



Rate Review Justification Instructions

For Transitional Policies

Updated April 9, 2018

PRA Disclosure Statement

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1. General Instructions

1.1 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 requirements for health insurance issuers (issuers) offering health insurance coverage for non-grandfathered products in the small group and/or individual markets to submit rate filing information on rate increases to the Centers for Medicare & Medicaid Services (CMS). On May 19, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a final rule, the “Rate Increase Disclosure and Review” (Rate Review Regulation) implementing section 2794 of the PHS Act.

On February 27, 2013, CMS published the Market Reform Rules (78 FR 13406). The Market Reform Rules, among other things, established the single risk pool requirement for the individual and small group markets, and amended 45 CFR Part 154 to require the submission of the Unified Rate Review (URR) Rate Filing Justification for proposed rate increases in the individual and small group markets. On November 14, 2013, CMS announced a transitional policy whereby health insurance issuers who chose to extend coverage of non-grandfathered plans issued prior to October 1, 2013 would not be considered out of compliance with certain Market Reform Rules if they renewed these policies from January 1, 2014 through October 1, 2014, and encouraged State agencies to adopt the same policy.¹ On March 5, 2014, CMS extended the transitional policy through October 1, 2016.² On February 29, 2016, CMS extended the transitional policy through December 31, 2017.³ On February 23, 2017, CMS extended the transitional policy through December 31, 2018.⁴ On April 9, 2018, CMS extended the transitional policy through December 31, 2019.⁵ Each time the transitional policy was extended, CMS specified in guidance that issuers of such policies must submit the required information to States and CMS to ensure compliance with PHS Act section 2794.

As the URR Rate Filing Justification was designed for submissions of products and plans that are subject to the single risk pool requirement, CMS made the Rate Review Justification (RRJ) module in the Health Insurance Oversight System (HIOS) available to allow issuers to satisfy the reporting requirements when they propose rate increases for transitional plans that are subject to review.

This manual provides instructions for issuers to submit a Preliminary Justification in the RRJ module of HIOS for transitional plans in the individual and small group markets.⁶ Issuers must submit a Preliminary Justification for all proposed rate increases that are subject to review.

1.2 Changes to the Instructions

Updates to the RRJ instructions since the last version include:

- Revisions to improve formatting and organization. Editorial or formatting changes in

¹ <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>

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

³ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf>

⁴ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-Transitional-Policy-CY2018.pdf>

⁵ See: Insurance Standards Bulletin Series – Extension of Transitional Policy through 2019 (April 9, 2018) at: <https://www.cms.gov/ccio>.

⁶ Student health insurance coverage effective on or after July 1, 2018 will be exempt from Federal rate review requirements. See HHS Notice of Benefit and Payment Parameters for 2019 Final Rule (April 9, 2018) at <https://www.cms.gov/ccio>.

- the instructions do not indicate a change to current practices and policies.
- Revisions to clarify that the HIOS RRJ module is only for transitional plans with rate increases that are subject to review.

1.3 Preliminary Justification

Issuers must submit a Preliminary Justification for all transitional plans with 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: Rate Increase Summary Form: A standardized Excel-based form that collects product-level summary data on the underlying medical and administrative cost drivers of the rate increase.
- 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. This section should clearly explain the information given in Part I.
- Part III: Rate Filing Documentation: This section of the Preliminary Justification *is only required to be filed when CMS is conducting the rate review for a State that does not have an Effective Rate Review Program*. Issuers must provide detailed rate information that will be used by CMS to conduct actuarial reviews.

1.4 Regulatory Review

Consistent with 45 C.F.R. § 154.210, RRJ Preliminary Justification submissions are reviewed to determine whether the rate increase is “Unreasonable” or “Not Unreasonable”. In States that have Effective Rate Review Programs in the applicable market, and allow transitional plans, the State regulator performs the review and makes the determination based on their applicable laws and regulations, in addition to an analysis of the relevant factors set forth in 45 C.F.R. § 154.301.⁷ In States that do not have an Effective Rate Review Program, CMS performs the review and makes the determination based on the definition for an unreasonable rate increase consistent with 45 C.F.R. § 154.205, including the factors in 45 C.F.R. § 154.301.

1.5 Submission Timing

The date that issuers must submit the Preliminary Justification to CMS 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.
- States without Rate Filing Requirements: Issuers must submit the Preliminary Justification prior to implementing the rate increase.

In States that do not have an Effective Rate Review Program,⁸ 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.

⁷ See http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html for the list of States with Effective Rate Review Programs.

⁸ For the 2019 plan year, the States that do not have an Effective Rate Review Program are Oklahoma, Texas and Wyoming.

1.6 Supplemental Information

If the State regulator is unable to conduct its review based on the Preliminary Justification materials, the regulator will require issuers to submit additional information. In a State that does not have an Effective Rate Review Program, CMS will send requests for supplemental information via email. The email will be sent to the issuer's designated point(s) of contact for a given product within the HIOS system. The email 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. The RRJ module will also display the requirements for the supplemental information request.

Issuers must upload the supplemental information via the RRJ Module in HIOS. Even if the issuer has already provided the supplemental information via an informal phone conversation with the regulator, the issuer must formally respond to the supplemental request by uploading the supplemental information in HIOS.

The regulator 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.

If the regulator requests supplemental information, issuers have 10 business days from the receipt of the request to upload supplemental materials in HIOS. The response time frame will shorten as the effective date of the rate increase gets closer. Consistent with 45 C.F.R. § 154.205, failure to provide the requested supplemental information in a timely fashion will result in a determination that the rate increase is "Unreasonable" due to insufficient justification.

1.7 Notification of Rate Review Determination

CMS or States, as applicable, will enter rate review determinations in the HIOS RRJ Module. The HIOS system will automatically generate an email to the issuer with the result of the determination. The email notification to issuers will include one of the following review determinations:

1. Unreasonable Rate Increase: The rate increase was determined to be unreasonable based on a review by a State or CMS.
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.
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.
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 or CMS review. In addition, if for any reason, a submission requires changes to be made after the submission has been "attested," the RRJ module will only

allow CMS to “withdraw” the submission and the issuer will have to create a new submission.

1.8 Final Justification

Consistent with 45 C.F.R. § 154.230(c), if a rate increase is determined to be unreasonable by either the State or CMS and the issuer implements the unreasonable rate increase, the issuer must provide a Final Justification that explains why the issuer is electing to implement the unreasonable rate increase. The Final Justification is not required when an issuer elects to withdraw the rate increase after an unreasonable determination or, in States with prior approval authority, where the rate increase is not approved.

Issuers have 10 business days from the date they are notified of the unreasonable determination to either: (1) submit a Final Justification in HIOS for rates that they intend to implement; or (2) withdraw the rate increase in HIOS. See section 1.7, *Notification of Rate Review Determination*, for more information on the notification process for unreasonable rate increases.

For the Final Justification, issuers must 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 or is otherwise not sufficient.

Issuers that implement an unreasonable rate increase are required to post the Final Justification and other specified information on their website. Please see section 1.9, *Public Disclosure*, for more information.

1.9 Public Disclosure

CMS posts on the CMS website⁹ information contained in the Parts I and II of the Preliminary Justification for RRJ submissions. Part III of these submissions is posted on the CMS website for those States that do not have Effective Rate Review Programs. CMS also posts the final determination and the issuer’s Final Justification when applicable.

1.9.1 Preliminary Justification Posting

Parts I and II of the Preliminary Justification are consumer-oriented documents and do not contain confidential or trade secret information. Therefore, the information in Part I is made available without redaction, and Part II is posted in its entirety. For Part III, for those States that do not have Effective Rate Review Program, CMS makes available to the public the information that is not a trade secret or confidential commercial or financial information as defined in the HHS Freedom of Information Act (FOIA) regulation, 45 C.F.R. § 5.31(d).

To facilitate the posting of the Part III Actuarial Memorandum, issuers are required to upload two versions for those States that do not have Effective Rate Review Program: a CMS version and a public version. The CMS version should contain all the data elements and information

⁹ See <https://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html>.

required in this manual with no redactions. The public version should redact any information that is a trade secret or confidential commercial or financial information.

1.9.2 Final Justification Posting

If an issuer implements an unreasonable rate increase, the issuer is required to post the Final Justification along with the Preliminary Justification and the regulator's rate determination on its website, or provide a link on its website to the relevant product-specific content 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 in a prominent location on their website that will be easily accessible by consumers. The posting must remain on the issuer's website for at least three years.

2. The “Subject to Review” Threshold

A proposed rate increase for transitional plans meets or exceeds the subject to review threshold if the average rate increase for all enrollees weighted by premium volume 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. 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 element of premiums, 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 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).

In the case of rolling periodic increases, the 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, 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, 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 10.4% 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 meets or exceeds 10%, then the set of increases would be subject to review.

3. HIOS Instructions

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 CMS to report any errors in attested submissions. Requests for the removal of attested data from the CMS website will be assessed by CMS on a case-by-case basis.

CMS anticipates that issuers may make changes to proposed rate increases following the submission of the Preliminary Justification. Accordingly, the HIOS RRJ Module includes several features for making changes to rate filings. In general, HIOS has three dedicated issuer user functions for addressing rate increase changes: delete, modify, and withdraw.

2.1 Delete: Prior to Attestation

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 (i.e., no information contained in the record will be web-posted or reviewed by the State or by CMS). The delete 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 Modify: After Attestation

Issuers may submit and attest to only one version of the Preliminary Justification. If an issuer needs to make changes to the Preliminary Justification after attestation, the issuer must modify the existing submission rather than creating a new submission. The “modify” function in HIOS takes the place of the delete function and is available until a rate determination has been entered into HIOS by CMS.

The modification function includes both a text box and a document upload feature. Issuers use the modify function to:

- Change the amount of the proposed increase.
- 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.
- Upload any documentation or exhibits related to the modification that CMS should consider as part of its ongoing review.
- Notify CMS if they are electing to withdraw a rate increase filing prior to completion of the rate 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.

Changes to Attested Submission: When CMS is performing the review, issuers must use the modification function to report all changes to attested submissions. 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. When States are reviewing rate increases, issuers are not required to use HIOS to document modification to rate increases unless their State requires it. However, States should describe any modifications to the rate increase when they enter the results of their reviews into HIOS. The published review determination will describe any applicable modification to the rate increase. The text describing the review determination will also provide the modified rate increase amount.

Withdrawal of Attested Submission: 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 the State of the withdrawal of a rate increase as issuers are expected to notify the State through their existing State communication processes and the State is required to enter the appropriate review determination status in HIOS.

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 business 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 CMS 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 CMS 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 (e.g., 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 and any subsequent increase must be entered as a new record in the system.

2.4 Monitoring of Rate Review Submissions

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.

4. Part I Instructions

4.1 General Information

Issuers must use the standardized Microsoft Excel file available for download under the “Download Rate Increase Summary Template” link in HIOS for completing Part I of the Preliminary Justification. Issuers may use Microsoft Excel 2007, 2010, or 2013 to complete Part 1 of the Preliminary Justification; however, all Part 1 files must be saved as an Excel 2003 file

(i.e., .xls file) or Excel 2007/2010 (i.e., .xlsx file).

Sections A and B of the worksheet require 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 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, administrative, 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; 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 rate 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. Issuers 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. This data is not intended to directly tie to the threshold rate increase.

4.2 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 Per Member Per Month (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 incurred but not reported (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.

4.3 Section B: Claims Projections

4.3.1 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 (e.g., deductibles, co-pays, and coinsurance) by service category. Values are displayed 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.

4.3.2 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 (e.g., 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 (e.g., 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 insured 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.

4.3.3 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.**

4.4 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).
- Line 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.

4.5 Section D: Components of 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:
 - o 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
 - o 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 lines 8b and 8a.
 - Line 9– Total: Calculated automatically as the sum of lines 1-8.
 - Claims ReStatement for Current Rate Period:
 - o 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.
 - o 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.

4.6 Section E: Rate Changes 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. 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.

4.7 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.

5. 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 in HIOS via a text box. Such information posted by the issuer will be clearly displayed on CMS' website as the Statements of the issuer. CMS will not edit the Statements provided by issuers for Part II, but CMS may require issuers to revise Part II if it is insufficient.

6. Part III Instructions

For RRJ submissions, 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. CMS conducts the rate review using the same criteria that States with Effective Rate Review Programs 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 Email
 - 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:
 - a. Type of Policy
 - b. Benefits
 - c. Renewability (individual business only)
 - d. General Marketing Method
 - e. Underwriting Method
 - f. Premium Classifications (an explanation of rating factors used for the product).
 - g. Issue Age or Attained Age Rating Structure, Issue Age Range (individual business only)
3. Scope and reason for the rate increase.
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 the individual market 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 ratio 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 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. 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.

Issuers may submit one or more files in HIOS using PDF, Microsoft Excel, or Microsoft Word format. 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.