that uniquely identifies the issuer submitting the memorandum. The information must be the same as the entries in the general information section of Worksheet 1 of the Part I Unified Rate Review Template (see the instructions for the Part I Unified Rate Review Template for additional definition of these fields):

- **Company Legal Name:** the organization's legal entity name associated with the HIOS Issuer ID
- **State:** the state that has regulatory authority over the policies
- **HIOS Issuer ID:** the HIOS ID assigned to the legal entity
- **Market:** the market in which the products and plans are offered
- **Effective Date:** the latest effective date for which rate increases are being submitted

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

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

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

In this section the actuary must provide information related to the proposed rate increase(s). If the proposed rate adjustment varies by product, the information provided should clearly identify which proposed adjustments apply to which products. Include all products which are part of the single risk pool, as defined by 45 CFR Part 156, §156.80, including those products for which no rate adjustment is being proposed. The information that must be provided includes the following items:

**Reason for Rate Increase(s):** Provide a narrative description of all significant factors driving a proposed rate increase. As an example, these factors could include but are not limited to:

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

If the requested rate increase is not the same across all products and plans, provide a narrative discussion as to why the rate changes vary by product or plan given they are based on the same single risk pool of experience for the market.

## **Experience Period Premium and Claims**

This section of the actuarial memorandum should include information related to the actuary's best estimate of premium and claims for the single risk pool during the experience period reported in Worksheet 1, Section I of the Part I Unified Rate Review Template.

**Paid Through Date:** Indicate the date through which payments have been made on claims incurred during the experience period.

**Premiums (net of MLR Rebate) in Experience Period:** Provide support for how the amount of premium earned during the experience period, net of MLR rebates to policyholders, was developed.

- Separately indicate the earned premium prior to MLR rebates and the amount of MLR rebates refunded (or expected to be refunded) for the market during the experience period. Earned premium should not be reduced for any reductions prescribed when calculating the issuer's MLR, such as taxes and assessments.
- For portions of the experience premium for which the MLR rebate has not been finalized, a best estimate of the rebates is to be included. Describe the methodology used to estimate such rebates.

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

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

## **Benefit Categories**

For each of the Benefit Categories in Worksheet 1, Section II, describe the methodology used to determine which category each claim in the experience period falls. For benefit categories where "Other" was selected as the Utilization Description in the Part I Unified Rate Review Template, please describe the measurement units that were used.

## Projection Factors

This section should include a description of each factor used to project the experience period allowed claims to the projection period, and supporting information related to the development of those factors. For each factor, the actuary should include a description of the source data or assumptions used, why they are appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for issuer specific experience, industry or internal studies, benefit design and credibility of the source data. At a minimum, include support for the following factors:

**Changes in the Morbidity of the Population Insured:** Describe any adjustment factors applied to the experience period claims to account for anticipated differences in the average morbidity of the pooled population underlying the experience period and the issuer's population anticipated to be insured in the projection period. These adjustments are shown in the "Pop'l risk Morbidity" column on Worksheet 1, Section II, and are in addition to the anticipated change in claims cost as a result of changes in the average mix by age and gender of the covered population (which are shown in the "Other" adjustment column). The morbidity of the population could be impacted by items such as guarantee issue, an individual mandate to maintain coverage, expansion of Medicaid programs, and the introduction of a Basic Health Program.

**Changes in Benefits:** Describe the development of factors used to adjust the experience period claims to reflect the average benefits that will be covered during the projection period, including any newly mandated benefits. These changes are reflected in the "Other" adjustments column on Worksheet 1, Section II. The factors could adjust for items including but not limited to the following:

- Addition of any benefits that must be covered under the essential health benefit package
- Any newly mandated benefits required under state law that are not reflected in the experience period claims
- Adjustment for the removal of benefits covered in the experience period claims that will not be covered in the projection period
- Anticipated changes in the average utilization of services due to differences in average cost sharing requirements during the experience period and average cost sharing requirements in the projection period

**Changes in Demographics:** Describe the development of factors used to adjust the experience period claims to reflect differences between the average mix of the population by age, gender, and region underlying the base period experience and the average mix anticipated to underlie the projection period. These changes are reflected in the "Other" adjustments column on

Worksheet 1, Section II. Describe and support the age/gender factors underlying the development of these claims-based demographic adjustment factors.

**Other Adjustments:** Describe any other adjustments, in addition to benefits and demographics which are specifically addressed above, that are reflected in the “Other” adjustments column on Worksheet 1, Section II. Also describe how these factors were developed.

**Trend Factors (cost/utilization):** Describe the source claims data used and methodology used for developing the cost and utilization projection factors, including all adjustments made to the data. Explain why the adjusted source data is applicable to the single risk pool. Some examples of such adjustments include but are not limited to the following:

- Normalization for changes in age
- Normalization for benefit changes that occurred during the period (Even if allowed claims are used to project trend a normalization adjustment may be warranted to account for the influence that changes in benefits have on utilization.)
- Adjustments for seasonality patterns underlying the claims that may skew calculated trends
- Normalization for any one-time events which are not anticipated to reoccur during the projection period
- Adjustments for anticipated changes in provider contracts that differ from those underlying the experience used
- For prescription drugs, any adjustments made to account for changes in the formulary, expiration of patents, or introduction of new drugs

## **Credibility Manual Rate Development**

For issuers with experience period claims that are not determined to be fully credible, the use of other credible claims experience must be employed in developing a credibility manual rate for blending with the experience period claims. The actuary must provide information related to the other experience and general methodology used in developing the manual rate.

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

- Multiple years of experience for the market for which rates are being submitted
- The issuer’s experience for similar policies nationwide, including rationale for inclusion/exclusion of various blocks of business

- A manual rate developed by a consultant with appropriate supporting documentation as to the underlying source data for development of the manual rate

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

**Inclusion of Capitation Payments:** If some of the services in the projection period will be provided under a capitation arrangement, specifically describe how these payments were accounted for in the development of the credibility manual.

## Credibility of Experience

In this section issuers must provide support for the credibility level assigned to their base period experience, with the complement being applied to a credibility manual. The requested information will include items such as:

- Description of the Credibility Methodology Used
- Resulting Credibility Level Assigned to Base Period Experience when applying the proposed credibility methodology.

When the base period experience is partially credible and included in experience used to develop the manual rate, the actuary must consider the extent to which the manual rate development double counts the base period experience. (See —The Complement of Credibility by Joseph A. Boor, *Proceedings of the Casualty Actuarial Society, May 1996, Volume LXXXIII.*) If the proposed manual rate lacks sufficient independence from the base period experience, the credibility percentage in the template should be adjusted such that the experience is assigned the appropriate credibility (based on the issuer’s credibility formula), taking into consideration the proportion of the manual experience that is from the subject base experience. In this case additional documentation should be included in the actuarial memorandum to demonstrate that the credibility factor applied in the template is consistent with the issuer’s credibility formula.

When determining credibility, the actuary should consider Actuarial Standard of Practice #25, *“Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages.”*

## Paid to Allowed Ratio

Provide support for the Paid to Allowed Average Factor in Projection Period for the market, shown in Worksheet 1, Section III. Demonstrate that the ratio is consistent with membership projections by plan included in Worksheet 2. The ratio for each plan should be relatively consistent with the metallic actuarial value for the plan to which the actuary is attesting,

however it is recognized that they may not be exactly the same due to differences between the issuer's experience and the experience underlying the AV Calculator.

## **Risk Adjustment and Reinsurance**

This section includes information related to the experience and methodology used to estimate risk transfer payments and charges, and reinsurance amounts that are incorporated in Worksheet 1, Section III and Worksheet 2, Sections III (if applicable) and IV.

### **Projected Risk Adjustments PMPM:**

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.

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. 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.

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.

### **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market and Combined Markets Only):**

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.

The Part I Unified Rate Review template requires issuers to report reinsurance payments net of reinsurance contributions. Issuers must describe the underlying experience data and assumptions that they used to develop their estimates of both reinsurance contributions and

payments. In particular, issuers should provide an explanation of how they developed an estimate of their claims liability between the reinsurance attachment point and cap. Issuers should describe any key aspects of their enrolled population that significantly impacted their claims assumptions.

Issuers must also describe how they allocated their anticipated reinsurance payments net of reinsurance contributions across the plans in their risk pool (as noted above reinsurance revenue should be allocated proportionally based on premium). 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.

As only non-grandfathered policies in the individual market are eligible for payments under the transitional reinsurance program, in a combined market, the pooled reinsurance adjustment should be based only on the portion of the issuer's combined market business eligible for reinsurance payments.

State the assumed amount of the assessment as a PMPM amount.

## **Non-Benefit Expenses and Profit & Risk**

**Administrative Expense Load:** Provide support for all expenses that do not reflect payments made to providers under the contract for covered medical services. 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.

For reporting purposes, the Administrative Expense Load should not include the Profit & Risk Load or the Taxes & Fees load, both described below, even though they are considered administrative expenses for the purposes of adjusting the index rate to arrive at premium in the pricing process.

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.

**Profit (or Contribution to Surplus) & Risk Margin:** Describe the target underwriting gain/loss margin, and any additional risk margin. To the extent that the target as a percent of premium has changed from the prior submission, provide additional support for why the change is warranted. Discuss how the percentage load varies by product or plan, if applicable.

Note that for pricing purposes, Profit & Risk Load is considered part of administrative expenses, per 45 CFR Part 156, §156.80(d). It is described separately in the actuarial memorandum to facilitate rate review.

**Taxes and Fees:** 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. 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 in this amount despite their treatment in MLR calculations, since Federal reinsurance is expressed in the template net of reinsurance premium. Any additional taxes and fees should be reflected in the Administrative Expense Load.

Note that for pricing purposes, Taxes & Fees (including Exchange user fees) are considered part of administrative expenses, per 45 CFR Part 156, §156.80(d). It is described separately in the actuarial memorandum to facilitate rate review.

Exchange user fees should be included in the template in Taxes and Fees. The issuer should provide a narrative verifying the exchange user fees are applied as an adjustment to the index rate at the market level. A description of the process the issuer used to calculate the adjustment should be included. The value should reflect the expected mix of exchange and non-exchange enrollees.

## **Projected Loss Ratio**

Indicate the projected loss ratio using the Federally prescribed MLR methodology. If the projected loss ratio is less than 80%, explain your plan to comply with the Federal MLR requirement found in PHSA 2718.

If the state requires a projected loss ratio demonstration, then such a demonstration should also be included.

## **Index Rate**

Provide support for the index rate in both the experience period and the projection period. It is the legal entity-specific rate for the state and market that is being submitted. The index rate represents the estimated total combined allowed claims experience PMPM of all non-grandfathered plans for essential health benefits within a market and state, and should not be adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange user fees. It is simply allowed claims PMPM for essential health benefits.

Describe the difference between the total allowed claims PMPM and the index rate. For example, describe any covered benefits in excess of essential health benefits that are included in allowed claims but excluded from the index rate.

For Part I Unified Rate Review Template submissions with an Experience Period Start Date of January 1, 2014 or later, it is expected that the Index Rate of the Experience Period reported in Worksheet 1 be consistent with the Experience Period Allowed Claims PMPM. While these two amounts may not be identical due to the inclusion of non-EHB services in the Experience Period Allowed Claims PMPM, which would not be included in the Index Rate of the Experience Period, it is anticipated that these amounts would be developed on a consistent basis.

For Part I Unified Rate Review Template submissions with an experience period start date prior to January 1, 2014, provide the methodology used to develop the reported Index Rate of Experience Period. Describe how claims for benefits which were covered during the experience period but are not essential health benefits were identified and removed.

If the submission is for the individual or combined market, the Index Rate for Projection Period should reflect the twelve month projection period shown on Worksheet 1, Section II. If the submission is for the small group market and includes prospective trend adjustments (only if permitted by the state), then the Index Rate for Projection Period should reflect the member weighted average of the projected index rates applicable for each effective date in the submission. Show the projected trended index rate for each effective date in the submission.

The projected index rate must reflect the anticipated claim level of the projection period with respect to trend, benefit and demographic differences. It must reflect the experience of all policies expected to be in the single risk pool (with all necessary adjustments to reflect the benefits, market rules, etc. applicable to policies upon issue or renewal during the entire projection period) of the applicable market regardless of the renewal date of the policies. For example, for policies issued on July 1, 2013 the experience of these policies should be included in projecting the January 1, 2014 index rate, and adjusted to reflect benefits, trend, market rules, etc. as if the policies were going to be renewed on January 1, 2014 with rates effective through December 31, 2014, despite the actual renewal not being scheduled to occur until July 1, 2014. If an issuer wants the renewal rates to increase with trend in the small group market as allowed by the state regulatory authority, the issuer may file the quarterly trend amounts for the twelve month period at one time. The quarterly trend factors applied to the issuer's rates should be included in the Part III Actuarial Memorandum. The Appendix to the Instructions for the Part I Unified Rate Review Template provides further guidance.

For qualified health plans (QHPs) offered in an exchange, the rates may only change at the uniform interval permitted by the exchange. For individual and combined market exchanges this would generally be annually. It is anticipated that issuers may be able to file for rate changes in the Small Business Health Options Programs (SHOPs) on a more frequent basis, such as quarterly, for example. While rate adjustments may be filed on a more frequent basis than annually (such as quarterly), these interim filings could include adjustments for other items, such as new products, more recent experience period claims, etc. However, the rate development for these interim filings must be based on the single risk pool. For example, take an issuer with two cohorts of small employers that files on an interim quarterly basis. The small employers with young enrollees renew in January, while the small employers with older enrollees renew in April. The issuer's index rate in the applicable submissions would be derived as follows (assuming the same experience period is used for the two submissions with no projected changes to the population between the experience period and the projection period):

	January effective date	April effective date	Total Single Risk Pool
Member Months (2012)	1000	1000	2000
Base Allowed Claims (2012) PMPM	\$250	\$400	\$325
Months of Trend	24	27	
Annual Trend Rate	5%	5%	
Single Risk Pool Projected Allowed Claims (= $\$325 \times (1 + \text{Annual Trend})^{(\text{Months of Trend}/12)}$ )	\$358.31	\$362.71	
Index Rate	\$358.31	\$362.71	

As shown in the table above, the projected index rate is based on the weighted average claims, benefit mix, demographic mix, etc. of the entire single risk pool, even if it is only submitted to be effective for a portion of the single risk pool (e.g., one quarter of renewals).

Describe in narrative form how the projected index rate was adjusted to arrive at each plan level rate based on the allowable adjustments outlined in 45 CFR 156.80(d). Rate justification is not being requested, but rather a description of the methodology used should be provided. Note that the index rate must be adjusted for payments and charges under the risk adjustment program and recoveries under the reinsurance program (in the individual and combined markets only), and Exchange user fees, on a market wide basis. Further, each plan level rate must be developed by adjusting for only the following additional items which must be actuarially justified, so long as the adjustments do not include any assumptions related to the morbidity of the members assumed to select a given plan:

- The actuarial value and cost-sharing design of the plan
- The plan's provider network, delivery system characteristics, and utilization management practices
- 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

- Administrative costs, excluding Exchange user fees
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans

Specifically for the catastrophic plan rate, describe the methodology used to estimate the adjustment reflecting differences in anticipated demographics and morbidity of the catastrophic population as compared to the single risk pool.

## **AV Metal Values**

The issuer must describe whether the AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were entirely based on the AV Calculator, or whether an acceptable alternative methodology was used to generate the AV Metal Value of one or more plans. If an alternate methodology was employed to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR Part 156, §156.135. The certification must be signed by a member of the American Academy of Actuaries, and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.

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

Actuaries are encouraged to refer to applicable practice note(s) for guidance on alternate methods of calculating actuarial value.

## **AV Pricing Values**

Identify the fixed reference plan selected as the basis for the AV Pricing Values. The reference plan is described further in the instructions for the Part I Unified Rate Review Template. For each plan, indicate 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 Part 156, §156.80(d)(2). If the adjustment for plan cost-sharing includes any expected differences in utilization due to these differences in cost sharing, describe in detail how the difference was estimated and how the methodology ensures that differences due to health status are not included in the adjustment.

## **Membership Projections**

Describe how the membership projections found in Worksheet 2 of the Part I Unified Rate Review Template were developed. Items impacting these projections could include but are not limited to changes in the size of the market due to introduction of guarantee issue requirements (individual market), the individual mandate, expansion of Medicaid, and the introduction of a Basic Health Program.

Describe any differences between the distribution of projected member months relative to the current membership distribution.

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

## **Terminated Products**

List the name of each product that will be terminated prior to the effective date. Include both products that have experience included in the single risk pool during the experience period and any products that were not in effect during the experience but were made available thereafter.

## **Plan Type**

In the event that the plan types listed in the drop-down box in Worksheet 2, Section I of the Part I Unified Rate Review Template do not describe an issuer's plan exactly and the issuer has selected the closest plan available, per the instructions, please describe the differences between the issuer's plan and the plan type selected.

## **Warning Alerts**

Describe any difference between the sum of the plan level projections in Worksheet 2 and the total projected amounts found on Worksheet 1. These differences are indicated by Warning Alerts in Worksheet 2.

## **Effective Rate Review Information (optional)**

45 CFR Part 154 §154.301 describes the elements of an effective rate review program. There are elements of an effective rate review for which the data needed to perform the review is not explicitly shown on the Part I Unified Rate Review Template, e.g., the health insurance issuer's capital and surplus. Issuers may optionally provide additional information to facilitate an effective review of the submitted rate increase(s). While this information is optional, it is noted that providing the information with the initial submission reduces the likelihood of the reviewer requesting supplemental information during the course of the rate review. In addition, states may have additional data requirements. Additional state-required data may be submitted with the submission, or it may be provided to the state separately.

## **Reliance**

If, in preparing the Part I Unified Rate Review Template submission, the certifying actuary relied on any information or underlying assumptions provided by another individual, the information relied upon and the name of the individual providing that information may be disclosed.

## Actuarial Certification

An actuarial certification must be provided for the following:

- 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 along with allowable modifiers are used in the development of plan specific premium rates.

State specific required information or certifications may also be included at the actuary's discretion. If an actuary chooses to exclude this information from the Part III Actuarial Memorandum, this information would need to be provided to the state regulatory agency under separate cover.

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

- ASOP No. 5, *Incurred Health and Disability Claims*
- ASOP No. 8, *Regulatory Filings for Health Plan Entities*
- ASOP No. 12, *Risk Classification*
- ASOP No. 23, *Data Quality*
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*
- ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*
- ASOP No. 41, *Actuarial Communications*

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

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 developed in accordance with generally accepted actuarial principles and methodologies.

For purposes of rate review, also include the reason an alternate methodology was used, and the chosen alternate methodology that was used for each applicable plan. Describe the process that was used to develop the AV metal value.

The actuary may 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.