

Rate Review Instructions Manual

Health Insurance Issuer Reporting Requirements*

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1. OVERVIEW

Section 2794 of the Public Health Service Act (PHS Act), as added by Section 1003 of the Patient Protection and Affordable Care Act (Affordable Care Act), establishes a process for the review of unreasonable rate increases in premiums for health insurance coverage. On May 19, 2011, the Center for Medicaid and Medicare Services (CMS) issued a final rule, the “Rate Increase Disclosure and Review” (Rate Review Regulation) (codified at 45 C.F.R. §§ 154.101-154.301) implementing section 2794 of the PHS Act.

This manual provides the technical instructions and the process for health insurance issuers to comply with the reporting and disclosure requirements of section 2794 of the PHS Act and the Rate Review Regulation.

1.1 Applicability

The Rate Review Regulation applies to health insurance issuers (Issuers) offering health insurance coverage in the individual market and small group market.¹ These requirements do not apply to grandfathered health plan coverage as defined in 45 C.F.R. § 147.140, or to excepted benefits as described in section 2791(c) of the PHS Act.²

2. PROCESS

2.1 Timing and Sequence of Reporting Requirements and Review Process

The Preliminary Justification is the primary rate review reporting requirement. Issuers are required to prepare and submit a Preliminary Justification for each rate increase that is “subject to review.”³

All rate increases that meet or exceed the “subject to review” threshold will be reviewed by the States or CMS,⁴ described in detail in section 3.1.2. When CMS performs a review of such rate increases, additional information may be requested from the Issuer if CMS is unable to conduct its actuarial review with the information provided in the Preliminary Justification.

If a rate increase is determined to be unreasonable by either the States or CMS, Issuers must provide a Final Justification for an unreasonable rate increase that explains why the Issuer is electing to implement an unreasonable rate increase. The Final Justification is not required in cases where Issuers elect to withdraw the rate increase after an unreasonable determination or, in States with prior approval authority where the rate increase is not approved.

CMS will post the Preliminary Justification and information related to the State or CMS review process on HealthCare.gov and the CMS.gov websites. Additionally, Issuers are required to post information on unreasonable rate increases on their websites.

¹ 45 C.F.R. § 154.103.

² 45 C.F.R. § 154.103.

³ 45 C.F.R. § 154.200.

⁴ 45 C.F.R. § 154.210.

Prior to submitting a Preliminary Justification, Issuers must identify whether the rate review will be conducted by the States or by CMS. Reviews conducted by the States and reviews conducted by CMS have different content requirements and reporting deadlines. Issuers can find state-by-state information on the entity that is responsible for conducting the rate review for all applicable market and product types at http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html.

This section of the manual provides detailed information on the process steps and timing of the rate review reporting requirements. Comprehensive technical instructions for completing the Preliminary Justification are provided in the next section.

2.1.1 Preliminary Justification Submission

Issuers must submit a Preliminary Justification submission for all rate increases that meet or exceed the subject to review threshold, regardless of whether the State or CMS is conducting the review. The Preliminary Justification consists of three parts:

- **Part I, the Rate Increase Summary Form:** a standardized Excel-based form that collects summary-level data on the underlying medical and administrative cost drivers of the rate increase. The excel worksheet is used to populate a standardized web-based consumer disclosure.
- **Part II, Written Explanation of the Rate Increase:** a brief, non-technical consumer-oriented explanation of the rate increase, intended to provide context for the quantitative information provided in Part I. Part II will be web-posted.
- **Part III, Rate Filing Documentation:** this section of the Preliminary Justification *is only required to be filed when CMS is conducting the rate review*. Issuers must provide detailed rate information that will be used by CMS to conduct actuarial reviews.

Issuers must submit the Preliminary Justification via the Rate Review Reporting Module of Health Insurance Oversight System (HIOS). CMS will provide the Issuers with the HIOS url and login information, following user registration by each individual accessing the HIOS system.

The Rate Review Regulation requires Issuers to submit the Preliminary Justification to both the States and CMS. This requirement is satisfied by a single submission of the Preliminary Justification in HIOS as all States can access Preliminary Justification submissions in HIOS (i.e., Issuers do not have to file a separate Preliminary Justification to the States).

A Preliminary Justification must be submitted for all filings that are subject to review and are made on or after September 1, 2011. The date on which the Preliminary Justification must be filed depends on whether the applicable State has a rate filing requirement:

- **States with Rate Filing Requirements:** Issuers must submit the Preliminary Justification on the same date that the rate filing is submitted to the state. Thus, Issuers must provide a Preliminary Justification for any rate increases that meet or exceed the subject to review threshold that are filed on after September 1, 2011.

- **States without Rate Filing Requirements:** Issuers must submit the Preliminary Justification prior to implementing the rate increase. Issuers must provide a Preliminary Justification for any rate increases that meet or exceed the subject to review threshold that go into effect on or after September 1, 2011.

Issuers are encouraged to submit the Preliminary Justification at least 60 days in advance of implementation of the rate increase so that CMS can complete its review and provide Issuers with its review determination prior to the effective date of the rate increase.

2.1.2 Supplemental Information Requests

For rate reviews conducted by CMS, CMS will utilize the HIOS Rate Review Reporting Module to request additional information or clarification. As stated in the Rate Review Regulation, Issuers are required to provide detailed rate filing documentation as part of their Preliminary Justification submissions when CMS is conducting the review. If CMS is unable to conduct its review based on the Preliminary Justification materials, CMS will request additional information from the Issuers. Issuers have 10 business days from the receipt of the request to provide supplemental materials to CMS.

Requests for supplemental information will be sent via e-mail. These e-mails will be sent to the Issuer's designated point(s) of contact for a given product within the HIOS system. The e-mail will provide a list of data elements or information that is required by CMS to complete its review and the deadline for submitting this information. As noted in the Rate Review Regulation, failure to provide the requested supplemental information will result in a determination that the rate increase is "unreasonable" due to insufficient justification.

If CMS modifies its request for supplemental information, the deadline for submission will be based on the date that CMS notified the Issuer of the modification. CMS may follow up with additional supplemental information requests in the event that the information provided was not responsive to the request or if the supplemental information provided raises additional questions or requires further clarification.

Issuers must upload the supplemental information via the Rate Review Reporting Module in HIOS. The details of the request for supplemental information that were provided in the e-mail notification will also be available within the HIOS system.

Even if an Issuer provides requested supplemental information via an informal phone conversation with CMS, the Issuer must formally respond to the supplemental request in the HIOS system and provide the requested supplemental information.

2.1.3 Rate Review Determination

Both CMS and States will enter rate review determinations in the HIOS Rate Review Reporting Module. The HIOS system will automatically generate an e-mail to the Issuer with the result of the determination. Information on the determination will also be posted on HealthCare.gov and State Department of Insurance websites.

The Rate Review Regulation does not specify a timeframe or deadline for rate review determinations. However, States will generally provide their determinations within their existing rate review timeframes. CMS intends to conduct timely reviews. Review determinations will generally be entered into HIOS within 60 days.

The e-mail notification to Issuers will include one of the following review determinations:

1. **Unreasonable Rate Increase:**⁵ the rate increase was determined to be unreasonable based on a review by a State or CMS. CMS will make a determination based on the definition for an unreasonable rate increase pursuant to 45 C.F.R. § 154.205.
2. **Unreasonable Rate Increase (Modified):** the Issuer modified its proposed rate increase during the review process and the modified rate increase was determined to be unreasonable based on a review by a State or CMS. States will make a determination based on their applicable regulations and laws. CMS will make a determination based on the definition for an unreasonable rate increase pursuant to 45 C.F.R. § 154.205.
3. **Unreasonable Rate Increase (Rejected by State):** the rate increase was determined to be unreasonable and rejected based on a review by a State.
4. **Not Unreasonable:** the rate increase was determined not to be unreasonable based on a review by a State or CMS review.
5. **Not Unreasonable (Modified):** the Issuer modified its proposed rate increase during the review process and the modified rate increase was determined not to be unreasonable based on a review by a State or CMS.
6. **Withdrawn Prior to Determination:** the rate increase will be assigned this determination when Issuers elect to withdraw the rate increase prior to the completion of the State's or CMS' review.

2.1.4 Final Justification Submission and Issuer Web Posting

Timing of Final Justification Submissions: An Issuer must provide a Final Justification for an unreasonable rate increase if it intends to implement a rate increase determined to be unreasonable. The Final Justification must be submitted within 10 days of e-mail receipt of a determination that a rate increase is unreasonable.

Issuers are not required to submit a Final Justification if they record in HIOS within 10 days from the date of the determination that the increase is unreasonable that they elect to withdraw the rate increase. Additionally Issuers do not have to submit a Final Justification for rate increases with an Unreasonable Rate Increase (Rejected by State) determination.

⁵ The HIOS "Unreasonable Rate Increase" and "Unreasonable Rate Increase (Modified)" status labels will include the term "Pre-Final Justification." The HIOS status label will be automatically updated to be "Unreasonable Rate Increase – Final Justification Submitted" or "Unreasonable Rate Increase (Modified) – Final Justification Submitted" following Issuer submission of the Final Justification.

Final Justification Content: For the Final Justification, Issuers should provide a non-technical, consumer-oriented explanation of why they are electing to implement a rate increase that has been determined to be unreasonable. The Final Justification should speak to the specific experience or assumptions that form the basis of the rate increase. Issuers may also respond to the findings that led to the determination that the rate increase is unreasonable. Issuers are required to limit Final Justification submissions to content that is directly relevant to the rate increase or review process. CMS will request revision of any Final Justification that contains content not relevant to the rate increase.

Issuer Web-Posting of the Final Justification: In addition to the web-posting by CMS, the Rate Review Regulation requires Issuers to post the Final Justification along with the Preliminary Justification and the CMS rate determination on its website.

In order to satisfy this requirement, Issuers must provide a link on their website to the relevant product-specific content on HealthCare.gov (i.e., it is not acceptable to use the general link to the rate review home page on HealthCare.gov). The Issuer's website posting must contain the following opening text for all Final Justification postings.

“The rate increase of [XX percent] for [product name] has been reviewed by [CMS or State] and has been determined to be unreasonable.”

Issuers must post the information and required links on their website for Final Justification postings in a prominent location on their website that will be easily accessible by consumers.

All Final Justifications must be posted on the Issuer's website for 3 years.

2.2 Documenting changes to Preliminary Justification submissions

CMS anticipates that Issuers may make changes to proposed rate increases following the submission of the Preliminary Justification. Accordingly, the HIOS Rate Review Reporting Module includes several features for documenting changes to rate increases. In general, the HIOS system has three dedicated Issuer user functions for addressing rate increase changes: delete, modify, and withdrawn.

2.2.1 Delete: Prior to Attestation

Submission of the preliminary justification is a two step process in HIOS: Issuers must 1) upload the preliminary justification and 2) attest to the record. The Issuer has discretion to assign the appropriate staff to the submitter and attester roles in HIOS. Attestation and submission rights can be assigned to more than one user for each Issuer. Attestation of the Preliminary Justification will trigger public posting on the CMS website. Attestation of the record will also initiate State or CMS review of the rate increase.

Issuers are strongly advised to employ proper review protocols to ensure the accuracy of submissions prior to attestation. CMS expects Issuers to resolve any errors in the submissions prior to attestation. CMS will only allow for changes to the web-posted information on a limited basis. Issuers must contact CCIIO to report any errors in attested submissions. Requests for the

removal of attested data from the CCIIO website will be assessed by CMS on a case-by-case basis.

Prior to attestation, Issuers may resolve any errors or other issues with a record by using the “delete” function. Using the delete function will entirely remove the record from the system - no information contained in the record will be web-posted or reviewed by States or by CMS. This feature is not available to the Issuer following attestation. Thus, as noted above, it is critical that the Issuer assess the accuracy of submissions prior to attestation.

When the delete feature is used to correct an error or make changes to a Preliminary Justification, the Issuer must restart the rate increase reporting process in HIOS, and upload a new Preliminary Justification.

2.2.2 Modify: Review Phase Following Attestation of the Preliminary Justification

CMS Reviews: As CMS will rely on information entered into HIOS to conduct its reviews, Issuers will be required to notify CMS via the HIOS system of any changes to a proposed rate increase while a review is in progress. Following Preliminary Justification attestation, Issuers will have access to the “modify” function in HIOS (this feature takes the place of the delete function and is available until a rate determination has been entered into HIOS by CMS).

Issuers must use this feature to 1) explain changes to the rate increase (or changes in the supporting data or assumptions associated with the rate increase) that would have a material impact on CMS’ review of the increase and 2) upload any documentation or exhibits related to the modification that CMS should consider as part of its ongoing review (the modification feature includes both a text box and a document upload feature). CMS will make note of any rate increase modifications when it enters its determination into HIOS and the modification will be clearly indicated in public rate review web content. Issuers are expected to document modifications in the system even if the modifications have been informally communicated through phone conversations with CMS rate review staff.

State Reviews: When States are reviewing Issuers’ rate increases, Issuers are not required to use HIOS to document modification to rate increase. However, States should describe any modifications to the rate increase when they enter the results of their reviews into HIOS.

Relationship Between the Preliminary Justification and Rate Increase Modifications:

Issuers may submit and attest to only one version of the Preliminary Justification. The Preliminary Justification originally submitted for a rate increase will not be replaced on the website with an updated version when Issuers modify a rate increase that is under review. Rather, when the States or CMS completes the review of the rate, the published review determination will describe any applicable modification to the rate increase. The text describing the review determination will provide the modified rate increase amount.

Rate Increases Withdrawn Prior to the Completion of the Review: For reviews conducted by CMS, Issuers are required to notify CMS via the “modify” feature if they are electing to withdraw a rate increase filing prior to completion of the rate review. In these cases, CMS will post that the rate increase was “Withdrawn Prior to the Completion of the Review.” States will assign the same review determination to such cases; however Issuers do not need to use the

modification feature to notify States of the withdrawal of a rate increase as they are expected to notify the State through its existing State communication processes and the State is required to enter the appropriate review determination status in HIOS.

Issuers should use the modification feature to report all changes to proposed rate increases that have been filed when CMS is conducting the review. If an Issuer is changing the amount of the proposed increase (either through withdrawing and submitting a new rate filing or through other means such as a filing amendment), the Issuer should use the “modify” feature to indicate the modified rate increase amount and to provide any documentation related to the change to the proposed rate increase that may be relevant to CMS’ review. Issuers should only use the modify feature to withdraw a rate increase in cases where they are entirely retracting their proposals to increase rates for a particular product.

This reporting approach is intended to limit the number of Preliminary Justifications that an Issuer must submit for a given rate increase. Issuers are required to submit only one Preliminary Justification regardless of how many modifications are made to the rate increase during the review process. This approach will help ensure continuity in the rate review process and in the public display of rate review information. Once a review is in progress, the modification notification process allows for a streamlined method for alerting CMS of relevant rate changes without stopping or excessively delaying the ongoing review.

2.2.3 Withdraw: Between Determination and Implementation

The “withdraw” function in HIOS takes the place of the modify function after a review determination has been entered into HIOS. Issuers must use the withdraw function to indicate changes to rate increases that occur between the date of the determination and the implementation date of the rate increase. The withdraw feature must be used to report any type of change- either complete retraction of the rate increase or modification of the increase amount.

The “withdraw” feature is not available for records with an “Unreasonable (Rejected by State)” determination, as this determination status denotes that the rate increase will not be implemented.

Determinations that a Rate Increase is Unreasonable: If an Issuer uses the withdraw function within 10 days of a determination that a rate increase is unreasonable, the Issuer does not have to provide a Final Justification for the rate increase. However, if the Issuer changes the rate increase in HIOS (as opposed to withdrawing the rate increase via the withdraw function) and the new increase amount meets or exceeds the subject to review threshold, the Issuer must submit a new Preliminary Justification for the updated rate increase (i.e., after HHS or the State has made a rate review determination, if the Issuer reduces the proposed increase but it still meets or exceeds the subject to review threshold, then the rate review process starts again and the Issuer must create a new record in HIOS).

Determinations that a Rate Increase is Not Unreasonable: Issuers must document any changes to a proposed rate increase following a determination that it is not unreasonable by using the withdraw function in HIOS. If the Issuer is changing the rate increase (as opposed to entirely retracting it) and the new increase amount is above the subject to review threshold, the Issuer must submit a new Preliminary Justification for the updated rate increase (i.e., after HHS or the

State has made a rate review determination, changes to the rate increase amount re-start the rate review process and the Issuer must create a new record in HIOS).

Use of the withdraw function in HIOS will not eliminate the public display of the review determination. Rather, the review status text on the website will be updated to reflect the status of the rate increase as withdrawn prior to implementation (i.e., ‘the rate increase was found to be unreasonable. The Issuer has withdrawn the rate increase prior to implementation’).

Additionally, once an Issuer implements a rate increase post-determination, the Issuer may not use the withdraw feature in HIOS. Any subsequent increase must be entered as a new record in HIOS.

2.3 Public Disclosure of Preliminary Justification

CMS will post all parts of the Preliminary Justification. Attestation of the Preliminary Justification in HIOS will trigger web posting. CMS will also post the rate review findings and Final Justifications.

2.3.1 Confidentiality

Parts I and II of the Preliminary Justification are consumer-oriented documents and do not contain confidential information. CMS will make available to the public the information contained in Part III of each Preliminary Justification that is not a trade secret or confidential commercial or financial information as defined in CMS’s Freedom of Information Act (FOIA) regulations, 45 CFR §5.65.⁶

Issuers are required to upload two versions of Part III: a CMS version and a public version. The CMS version should contain all the data elements and information required in this manual. Additionally, the CMS version must clearly identify the information that the Issuer asserts should be protected based on trade secret or confidential commercial standards set forth in CMS’ FOIA regulation. The Issuer may redact this protected information from the public version of Part III. The Issuer must supply a public version that displays redacted or “blackened out” text (i.e., redactions must be clearly documented in the public version). As stated in the Rate Review Regulation, CMS will review the Issuer’s confidentiality determinations and may request modifications to the public version, if the redacted information does not satisfy the exemptions set forth in CMS’ FOIA regulations.

2.4 CMS Monitoring of Rate Review Reporting Requirements

CMS will monitor rate review submissions on an ongoing basis. CMS will run automated validation checks on the quantitative portions of the Preliminary Justification. CMS may contact Issuers to address any deficiencies and noncompliance with the reporting instructions contained in this manual and may require Issuers to resubmit information.

⁶ 45 C.F.R. § 154.215 (i)(2).

3. TECHNICAL INSTRUCTIONS FOR COMPLETING THE PRELIMINARY JUSTIFICATION⁷

3.1 Preliminary Justification Reporting Requirements

3.1.1 Overview of Preliminary Justification

Under the Rate Review Regulation, Issuers are required to provide the States and CMS with a Preliminary Justification for rate increases that are above a defined threshold, or the “subject to review” threshold.⁸ This section provides technical instructions for completing the Preliminary Justification. The Preliminary Justification consists of three parts:

1. Part I- Rate Increase Summary;
2. Part II- Written Explanation of the Rate Increase;
3. Part III- Rate Filing Documentation.

Parts I and II of the Preliminary Justification must be completed for all rate increases that meet or exceed the “subject to review” threshold. Part III of the Preliminary Justification is only required in cases in which CMS is reviewing the rate increases.

3.1.2 Calculation of the “Subject to Review” Threshold

The Rate Review Regulation states that in the first year of the rate review program (September 1, 2011 through August 31, 2012), a rate increase exceeds the subject to review threshold if the average rate increase for enrollees is at or above 10%.

Issuers must identify and report on “subject to review” rate increases at the product level. The term “product” is a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that an Issuer offers in a State, for which a rate increase is being requested.⁹ If an Issuer has a rate increase that meets or exceeds the reporting threshold for multiple products, the Issuer may submit a single Preliminary Justification for the combination of those products, provided that: 1) the experience of all combined products has been pooled to calculate the rate increases; and, 2) the rate increase is the same across all combined products. Separate Preliminary Justifications must be submitted for products that do not meet both of these criteria.

This process is intended to measure changes in the underlying rate structure, not changes resulting from the application of previously approved elements of premium such as aging, moves across different geographic rating zones, population changes, benefit changes, or even changes in the employer contribution for small group resulting in a change in the employee’s contribution for coverage. Of course, a filing that proposes a change in the factors underlying such elements as aging, geography, or benefits would be considered a rate change and would be studied as part

⁷ This section may be updated pending receipt of the Paperwork Reduction Act approval.

⁸ 45 C.F.R. § 154.200(a).

⁹ 45 C.F.R. § 154.102.

of the rate filing. If there is no change in the rate structure, but only the application of a previously approved element of premium that is not a rate, the change studied is zero.

If an increase is implemented within 12 months of a previous increase the aggregate effect of the two increases will be considered. Thus, the threshold test that determines whether an increase is subject to review would include the aggregate effect of any increases implemented within a year of the increase being considered. The frame of reference is the effective date of any increase.

If an increase does not trigger the threshold and become subject to review, a later increase will not cause that filing to change status and become subject to review should their combined effect trigger the threshold.

When only the combined effect of two increases triggers the threshold, then only the later filing for the incremental increase would become subject to review. The earlier filing will not retroactively be made subject to review, it can only become so when tested at the time it is filed (or for States that do not require an increase to be filed, when first implemented).

Examples:

- 1) If there was a simple 12% increase effective on January 1, the threshold test would be triggered as this exceeds the 10% threshold.
- 2) If there was a simple 8% increase effective on January 1, the threshold test would not be triggered as this does not meet or exceed the 10% threshold.
- 3) If there were already a simple 8% increase effective January 1, and there was a second 4% increase effective July 1 added to the same product, then, using the annual window and the point of reference of the effective date of the 8% increase January, 1 the average compound increase for one year would be 12% which exceeds the 10% threshold and makes the increase subject to review.

If these increases were filed separately the first 8% increase would not trigger the threshold and it would not become subject to review. The second increase however would trigger the threshold and become subject to review since it is really part of a compound increase (two increase implemented within one year).

- 4) If there was a 6% increase implemented semi-annually beginning January 1, this would trigger the threshold since the annual increase is a compound increase comprised of two 6% pieces, or 12%. If the first 6% increase (January) was filed separately from the second (July) the first 6% increase would not trigger the 10% threshold in and of itself. The second semi-annual increase when combined with the first 6% increase would result in a combined 12% average annual increase and trigger the threshold from the point of reference of the effective date of the second increase.

In the case of rolling periodic increases, each set of increase, or cumulative increase would be examined from within the one year window period measured from the effective date of each increase. Thus, in the case of quarterly increases implemented effective January 1, and quarterly thereafter, each quarter the combined four quarter increase spanning the annual period ending on

the effective increase date would be tested against the 10% threshold. If the threshold rate increase meets or exceeds the threshold value then the combined increase would trigger reporting. If it does not meet or exceed the threshold increase it would not be subject to review. Thus, a 2.5% compounded quarterly increase would equal a 10% annual increase and trigger the threshold using the frame of reference of the fourth such quarterly increase.

A 10% increase applied to monthly cohorts upon renewal would represent an average 10% increase in the threshold test and trigger the threshold.

In the case of any set of multiple increases considered together, if any threshold rate increase value exceeds 10% the set of increases would be subject to review.

3.1.3 Part I instructions

3.1.3.1 General Information

Issuers must use the standardized Microsoft Excel 2003 worksheet available for download in the HIOS system for completing Part I of the Preliminary Justification, the Rate Summary Worksheet. Issuers may use Microsoft Excel 2007 or 2010 to complete Part 1 of the Preliminary Justification. However, all Part 1 files must be saved as an Excel 2003 file (i.e., an .xls file). A draft of the Excel template is available to download on the CMS/CCIIO website. Note if Excel 2007 or 2010 is used to complete Part 1 of the Preliminary Justification and Issuers save the file down to Excel 2003, a “loss of fidelity” warning message will appear in Microsoft Excel. Issuers should disregard this message, as saving down to Microsoft 2003 will not affect the integrity of the file.

Sections A and B of the worksheet requires Issuers to provide historical and projected claims experience data (referred to on the form as the ‘Base Period’ data and ‘Projection Period’ data, respectively):

- **Base Period Data:** The base period data is the data from the base period that was used to develop the rate projections that are calculated in the Rate Summary Worksheet. The base period data may include data from other products or sources if the experience for the product is not fully credible (e.g., national level data). In general, this section should be completed using the same data that was used to develop the rate increase and/or prepare any applicable state rate filing.
- **Projection Period:** The allowed costs are projected from the base period to the projection period for the proposed rates in two steps. Section B1 projects allowed costs from the base period to the 12-month period immediately preceding the effective date of the proposed rate change based on updated pricing assumptions. Section B2 further projects allowed costs from the projection period for current rates to the projection period representing the effective dates of the proposed rates. The projection periods are 12-month periods immediately before and after the effective date of the proposed rate increase.

The claims data entered in the base period are trended forward for each of the projection periods by an overall medical trend factor. Issuers must enter an overall medical trend factor for each of

the claims service categories provided on the worksheet. The overall medical trend factor should reflect all of an Issuer's cost, utilization, and other trend assumptions for the projection periods.

Note that in the process of calculating rate increases, wherever that occurs, the populations must be identical immediately before and immediately after the rate increases. This is necessary in order to capture only the rate changes per se and not additional premium changes (such as aging or moving across geographic rating zones) that are outside the scope of the pure rate increases.

Issuers should use the following definitions for reporting service category data on the worksheet:

- **Inpatient:** Includes non-capitated facility charges for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other inpatient facility.
- **Outpatient:** Includes non-capitated facility charges for surgery, emergency room, lab, radiology, observation and other outpatient facility.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose reimbursement is included in facility fees.
- **Prescription Drugs:** Includes drugs dispensed by a pharmacy.
- **Other:** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.
- **Capitation:** All items capitated.

The worksheet uses the inputted data on claims, admin, and underwriting information for the 12 month periods immediately before and after the rate increase effective date to calculate an overall rate increase in Section C. This rate increase may not always match the rate increased derived from the subject to review threshold test (this value is reported separately on the form in Section F).

The two rate increase values may be the same when issuers are not implementing multiple or phased in rate increases such as for example a one time 11% increase that is assessed to all beneficiaries on the rate increase effective date.

However, the calculated rate increase amount in Section C will not match the threshold rate increase in cases where an issuer implements multiple periodic increases. For example, the threshold increase will not match the overall rate increase calculation in Section C if the issuer is proposing a rate increase implemented quarterly upon policy renewal.

The rate increase exercise on the worksheet requires issuers to show how their anticipated costs will change between the current year (status quo) and under the rate increase. Issuers should always enter Sections A,B, and C with historical and projected data that represents their actual experience and trend assumptions. Issuer should not modify their data in order to make the overall rate increase calculation in Section C match the threshold rate increase.

The information contained in Sections A,B, and C of the preliminary justification are intended to give consumers a standardized presentation of changes in issuers' claims, administrative and underwriting gain/loss revenue needs. These data are not intended to directly tie to the threshold rate increase.

3.1.3.2 Description of Worksheet Data Elements

Section A: Base Period Data

- **Base Period Data - Start and End Periods:** Enter the beginning and end dates of the base period in “MM/DD/YYYY” format.
- **Member Months:** Enter the total member months for the base period data for each service category. Where necessary, the Issuer should total membership for base medical coverage for all service categories for purposes of PMPM calculations in Parts 1 and 2 of the preliminary justification form.
- **Total Allowed:** Enter amount of claims incurred in the base period by service category on an allowable basis including estimates of unpaid claims. If IBNR values are not developed on an allowed basis, the Issuer should adjust this value accordingly. This value may also be adjusted for coordination of benefits. Total allowed costs are summed automatically.
- **Cost Sharing:** Calculated automatically by service category from total allowed dollars and net claims (dollars).
- **Net Claims:** Enter amount of claims incurred in the base period by service category including estimates of unpaid claims and net of member cost sharing. Total net claims (dollars) are summed automatically.
- **Cost Sharing Per Member Per Month Percentage:** Calculated automatically by service category and in total based on member's cost sharing (dollars) and member months.
- **Net Claims PMPM:** Calculated automatically by service category and in total based on net claims and member months.
- **Allowed Claims PMPM:** Calculated automatically by service category and total based on allowed dollars and member months.

Section B Claims Projections

B1. Adjustment to the Current Rates

This section projects allowed costs from the base period to the projection period for current rates based on updated pricing assumptions.

- **Start and End Periods:** Enter the starting date of the projection period for current rate, which is 12 months prior to the effective date of the proposed rate change. Enter the ending

date of the projection period for current rate, which is one day prior to the effective date of the proposed rate change. Dates should be entered in “MM/DD/YYYY” format.

- **Overall Medical Trend:** Enter the overall medical trend factor for each service category. Values are displayed in the format “1.xxxx”.
- **Projected Allowed PMPM:** Calculated automatically by service category as the product of the base period allowed claims PMPM, and the overall medical claims trend in this section (projection period for current rate).
- **Cost Sharing:** Enter the average of all cost sharing for the projection period for current premium rates (for example, deductibles, co-pays, and coinsurance) by service category. Values are displayed in the format in the decimal format “.xx”. This factor is used to calculate net claims PMPM from projected allowed claims PMPM. The total member cost share factor is calculated automatically as 1 minus the ratio of net claims PMPM to total projected allowed claims PMPM.
- **Net Claims PMPM:** Calculated automatically by service category based on projected allowed PMPM and member’s cost sharing PMPM. Total net claims PMPM is summed automatically.

B2. Claims Projection for the Future Rates

This section projects the claims experience from the midpoint of the projection period for current premium rates to the midpoint of projection period for future premium.

- **Projection Period for Future Rates - Start and End Period:** Enter the effective date of the proposed rates, for example, 1/1/2012. The end date should be exactly one year after the start date.
- **Overall Medical Trend:** Enter the overall medical trend factor for each service category. Values are displayed in the format “1.xxxx”.
- **Projected Allowed PMPM:** Calculated automatically by service category as the product of the current rate allowed PMPM, and the overall medical claims trend in this section (projection period for the future premium)
- **Cost Sharing:** Enter the average of all cost sharing for the projection period for future rate (for example, deductibles, copays, and coinsurance) by service category. Values are displayed in the format “.xx”. This factor is used to calculate net claims PMPM from projected allowed PMPM. The total member’s cost share factor is calculated automatically as 1 minus the ratio of total net claims PMPM to total projected allowed PMPM. If the Issuer believes that not all cost sharing has been captured (a situation that can easily arise in a number of situations including but not limited to capitation), an estimate of missing cost sharing should be used to provide the insureds a good estimate of their cost sharing.

- **Net Claims:** Calculated automatically by service category based on projected allowed claims PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

Section B3. Medical Trend Breakout

For the impact of medical trend, estimate the proportions of trend attributable to each of (1) utilization changes, (2) unit cost changes, and (3) all other components of trend combined. These fields should sum to one.

Section C: Components of Current and Future Rates

This section collects information on the net claims, administrative, and underwriting gain/loss components of the current and future rates. The administrative and underwriting gain/loss components should be reported consistent with how these terms are determined for state rate filings and financial reporting.

Future Rates

- **Line 1 – Projected Net Claims:** Populated based on net claims amount in Section B.2.
- **Line 2 – Administrative Costs:** Enter estimated administrative costs for the future rate.
- **Line 3 – Underwriting Gain/Loss:** Enter the gain loss estimate for the future rate
- **Line 4 – Total Rate:** Calculated automatically as the sum of lines 1 through 3.
- **Line 5 – Overall Rate Increase:** Calculated automatically.
- **Percentage of Rate (Lines 1-4):** Calculated automatically.

Prior Estimate of Current Rate

Complete these fields with the net claims PMPM and projected non-claim expenses PMPM based on the pricing assumptions in an earlier rate filing for the current rate.

- **Line 1 – Projected Net Claims:** Enter prior estimate of net claims from prior rate filing using enrollment and product mix that will be affected by the increase. The estimated projected net claims should be developed from the rates that were in effect 12 months prior to the proposed rates and reflect the same population and benefits that are included in the claims projections in section B2. If recent filings have been on a more recent basis than annual, base this value on the most recent filing (i.e., the claims estimate being updated in the current requested rate increase).
- **Lines 2 – Administrative Costs:** Enter prior estimate of estimated administrative costs for the current rate.

- **Line 3 – Underwriting Gain/Loss:** Enter prior estimate of the underwriting gain/loss for the current rate period
- **Line 4 – Total rate:** Calculated automatically as the sum of lines 1 through 3.
- **Percentage of rate (Lines 1-4):** Calculated automatically.

Difference

These fields **are calculated automatically.**

Section D: Components Rate Increases

This section displays the difference in medical claims between the projected rate and the current rate.

- **Line 1 – Inpatient:** Calculated automatically as the product of the overall trend for inpatient entered in B2 (the projection period for future rate) minus 1 and the inpatient net claims amount in B1 (the projection period for the current rate).
- **Line 2 – Outpatient:** Calculated automatically as the product of the overall trend for outpatient entered in B2 (the projection period for future rate) minus 1 and the outpatient net claims amount in B1 (the projection period for the current rate).
- **Line 3 – Professional:** Calculated automatically as the product of the overall trend for professional entered in B2 (the projection period for future rate) minus 1 and the professional net claims amount in B1 (the projection period for the current rate).
- **Line 4 – Prescription Drugs:** Calculated automatically as the product of the overall trend for prescription drugs entered in B2 (the projection period for future rate) minus 1 and the prescription drugs net claims amount in B1 (the projection period for the current rate).
- **Line 5 – Other:** Calculated automatically as the product of the overall trend for other entered in B2 (the projection period for future rate) minus 1 and the other net claims amount in B1 (the projection period for the current rate).
- **Line 6 – Capitation:** Calculated automatically as the product of the overall trend for capitation entered in B2 (the projection period for future rate) minus 1 and the capitation net claims amount in B1 (the projection period for the current rate).
- **Line 7 – Cost Sharing:** Calculated automatically by summing the products of
 - the difference in cost sharing amounts entered in B2 and B1 (the projection periods for the future and current rate) for each service category, and
 - the allowed claims amount in B2 for each service category.

- **Line 8 – Correction of Prior Net Claims Estimate:** Calculated automatically based on the difference between 8b and 8a.
 - **Line 8a– Prior Net Claims Estimate for Current Rate Period:** Populated as the projected net claims for the current rate prior estimate in Section C, line 1.
 - **Line 8b – Re-Estimate of Net Claims PMPM for Current Rate Period:** Populated as the total net claims PMPM for the projection period for the current rates in Section B1.
- **Line 9– Total:** Calculated automatically as the sum of lines 1-8.
- **Claims Restatement for Current Rate Period**
 - Line 8a - Prior net claims estimate for current rate period: Populated as the projected net claims for the current rate prior estimate in Section C, line 1.
 - Line 8b - Re-estimate of net claims PMPM for current rate period: Populated as the total net claims PMPM for the projection period for the current rate rates in Section B1.

Section E: List of the Annual Average Rate Change Requested and Implemented in the Past Three Calendar Years

- For the past three calendar years enter:
 - **Calendar Year:** The calendar years (in reverse chronological order).
 - **New Form:** Input “Y”, to indicate that the product was in its first year and there was no rate increase and fill in a numerical zero in the requested and implemented fields; or input “N”. Fill in a numerical zero in all blocks in section E where there are no rate increases.
 - **Requested:** The average rate increase that was filed or otherwise placed into effect (for example, in a state that did not approve rates in advance) for this product(s). The average annual rate increase should be weighted by premium and should be calculated for each calendar year. A zero value should be entered for any year where there was no rate increase. Decreases should be entered as a negative number.
 - **Implemented:** The average rate increase that was implemented for this product. The average annual rate increase should be weighted by premium and should be calculated for each calendar year. A zero value should be entered for any year where there was no rate increase. Please note for emphasis that the population should be the same before and after the rate increase. Decreases should be entered as a negative number.

Section F: Range and Scope of the Proposed Increase

- **Number of Covered Individuals:** Enter the number of covered individuals as of the effective date of the increase.

- **Threshold Rate Increase:** this is the rate increase calculated under the “subject to review” threshold test. In many cases, the percent value entered in this field will not match the overall rate increase amount calculated in Section C.
- **Minimum and Maximum Rate Increases:** enter the minimum and maximum percentage rate increases as determined by changes in the rate table and its various factors. Note again that the population before and after the rate increase should be identical, and that a change in the employer contribution is not to be considered a rate increase.

3.1.4 Part II Instructions

Issuers must provide a brief, non-technical description of why the Issuer is requesting this rate increase. This explanation should help consumers interpret the rate summary data provided in Part I of the Preliminary Justification. Accordingly, it should identify and explain the key drivers of the rate increase in Part I of the Preliminary Justification. For example, if inpatient costs are reported as the main factor of the rate increase, the written explanation should describe why hospital costs are increasing.

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

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

There is no standardized reporting form for Part II of the Preliminary Justification, but Issuers are expected to cover items listed above in their submissions. The written statement must be submitted as in HIOS via a text box. Such information posted by the Issuer will be clearly displayed as the statements of the Issuer. CMS will not edit the statements provided by Issuers for Part II. .

3.1.5 Part III Instructions

Issuers are only required to complete Part III of the Preliminary Justification, the rate filing documentation, when CMS is reviewing the rate increase. HIOS will automatically prompt Issuers to submit Part III when it is required.

The final rule states that CMS will conduct the rate review using the criteria that the effective rate review states will follow. This review must take into account, to the extent appropriate, the following factors:

1. The impact of medical trend changes by major service categories;
2. The impact of utilization changes by major service categories;
3. The impact of cost-sharing changes by major service categories;
4. The impact of benefit changes;
5. The impact of changes in enrollee risk profile;
6. The impact of any overestimate or underestimate of medical trend for prior years related to the rate increase;
7. The impact of changes in reserve needs;
8. The impact of changes in administrative costs related to programs that improve health care quality;
9. The impact of changes in other administrative costs;
10. The impact of changes in applicable taxes, licensing or regulatory fees;
11. Medical loss ratio; and
12. The health insurance issuer's capital and surplus.

In order for CMS to conduct the review, the Issuer must provide the following items.

List of Part III Reporting Requirements:

1. Description of the type of policy, benefits, renewability (individual business only), general marketing method and issue age limits (individual business only).
 - a. Insurance Company Name
 - b. NAIC Company Code
 - c. Contact Person and Title

- d. Contact Telephone Number and E-mail
 - e. Date of Submission
 - f. Proposed Effective Date
 - g. Insurance Company's Filing Number
 - h. Form Number
 - i. Product Number
 - j. Market Type (Individual/Small group)
 - k. Status: (Open/Closed Block)
2. Brief Description:
- i. Type of Policy
 - ii. Benefits
 - iii. Renewability(individual business only)
 - iv. General Marketing Method
 - v. Underwriting Method,
 - vi. Premium Classifications (an explanation of rating factors used for the product).Issue Age or Attained Age Rating Structure, Issue Age Range (individual business only),
3. Scope and reason for the rate increases.
4. Average annual premium per policy, before and after the rate increase.
- a. Describe past rate increases. For any increase having even partial implementation in 2008 or later, give implementation details including the initial effective date, range of effective dates, and the method of implementation (on policy anniversaries, etc.)
 - b. Description of Proposed Increase in Dollar Amount
5. Past experience, and any other alternative or additional data used.
- a. Number of Policyholders
 - b. Number of Covered Lives

- c. Total Written Premium
 - d. Experience Period, Projection Period
 - e. Past Experience, including:
 - i. Cumulative Loss Ratio (Historical/Past)
 - ii. Any Alternative Experience Data Used
 - f. Credibility Analysis
 - g. Claims incurred but unpaid included in the experience in (e) above, with disclosure of the “paid through” date of the claims used to generate that data. The “paid through” date should be the same for purposes of these claims incurred but unpaid as for the calculation of paid claims.
 - h. Contract Reserves
6. A description of how the rate increase was determined, including the general description and source of each assumption used.
- a. Expenses
 - i. Profit and Contingency
 - ii. Commissions and Brokers Fees
 - iii. Taxes, License and Fees
 - iv. General Expenses
 - v. Other Administrative Costs
 - vi. Reinsurance
 - b. Impact of Statutory Changes, including Mandates
 - c. Overall Premium Impact of Proposed Increase, showing the
 - i. Average Annual Premium Per Policy
 - ii. Before and After Rate Increase
 - d. Descriptive Relationship of Proposed Rate Scale to Current Rate Scale
 - e. Premium Basis
 - i. Brief Description of How Revised Rates were Determined, including:

1. General Description
2. Source of Each Assumption Used
 - ii. For expenses, including:
 1. Percent of Premium
 2. Dollars Per Policy or Dollars Per Unit of Benefit
 - iii. Trend Assumptions
 - iv. Interest Rate Assumptions
 - v. Other Assumptions, including but not limited to Morbidity, Mortality and Persistency
- f. Company Financial Condition
 - i. Company Surplus
7. The cumulative loss ratio and a description of how it was calculated (for individual only).
8. The projected future loss ratio (a one year projection from the effective date of the rate increase) and a description of how it was calculated. This is not the “adjusted” federal loss ratio.
9. The projected lifetime loss ratio¹⁰ that combines cumulative and future experience, and a description of how it was calculated. This is for individual business only. Include a loss ratio exhibit that shows the details of the loss ratio. Issuers should provide this information in a manner that will allow for testing associated with any applicable State lifetime loss ratio calculation. In the absence of a State standard, Issuers should provide data that will allow for lifetime loss ratio testing under the National Association of Insurance Commissioners’ Model Rule, “Guidelines for Filing of Rates for Individual Health Insurance Forms” (MDL 134) (2000).
10. The Federal medical loss ratio (MLR) standard in the applicable market to which the rate increase applies. Issuers must provide a 12-month projected loss ratio for the period of the rate increase both at the market level and at the applicable filing level using the loss ratio calculation provided in the Federal MLR regulation. Consistent with the regulation, Issuers may make adjustments for costs related to quality improvement, taxes and fees. However, Issuers may not apply the credibility adjustments described in the regulation. Rather, Issuers should take credibility into account as part of their projection estimates, using the assumptions and adjustments that they would normally apply to address

¹⁰ The projected lifetime loss ratio is a projection of the kind normally used in calculating a state level lifetime loss ratio. A traditional state lifetime loss ratio does not include quality improvement expenses, for example, which is included in the Federal standard. The future loss ratio included is not the same as the future loss ratio in (10) above, in that this is not “adjusted” and is not under the federal standard.

credibility in projection calculations. Issuers must provide data supporting their projected loss ratio, including data supporting any applicable adjustments.

Issuers must clearly identify any element listed above that the Issuer believes is not relevant to the development of the rate increase, and explain in detail why the Issuer believes it is not relevant. Information must be provided on the remaining elements. Health Insurance Issuers have the discretion to select the format in which they present the required Part III reporting elements. As a general rule, Part III submissions must contain sufficient detail to allow HHS to conduct a thorough actuarial review of the rate increase. Part III submissions must clearly describe the rate making methodology, underlying data, and assumptions that were used to develop the rate increase.

Issuer may submit one or more files in HIOS using PDF, Microsoft Excel, or Microsoft Word format. As stated in the regulation, Issuers may submit their state rate filing in lieu of the Part III requirements if the rate filing satisfies all of the Part III data reporting requirements. If the Issuer's state rate filing only partially meets the Part III reporting requirements, the Issuer may submit its state filing and supplement it with the remaining Part III materials.

4. LIST OF UPDATES TO MANUAL

09/14/11 Updates

1. Footnote on page 22 updated from

The projected lifetime loss ratio is a projection of the kind normally used in calculating a state level lifetime loss ratio. A traditional state lifetime loss ratio does not include quality improvement expenses, for example, which is included in the Federal standard. The future loss ratio included is not the same as the future loss ratio in (7) above, in that this is not “adjusted” and is not under the federal standard.

To

The projected lifetime loss ratio is a projection of the kind normally used in calculating a state level lifetime loss ratio. A traditional state lifetime loss ratio does not include quality improvement expenses, for example, which is included in the Federal standard. The future loss ratio included is not the same as the future loss ratio in (10) above, in that this is not “adjusted” and is not under the federal standard.

2. Instructions for prior estimate on page 15 changed from

Line 1 – Projected Net Claims: Enter prior estimate of net claims from prior rate filing using enrollment and product mix that will be affected by the increase. The estimated projected net claims should be developed from the rates that were in effect 12 months prior to the proposed rates and reflect the same population and benefits that are included in the claims projections in section B2. If recent filings have been on a more recent basis than annual, and the review threshold is reached based on those multiple increases, report for this purpose the net claims one year prior to the effective date of the increase that engages the trigger.

Lines 2 – Administrative Costs: Enter prior estimate of estimated administrative costs for the future rate.

To

Line 1 – Projected Net Claims: Enter prior estimate of net claims from prior rate filing using enrollment and product mix that will be affected by the increase. The estimated projected net claims should be developed from the rates that were in effect 12 months prior to the proposed rates and reflect the same population and benefits that are included in the claims projections in section B2. If recent filings have been on a more recent basis than annual, base this value on the most recent filing (i.e., the claims estimate being updated in the current requested rate increase).

Lines 2 – Administrative Costs: Enter prior estimate of estimated administrative costs for the current rate.

