COMMONWEALTH OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE

March 24, 2014

RULING LETTER NO. CN-2014-175-AS

TO ALL DISABILITY INSURERS AND HEALTH INSURANCE SERVICES ORGANIZATIONS THAT WRITE HEALTH INSURANCE PLANS IN PUERTO RICO

FORM AND RATE FILINGS SUBMISSIONS TO BE EFFECTIVE FOR CALENDAR YEAR 2015

Dear Sirs and Madams:

Under Section 2794 of the Public Health Service Act, as amended by Section 1003 of the Federal Patient Protection and Affordable Care Act ("ACA"), and in conformity with Chapters 8 and 10 of the Health Insurance Code of Puerto Rico, disability insurers that write individual and small group health plans in Puerto Rico should submit to the Office of the Commissioner of Insurance ("OCI"), for review and approval, new rates in relation to products in compliance with ACA, all rates for ACA-compliant plans even if no change has been made and rate increases equal to or greater than 10% of current rates. The requirements to file rates with the OCI, as set forth in Section 19.080(2)(a) of the Puerto Rico Insurance Code, 26 P.R.L.A, sec. 1908(2)(a), must be complied with by all health services organizations (HMO's) and file all rate changes or modifications, including all rates for ACA-compliant plans even if no change has been made.

In order to implement appropriate guidelines to promote an orderly form and rate filing submission for plans to be effective on January 1, 2015, the OCI is hereby implementing the following standards:

Rates Submission

I. Timeline

Rate filings for non-grandfathered individual and small group plans that will be effective on January 1, 2015 should be submitted to the OCI on or before May 30, 2014. A carrier wishing to have quarterly rate changes on small group plans in 2015 must file rates for all quarters on or before May 31, 2014.

Grandfathered individual and small group rate increases for HMO's and rate increases over 10% for Disability insurers must be filed 90 days or more before they are to be used.

II. Rate Filing Submission Requirements

A. Every filing should be properly submitted through the SERFF system, including all the information required in this ruling letter and its attachments. See SERFF rate filing submissions instructions in Section VI of this ruling letter.

B. Be advised that incomplete filings will be returned without further evaluation.

C. All Excel files should be submitted in Excel, as well as in PDF print out form.

D. All rate filings should be submitted in accordance with the requirements established in the Puerto Rico Rate Filing Instruction Manual (See Attachment 1).

E. The following documents must be included in the rate submission:

1) Federal Rate Review Justification Part I-Unified Rate Review Template (URRT 2015 version in Excel and in PDF) (See Federal Instructions Manual and Standard Format in Attachment 2);

2) Public form of the rate filing information to be placed on the OCI (OCS) website and used for the HIOS Federal Rate Review Justification Part II-Written explanation of any rate increase that is 10% or over; (English & Spanish version);

3) Actuarial Memorandum meeting the requirements of Puerto Rico and the Part III Federal 2014 Actuarial Memorandum and Certification Instructions 2.0 . (See Attachment 3);

4) Puerto Rico Actuarial Certification ;

5) Actuarial Value Calculator Screenshots (for ACA compliant only);

6) SERFF Rate template(in Excel);

7) Rate Manual;

8) Puerto Rico Benefits Map (if different from the Benefits Map already filed with the OCI (OCS) or indicate that the Benefits Map has been filed (See Attachment 4); and

9) Puerto Rico Rate Filing Checklist (See Attachment 5).

III. Use of Approved Rates and Prospective Revisions

A. The carriers must only use the rates filed and approved by the OCI.

B. Lower or higher rates cannot be used, even if the revised rate is on a group level and the rate is not greater than the approved one. Please note that audits will be made to verify that only approved rates are being charged.

C. Carriers will not be allowed to implement rate changes to current rates before January 1, 2015, unless a carrier can prove that their financial solvency will be dangerously low without a rate change.

D. Once the rates are approved they cannot be changed during the year, unless a carrier can prove that their financial solvency will be dangerously low without a rate change.

E. For the small group market, if the rates are increased on a quarterly basis they should be pre-filed all at the same time. No other quarterly rate increases will be accepted, unless the carrier can show the OCI that the projected losses would threaten their solvency.

IV. Rates to be made Public

A. The only documents that will be public on the OCI website after the approval are the rates and the public summary of the rate filing information prepared by the carrier to be placed on the OCI website.

B. All documents will be made public at the same time on September 1, 2014.

V. Grandfathered Rates Submission

A. Every filing should be properly submitted through the SERFF system including all the information required in this ruling letter and its attachments.

See SERFF rate filing submissions instructions in Section VI of this ruling letter.

B. Be advised that incomplete filings will be returned without further evaluation.

C All Excel files should be submitted in Excel, as well as in PDF print out form.

D. All HMO's rate increases and all Disability insurer's rate increases equal to or greater than 10% of rates one year prior, should be submitted in accordance with the requirements established in the Puerto Rico Rate Filing Instruction Manual (Attachment 1).

E. The documents previously mentioned in item II (E) of this ruling letter should be included as part of the rate submission.

VI. SERFF Submissions

A. Every SERFF filing shall be accompanied with a Transmittal Letter including the name of the insurer or health services organization making the filing under the signature of an authorized person, in compliance with Section 3(a)(1) of Rule XXIV of the Regulations of the Insurance Code of Puerto Rico. The transmittal letter should be attached in the "Supporting Documentation Tab".

B. All the fields required in the "Rate Rule Schedule Tab" should be completed.

C. Any supporting documentation should be included in the "Supporting Documentation Tab", including the Federal Rate Review Justification Part I-Unified Rate Review Template (URRT - both Excel and PDF formats), the Public form of the rate filing information to be placed on the OCI, Puerto Rico Actuarial Memorandum, Federal 2014 Actuarial Memorandum and Certification, Puerto Rico Actuarial Certification, Actuarial Value Calculator Screenshots, Rate Manual, Puerto Rico Benefits Map and the Puerto Rico Rate Filing Checklist.

D. The submitted rates to be approved shall be included in the "Rate Rule Schedule Tab".

E. Documents must be saved in a non-protected PDF format so that the file remains searchable and text can be copied from the document.

F. Every communication should be included in SERFF as a "Note to Reviewer" or a "Response Letter", as applicable. Any other way of communication will not be considered as received.

VII. Large Group Rates and Form Filings

Large groups' rates filings should not be submitted for the OCI's evaluation and approval. This standard does not apply to the HMO's, which need to comply with the provisions of Section 19.080(2)(a) of the Puerto Rico Insurance Code.

In addition, we must point out that large group forms are subject to our review and approval. Large group forms must comply with all the applicable provisions of the ACA and the Health Insurance Code of Puerto Rico, which include among others, the following Sections of the Public Health Service Act: Section 2711 (No Annual or Lifetime Limits), Section 2713 (Coverage of Preventive Health Services),[1] Section 2714 (Extension of Dependent Coverage), Section 2704 (Preexisting Condition Exclusions). Large group forms that are not in compliance with the law must be updated and filed for our review and approval immediately.

Supplemental Health Care Exhibit (SHCE)

All carriers are hereby required to complete and submit the Supplemental Health Care Exhibit to the NAIC and the OCI before March 30 of each year for Disability insurers, and before March 31 of each year for health services organizations.

Product Submissions

I. Timeline

Product filings for individual and small group plans that will be effective on January 1, 2015 should be submitted to the OCI on or before May 31, 2014.

II. Product Filing Submission Requirements

A. Every filing should be properly submitted through the SERFF system including all the information required in this ruling letter and its attachments. See SERFF product submissions instructions in Section IV of this ruling letter.

B. No endorsement for previously approved ACA compliant products will be accepted.

[1] Does not apply to grandfathered plans.

C. Be advised that incomplete filings will be returned without further evaluation.

D. All forms and documents should be submitted in PDF print out form.

E. The following documents must form part of the product submission:

1. Essential Health Benefit and Preventive Services Checklist (See Attachment 6).

2. Puerto Rico Form Filing Checklist (See Attachment 7).

F. All products and the copayment structure have to be filed at the same time and cannot be changed during the year.

G. No new metallic products can be submitted to be effective for calendar year 2014.

H. The ACA compliant products to be effective for calendar year 2015 should only include one Maximum Out of Pocket Limit (MOOP), including prescription drug benefits. The MOOP Limit for calendar year 2015 established by our Office is $6,350 for self-only coverage and $12,700 for all other coverage.

I. The carriers must market all the ACA compliant products filed and approved by the OCI.

III. Product Information to be made Public

Each product's description of benefits, metallic level plans, and their corresponding table of copayment, coinsurance and deductibles will be made public, after approved, at the same time for all the carriers on September 1, 2014. The Table of Copayment, Coinsurance, and Deductible should be submitted using an Excel format. (See Attachment 9).

IV. SERFF Submissions

A. Every SERFF filing shall be accompanied with a Transmittal Letter including the name of the insurer or health services organization making the filing under the signature of an authorized person, in compliance with Section 3(a)(1) of Rule XXIV of the Regulations of the Insurance Code of Puerto Rico. The transmittal letter should be attached in the "Supporting Documentation Tab".

B. Any supporting documentation should be included in the "Supporting Documentation Tab", including evidences of previous approval, the table with copayments, coinsurance and deductibles, certifications, memorandum of variable material, among others.

C. The submitted forms to be approved should be included in the "Form Schedule Tab".

D. Forms and documents must be saved in a non-protected PDF format so that the file remains searchable and text can be copied from the document.

E. Every communication should be included in SERFF as a "Note to Reviewer" or a "Response Letter". Any other way of communication will not be considered as received.

In view of these new standards, Ruling Letter No. 2011-128-AV of July 12, 2011, is hereby repealed.

Strict compliance with the provisions of this ruling letter is required.

Cordially,

Ángela Weyne-Roig
Commissioner of Insurance

Puerto Rico

Rate Filing Instruction Manual

Overview

This instruction manual supports implementation of the requirement of Ruling Letter NO. CN-2014-175-AS. For all ACA compliant products, rates for new products and all rate changes must be submitted to the OCI for approval.

For all grandfathered products only rate increases must be filed with the OCI. Under Section 2794 of the Public Health Service Act, as amended by Section 1003 of the Federal Patient Protection and Affordable Care Act ("PPACA"), disability insurers that write medical plans in Puerto Rico have the obligation to submit to the Office of the Commissioner of Insurance ("OCI","OCS"), for review and approval, any rate increase for non-grandfathered plans where the average increase is equal to or greater than ten percent (10%) of current rates, effective September 1, 2011. For Health Service Organizations all rate increases must be submitted to OCI no matter the amount of the increase. The purpose of this requirement is to allow the OCI (OCS) to determine whether the proposed rate increase for small group and individual markets is unreasonable. Rates that are subject to approval by the OCI (OCS) must be submitted at least sixty (60) days before the effective date.[1] If there is an objection from the OCI (OCS), the time required for the objection to be answered will not be included in the 60 days and therefore may delay the implementation date.

The carrier MUST only use the rates filed and approved.

A complete rate filing must include all of the information required by Ruling Letter NO. CN-2014-175-AS, as applicable. The manual and templates do not supersede the regulations, they merely standardize and make explicit the information already required or allowed to be requested by those regulations.

Carriers must use SERFF to submit their rate filings as required by Ruling Letter 2012 140-AV of February 7, 2012. Carriers must fill out all the SERFF data elements, including Affordable Care Act ("ACA") data elements, or the filing will be rejected as incomplete. ACA requires that if there is any rate change to an ACA compliant product, rates for all ACA compliant products in that market (individual or small group) must be filed together. That is if any rates change all previously filed rates must be filed again with the new rates.

Under the Affordable Care Act and rules that became effective on 9/1/2011, carriers with average rate increases of more than 10% per year must submit rate justification information to the Federal Center for Consumer Information and Insurance Oversight ("CCIIO"). For non-ACA compliant products[2], the federal rate summary worksheet and Preliminary Justification also should be submitted to the Centers for Medicare & Medicaid Services ("CMS") on the same date as the filing with the OCI (OCS). Please note that the information submitted to the OCI (OCS) should be consistent with the information submitted to the "CCIIO" and "CMS." In Puerto Rico, all rate increases by HMOs must be filed with the OCI (OCS) if they are ACA compliant or not.

[1] To ensure that rates are approved before they are effective the OCI is requesting that all rates be filed 90 days before they are used. This will be May 30, 2014 for rate filings for 2015 rates.

[2] Non-ACA compliant policies include grandfathered policies and transitional policies.

Consistent with ACA, the OCI (OCS) requires rate filings to include the following parts, if there is any change in rates or plans offering of ACA compliant products in a market. For all ACA compliant products the following should be filed once a year even if there is no rate change. For ACA compliant products and all grandfathered HMO rate increases and non-HMO rate increases over 10% should also submit the following:

1) Federal Rate Review Justification Part I: Unified Rate Review Template (URRT);
2) Public form of the rate filing information to be placed on the OCI (OCS) website and used for the HIOS Federal Rate Review Justification Part II: Written explanation of any rate increase that is 10% or over;
3) Actuarial Memorandum meeting the requirements of Puerto Rico and the federal 2014 Actuarial Memorandum and Certification Instructions 2.0 (Part III).
4) Puerto Rico actuarial certification;
5) Actuarial value calculator screenshots (for ACA compliant only);
6) SERFF Rate template;
7) Rate manual
8) Puerto Rico Benefits Map (if different from the Benefits Map already filed with the OCI (OCS) or not Benefits Map has been filed; and
9) Rate filing checklist (see Appendix A: Rate Filing Checklist).

Section I: Unified Rate Review Template (URRT)

Provide a copy of the URRT template in Excel and also in a PDF printout version. The URRT should be completed with all HIOS information.

For a more complete description of the items in the URRT, please refer to the Department of Health and Human Services (HHS) instructions.

Section II: Written Explanation

For all rate increases that are greater than the review threshold, a brief written explanation of the rate increase must be submitted. This written explanation must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase. This includes:

1) Brief description in simple language the reasons why the rate increase is being requested;

2) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increase reported in the rate increase summary; and

3) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

This summary will be uploaded to the OCI website for public use and it will also be used for the HIOS Preliminary Justification Part II that is required for all rate increases over 10%.

Section III: Federal Actuarial Memorandum and Certification[3]

The Actuarial Memorandum and Certification documents the methodology used in developing the rates and includes an actuarial opinion signed by a qualified actuary providing an opinion that the rate filing was developed according to actuarial standards and principles and the laws of Puerto Rico.

A Part III Federal Actuarial Memorandum, including a corresponding actuarial certification, must be submitted with each Part I Unified Rate Review Template.

The purpose of the Part III actuarial memorandum is to provide support for the values entered into the Part I Unified Rate Review Template. The documentation should clearly identify the plans applicable to each piece of information. All assumptions should be adequately justified with supporting data, where possible, and the rationale for the use of the chosen assumptions.

For a more complete description of the items in the Part III Actuarial Memorandum and Certification, please refer to the Department of Health and Human Services (HHS) instructions.

Section IV: Puerto Rico Actuarial Memorandum

In order to review rates in Puerto Rico the OCI requires information in addition to the federal actuarial memorandum. We encourage carriers to submit both the federal information and the additional Puerto Rico information in the same document. Information that we believe to be in addition to the federal requirements is italicized below. This difference may change in the future as the federal requirements change.

The carrier must provide a detailed description of the method used to develop the premium rates. Since there is much overlap with the Federal Actuarial Memorandum, one actuarial memorandum can be submitted as long as it contains all of the information required in both memorandums. The major difference is the Puerto Rico requirements is the addition of quantitative support for assumptions. The memorandum should also include more detail on any item that the carrier believes is driving the rate increase projections or would be of particular concern when reviewing the rate filing.

Overview of Rate Increase

Provide a brief explanation of why a rate increase is being requested and on what policy forms including the names of the policy forms affected.

Describe the scope and driving factors impacting the rate increase including a description of how the rates were determined.

Provide a description of:

1) *Type of Products;*
2) *Benefits;*
3) *General Marketing Method;*

[3] See Appendix B for Actuarial Certification

4) *Premium Classifications or Rating Factors; and*

5) *Underwriting Method (grandfathered only).*

Rate increase information including:

1) *Historic rate increases for the last 3 years;*

2) *Proposed effective date of the rate increase (grandfathered only);*

3) *Requested minimum, maximum and average rate increase – from current rates and annual from one year prior; and*

4) *Effective through date and any rate increase schedule applicable (small group only).*[4]

Base Period Experience

Provide an explanation of the base period experience used *indicating the basis of the data used*, the first incurred date included and the last incurred date included. The last paid date used should be provided, which indicates the paid through date for the base period experience.

Provide an explanation of how incurred claims were estimated from paid claims including the average completion factor[5] used and an explanation of adjustments made to base period claims experience.

If contract reserves were established for these contracts, describe what they are for, how they were developed and how they impacted the rate development.

Describe the treatment of large claims and claims pooling, if any.

Treatment of commercial reinsurance, if any. This is separate from the Transitional Federal Reinsurance program, but is adjustments for commercial reinsurance purchased by the carrier to protect against the risk of large claims.

Provide an exhibit showing current age distribution and the age distribution anticipated for projection period, if different.

Capitation Payments

Describe what is covered by any capitation payments and the PMPM impact.

Projection Factors and Claims Trends

Provide documentation of all assumptions and methodologies used in the development of the impact of morbidity and enrollee mix.

If there were changes in the benefits covered, provide a description of all benefit changes and *quantitative support of their impact*.

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[4] Small group rate increases can only be on a quarterly basis.

[5] The average completion factor is the ratio of the incurred claims for a period of time to the paid claims for the same period as of the last paid date used for the base period experience. The incurred claims are the total claims that are expected to be paid in the base experience. The paid claims are the amounts that have actually been paid as of any point in time. As time goes on more claims are paid and the ratio is higher.

For each Essential Health Benefit (EHB) not covered previously, the additional cost per-member-per-month (PMPM) *with an actuarial explanation of how the additional cost was developed*.

Provide a description of all changes in the rating structure, if any, and provide quantitative support of their impact including all assumptions used.

Provide quantitative support of the impact due to changes to network, if any.

If there are other changes impacting rates, provide a description and quantitative documentation of all factors, including any adjustments for past experience due to actual loss ratios differing from target loss ratios.

Provide quantitative documentation of the trend development including as well as an explanation of the data, assumptions, and periods used.

Provide:

- *Changes in medical cost trend by major service categories for the past three years and future projections.*
- *Changes in the use of services by major service categories for the past three years and future projections.*

Historic cost and utilization assumptions used compared to the actual trends experienced. Until 2015 filings for the 2016 rates, there may be little or no information, but starting in 2015 you should provide the past projections compared to the actual experience.

Please explain significant changes in assumptions from the prior filing assumptions.

Manual Rate Development

If the experience for the product is too small to be considered credible, alternative claims experience can be used. *Include detail description of all alternative experience data used and how it was adjusted to be appropriate for the market including any adjustments similar in type to the adjustments made to base data*.

Credibility

Indicate the credibility methodology and credibility level of the base period experience.

Paid to Allowed Ratio

Provide a quantitative demonstration of the development of the paid to allowed ratio.[6] *Since Puerto Rico has different claims distribution patterns than those used as the basis of the AVC, it has been determined that company specific projections, which will not be similar to the AVC outputs, should be used for Puerto Rico rate development and in the URRT Market Experience worksheet cell V33.* [7]

[6] This ratio is actually the incurred claims to allowed claims ratio

[7] The AVC should be used for the determination of metal levels unless it is replaced by a Puerto Rico specific calculator

Risk Adjustment and Reinsurance

Risk adjustment and reinsurance do not apply to Puerto Rico.

Non-Benefit Expense Projections

The methodology used to project non-benefit expenses, including gain/loss margins, should be explained. *If a loss ratio approach was used, the carrier should explain how the target loss ratio was developed.*

Administrative Costs

Identify the main factors that affect changes in administrative costs. Discuss how changes in projected administrative costs and profit are impacting the rate increase and what is driving these changes.

If budgets were used, the carrier should explain when the budgets were developed and for what time period.

Provide actual administrative expenses PMPM for the last three years and explain any significant changes in administrative expenses from the prior filing.

Provide a breakdown of projected administrative expenses with any marketing, commission, and quality improvement costs separated. If there are no quality improvement costs in the administrative costs, indicate zero.

If administrative expenses vary by plan explain why.

Projected Gain/Loss Margins

Provide an explanation of how the projected gain/loss margins were developed and any changes from prior filings.

Taxes and Fees

Provide a description of applicable taxes and fees, their impacts, and an explanation of how they were allocated across plans.

Provide a breakdown of projected taxes with amounts of each and their quantitative development.

Medical Loss Ratio

Describe how the projected federal medical loss ratio was calculated. Describe how the credibility adjustment was determined. A demonstration of the projected loss ratio using the federal loss ratio formula should be provided including the values used.

If the loss ratio is less than the federal rebate requirement, explain the plan to xomply with the Federal MLR requirement.

Index Rate

This documentation should provide a descriptive and quantitative development of the plan index rates starting with the market index. This development should be supported by excel exhibits with formulas intact. The following steps should be explicit:

1) Plan level adjustments
    a. *Projected ratio of incurred claims to allowed claims (pricing actuarial value) for each plan and any adjustment to utilization due to cost sharing (separate, if possible)*;
    b. Provider network, delivery system and utilization management adjustment;
    c. Benefits in addition to EHBs *(the estimate of these benefits should be shown in a quantitative development*);
    d. Impact of the eligibility for the catastrophic plan; and
    e. Administrative costs.
2) Calibration for base characteristics to base market allowed:
    a. *Weighted average age*;[8]
    b. *Calibration for family composition;*[9], and
    c. Calibration for tobacco usage.[10]

Provide quantitative documentation of the rating factor for tobacco.

Provide an example procedure of determining a family rate. Demonstrate that this family rating complies with the federal rating rules of the ACA.

AV Metal Values

The AV Metal Values must be determined using the Federal Actuarial Value Calculator. If an alternative methodology was used due to a unique plan design, it must be well documented.

Plan Adjusted Index Rate

Provide quantitative development in excel with all formulas of the plan adjusted index rate. This development should start with the market index rate and show all adjustments in the development of the plan adjusted index rate. The plan adjusted index rate divided by the average age factor should result in the plan base rate (age 21 non-tobacco rate).

Membership

Provide documentation of all assumptions used to project membership and provide support for those assumptions.

Company Financial Condition

Describe the financial situation of the company, including surplus, if any. Provide 5 years of RBC ratio levels.

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[8] The federal instructions only ask for a weighted average age, but we are requesting the calibration factor, which is typically the inverse of the weighted average age factor.

[9] This calibration is for the situation where there are more than three children, but only three can be included in the premium.

[10] At this time we believe that the federal instructions will be to add this calibration to the actuarial value adjustment, but we would like to see it separated out.

Provide historic loss ratios for the last five years.

Small Groups Affected

The carrier should provide a list of all small groups affected by the proposed rate increase, the proposed increase for each group, the date of the group's contract renewal, and the effective date for each group 30 days prior to implementation. The list of small groups affected and renewal dates will depend on the proposed effective date of the rate increase. The carrier should list all small groups that will receive a rate increase in the next 30 day period with each group's average rate increase, renewal date and rate increase effective date in an Excel file attached to an email to the OCI. This information will eventually be posted to the OCI website.

Section V: Public Information

Every carrier must provide a written summary of the rate filing to be displayed on the OCI (OCS) public website. For rate increases over 10% this will also serve as the Preliminary Justification Part II that should be uploaded to HIOS.

Section VI: Rate Template

Provide the federal SERFF Rates Template in excel. This may need to be uploaded in a zip file if they are too large to upload to SERFF.

Section VII: Benefits Map and Actuarial Value

Every carrier should provide to the OCI a benefits map which shows, for all plans, all benefits covered and their respective cost sharing amounts and limits. If the benefits map for a plan has not changed from the prior filing, it does not need to be resubmitted. The carrier should submit a list of plans with an indication of which Benefits Maps are included and the date submitted for any that were submitted previously.

Also for all plans, screenshots of the federal Actuarial Value Calculator (AVC) populated with plan cost share information should be submitted. If the plan has a unique plan design that does not work with the federal Actuarial Value Calculator, a certification of unique plan should be submitted to the OCI as well as quantitative documentation of all adjustments and explanation of all differences that could not be accommodated using the AVC . If the plan decides not to use the AVC, they should provide a certification of unique plan design, an explanation of why they did not use the AVC, and quantitative support for the calculation of each plan's actuarial value.

If several plans are offered at the same metal level in the same region, the sponsor should provide further information on them describing what differentiates them and what the target market is for each.

Section VIII: Rate Manual

If the rate manual has changed or if a carrier has a new product, it should file the rate manual with the OCI.

Appendix A - Rate Filing Checklist

Carrier Name:	
Date of Initial Filing:	
Is this Original or Replacement:	
NAIC Company Code:	
SERFF Tracking Number:	
Market:	

			For OCI Use Only		
Item	**File name and page or worksheet**	**Carrier verified complete filing (initial)**	**Complies**	**Does not Comply**	**Comments**
Unified Rate Review Template (Excel and PDF)					
Public Form of the Rate Filing Information to be Placed on the OCI website (For Increases Greater than 10% this will be the Preliminary Justification Part II)					
Brief description in simple language the reasons why the rate increase is being requested.					
Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary					
Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.					
Actuarial Memorandum meeting the requirements of Puerto Rico and the Federal 2014 Actuarial Memorandum and Certification Instructions 2.0 (Part III)					
General Information					
Company legal name					
HIOS issuer ID					

Market					
Effective date					
Primary contact name, telephone number, email address					
Overview of Rate Increase					
Provide a brief explanation of why a rate increase is being requested and on what policy forms including the names of the policy forms affected.					
Describe the scope and driving factors impacting the rate increase including a description of how the rates were determined.					
Overview of products. This should be a description of type of products, benefits, marketing method, premium classifications, renewability, and underwriting method.					
Historical rate increase for last 3 years.					
Rate increase detailed information such as averages, minimum and maximum					
Effective through date and any rate increase schedule applicable (small group only)					
Include all products which are part of the single risk pool, including those with no proposed rate adjustment					
Base Period Experience					
Explanation of the base period used indicating the basis of the data used, first and last incurred date included.					
Indicate paid through date					
Provide support for the development of the actuary's best estimate of allowed and paid claims incurred during the experience period					
Describe the treatment of large claims and claims pooling, if any.					
Treatment of commercial reinsurance, if any. This is separate from the Transitional Federal Reinsurance program, but is adjustments for commercial reinsurance purchased by the carrier to protect against the risk of large claims.					
Indicate the amount of MLR rebates refunded during experience period					

Exhibit showing current age distribution with those anticipated for projection period					
Capitation Payments					
Describe what is covered by any capitation payments.					
Projection Factors					
Provide documentation of all assumptions and methodologies used in the development of the impact of morbidity and enrollee mix.					
If there were changes in the benefits covered, provide a description of all benefit changes and quantitative support of their impact.					
For each Essential Health Benefit (EHB) not covered previously, the additional cost per-member-per-month (PMPM) with an actuarial explanation of how the additional cost was developed.					
For adjustment factors related to differences in demographics, if applicable, include a description of the source data or assumptions used, why they are appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for issuer specific experience, industry or internal studies, benefit design and credibility.					
If there are other changes impacting rates, provide a description and quantitative documentation of all factors.					
Provide a description of all changes in the rating structure, if any, and provide quantitative support of their impact including all assumptions used.					
Provide quantitative support of the impact due to changes to network, if any.					
Provide quantitative documentation of the trend development including as well as an explanation of the data, assumptions, and periods used.					
Changes in medical cost trend by major service categories for the past three years and future projections.					
Changes in the use of services by major service categories for the past three years and future projections.					
Please explain significant changes from the prior filing assumptions.					

Manual Rate Development, if applicable					
Describe the source data used to develop the manual rate and why such data is appropriate.					
Describe all adjustments made to the data underlying the development of the manual rate to account for differences in demographics, benefits and morbidity/risk to ensure that that resulting manual rate is appropriate for blending with the adjusted experience period claims.					
Credibility					
Indicate the credibility methodology and credibility level of the base period experience.					
Paid to Allowed Ratio					
Provide a quantitative demonstration of the development of the paid to allowed ratio based on company specific projections.					
Non-Benefit Expense Projections					
Administrative Costs					
The methodology used to project administrative expenses, including gain/loss margins, should be explained.					
Identify the main factors that affect changes in administrative costs. Discuss how changes in projected administrative costs are impacting the rate increase and what is driving these changes.					
Actual administrative expenses PMPM for the last three years and explain any changes in administrative expenses from the prior filings.					
Breakdown of projected administrative expenses with any quality improvement costs separated.					
Discuss how and why the percentage administrative load varies by product or plan, if applicable					
Projected Gain/Loss Margins					
Describe the target underwriting gain/loss margin, and any additional risk margin					
To the extent that the target as a percent of premium has changed from the prior submission, provide additional support for why the change is warranted					

Discuss how the percentage load varies by product or plan, if applicable					
Taxes and Fees					
Describe each tax and/or fee and indicate the amount for each, either as a percent of premium or a PMPM amount and a quantitative development.					
Provide an explanation of how taxes and fees were allocated across plans.					
Medical Loss Ratio					
Provide a demonstration of the projected loss ratio using the federal rebate loss ratio formula including the values used.					
Describe how the credibility adjustment was determined, if applicable.					
If the projected loss ratio is less than federal requirement, explain the plan to comply with the Federal MLR requirement.					
Index Rate					
Demonstrate in Excel with formulas how the projected market level index rate was adjusted to arrive at each plan level index rate.					
Provide an example procedure of determining a family rate. Demonstrate that this family rating complies with the federal rating rules of the ACA.					
For the catastrophic plan rate, describe the methodology used to estimate the adjustment reflecting differences in anticipated demographics and morbidity of the catastrophic population as compared to the single risk pool					
AV Metal Values					
The issuer must describe whether the AV Metal Values included were entirely based on the AV Calculator, or whether an acceptable alternative methodology was used to generate the AV Metal Value of one or more plans					
If an alternate methodology was employed to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR Part 156, §156.135					

Provide all AVC screen shots					
Plan-Adjusted Index Rate					
Quantitative development in Excel (with working formulas) of the plan-adjusted index rates starting with the market index rate.					
Membership Projections					
Describe how the membership projections were developed					
Describe any differences between the distribution of projected member months relative to the current membership distribution					
Company Financial Condition					
Describe the financial situation of the company, including surplus, if any. Provide 5 years of RBC ratio levels.					
Provide historic loss ratios.					
Terminated Products					
List the name of each product that will be terminated prior to the effective date including other products that have experience included in the single risk pool during the experience period and any products that were not in effect during the experience but were made available thereafter					
Plan Type					
In the event that the plan types listed in the drop-down box in Worksheet 2, Section I of the Part I Unified Rate Review Template do not describe an issuer's plan exactly and the issuer has selected the closest plan available, per the instructions, please describe the differences between the issuer's plan and the plan type selected.					
Warning Alerts					
Describe any difference between the sum of the plan level projections and the total projected amounts					
Reliance					
If the certifying actuary relied on any information or underlying assumptions provided by another individual, the information relied upon and the name of the					

individual providing that information may be disclosed.					
For All Small Groups Affected					
Name of group					
Group's average rate increase					
Date of contract renewal					
Effective date of rate increase					
Federal Actuarial Certification					
Puerto Rico Certification Letter					
SERFF Rates Template (Excel)					
Rating Manual (if filed previously indicate date filed)					
Puerto Rico Benefits Maps for each plan (if filed previously indicate date filed)					

Appendix B – Standardized Actuarial Certification Letter

Certification

Standardized Excel Worksheet/Written Filing Documentation/Rate Manual

I _____ hereby certify that I was in charge of the preparation, revision or supervision of the worksheet data information corresponding to the submitted rate increase filing. In addition, I certify that the submitted information is accurate, true and complete.

I also acknowledge responsibility for the validity, accuracy and completeness of the contents of the Written Filing Documentation and the Rate Manual.

_____
Signature

_____
Title

_____
Carrier

_____
Date

B5 Tabonuco Street, Suite 216 • PMB 356 • Guaynabo, PR 00968-3029
Phone: (787) 304-8686 • Fax: (787) 273-6082
www.ocs.gobierno.pr

Attachment 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Part I Unified Rate Review Template Instructions

February 3, 2014

Part I Unified Rate Review Template v2.0.1

The Part I Unified Rate Review template is required to be submitted by all issuers in the individual, small group and/or combined markets that are proposing a rate increase on any single risk pool compliant products. In addition, all issuers applying to offer at least one QHP in the state must submit the template for the market in which the QHP would be offered. The template may also be required by regulatory authority for products in the single risk pool. Issuers are required to submit the annual rate change (i.e. January rate changes). In addition, quarterly rate increases for the small group market are allowed if allowed by the state regulatory authority. See the Appendix for additional detail on the timeframe for submission.

All issuers are required to set the Index Rate for an effective date of January 1 of each year, and file the Index Rate with the applicable regulatory authority. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remaining quarters of the calendar year.

The Part I Unified Rate Review template is intended to:

- Demonstrate compliance with the Single Risk Pool requirement of 45 CFR Part 156.80,
- Provide support for the development of the Index Rate which is defined in 45 CFR Part 156.80(d),
- Identify product level rate increases to determine whether a rate increase is subject to review under 45 CFR Part 154, and
- Provide supporting information to State or Federal regulators for product level rate increases

Additional information about how CCIIO uses or discloses information from the template is described in the Appendix.

Specific instructions for the treatment of dental plans within the Part I Unified Rate Review template have been developed for plans offered in 2015 and beyond.

- Only embedded pediatric dental benefits within a medical plan should be reflected in the Part I Unified Rate Review Template. Further, in order for the dental costs to be included in the Part I Unified Rate Review Template the dental costs must be spread across the entire single risk pool in accordance with the market rating rules in calculating the projected Index Rate.

- Under no circumstances should stand-alone dental plans be reflected in the Part I Unified Rate Review Template.

Further details explaining how dental plans should be reflected in the template can be found in the instructions for Worksheet 2.

Beginning with plans effective in 2015 and beyond, ALL benefits to be offered in a plan must be included in that plan. So if an issuer wants to offer an "optional" benefit, there are two options an issuer can use to meet this goal.

- The issuer can create a separate plan with the required EHBs and the "optional" benefit included.

- The issuer can offer a separate policy which is a supplemental policy providing non-EHB benefits.

The concept of "optional riders" is incongruent with federal rating rules and the single risk pool requirements.

It is critically important that information be entered into the template as accurately as possible with the information available to the issuer at the time of submission. Failure to provide accurate information in the first submission increases the likelihood of the need to provide additional data to the State or Federal regulators reviewing the template. Failure to provide accurate information also slows the speed of any required approvals or certification and puts the products and plans at risk for missing critical deadlines to be offered in the markets.

Beware, if an issuer copies and pastes values into cells that do not match the formatting requirements of those cells, the mismatch may cause validation or submission errors resulting in either submissions being rejected or requiring resubmissions at a later date. Issuers should verify the data entered in the Part I Unified Rate Review Template is consistent with formatting requirements and instructions to avoid delays in the approval process.

Under no circumstances should issuers attempt to overwrite protected cells. For example, the totals in column F of Worksheet 2 are protected and calculated by formula. Issuers should not attempt to overwrite the values calculated by the template. Any overwriting of the workbook's protection is likely to result in delays and resubmissions.

The following should be considered an instructional tool in developing issuer pricing, as allowed under the market and rating rules for the single risk pool.

ACA & MARKET RATING RULES - ALLOWABLE RATING & PRICING

Allowable rating methods and factors

- The Single Risk Pool should include ALL (non-grandfathered) covered persons (lives) an issuer has in a state, within a market (individual, small group or combined). This includes transitional products/plans for purposes of base period experience used to demonstrate the single risk pool. The projection period should reflect experience of transitional policies to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period.

- The Index Rate is defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives. As a result, the Index Rate should be the **same** value for ALL non-grandfathered plans for an issuer in a state and market. This includes claims and enrollment in transitional products/plans in the experience period, and in the projection period to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period. Note that if an issuer opted to continue policies under the President's transitional memorandum, experience for these policies should be included in the issuer's 2013 experience for developing rates for the 2015 year. Appropriate adjustments should be made in Worksheet 1 – Section II of the Unified Rate Review Template to bring these policies in line with all requirements of non-grandfathered policies projected in the Single Risk Pool in 2015. For example, in the projection period, include projected experience and membership at the point when these products become ACA-compliant and the membership renews to the ACA-compliant plan, or at the point when the members in these plans move to an ACA-compliant plan, if the plans are closed to new membership in 2015.

- The Market Adjusted Index Rate is the Index Rate adjusted for Risk Adjustment, Reinsurance and Exchange Fees (with impacts and costs spread across the whole risk pool). As a result, the Market Adjusted Index Rate should be the **same** value for ALL non-grandfathered plans for an issuer in a state and market.

- The Plan Adjusted Index Rate is the Market Adjusted Index Rate further adjusted for plan specific factors allowed by 45 CFR Part 156.80(d)(2) such as provider network, utilization management, benefits in addition to Essential Health Benefits (EHBs), actuarial value and cost sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.

- Note, fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Exchange User fees, which are applied at the market level to the Index Rate. All other fees must be included in the development of the Plan Adjusted Index

Rate, prior to the application of member level rating factors, such as age factors. No additional fees may be charged outside of the development of the Plan Adjusted Index Rate. For example, if it costs an issuer $35 to process an application, that cost must be included in the premium rate development of all policies (new issues and renewals) and subject to the member level rating factors such as age and geographic region factors. The issuer may not, in that example, charge a $35 fee per policy for submission of the application.

- A calibration may be required to allow the rating factors to be directly applied in order to generate the Consumer Adjusted Premium Rates.

  For each allowable rating factor (i.e. age, geography, and tobacco) there is ONLY ONE calibration allowed. That is, the calibration from the single risk pool to the allowable rating factors may not vary by plan; it must be a common adjustment for all plans in a state and market. The **only** allowable consumer level premium rate modifiers that can be calibrated are age, geography and tobacco.

  The calibration with respect to the age curve is allowed and identifies the value on the age curve associated with the weighted average age on the standard age curve. The Plan Adjusted Index Rate and the age curve can then be used to generate the schedule of premium rates for all ages for each plan. Calibration may be required for the geographic factors and tobacco factors. More detailed instructions are provided later in this document regarding the requirements for the calibration.

  It is important to note that the calibration process (described above) should ONLY occur after the Plan Adjusted Index Rate has been determined, not at any point before. The cost of all benefits (EHB and non-EHB) and other expenses may not be charged to the consumer using a flat dollar amount. All components under the plan must be part of the premium charged. All components of the premium are subject to the consumer level rating adjustments and therefore all components of the premium should likewise have the calibration applied to them.

  The result of this calibration process should be that the Plan Adjusted Index Rate calibrated for geography and tobacco (but not age), multiplied by the geographic factor for a given region should be similar to the Premium Rate for that particular plan for a non-tobacco user in the given geographic region for the weighted average age (rounded to a whole number) of the projected single risk pool.

- The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography and tobacco if

necessary, and applying the allowable rating factors. Allowable rating factors are Age (3:1 standard age curve or state specific age curve), Tobacco, Geography and Family tiering/structure, unless otherwise prohibited by state law.

Once the Plan Adjusted Index Rate is calibrated to the age curve using the weighted average age, the entire set of age rates is determined using the standard age factor of each age relative to the standard age factor for the rounded weighted average age. The age factors must be the standard age curve set by HHS or a state specific age curve (if the state requires different age factors than the standard federal age curve).

The tobacco factors can be issuer specific but cannot vary by product/plan for an issuer (i.e. an issuer must use the same tobacco factors across all products/plans within a state and market).

Geographic rating areas are set specific to each state and all issuers in the state are required to follow them and may only set one rating factor per rating area per state per market and that factor is applied to all plans the issuer has in that rating area uniformly. If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have a separate plan for each network with the rating area.

Family structure takes into account family composition and the maximum of 3 child dependents. This is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor. Family tiering only occurs in states that use pure community rating and are uniformly applied to all plans in the risk pool (and published to the cciio.cms.gov website).

Worksheet 1 – Market Experience

The purpose of Worksheet 1 is to capture information at the market level for non-grandfathered products, consistent with the requirement to set premium rates using a single risk pool, as defined in 45 CFR Part 156, §156.80. The worksheet is not intended to prescribe a rate development methodology. Rather, the worksheet captures experience period data and key assumptions consistent with those used in the development of the proposed premium rate increases. The worksheet uses the data to show that the average gross premium rate complies with the requirements of the single risk pool, and reports the total and annualized change in the gross premium relative to the experience period. These calculated changes in the average premium are not equal to the average rate increase of the pool, but rather provide information

on how the average gross premiums have changed over time. There are four sections in this worksheet.

- The General Information section captures information about the issuer, state and the health insurance market to which the proposed rate increases will apply. This information is displayed on all worksheets of the Part I Unified Rate Review Template.

- Section I captures summarized historical financial and enrollment information from a recent historical experience period.

- Section II captures historical claims experience on a more granular level, along with the key assumptions employed to project the experience period information forward to the projection period of the effective date.

- Section III displays the assumptions used to adjust the projected allowed claims to incurred claims at the average anticipated benefit level. Administrative expense loads and risk/profit charge loads are also captured. Using this information, the average gross premium for the single risk pool is generated.

General Information

Company Legal Name: Enter the organization's legal entity name.

> The name entered in this cell must be the name that is associated with the HIOS Issuer ID.

State: Enter the state that has regulatory authority over the policies. A separate template must be completed for each state in which the issuer is applying for QHP certification or proposing a rate increase on non-grandfathered policies in the individual, small group or combined markets.

HIOS Issuer ID: Enter the HIOS ID assigned to the legal entity.

Market: Select the applicable market from the drop-down box. Valid markets are Individual, Small Group, or Combined.

> The market chosen must be consistent with the state's determination of their allowable markets (e.g. if a state chooses to merge the individual and small group market, the issuer must choose "Combined").

Effective Date: Enter the effective date for which rates are being submitted.

> If the submission is for the individual or combined markets, the effective date must be January 1 of the year for which rates are being submitted. If the submission is for the small group market, enter the effective date for which the Index Rate is being revised. For example, if the small group submission revises the Index Rate for July 1, 2015

effective dates and includes a trend increase applicable on October 1, 2015, enter July 1, 2015. See the Appendix for further guidance on trend increases in the small group market.

All issuers are required to file the Part I Unified Rate Review Template and Part III Actuarial Memorandum annually for an effective date of January 1 of each year. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remainder of the calendar year. However, the change in the Index Rate is only allowed to occur for the remainder of the calendar year and subsequent submission is required for the beginning of the next calendar year.

For example, if a small group issuer submits the Part I Unified Rate Review Template for January 1, they may submit a subsequent Part I Unified Rate Review Template that resets the Index Rate effective July 1 of that same year. The Part I Unified Rate Review Template effective July 1 in this example is only allowed to contain a trend increase for October 1 of that same year. Quarters after October 1 would be included in the next annual submission effective January 1 of the next calendar year.

All products and plans must have the same effective date; however, some products or plans may have a 0% rate change. The term "product" is defined as a unique combination of benefits, various cost sharing options and a network design(s) to a particular service area. "Product" has the same meaning as included in 45 CFR Part 154. The term "plan" is defined as a unique combination of benefits to a specific set of cost sharing options and network design(s) to a particular service area. Most products will be made up of multiple plans produce an actuarial value equal to one of the metal levels permitted under Title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA).

Section I

The financial and enrollment information entered in this section should reflect the experience of all non-grandfathered policies for the specified market and state. The information is intended to reflect the single risk pool for the market as required by the ACA and 45 CFR 156.80. The information in this section should reflect historical financial and enrollment information for the identified legal entity only.

Experience Period: Enter the first date of the experience period.

The Experience Period must be a twelve month period. The template calculates the end date of the experience period such that the period is twelve months long.

For individual and combined market submissions, the Experience Period must be a calendar year period. It should be the most recently completed calendar year; if not, include an explanation in the Part III Actuarial Memorandum. Therefore, the first date of the Experience Period must be January 1. For small group market submissions, the first date of the Experience Period must be the first date of a calendar quarter, i.e., January 1, April 1, July 1, or October 1.

If an experience period other than that required to be shown is used in the derivation of the Index Rate, then the credibility manual rate section should be used to show the Index Rate development and described in the Part III Actuarial Memorandum.

The Experience Period reflects a period during which premiums were earned and claims were incurred. For example, if the Experience Period is January 1, 2012 through December 31, 2012 the issuer may include claims payments through a date beyond the end of the experience with dates of service within the Experience Period (e.g., February 28, 2013) when estimating the total claims incurred during the period. The paid through date is not captured in the template, but is requested in the Part III Actuarial Memorandum.

Premiums (net of MLR Rebate) in Experience Period: Enter the amount of premium earned during the experience period, net of rebates to policyholders on an incurred basis due to the medical loss ratio (MLR) requirements as defined in 45 CFR Part 158.

Start with premiums earned during the experience period. Subtract the actual or estimated MLR rebates incurred during the experience period.

Enter the aggregate net premium dollars earned. The template will calculate the per member per month (PMPM) premium amount and the percent of premium.

Do not subtract amounts from the net earned premium that would be subtracted from earned premium in the denominator of the MLR calculation, such as taxes and fees. For portions of the experience period for which the MLR rebate has not been finalized, include a best estimate of the rebates in the reported net premium. See the Part III Actuarial Memorandum instructions for required documentation of the method used to estimate rebates.

Incurred Claims in Experience Period: Enter total claims incurred in the Experience Period.

Enter the aggregate incurred claims. The template calculates the PMPM incurred claims amount and the incurred claims as a percent of premium. The calculated percent of premium attributable to claims is not equivalent to the MLR, and therefore may be less than 80%.

Incurred claims are defined as allowed claims (defined immediately below) less member cost sharing and cost sharing paid by HHS on behalf of low-income members.

Member cost sharing is defined as payments made against the allowed claims by the member for health care services (e.g., deductible, coinsurance and copayments). This does not include premium or the amount of billed charges the member must pay in excess of the issuer's contractual allowed amount (often described as "balance billing").

Allowed Claims: Enter total allowed claims with dates of service during the Experience Period.

Allowed Claims are defined as the total payments made under the policy to healthcare providers on behalf of covered members, and include payments made by the issuer, member cost sharing, and cost sharing paid by HHS on behalf of low-income members. Consequently, they include actual payments made or estimates of costs incurred but not yet paid during the period. See Part III of the Actuarial Memorandum instructions for guidance related to incurred but not paid claim reserve documentation. They also include claims not tied to a specific date of service, such as capitation or risk sharing payments, if the payments were for services provided during the Experience Period. They include claims for essential health benefits (EHB) as well as benefits other than EHB. This would not include the amount of billed charges the member must pay in excess of the issuer's contractual allowed amount (often described as "balance billing").

By definition, "Allowed Claims" do not include:

- Ineligible claims such as duplicate claims, third party liabilities (e.g. coordination of benefits claims), and any other claims that are denied under the policy terms.
- Payments for services other than medical care provided, (e.g., medical management, quality improvement, and fraud detection and recovery expenses) even if these amounts are included in claims for MLR reporting purposes.
- Recovery payments the issuer may receive from private reinsurance or internal large claim pooling mechanisms. These types of adjustments should be handled in the Other adjustment factor found in Section II of Worksheet 1.
- Active life reserves (policy reserves, contract reserves, contingency reserves, or any kind of reserves except traditionally defined reserves for claims incurred but not paid) or change in such reserves.

Index Rate of Experience Period: Enter the Index Rate underlying the Experience Period. The value entered in this field must be a whole dollar value (i.e. the rate must be rounded to the nearest $1). Please note, if an issuer copies and pastes a value in this cell which contains decimals, the Part I Unified Rate Review Template submission could be rejected or an issuer

may be required to make a resubmission later in the process which could delay the rate review process and approval.

> The Index Rate represents the average allowed claims PMPM for essential health benefits. It is the legal entity-specific rate for the market that is being submitted – i.e., the issuer's individual market, small group market or combined market. It should not be adjusted for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply allowed claims PMPM for essential health benefits.
>
> The Index Rate should be developed using all covered members, even if premium was not explicitly collected for all members. For example, if the number of members in a given family or policy was capped for premium setting purposes either voluntarily by the issuer or as required by law, all family members covered by the policy should be included.
>
> The experience period Index Rate should be adjusted to exclude benefits that are in excess of essential health benefits, but should not be adjusted to include essential health benefits that were not covered during the experience period, such as, in some cases, maternity coverage in the individual market.

Experience Period Member Months: Enter the total number of months of coverage in the Experience Period for all members that had coverage during any portion of the Experience Period.

> For example, if a given member had coverage for five months during the Experience Period, that member would contribute five member months to the total member months for the period. The number entered must be an integer. For partial months, issuers should define a methodology for counting partial months and apply the methodology consistently to all members. Possible methodologies include but are not limited to rounding up, rounding down, rounding to nearest, counting the member month if the member is active on the 15th of the month, etc.
>
> Include all covered members even if premium was not explicitly collected for all members. For example, if the number of members in a given family or policy was capped for premium setting purposes either voluntarily by the issuer or as required by law.

Section II: Allowed Claims, PMPM basis

Projection Period: The projection period is determined by the template. The Projection Period starts on the effective date entered in the General Information section of the template. The Projection Period end date is calculated such that the Projection Period is a twelve month

period. The template also calculates the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period.

Benefit Category

Several fields that follow require issuers to enter data by Benefit Category. Issuers are required to describe the Benefit Category definitions in the Part III Actuarial Memorandum. The preferred definitions of the Benefit Category follow:

***Inpatient Hospital*:** Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

***Outpatient Hospital*:** Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the 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 payments are included in facility fees.

***Other Medical*:** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.

***Capitation*:** Includes all services provided under one or more capitated arrangements.

***Prescription Drug*:** Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

Experience Period on Actual Experience Allowed

The experience entered in this section needs to reflect the state and market identified in the General Information section and the Experience Period identified in Section I of this worksheet. The actual experience for this period, state and market should be entered in the template, regardless of the credibility level.

Utilization Description: For each Benefit Category, choose the appropriate measurement unit that reflects the utilization per 1,000 covered members per year from the drop down menu. Valid entries are shown below.

Admits (for Inpatient service category only)
Days (for Inpatient service category only)
Benefit Period (for Capitation service category only)
Visits

Services
Prescriptions (for Prescription Drug service category only)
Other

In cases where "Other" is selected provide additional descriptions of the measurement units in the Part III Actuarial Memorandum.

Utilization per 1,000: Enter the total utilization per 1,000 covered members per year for claims incurred during the Experience Period.

The utilization must be entered on an annualized basis. Include any necessary estimates of utilization related to claims incurred but not yet paid.

Average Cost/Service: Enter the average allowed cost per unit of service for claims incurred during the Experience Period.

While not required, issuers may adjust the average cost per service for claims incurred but not yet paid if the issuer estimates the claims not yet paid to have a different average cost per service than those already paid. If an adjustment is made it should be described in the Part III Actuarial Memorandum.

PMPM: The Allowed Claims PMPM is calculated by the template, and is equal to utilization per 1,000 times average cost per service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM. The calculated PMPM must equal the Allowed Claims PMPM calculated by the template in Section I of Worksheet 1.

Adjustments from Experience to Projection Period

Population risk Morbidity: Enter the assumed change in morbidity of the covered population from the Experience Period to the Projection Period.

"Change in morbidity" means that component of the change in average allowed claims PMPM (as described earlier in these instructions) that will occur under the circumstances where all demographic (e.g., age, gender, and region) and product mix, all provider network contracts and time parameters (i.e., trends = 0) are held constant on the population that exists in the Experience Period.

The change in morbidity must be entered as 1 plus the total anticipated percent change in morbidity from the Experience Period to the Projection Period. For example, if in a 24 month period from the Experience Period to the Projection period the morbidity is expected to increase by 10%, enter 1.100. Similarly, if the morbidity is expected to *decrease* by 10% over the 24 month period, enter 0.900.

This category may include a number of adjustments since the market rules during the Projection Period may be significantly different from those in the Experience Period. In addition, the impact of new market rules is expected to vary significantly state to state. Some of the adjustments issuers might include are:

- Guarantee issue
- Take-up rate of the uninsured (the percent of currently uninsured that purchase coverage during the projection period)
- Health status of newly insured
- Enrollment from prior high risk pools
- Induced demand of newly insured
- Pent-up demand of newly insured
- Subsidy effects

Expected changes in the demographic mix (e.g. age, gender, and region) and tobacco status should not be included in this factor. These factors can be included in the "Other" factor.

A description of the methodology used to develop the adjustment must be included in the Part III Actuarial Memorandum.

Other: Enter the assumed change in cost related to things other than a change in population morbidity, cost trend, and utilization trend. Cost trend and utilization trend are defined in the section immediately following.

The other change must be entered as 1 plus the total anticipated percent change in cost from the Experience Period to the Projection Period, similar to the Population risk Morbidity adjustment.

Some of the adjustments an issuer might include in this section are:

- Changes in covered services

- Significant changes in the provider network, such as adding or removing a provider system, or introducing a limited network option. Shifts in the distribution of services across existing network providers should be reflected in the Cost Trend.

- Projected changes in cost related to demographics of the projected covered population

- Projected changes in pharmacy rebates relative to the pre-rebate prescription drug allowed claims

- In the event an issuer has capitation in the experience period but does not expect to have capitation in the projection period, the issuer should enter a near-zero value in the "Other" projection factor to remove the costs. It is not anticipated that other EHB categories would need to remove the experience for the entire benefit category.

A description of the methodology used to develop the adjustment must be included in the Part III Actuarial Memorandum.

Annualized Trend Factors

Cost Trend: Enter the assumed change in cost per service from the Experience Period to the Projection Period.

The Cost Trend must be entered as 1 plus the annualized trend assumption. For example, if the period from the midpoint of the Experience Period to the midpoint of the Projection Period is 24 months and if costs in the projection period are expected to be 10.25% higher than the Experience Period, then the annual trend is 5.0% ($\sqrt{1.1025}$ - 1). In this example, the user should enter 1.050 ($\sqrt{1.1025}$).

Include only the increase in cost for a fixed basket of services. Changes in cost related to changes in mix of services should not be reflected here (they will be reflected in utilization trend described below). Changes in cost related to a change in the distribution of services across network providers should be included. Significant changes in network, such as adding or removing a provider system, or introducing a limited network option should be reflected in the "Other" adjustment and described in the Part III Actuarial Memorandum.

Projected changes in prescription drug cost related to manufacturer rebates should be reflected in the "Other" adjustment.

Utilization Trend: Enter the assumed change in utilization per 1,000 members from the Experience Period to the Projection Period.

The Utilization Trend must be entered as 1 plus the annualized trend assumption, in the same manner as the cost trend.

Utilization Trend should include the change in the number of units per 1,000 members for a fixed level of illness burden. If utilization is expected to increase/decrease due to a change in the average health status of the population, that change should be reflected in the Population risk Morbidity adjustment described above.

Utilization Trend should include assumed changes in the mix or intensity of services provided for a fixed level of illness burden.

Utilization Trend should also reflect changes related to shifts in product mix. This includes changes in induced demand related to product shifts. It also includes any effects of selection since this cannot be reflected in the relative cost of the various products and plans offered.

Projections, before credibility Adjustment

Projections before credibility adjustment are calculated by the template.

Utilization per 1,000: The template calculates projected utilization per 1,000 by multiplying the experience period utilization per 1,000 by the Population risk Morbidity adjustment and the utilization trend assumption. The Utilization Trend assumption in this calculation is raised to the power of the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period (calculated previously by the template), divided by 12.

Average Cost/Service: The template calculates the projected average cost per service by multiplying the experience period average cost per service by the Other adjustment and the cost trend assumption. The Cost Trend assumption in this calculation is raised to the power of the number of months between the midpoint of the Experience Period and the midpoint of the Projection Period (calculated previously by the template), divided by 12.

PMPM: The projected allowed claims PMPM is calculated by the template, and is equal to projected Utilization per 1,000 times projected Average Cost/Service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM.

Credibility Manual

The credibility manual Utilization per 1,000 and Average Cost /Service need only be populated with values greater than zero if the experience period claims data is less than 100% credible for projecting future premium rates. When the experience period claims data is 100% credible zeros must still be entered in the credibility manual section so as not to produce errors when the template is validated. While credibility may not be applied in this manner in rate development, it must be shown in this manner for reporting purposes.

Utilization per 1,000: Enter the assumed utilization per 1,000 for the data underlying the credibility manual.

The Utilization per 1,000 must reflect the population and covered services for which rates are being submitted. If the issuer uses another credible block of business as the credibility manual, for example, the utilization of that population should be adjusted to reflect morbidity consistent with the projected population. Other adjustments may be necessary. The source of the credibility manual Utilization per 1,000 and the adjustments applied to it should be described in the Part III Actuarial Memorandum.

Average Cost/Service: Enter the assumed average cost per service for the data underlying the credibility manual.

> The cost per service must reflect the projected cost for the population and covered services for which rates are being submitted. If the issuer uses another credible block of business from a different geographic region as the credibility manual, for example, the cost for that population should be adjusted to reflect differences in provider contracting of the two regions. The source of the credibility manual average cost per service and the adjustments applied to it should be described in the Part III Actuarial Memorandum.

PMPM: The projected credibility manual PMPM is calculated by the template, and is equal to the credibility manual Utilization per 1,000 times the credibility manual Average Cost/Service, divided by 12,000. The template sums the PMPM from each Benefit Category to calculate the total PMPM.

Section III: Projected Experience

Projected Amounts After Credibility

Credibility Percentage: Enter the assumed level of credibility to be applied to the experience period claims that have been projected to the rating period.

> The percentage must be between 0% and 100%. Describe the methodology used to determine the Credibility Percentage in the Part III Actuarial Memorandum.
>
> The template calculates the credibility to be assigned to the credibility manual, and is equal to 1 minus the credibility assigned to the projected experience claims.

Projected Allowed Experience Claims PMPM (w/ applied credibility if applicable): The template calculates this value as the sum of the projected experience PMPM multiplied by its credibility, and the credibility manual PMPM multiplied by the complement of the credibility (calculated previously by the template).

Paid to Allowed Average Factor in the Projection Period: Enter the average paid to allowed factor for the Projection Period.

> This amount is not from the AV calculator. It should equal the total expected paid claims that are the liability of the issuer divided by the total expected allowed claims for the Projection Period, for the population anticipated to be covered in the Projection Period. Allowed claims have the same definition as in Section I. Paid claims are analogous to the Incurred Claims defined in Section I. Paid claims are net of member cost sharing and cost sharing paid by HHS on behalf of low-income members. The Paid to Allowed Average Factor in the Projection Period should reflect the average benefit level anticipated during the projection period. For example, if the issuer's members were enrolled

primarily in Silver plans in the experience period, but are anticipated to shift to Bronze, then the Paid to Allowed Average Factor in the Projection Period should reflect Bronze cost sharing levels.

Since the paid claims in the numerator are the trended amounts for the Projection Period, they should reflect any leveraging of fixed dollar cost sharing inherent in the benefit plans. That is, if no change in benefit mix is anticipated relative to the Experience Period, the paid to allowed ratio should be higher in the projection period than what was realized in the experience period due to the leveraging of cost sharing.

Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM: The template calculates this value by multiplying the Projected Allowed Experience Claims PMPM (w/ applied credibility if applicable) by the Paid to Allowed Average Factor in the Projection Period.

Projected Risk Adjustments, PMPM: Enter the projected PMPM amount of net federal risk adjustment transfers (i.e., net effect of risk adjustment payments and charges) for the Projection Period, and net of risk adjustment user fees.

The risk transfers should reflect the projected morbidity, including any projected Population risk Morbidity changes in column J in Section II.

If the issuer expects to receive a projected risk adjustment charge, then the entry should be a positive value. If the issuer expects to make a projected risk adjustment payment, then the entry should be a negative value.

Risk adjustment user fees should be reflected here, and not in the Taxes & Fees.

The calculation of the projected risk adjustments should consider the appropriate published transfer equation. Please describe the methodology for estimating the PMPM amount in the Part III Actuarial Memorandum.

Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM: The template calculates this value by subtracting the Projected Risk Adjustments, PMPM from the Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM.

Projected ACA Reinsurance Recoveries, Net of Premium: Enter projected reinsurance recoveries, referred to as reinsurance payments in the HHS Notice of Benefit and Payment Parameters, from the Federal reinsurance program, less contributions made to the program (referred to as "Premium" in the template).

Recoveries should be entered as positive amounts. For example, in the individual market where recoveries will likely exceed assessments the amount should be positive. In combined markets, the value may be positive or negative depending upon the portion of the market that is expected to be comprised of individuals and small groups. In a

combined market, the pooled reinsurance adjustment should be based only on the portion of the issuer's individual market business eligible for reinsurance payments. For the small group market, this amount only reflects the reinsurance assessment and should be entered as a negative number.

Projected Incurred Claims: The template calculates this value by subtracting Projected Risk Adjustments, PMPM and Projected ACA Reinsurance Recoveries, Net of Premium from Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM.

Administrative Expense Load: Enter the administrative expense load included in the premiums being filed for the effective date.

Enter the load as a percentage of premium. The template uses the percentage to calculate the PMPM administrative expense load.

If the Administrative Expense Load varies by product or plan, enter the average expense load for the single risk pool, using a premium-weighted average.

The Administrative Expense Load should include expense loads related to quality improvement and fraud detection/recovery, even if those expenses are considered part of incurred claims for purposes of MLR rebate calculations. It should also include loads for taxes and fees that may not be subtracted from premium in the MLR rebate calculation. For reporting purposes, it should not include the profit and risk load or the taxes and profit load, both described below, even though they are considered administrative expenses for purposes of adjusting the Index Rate to arrive at premium in the pricing process.

Profit & Risk Load: Enter the profit and risk load included in the premiums being filed for the effective date.

Enter the load as a percentage of premium. Not-for-profit issuers should enter the load for contribution to surplus in this entry. The template uses the percentage to calculate the PMPM profit and risk load.

If the Profit & Risk Load varies by product or plan, enter the average profit and risk load for the single risk pool, using a premium-weighted average.

Since taxes (including any federal income tax) are captured separately in the Taxes & Fees input, the profit and risk load should reflect after-tax amounts.

Note that for pricing purposes, profit and risk load is considered part of administrative expenses, per 45 CFR Part 156, §156.80(d). It is shown separately on the template to facilitate rate review.

Taxes & Fees: Enter the taxes and fees included in the premiums being filed for the effective date.

> Enter only the portion of any load that is for taxes and fees that may be subtracted from premiums for purposes of calculating MLR. This includes federal income tax. However, do not include any contributions to the Federal transitional reinsurance program or risk adjustment user fees in this amount despite their treatment in MLR calculations, since Federal reinsurance and risk adjustment amounts are expressed in the template net of reinsurance premium and risk adjustment user fees. Any additional load for taxes and fees should be reflected in the Administrative Expense Load. The template uses the percentage to calculate the PMPM Taxes & Fees.
>
> If the Taxes & Fees percentage varies by product or plan, enter the average Taxes & Fees percentage for the single risk pool, using a premium-weighted average.
>
> Note that for pricing purposes, taxes and fees are considered part of administrative expenses, per 45 CFR Part 156, §156.80(d). It is shown separately on the template to facilitate rate review.

Single Risk Pool Gross Premium Avg. Rate, PMPM: The template calculates this value by dividing the Projected Incurred Claims by 1 minus the Administrative Expense Load percentage less the Profit & Risk Load percentage less Taxes & Fees percentage.

Index Rate for Projection Period: Enter the projected Index Rate.

> As noted in Section I, the Index Rate represents the average allowed claims PMPM for essential health benefits. This legal entity-specific rate for the projection period should not reflect any adjustments for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply projected allowed claims PMPM for essential health benefits. If the submission is for the individual or combined market, the projected Index Rate should reflect the twelve month projection period, or rating period. For the individual or combined market, if the issuer will not be covering benefits in excess of EHB, the Index Rate for the projection period will be equal to the Projected Allowed Experience Claims PMPM (w/ applied credibility if applicable). If the submission is for the small group market and includes prospective trend adjustments (only if permitted by the state), then the Index Rate for Projection Period should reflect the member weighted average of the projected trended Index Rates applicable for each effective date in the submission. See Section I for additional information about the Index Rate. See the Appendix for further guidance on calculation of the small group weighted average projected Index Rate.

% increase over Experience Period: The template calculates this value which represents the percent increase in the projected average gross premium PMPM over the average gross premium PMPM in the experience period. The average gross premium PMPM for the

experience period is calculated by the template in Section I (Premiums (net of MLR Rebate) in Experience Period).

> The calculated increase is not the proposed rate increase. The calculated increase may include changes in premium PMPM related to shifts in the covered benefit, age, geographic area, or tobacco status of the population, some of which may be charged to the consumer through allowable rating factors.
>
> The period of time over which the increase is calculated is dependent upon the Experience Period entered by the issuer. For example, if the length of time between the Experience Period and the Projection Period is two years, the increase calculated will represent a two-year increase.

% increase, annualized: The template calculates this value by annualizing the % increase over Experience Period. Like the % increase over Experience Period, the calculated increase may include changes in premium PMPM related to shifts in the covered benefits, age, geographic area, or tobacco status of the population, some of which may be charged to the consumer through allowable rating factors.

Projected Member Months: Enter the number of member months expected to be covered during the Projection Period.

> See 'Experience Period Member Months' in Section I for more information on how to calculate member months. Since the Projection Period must be a one-year period, the projected member months might be equal to 12 times the projected enrollment in the first month of the Projection Period, for example. Issuers should describe how the member months were projected in the Part III Actuarial Memorandum.
>
> Include all covered members even if premium is not expected to be explicitly collected for all members, for example if the number of child members in a given family exceeds three and must be capped for premium setting purposes as required by law.

Projected Period Totals: The template calculates aggregate dollar amounts for Section III PMPM values entered into or calculated by the template. The amounts are calculated by multiplying the Projected Member Months by the applicable PMPM value.

Worksheet 2 – Plan Product Information

The purpose of Worksheet 2 is to capture information at the product and plan level. The worksheet captures information on experience period data, the projection period data and other information related to each product or plan. There are four sections in this worksheet.

- Section I captures information about each product and plan. This includes general information such as the plan and product IDs, along with more specific information such as the effective date, actuarial values and proposed rate increase.

- Section II displays the proposed rate increase by major service category and the expected increase in cost sharing on a per member per month basis for each product and plan.

- Section III captures historical information such as premium and claims in a more detailed manner than in Worksheet 1. Information regarding the portion of the premium and claims related to the EHBs and non-EHBs is required, as well as information related to risk transfer charges and payments, Federal reinsurance payments, and cost sharing reduction amounts.

- Section IV contains the same information collected in Section III, but for the twelve month period following the effective date shown in the rate filing for each product.

If a product contains both grandfathered and non-grandfathered insurance policies, the experience of grandfathered policies may be included on Worksheet 2 if the grandfathered policies share the same rating practices as non-grandfathered policies, including pooling of risks and common rate increases or as permitted by the governing state regulatory body. If experience of grandfathered policies is included, then the total experience on Worksheet 2 will exceed that shown on Worksheet 1 which includes only non-grandfathered experience.

Plan level data is required because it could be used in calculating the advance premium tax credits and cost sharing subsidy advance payments. If the plan level data is not provided for each plan, the calculation of the advance premium tax credit and cost sharing subsidy advance payments may be incorrect for an issuer which may result in significant over or under advance payments.

In all cases, reasonable projected values are to be entered for all plans, either directly or by using the plan averaging option. For example, if an issuer chooses to enter information separately for each plan, all information input into the Part I Unified Rate Review Template for each plan must reflect experience or best estimate projections for each specific plan. For example, projected member months must reflect the issuer's best estimate of expected enrollment in each plan. With the exception of terminated plans, no plan should have expected membership of zero, and all membership projections should be supportable and represent the actuary's best estimate of enrollment. If zeros are entered in the Part I Unified Rate Review

Template, an issuer may be required to resubmit the template which may cause delays in the rate review and approval process.

Section I

Product: Enter the product name in the corresponding column(s).

The term "product" is defined as a unique combination of benefits, various cost sharing options and a network design(s) to a particular service area. "Product" has the same meaning as included in 45 CFR Part 154.

All products included in the single risk pool experience shown on Worksheet 1 must be entered in this section of Worksheet 2. This includes any products that are terminated but have experience included in the single risk pool during the experience period. It also includes any products that were not in effect during the experience but were made available thereafter.

If multiple products will be closed prior to January 1, 2015, these products may be combined for reporting purposes and shown as a single product in the template. The term "Terminated Products" should be entered as the plan name in this case. The list of product names for the terminated products should be included in the Part III Actuarial Memorandum.

Currently, HIOS does not report product names containing special characters, e.g., %. It is recommended that products containing special characters spell out the name of the special character, e.g. "20Percent Coinsurance" for "20% Coinsurance."

Product ID: Enter the product ID that corresponds with each product. The two-letter state code portion of the Product ID must be entered using capital letters.

The "Product ID" should be the product number assigned by HIOS. Each product included in the single risk pool during the Experience Period, as well as new products that are part of the rate filing, must be identified in Worksheet 2 of the template.

If multiple products will be closed prior to January 1, 2015, these products may be combined for reporting purposes and shown as a single product in the template. Enter the Product ID for the largest product (measured by member months during the experience period) being terminated. A list of Product IDs for the terminated products should be included in the Part III Actuarial Memorandum.

Metal: For each "plan" within a product, choose the corresponding metal level from the drop down menu in the template. Plans that are included in a QHP certification application must show the same Metal as is shown in the QHP application.

In these instructions, the term "actuarial value" is used to describe a manner of estimating the value of a plan, but not a specific manner. AV Metal Value refers to the federal definition of actuarial value as prescribed in 45 CFR Part 156, §156.20. AV Pricing Value is defined below.

The ACA requires that all plans offered in the market must have an actuarial value that corresponds to a defined metal level. For guidance on the definition of "plan" please see the definition of "Plan Name" in these instructions. The metal actuarial values are defined as "the percentage paid by a health plan of the percentage of the total allowed costs of benefits."[1] There are five levels of coverage that can be offered: Platinum, Gold, Silver, Bronze and Catastrophic. The actuarial values for each of these metal levels are shown in the table below. The actuarial value used in determining the metal level must be based on the Actuarial Value Calculator (AV Calculator) or an acceptable alternative if a health plan's design is not compatible with the AV Calculator. For further guidance on the calculation of the AV Metal Value in the determination of the metal level, please see the instructions for the Part III Actuarial Memorandum.

The actuarial value used to determine the metal level must be within a de minimis variation from the actuarial values defined in the ACA. The Secretary has provided guidance that the de minimis variation standards will be ± 2 percentage points. For example, plans with an AV value between 68% and 72% meet the requirements for a silver level plan.

Metal Level	AV Requirements
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%
Catastrophic	Not specified by law*

**Catastrophic level* – a plan offered in the individual market only and is only available to individuals below the age of 30 or those for whom premium for minimum essential coverage exceeds 8% of income.

For products that are reported on a combined basis as terminated products prior to January 1, 2015, enter "Catastrophic".

[1] 45 CFR Part 156, §156.20

AV Metal Value: For each plan, enter the corresponding AV value that results from the AV Calculator or a permissible alternative method that complies with 45 CFR Part 156 §156.135(b).

For products that are reported on a combined basis as terminated products prior to January 1, 2015, enter zero.

For Catastrophic plans, enter an approximate AV Metal Value for the plan (e.g., 0.580). Since there is not a Catastrophic continuance table within the AV Calculator, the actuary should use their best judgment in estimating the AV Metal Value.

AV Pricing Value: For each plan enter the corresponding AV Pricing Value.

It is important to note that the AV Pricing Value may be different from the AV Metal Value for several reasons. The AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate. It is likely to have a spread from one plan to another that emulates the spread in the Plan Adjusted Index Rates of the same plans.

The AV Metal Value compares the amount paid by a health plan to total allowed costs of benefits for the given plan (e.g. the estimated paid costs for a gold plan is compared to estimated allowed costs for a gold plan to generate a ratio between 0.78 and 0.82).

Another difference between the AV Pricing Value and the AV Metal Value is the data used to generate the ratios. The AV Pricing Value is determined from the Issuer's own experience rather than the experience of the standard population or standard tables that are used in the calculation of the AV Metal Value. In addition the AV Pricing Value should reflect all of the allowable plan level adjustments to the Index Rate that are used by the issuer. This may include some or all of the following adjustments, so long as the adjustments do not include any assumptions related to the morbidity of the members assumed to select a given plan:

- The cost-sharing design of the plan. This adjustment may include expected differences in utilization of services based on differences in cost sharing. For example, lower cost sharing is generally associated with higher utilization of services, independent of health status. This adjustment must not include any differences in utilization due to differing health status of people with different cost-sharing designs.

- The plan's provider network and delivery system characteristics, as well as utilization management practices.

- Plan benefits in addition to the essential health benefits. The additional benefits must be pooled with similar benefits provided in other plans to determine the allowable rate variation for plans that offer those benefits.

- Administrative costs, excluding Exchange user fees.
- For catastrophic plans, the expected impact of specific eligibility categories for these plans.

Plan Type: Select the applicable plan type from the drop-down box. Valid Plan Types are Indemnity, PPO, POS, HMO or EPO.

In the event that the list of plan types does not describe an issuer's plan exactly, the issuer should select the closest plan available and provide further explanation of the Plan Type in the Part III Actuarial Memorandum.

Definitions of each of these categories can be found on the Healthcare.gov website in the glossary. However, each state may have its own definition of these terms which would dictate the plan type.

Plan Name: Enter the name of each plan within a product.

The term "plan" is defined as a unique combination of benefits to a specific set of cost sharing options and network design(s) to a particular service area. Most products will be made up of multiple plans that produce an actuarial value equal to one of the metal levels permitted under the ACA. The Plan Name is the marketing name used when referring to the specific set of benefits and cost sharing values. The Plan Name shown should be consistent across submissions (e.g., QHP application, state filings).

All plans included in the single risk pool experience shown on Worksheet 1 must be entered in this section of Worksheet 2. This includes any plans that are terminated but have experience included in the single risk pool during the Experience Period. It also includes any plans that were not in effect during the Experience Period but were made available thereafter. Issuers should not enter cost sharing reduction plan variations separately, since as described in 45 CFR 156.400-156.420, plan variations are not separate plans, but rather variations of the corresponding standard plans, with the same premium, benefits, and network as the standard plan. Further instructions are provided in Sections III and IV, below, on how to account for cost sharing reductions in this template.

For products that are closed to new entrants prior to January 1, 2015, the issuer should indicate that there is one plan in the product when completing the template. The Plan Name for the product or grouping of terminated products should be entered as "Terminated Products."

Currently, HIOS does not report plan names containing special characters, e.g., %. It is recommended that plans containing special characters spell out the name of the special character, e.g. "20Percent Coinsurance Plan" for "20% Coinsurance Plan."

Plan ID: Enter each assigned Plan ID. The two-letter state code portion of the Plan ID must be entered using capital letters.

> The Plan ID is a unique identifier for the set of benefits and cost sharing values offered within a product by the HIOS issuer, or in other words, a unique identifier of each plan. Plan IDs contain three digits. This field must be entered as a text input and must include any leading zeros (e.g. 001).
>
> For products that are closed to new entrants prior to January 1, 2015, the issuer should indicate that there is one plan in the product when completing the template. The Plan ID for the product or grouping of terminated products should be populated with the Product ID discussed above.

Exchange Plan: For each plan, enter an indicator (yes or no) as to whether the plan will be offered inside a State-based or Federally Facilitated Exchange or Small Business Health Options Program (SHOP), regardless of whether or not it will also be offered in the outside market. If an application for qualified health plan status is pending, enter "yes." This indicator should not be used to identify whether a plan is offered on a private exchange.

Historical Rate Increases: For each product, enter the historical rate increase for the period two years prior to the current calendar year, one year prior to the current calendar year, and the current calendar year.

> For example, if the template is submitted in 2013 for an Effective Date of January 1, 2014, the current calendar year is 2013. Rate increases are therefore required to be entered for 2011, 2012, and 2013.
>
> Rate increases must reflect the full rate increase that is applied to a policy during the applicable year. For example, if rate tables in the market change quarterly but each policyholder's premium rates change annually, then the rate increase for policies renewing during the year must reflect the total rate change that applies to each policyholder during that year, which is the cumulative effect of the four quarterly rate changes.
>
> If multiple rate increases were implemented during the calendar year period being reported, enter the premium weighted average rate increase across the entire calendar year. For example, assume the submission is for the small group market in which 50% of groups (representing 50% of the annual revenue) renew in January, 25% renew in April, and 25% renew in October. The calendar year increases are 7% in January, 6% in April, and 5% in October, then the calendar year average rate increase is 6.25% (=7%*50% + 6%*25% + 5%*25%).
>
> For the current calendar year, include all rate changes that have been approved, are currently under review by the applicable regulatory agency, or are anticipated to be

submitted. For example, if the template is being submitted in April 2013 for an effective date of January 1, 2014 for a market in which rates change quarterly, include in the average rate increase for 2013 any rate increases that have already been approved or are intended to be implemented in 2013 including those implemented after the submission (e.g., effective July 2013 and October 2013).

For new plans, enter a value of -999% in the Historical Rate Increases. If a plan was recently offered for the first time, and therefore does not have experience in the Experience Period, enter the actual Historical Rate Increases in the same manner as other existing plans. If an existing plan has not previously had a rate increase, enter 0.00%.

For terminated products, the historical rate increase fields are optional. However, since the template expects an entry, enter -999% to avoid validation warnings.

Effective Date of Proposed Rates: For each plan, enter the corresponding effective date of the proposed rate increases.

See Worksheet 1 instructions for Effective Date. All products and plans must have the same effective date. If some products or plans will have a rate change and others will not, then a 0% rate change may be entered in the "Rate Change % (over prior filing)" field described immediately below for those plans that will not have a rate change on the product's effective date.

As on Worksheet 1, if the submission is for the small group market, enter the effective date on which the products' rates will change due to the Index Rate being revised. For example, if the small group submission revises the Index Rate for July 1, 2015 effective dates and includes a trend increase applicable on October 1, 2015, enter July 1, 2015.

Rate Change % (over prior filing): Enter the average change in premium rates over the rates included in the prior filing for each plan.

For new plans enter 0.00% in this field.

Cum'tive Rate Change % (over 12 mos prior): Enter the average change in premium rates over the twelve month period prior to the effective date for each plan. This should be the premium-weighted average of the 12-month increases that apply at renewal.

For new plans enter -999.00% in this field. It is important to enter this value in the template in this case so other calculated fields in the template are correctly generated.

Proj'd Per Rate Change % (over Exper. Period): For each plan, the percentage change in rates between the Experience Period and the Projection Period is shown. This is a calculated field.

Product Threshold Rate Increase %: The template calculates the threshold rate increase for each product. This is the rate increase that determines whether the rate increase is subject to review, per 45 CFR Part 154 §154.200.

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

This section can be completed with variations only at the product level or variations at each plan level within a product.

> If the information is entered with the product level variation, this means the issuer enters the information for the total product spread evenly across all plans within the product. If the issuer chooses this methodology, the proposed rate increase for each plan within the product must be identical.
>
> If the issuer chooses to enter the information separately for each plan within a product rather than use the simplified approach of entering the product averages, the proposed rate increase for each plan can vary for items allowable by state and Federal laws and regulations. If an issuer chooses to enter information separately for each plan, all information input into the Part I Unified Rate Review Template for each plan must reflect experience or best estimate projections for each specific plan. For example, projected member months must reflect the issuer's best estimate of expected enrollment in each plan. With the exception of terminated plans, no plan should have expected membership of zero. If zeros are entered in the Part I Unified Rate Review Template, an issuer may be required to resubmit the template which may cause delays in the rate review and approval process.

Inpatient: Enter the portion of the increase in the premium rate that corresponds to benefits provided for inpatient services for each plan. See the instructions for Worksheet 1, Section II for the definition of Inpatient Hospital services.

Outpatient: Enter the portion of the increase in the premium rate that corresponds to benefits provided for outpatient services for each plan. See the instructions for Worksheet 1, Section II for the definition of Outpatient Hospital services.

Professional: Enter the portion of the increase in the premium rate that corresponds to benefits provided for professional services for each plan. See the instructions for Worksheet 1, Section II for the definition of Professional services.

Prescription Drugs: Enter the portion of the increase in the premium rate that corresponds to benefits provided for prescription drugs for each plan. See the instructions for Worksheet 1, Section II for the definition of Prescription Drug services.

Other: Enter the portion of the increase in the premium rate that corresponds to benefits provided for services defined in the "other" benefit category for each plan. See the instructions for Worksheet 1, Section II for the definition of Other Medical services.

Capitation: Enter the portion of the increase in the premium rate that corresponds to benefits provided for services defined under capitation for each plan. See the instructions for Worksheet 1, Section II for the definition of Capitation.

Administrative Expenses: Enter the portion of the increase in the premium rate that corresponds to administrative expenses incorporated in the premium rates for each plan. See the instructions for Worksheet 1, Section III for the definition of Administrative Expense Load.

Taxes & Fees: Enter the portion of the increase in the premium rate that corresponds to the taxes and fees incorporated in the premium rates for each plan. Also include expected changes in the payments and charges under the risk adjustment and reinsurance programs, in addition to the administrative costs associated with these programs. Since the total rate increase is affected by changes in anticipated transfer payments, these need to be reflected in order for the total to be calculated correctly.

Risk & Profit Charges: Enter the portion of the increase in the premium rate that corresponds to the risk and profit charges incorporated in the premium rates for each plan. See the instructions for Worksheet 1, Section III for the definition of Profit & Risk Load.

Total Rate Increase: This is a calculated field and equals the sum of the benefit categories, administrative expenses and the risk and profit charges for each plan. It should equal the difference between the projected Average Rate PMPM and the Average Current Rate PMPM.

Member Cost Share Increase: Enter the expected increase in the member's cost sharing portion from the period underlying the current rate for the plan to the projected rating period of the plan. This includes cost sharing paid by HHS on behalf of low-income members.

> This might reflect the impact of trend on coinsurance, for example. This would not include any increase in the member's cost associated with the increase in premium rates.

Average Current Rate PMPM: Enter the average premium rate on a per member basis for each plan for the most recently approved rates.

> The Average Current Rate PMPM should be generated using the projected membership, not the currently enrolled membership.
>
> In the case of small group rates where a trend factor is filed and approved, the Average Current Rate PMPM should reflect the latest approved rate. For example, assume the current rates were filed for effective dates between January and December with a

quarterly trend factor. The current rates that should be entered in the rate filing would be the rates with effective dates October through December.

For new plans (i.e., those with Cum'tive Rate Change % (over 12 mos prior) entered as -999.00% as instructed above), enter the projected average rate PMPM for each plan in this field. It is understood that these new plans do not actually have current rates. However, it is necessary to populate this field with the projected average rate so that the projected Average Rate PMPM in Section IV is calculated correctly by the template. It is also understood that the calculated Average Current Rate PMPM across all plans will not reflect the true current average in the event that there are new plans or very recently offered plans with Projected Member Months (which are used to calculated the overall average) but whose current rate reflects a rate for a later effective date than the remaining plans that are not new. In fact, any time the Projected Member Months have a different distribution across plans than the current distribution, the Average Current Rate PMPM will not represent the true current average rate.

Projected Member Months: Enter the projected member months by plan that correspond to the effective period of the rates for each plan. See the instructions for Worksheet 1, Section II for the definition of Projected Member Months. The sum of the Projected Member Months for each of the plans should equal the Projected Member Months on Worksheet 1.

The total Member Months in the projection period should be consistent with the Projected Member Months entered in Section III of Worksheet 1. However, the member months may differ if there are different effective dates for the products/plans. The template includes a "Warning" indicator if there is a significant difference between the member months found in Worksheet 1 and in Worksheet 2. In these cases, support for the member months in both worksheets should be documented in the Part III Actuarial Memorandum.

If an issuer chooses to enter information at the plan specific level, projected member months entered in the template must reflect an issuer's best estimate of projected enrollment for that specific plan. With the exception of terminated plans, the projected member months for a plan should not be zero. If the projected membership does not meet this criteria, issuers may be required to resubmit the Part I Unified Rate Review Template which may cause delays in the rate review and approval process.

Section III: Experience Period Information

The information shown in this section captures the historical data for the twelve month period used in the base period experience. This should be the same time period as the Experience Period found in Worksheet 1. See the instructions for Worksheet 1 for the definition of the Experience Period.

Similar to Section II of this worksheet, the information requested in this section can be entered at the product level or at the plan level. See Section II for a description of these variations.

Average Rate PMPM: Enter the average premium rate PMPM for each plan during the experience period. The average should be generated using membership consistent with the Experience Period for each plan.

> It is anticipated that the overall Average Rate PMPM during the Experience Period should be similar to the average premium rate found in Section I of Worksheet 1. The template includes a "Warning" indicator if there is a significant difference between the average premiums on the two worksheets. If the Warning is indicated, additional information should be provided in the Part III Actuarial Memorandum that explains the differential.

Member Months: Enter the total member months during the Experience Period. See the instructions for Worksheet 1 for the definition of Experience Period Member Months.

> The total Member Months in the Experience Period should be consistent with the Experience Period Member Months entered in Worksheet 1. The template includes a "Warning" indicator if there is a significant difference between the member months found in Worksheet 1 and in Worksheet 2. In these cases, support for the member months in both worksheets should be documented in the Part III Actuarial Memorandum.

Total Premium (TP): The total premium earned in the Experience Period for each plan is calculated as the Average Rate PMPM multiplied by the Member Months in a given plan.

> The Total Premium (TP) in the experience period should be consistent with the total premium found in Section I of Worksheet 1. The template includes a "Warning" indicator if there is a significant difference between the total premiums shown on both worksheets. If the Warning is indicated, additional information should be provided in the Part III Actuarial Memorandum that explains the cause.

EHB Percent of TP: Enter the percentage of the total premium that is associated with EHB services in each plan (including administrative expenses and profit associated with those services). Note these fields are optional for submissions with an experience period that ends prior to January 1, 2014.

> When calculating the EHB Percent of TP, the Administrative Expense Load, Profit & Risk Load, and Taxes & Fees should be allocated to the various categories in this section (EHB, state mandated benefits that are not EHB, and other benefits) of the template in proportion to the claims expenses. For example, if 95% of claims are EHB and 5% of claims are other benefits, then the EHB Percent of TP should be 95%. Similarly, the Other benefits portion of TP should be 5% in the example and would be calculated as

such by the template. Administrative expenses and profit should not be disproportionately allocated to one benefit over another. The sum of the EHB percentage, the state mandated benefits percentage and the other benefits percentage should equal 100%.

If abortion services are included in the EHB package, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below.

- If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Since subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.

- If the plan is not a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, but rather is only offered in the outside market, the percentage of premium associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the exchange.

State mandated benefits portion of TP that are other than EHB: Enter the percentage of the total premium for each plan that is associated with state mandated benefits that are not part of the EHB package. Note these fields are optional for submissions with an experience period that ends prior to January 1, 2014.

Similar to the EHB percentage, the state mandated benefit percentage of the total premium should include the portion of administrative expenses, taxes and fees and risk and profit loads associated with these services.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured as to whether or not to purchase the benefits) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The premium associated with these types of benefits should be included in the Other benefits portion of the premium, which is defined below.

The percentages in these fields are required (except for the optional treatment described above) as states will need to fund the portion of the premium for state mandated benefits that are not included in the EHB package.

Other benefits portion of TP: This is a calculated field which generates the remaining percentage of the total premium based on the values entered from the EHB and state mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the state mandated benefit portion not associated with EHBs and the other benefits portion should equal 100%.

Total Allowed Claims (TAC): Enter the total allowed claims for each benefit plan with service dates within the Experience Period.

The Total Allowed Claims (TAC) across all benefit plans for the Experience Period should be consistent with the Allowed Claims entered in Section I of Worksheet 1. The template includes a "Warning" indicator when the allowed claims between Worksheet 1 and Worksheet 2 are significantly different. If a Warning is indicated, the issuer should provide additional support for the difference between the total allowed claims between Worksheet 1 and 2 in the Part III Actuarial Memorandum.

EHB Percent of TAC: Enter the percentage of the total allowed claims that are associated with EHB services in each plan during the Experience Period. Note these fields are optional for submissions with an Effective Date, as shown on Worksheet 1, in calendar year 2015.

If abortion services are included in the EHB package, the portion of the allowed claims related to these services is to be handled in two different methods in accordance with the criteria described below.

- If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the allowed claims associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB package).

- If the plan is not a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, but rather is only offered in the outside market, the percentage of allowed claims associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB package, any covered abortion services should be reflected in either the state mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the exchange.

State mandated benefits portion of TAC that are other than EHB: Enter the percentage of the total allowed claims for each plan that are associated with state mandated benefits that are not part of the EHB package. Note these fields are optional for submissions with an experience period ending prior to January 1, 2014.

> State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The allowed claims associated with these types of benefits should be included in the Other benefits portion, which is defined below.

Other benefits portion of TAC: This is a calculated field which generates the remaining percentage of the total allowed claims based on the values entered from the EHB and state mandated benefits portions, described above.

> As stated previously, the sum of the EHB portion, the state mandated benefit portion not associated with EHBs and the other benefits portion should equal 100%.

Allowed Claims which are not the issuer's obligation: Enter the portion of the allowed claims (as defined on Worksheet 2) that were paid by the insured or other funds for each plan separately during the experience period. These would include the following types of payments:

- Member cost sharing (i.e. deductible, coinsurance and copays). This should be based on the cost sharing associated with the benefits of each plan. For those plans with reduced cost sharing subsidies for the member, the cost sharing amount included this value should reflect both the amount paid by the member and the subsidies. For example, for the silver plan variation with 94% cost sharing, the value of the cost sharing included in this field should reflect the approximately 6% cost sharing expected from the member and the approximately 24% cost sharing covered by the federal subsidy for a total cost sharing value of approximately 30% (6% + 24%).

- Risk transfer charges or payments associated with the risk adjustment program. In this case, risk adjustment charges made to the program should be entered as a negative amount and payments received from the program should be entered as a positive amount. The issuer should estimate the risk transfer charge or payment by plan and provide detailed information in the Part III Actuarial Memorandum on the methodology used to allocate the payments between plans. The risk adjustment user fees should not be included since they are not part of allowed claims.

- Federal reinsurance payments received should be included in this field. The federal reinsurance payments should be entered by plan. Payments should be entered as positive amounts. The method used to determine these payments by plan should be described in the Part III Actuarial Memorandum. The federal reinsurance contributions should not be included since they are not part of allowed claims.

- Other claims that are not described above but included in this cell should be described in detail in the Part III Actuarial Memorandum.

Portion of above payable by HHS's fund on behalf of insured person, in dollars: Enter the portion of the total dollars that are attributable to HHS during the Experience Period. This is the cost sharing reduction subsidies.

Portion of above payable by HHS on behalf of insured person, as %: This is a calculated field and displays the percentage of claims covered by HHS over the value of all claims not covered by the issuer.

Net Amt of Rein: Enter the Federal reinsurance amount received for each plan during the Experience Period.

This value should be calculated consistently with the federal reinsurance amount included in the Allowed Claims which are not the issuer's obligations. However, it will differ from that amount in that this field is net of the reinsurance contribution amount.

For time periods prior to 2014, the value should be zero, as the program was not operational until 2014.

Net Amt of Risk Adj: Enter the risk transfer charge or payment during the Experience Period for each plan.

This value should be calculated consistently with the risk transfer charge or payment included in the Allowed Claims which are not the issuer's obligation. However, it will differ from that amount in that this field is net of the risk adjustment user fees. If the transfer amount is a charge (liability payment made to other issuers) the value should be a negative amount. If the transfer amount is a payment received from other issuers the value should be entered as a positive amount.

For time periods prior to 2014, the value should be zero, as the program was not operational until 2014.

Section IV : Projected (12 months following effective date)

The information shown in this section captures the projected data for the twelve month period following the effective date for each plan. Similar to Sections II and III of this worksheet, the information requested in this section can be entered at the product level or at the plan level. See Section II for a description of these variations.

It is expected that in general, the projection period found in this section should be the same as the Projection Period found in Section II of Worksheet 1. However, there are circumstances

where the projection periods may differ. These circumstances occur in the small group market when prospective trend is included in the submission (if permitted by the state). In this case:

> Similar to the Index Rate for Projection Period on Worksheet 1, the Plan Adjusted Index Rate must reflect the member weighted average of the projected trended plan adjusted Index Rates applicable for all effective dates in the submission. See the Appendix for more information on the calculation of the member weighted average Index Rate.
>
> Member months should be consistent with those reflected on Worksheet 1. Since the single risk pool requires the Index Rate be based on ALL enrollees in the market in the state for that issuer, the member months should reflect all projected member months for the single risk pool in the projection period, regardless of the expected renewal month.
>
> Since Total Premium (TP) for the projection period is calculated as the Plan Adjusted Index Rate multiplied by the member months, this will reflect the weighted average Plan Adjusted Index Rates for all effective dates.

All data entered in the Claims Information section (rows 86 through 96) should be consistent with the projection period shown on Worksheet 1. Therefore, the amount of trend reflected in the claims section will differ from that reflected in the premium information.

Plan Adjusted Index Rate: Enter the projected Plan Adjusted Index Rate into these cells for each plan ID for the effective period of the proposed rates.

> The Plan Adjusted Index Rate is the Market Adjusted Index Rate (defined in the introduction of these instructions) further adjusted for plan specific factors allowable by 45 CFR Part 156.80(d)(2) such as provider network, utilization management, benefits in addition to Essential Health Benefits (EHBs), actuarial value and cost sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.
>
> The overall weighted average of the Plan Adjusted Index Rates should be similar to the Single Risk Pool Gross Premium Avg. Rate, PMPM found in Section III of Worksheet 1. The template includes a “Warning” indicator if there is a significant difference between the average premiums on the two worksheets. If the Warning is indicated, additional information should be provided in the Part III Actuarial Memorandum that explains the differential. One explanation that may apply is that the small group Plan Adjusted Index Rates reflect the member weighted average of the rates for all effective dates in the filing, whereas the Worksheet 1 Single Risk Pool Gross Premium Avg. Rate reflects the effective date of the change in the Index Rate.

Member Months: The template populates the projected Member Months using the Projected Member Months entered in Section II of the worksheet.

Total Premium (TP): The total premium earned in the projection period for each plan is calculated as the Average Rate PMPM multiplied by the Member Months in a given plan.

> The Total Premium (TP) in the projection period should be similar to the total premium found in Section III of Worksheet 1. The template includes a "Warning" indicator if there is a significant difference between the total premiums shown on both worksheets. If the Warning is indicated, additional information should be provided in the Part III Actuarial Memorandum that explains the cause.

EHB Percent of TP: Enter the percentage of the total premium that is associated with EHB services in each plan. It is critical that this percentage be entered correctly, and consistently with any QHP application. It is likely that this field will be used by CCIIO to calculate the advance premium tax credits for subsidy-eligible enrollees. If the values in this field are not entered correctly, the calculation of the advance premium tax credits may be incorrect for an issuer.

For non-terminated ACA compliant plans, the value entered into the EHB Percent of TP field must be greater than zero. It is critical that this percentage be entered correctly as it is likely it will be used to calculate the advance premium tax credits for subsidy-eligible members.

For pre-ACA plans and terminated plans, the field may be left blank.

> When calculating the EHB percentage, the Administrative Expense Load, Profit & Risk Load, and Taxes & Fees should be allocated to the various categories in this section of the template in proportion to the claims expenses. The sum of the EHB percentage, the state mandated benefits percentage and the other benefits percentage should equal 100%.
>
> If abortion services are included in the EHB package, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below.
>
> - If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Since subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.
>
> - If the plan is not a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, but rather is only offered in the outside market, the percentage of premium associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the exchange.

Submission of the Part I Unified Rate Review Template and corresponding Part III Actuarial Memorandum satisfies the requirements of 45 CFR 154.215 and 156.470.

State mandated benefits portion of TP that are other than EHB: Enter the percentage of the total premium for each plan that is associated with state mandated benefits that are not part of the EHB package.

Similar to the EHB percentage, the state mandated benefit percentage of the total premium should include the portion of administrative expenses, taxes and fees and risk and profit loads associated with these services.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The premium associated with these types of benefits should be included in the Other benefits portion of the premium, which is defined below.

The percentages in these fields are required as states will need to fund the portion of the premium for state mandated benefits that are not included in the EHB package.

Other benefits portion of TP: This is a calculated field which generates the remaining percentage of the total premium based on the values entered from the EHB and state mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the state mandated benefit portion not associated with EHBs and the other benefits portion should equal 100%.

Total Allowed Claims (TAC): Enter the total allowed claims for each benefit plan with service dates within the projection period. See the instructions for Worksheet 1 for the definition of Allowed Claims.

The Total Allowed Claims (TAC) across all benefit plans for the projection period should be consistent with the total allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries entered in Section III of Worksheet 1. The template includes a "Warning" indicator when the sum of the allowed claims, the projected risk adjustments and the projected ACA reinsurance recoveries in Worksheet 1 and the allowed claims in Worksheet 2 are significantly different. If a Warning is indicated, the issuer should provide additional support for the difference between these amounts in the Part III Actuarial Memorandum.

EHB Percent of TAC: Enter the percentage of the total allowed claims that are associated with EHB services in each plan during the projection period. If abortion services are included in the EHB package, the portion of the allowed claims related to these services is to be handled in two different methods in accordance with the criteria described below. It is critical that this percentage be entered correctly. This field is used by CCIIO to calculate cost sharing reduction advance payments for subsidy-eligible enrollees. If the values in this field are not entered correctly, the calculation of the cost sharing reduction advance payments may be incorrect for an issuer.

- If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the allowed claims associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB package).

- If the plan is not a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, but rather is only offered in the outside market, the percentage of allowed claims associated with abortion services should be included in the EHB percentage.

If abortion services are not included in the EHB package, any covered abortion services should be reflected in either the state mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the exchange.

Submission of the Part I Unified Rate Review Template and corresponding Part III Actuarial Memorandum satisfy the requirements of 45 CFR 154.215 and 156.470.

State mandated benefits portion of TAC that are other than EHB: Enter the percentage of the total allowed claims for each plan that are associated with state mandated benefits that are not part of the EHB package.

State mandated benefits that are not part of the EHB package that are required to be offered only (i.e. it is the choice of the insured whether the benefits are purchased) should **not** be included in this component as the benefit is optional from the purchaser's perspective. The allowed claims associated with these types of benefits should be included in the Other benefits portion, which is defined below.

Other benefits portion of TAC: This is a calculated field which generates the remaining percentage of the total allowed claims based on the values entered from the EHB and state mandated benefits portions, described above.

As stated previously, the sum of the EHB portion, the state mandated benefit portion not associated with EHBs and the other benefits portion should equal 100%.

Allowed Claims which are not the issuer's obligation: Enter the portion of the allowed claims (as defined in Worksheet 2) that were paid by the insured or other funds for each plan separately during the projection period. These would include the following types of payments:

- Member cost sharing (i.e. deductible, coinsurance and copays). This should be based on the cost sharing associated with the benefits of each plan. For those plans with reduced cost sharing subsidies for the member, the cost sharing amount included this value should reflect both the amount paid by the member and the subsidies.

- Risk transfer charges or payments associated with the risk adjustment program. In this case, risk adjustment charges made to the program should be entered as a negative amount and payments received from the program should be entered as a positive amount. The issuer should estimate the risk transfer charge or payment by plan and provide detailed information in the Part III Actuarial Memorandum on the methodology used to allocate the payments between plans.

- Federal reinsurance payments expected to be received should be included in this field. The federal reinsurance payments should be entered by plan. Payments should be entered as positive amounts. The method used to determine these payments by plan should be described in the Part III Actuarial Memorandum.

- Other claims that are not described above but included in this cell should be described in detail in the Part III Actuarial Memorandum.

Portion of above payable by HHS's fund on behalf of insured person, in dollars: Enter the portion of the total dollars that are attributable to HHS during the projection period. This is the cost sharing reduction subsidies.

These estimates should be based on the issuer's expected enrollment of cost sharing reduction eligible members. The methodology used to estimate these values should be explained in the Part III Actuarial Memorandum.

Since this value is a portion of the payments entered in the Allowed Claims which are not the issuer's obligations (described above), the same methodology to estimate these payments should be employed.

Portion of above payable by HHS on behalf of insured person, as %: This is a calculated field and displays the percentage of claims covered by HHS over the value of claims not covered by the issuer.

Net Amt of Rein: Enter the Federal reinsurance amount expected to be received for each plan during the projection period, net of the reinsurance assessments.

This value should reflect both assessments charged and payments received under the program. The amount entered should be consistent with the amount that reflects payments received or assessments charged under the Federal reinsurance program that is included in the Allowed Claims which are not the issuer's obligations.

Net Amt of Risk Adj: Enter the amount of any risk transfer payment expected to be received during the projection period for each plan. If a risk transfer charge is anticipated to be assessed, the value entered should be negative.

This value should be consistent with the risk transfer payment, if any, included in the Allowed Claims which are not the issuer's obligation. If the transfer amount is expected to be a payment received from other issuers the value should be entered as a positive amount. If the transfer amount is expected to be a charge (liability payment made to other issuers) a negative value should be entered.

Validation and Finalization of Part I Unified Rate Review Template (URRT) in HIOS

An issuer must validate the URRT submission in order to complete the upload process within HIOS. The following steps are to be taken in order to complete the process.

1. The issuer creates the initial submission and uploads the required documentation. At this point the submission is in the Pre-Validation status.
2. The issuer must check the validation box on the submission summary. Once the issuer checks this box, the submission is in the Record Validated status.

Appendix

Single Risk Pool and Index Rate Requirements

The Single Risk Pool and Index Rate Requirements are specified in 45 CFR Part 156.80.

45 CFR Part 156.80(a), (b), and (c) require that health insurance issuers consider the claims experience of all enrollees in all non-grandfathered health plans subject to section 2701 of the Public Health Services Act and offered by the issuer in the state to be members of a single risk pool for each of the individual, small group, and combined markets.

45 CFR Part 156.80(d) requires that a health insurance issuer establish an Index Rate for each of the individual, small group, or combined markets annually. The Index Rate for each market is based on the total combined claims costs for providing Essential Health Benefits within the Single Risk Pool for that state market.

Timeframe for Part 1 Unified Rate Review Template Submissions

The following table provides the guidelines for the submission of the Part 1 Unified Rate Review Template for rates associated with the different types of public exchanges (i.e. FFM/SPM), and non-QHPs. This applies to filings for January 1 effective dates in all markets.

Type of Filing	Issuer Submission Date for 2015 Rates
QHP Filing – FFM/SPM	[TBD]
QHP Filing – SBM	Based on state regulatory agency requirements
Non-QHP Filing	Based on state regulatory agency requirements

In addition, issuers may file revised rates for small group plans on a quarterly basis, subject to other state requirements. For example, a state may not allow issuers to submit revised rates for fourth quarter. The table below shows suggested guidance for a timeline of submission of these plans. However, the specific submission dates may vary from these guidelines depending upon specific requirements for individual states.

Small Group Quarterly Submission Schedule (Non-Grandfathered Single Risk Pool Plans)

Type of Filing	Issuer Submission Date	Finalization Date for 2015 Rates
QHP Filing – FFM/SPM	At least 90 days prior to effective date	At least 45 days prior to effective date
QHP Filing – SBM	At least 90 days prior to effective date	At least 45 days prior to effective date
Non-QHP Filing	Based on state regulatory agency requirements	At least 45 days prior to effective date

Use of the Data Submitted in the URRT

CCIIO uses the data submitted in the URRT in a variety of ways.

In states where CCIIO performs the Market Reform Rules compliance reviews, CCIIO uses the URRT in conjunction with other information to perform the compliance reviews.

CCIIO's Financial Management may use certain fields in the calculation of Advance Premium Tax Credit (APTC) payments and Cost Sharing Reduction (CSR) advance payments.

Disclosure of the URRT data

Upon completion of the Freedom of Information Act review that is underway, CCIIO will disclose the data included in the URRT on its website.

URRT Submission Statuses

URRT submissions are in the following statuses under various circumstances.

The URRT contains no rate increases that are subject to review

Pre-validation – the issuer has successfully created the URRT submission

Record Validated – this issuer has validated the URRT submission. Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission.

Pending Resubmission – the URRT submission has been "unlocked" to allow the issuer to upload a revision to one or more of the documents. The URRT submission needs to be re-validated after the revised documents have been uploaded.

Rate Filing Accepted – review of the URRT submission has been completed. If any revisions are necessary after the submission is put into this status, the submission will need to be deactivated and the issuer will need to create a new URRT submission

The URRT contains one or more rate increases that are subject to review

Pre-validation – the issuer has successfully created the URRT submission

Record Validated – this issuer has validated the URRT submission. Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission.

Pending Resubmission – the URRT submission has been "unlocked" to allow the issuer to upload a revision to one or more of the documents. The URRT submission needs to be re-validated after the revised documents have been uploaded.

Submission Filed – preliminary review of the submission has been completed by the appropriate regulator.

Review in Progress – submission is pending final determination.

Review Complete – final determination has been entered by the appropriate regulator.

How to Request a Revision to a URRT Submission

While a submission is in the "Pre Validation" status, the issuer may revise the submission at will.

Once the issuer has validated the submission, the issuer must request authorization if they need to revise the submission. To request authorization to revise the submission, send an email to ratereview@cms.hhs.gov with the following information:

- Submission tracking number.
- Description of the specific changes you are requesting. Include any necessary explanation of the revisions and the reasons the revisions are required.
- An indication that the appropriate regulator has authorized the requested revision.
- An indication of whether the submission contains any Exchange plans.
- An indication of whether the Index Rate will change as a result of the revisions to the submission.

If the requested revision is authorized, the issuer needs to re-validate the submission after the revised documents have been uploaded.

Guidance for Quarterly Rate Increases

This appendix provides guidance on a methodology for the completion of the Part I Unified Rate Review template in the small group market when an issuer chooses to file rates with predefined quarterly trend increases. The guidance provided is not the required methodology, but rather an example of how the template could be completed.

Premium rates for products in the small group market may be allowed to change on a quarterly basis for trend, if not prohibited by the state. If an issuer chooses to increase rates on a quarterly basis for trend, the issuer may file for trend increases for a specified period of time. However, the Index Rate for the projection period must be reflective of each of the trended rates effective during the period.

A methodology that could be used to calculate the Index Rate would be to develop a weighted average using each effective premium rate and the expected number of members at the corresponding premium level. This would be performed for each renewal month during the twelve month period. For example, in the template filed for a January effective date, the Index Rate would be calculated for each renewal month (January through December). The December rates in this example would be weighted with the expected enrollment for December renewals

for the twelve-month rating period from December of that year through November of the next year. The table below shows an example of this calculation and the Index Rate that could be entered into the Part I Unified Rate Review template.

The example is an issuer that wishes to change their small group rates on a quarterly basis using an annual trend of 5%. The template is submitted for a January 1 effective date.

	Effective Dates				
	January	April	July	October	Total Single Risk Pool
Member Months	1000	500	1000	500	3000
Base Allowed Claims	$ 250.00	$ 250.00	$ 250.00	$ 250.00	$ 250.00
Months of Trend	24	27	30	33	
Annual Trend Rate	5%	5%	5%	5%	
Single Risk Pool Projected Allowed Claims	$ 275.63	$ 279.01	$ 282.43	$ 285.90	$ 280.17
Index Rate Entered in January Template	$ 280.17				
Effective Date Entered in January Template	1/1/xxxx				

The quarterly trend factor for each quarter should be included in the Part III Actuarial Memorandum, and support should be provided. Please see the instructions for the Part III Actuarial Memorandum for further information.

Unified Rate Review v2.0.2

Company Legal Name: | State:
HIOS Issuer ID: | Market:
Effective Date of Rate Change(s):

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: to 12/30/1900

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:		#DIV/0!	#DIV/0!
Incurred Claims in Experience Period		#DIV/0!	#DIV/0!
Allowed Claims:		#DIV/0!	#DIV/0!
Index Rate of Experience Period			
Experience Period Member Months			

Section II: Allowed Claims, PMPM basis

Projection Period: 1/0/1900 to 12/30/1900 Mid-point to Mid-point, Experience to Projection: -6 months

	Experience Period on Actual Experience Allowed				**Adj't. from Experience to Projection Period**		**Annualized Trend Factors**		**Projections, before credibility Adjustment**			**Credibility Manual**		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital				$0.00					#DIV/0!	#DIV/0!	#DIV/0!			$0.00
Outpatient Hospital				0.00					#DIV/0!	#DIV/0!	#DIV/0!			0.00
Professional				0.00					#DIV/0!	#DIV/0!	#DIV/0!			0.00
Other Medical				0.00					#DIV/0!	#DIV/0!	#DIV/0!			0.00
Capitation				0.00					#DIV/0!	#DIV/0!	#DIV/0!			0.00
Prescription Drug				0.00					#DIV/0!	#DIV/0!	#DIV/0!			0.00
Total				$0.00							#DIV/0!			$0.00

Section III: Projected Experience:

			After Credibility	**Projected Period Totals**
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)		100.00%	#DIV/0!	#DIV/0!
Paid to Allowed Average Factor in Projection Period				
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			#DIV/0!	#DIV/0!
Projected Risk Adjustments PMPM				0
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			#DIV/0!	#DIV/0!
Projected ACA reinsurance recoveries, net of rein prem, PMPM				0
Projected Incurred Claims			#DIV/0!	#DIV/0!
Administrative Expense Load			#DIV/0!	#DIV/0!
Profit & Risk Load			#DIV/0!	#DIV/0!
Taxes & Fees			#DIV/0!	#DIV/0!
Single Risk Pool Gross Premium Avg. Rate, PMPM			#DIV/0!	#DIV/0!
Index Rate for Projection Period				
% increase over Experience Period			#DIV/0!	
% Increase, annualized:			#DIV/0!	
Projected Member Months				

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name:
HIOS Issuer ID:
Effective Date of Rate Change(s):

State:
Market:

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	
Product ID:	
Metal:	
AV Metal Value	
AV Pricing Value	
Plan Type:	
Plan Name	
Plan ID (Standard Component ID):	
Exchange Plan?	
Historical Rate Increase - Calendar Year - 2	
Historical Rate Increase - Calendar Year - 1	
Historical Rate Increase - Calendar Year 0	
Effective Date of Proposed Rates	
Rate Change % (over prior filing)	
Cum'tive Rate Change % (over 12 mos prior)	
Proj'd Per Rate Change % (over Exper. Period)	
Product Threshold Rate Increase %	

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total
Inpatient	#REF!
Outpatient	#REF!
Professional	#REF!
Prescription Drug	#REF!
Other	#REF!
Capitation	#REF!
Administration	#REF!
Taxes & Fees	#REF!
Risk & Profit Charge	#REF!
Total Rate Increase	#REF!
Member Cost Share Increase	#REF!

Average Current Rate PMPM	#REF!
Projected Member Months	#REF!

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total
Average Rate PMPM	#REF!
Member Months	#REF!
Total Premium (TP)	#REF!
EHB Percent of TP, [see instructions]	#REF!
state mandated benefits portion of TP that are other than EHB	#REF!
Other benefits portion of TP	#REF!
Total Allowed Claims (TAC)	#REF!
EHB Percent of TAC, [see instructions]	#REF!
state mandated benefits portion of TAC that are other than EHB	#REF!
Other benefits portion of TAC	#REF!
Allowed Claims which are not the issuer's obligation:	#REF!
Portion of above payable by HHS's funds on behalf of insured person, in dollars	#REF!
Portion of above payable by HHS on behalf of insured person, as %	#REF!
Total Incurred claims, payable with issuer funds	#REF!
Net Amt of Rein	#REF!
Net Amt of Risk Adj	#REF!
Incurred Claims PMPM	#REF!
Allowed Claims PMPM	#REF!
EHB portion of Allowed Claims, PMPM	#REF!

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total
Plan Adjusted Index Rate	#REF!
Member Months	#REF!
Total Premium (TP)	#REF!
EHB Percent of TP, [see instructions]	#REF!
state mandated benefits portion of TP that are other than EHB	#REF!
Other benefits portion of TP	#REF!
Total Allowed Claims (TAC)	#REF!
EHB Percent of TAC, [see instructions]	#REF!
state mandated benefits portion of TAC that are other than EHB	#REF!
Other benefits portion of TAC	#REF!
Allowed Claims which are not the issuer's obligation	#REF!
Portion of above payable by HHS's funds on behalf of insured person, in dollars	#REF!
Portion of above payable by HHS on behalf of insured person, as %	#REF!
Total Incurred claims, payable with issuer funds	#REF!
Net Amt of Rein	#REF!
Net Amt of Risk Adj	#REF!

Attachment 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Part III Actuarial Memorandum and Certification Instructions

February 3, 2014

Actuarial Memorandum and Certification

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

All issuers are required to set the Index Rate for an effective date of January 1 of each year, and file the Index Rate with the applicable regulatory authority. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remaining quarters of the calendar year.

The purpose of the actuarial memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. All assumptions should be adequately justified with supporting data, where possible, or other rationale for the use of the chosen assumptions.

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

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

- the methodology used to calculate the AV Metal Value for each plan
- the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based,
- the Index Rate is developed in accordance with federal regulations and the Index Rate along with allowable modifiers are used in the development of plan specific premium rates

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

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

ACA & MARKET RATING RULES - ALLOWABLE RATING & PRICING

Allowable rating methods and factors

- The Single Risk Pool should include ALL (non-grandfathered) covered persons (lives) an issuer has in a state, within a market (individual, small group or combined). This includes transitional products/plans for purposes of base rate experience used to demonstrate the single risk pool. The projection period should reflect experience of transitional policies to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period.

- The Index Rate is defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives. As a result, the Index Rate should be the **same** value for ALL non-grandfathered plans for an issuer in a state and market. This includes claims and enrollment in transitional products/plans in the experience period and to the extent an issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period. Note that if an issuer opted to continue policies under the President's transitional memorandum, experience for these policies should be included in the issuer's 2013 experience for developing rates for the 2015 year. Appropriate adjustments should be made in Worksheet 1 – Section II of the Unified Rate Review Template to bring these policies in line with all requirements of non-grandfathered policies projected in the Single Risk Pool in 2015. For example, in the projection period, include projected experience and membership at the point when these products become ACA-compliant and membership renews to the ACA-compliant plan, or at a point when the members in these plans move to an ACA-compliant plan, if the plans are closed to new membership in 2015.

- The Market Adjusted Index Rate is the Index Rate adjusted for Risk Adjustment, Reinsurance and Exchange Fees (with impacts and costs spread across the whole risk pool). As a result, the Market Adjusted Index Rate should be the **same** value for ALL non-grandfathered plans for an issuer in a state and market.

- The Plan Adjusted Index Rate is the Market Adjusted Index Rate further adjusted for plan specific factors allowed by 45 CFR Part 156.80(d)(2) such as provider network, utilization management, benefits in addition to Essential Health Benefits (EHBs), actuarial value and cost sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.

- Note, fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Exchange User fees, which are applied at the market level to the Index Rate. All other fees must be included in the development of the Plan Adjusted Index Rate, prior to the application of member level rating factors, such as age factors. No

additional fees may be charged outside of the development of the Plan Adjusted Index Rate. For example, if it costs an issuer $35 to process an application, that cost must be included in the premium rate development of all policies (new issues and renewals) and subject to the member level rating factors such as age and geographic region factors. The issuer may not, in that example, charge a $35 fee per policy for submission of the application.

- A calibration may be required to allow the rating factors to be directly applied in order to generate the Consumer Adjusted Premium Rates.

  For each allowable rating factor (i.e. age, geography, and tobacco) there is ONLY ONE calibration allowed. That is, the calibration from the single risk pool to the allowable rating factors may not vary by plan; it must be a common adjustment for all plans in a state and market. The **only** allowable consumer level premium rate modifiers that can be calibrated are age, geography and tobacco.

  The calibration with respect to the age curve is allowed and identifies the value on the age curve associated with the weighted average age on the standard age curve. The Plan Adjusted Index Rate and the age curve can then be used to generate the schedule of premium rates for all ages for each plan. Calibration may be required for the geographic factors and tobacco factors. More detailed instructions are provided later in this document regarding the requirements for the calibration.

  It is important to note that the calibration process (described above) should ONLY occur after the Plan Adjusted Index Rate has been determined, not at any point before. The cost of all benefits (EHB and non-EHB) and other expenses may not be charged to the consumer using a flat dollar amount. All components under the plan must be part of the premium charged. All components of the premium are subject to the consumer level rating adjustments and therefore all components of the premium should likewise have the calibration applied to them.

  The result of this calibration process should be that the Plan Adjusted Index Rate calibrated for geography and tobacco (but not age), multiplied by the geographic factor for a given region should be similar to Premium Rate for that particular plan for a non-tobacco user in the given geographic region for the weighted average age (rounded to a whole number) of the projected single risk pool.

- The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography and tobacco if necessary, and applying the allowable rating factors. Allowable rating factors are Age

(3:1 standard age curve or state specific age curve), Tobacco, Geography and Family tiering/structure, unless otherwise prohibited by state law.

Once the Plan Adjusted Index Rate is calibrated to the age curve using the weighted average age, the entire set of age rates is determined using the standard age factor of each age relative to the standard age factor for the rounded weighted average age. The age factors applied must be the standard age curve set by HHS or a state specific age curve (if the state requires different age factors than the standard federal age curve). The tobacco factors can be issuer specific but cannot vary by product/plan for an issuer (i.e. an issuer must use the same tobacco factors across all products/plans within a state and market).

Geographic rating areas are set specific to each state and all issuers in the state are required to follow them and may only set one rating factor per rating area per state per market and that factor is applied to all plans the issuer has in that rating area uniformly. If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have a separate plan for each network with the rating area.

Family structure takes into account family composition and the maximum of 3 child dependents. This is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor. Family tiering only occurs in states that use pure community rating and are uniformly applied to all plans in the risk pool (and published to the cciio.cms.gov website).

The following graphic depicts the flow of the rate development:

General Information

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

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

- Company Legal Name: the organization's legal entity name associated with the HIOS Issuer ID
- State: the state that has regulatory authority over the policies
- HIOS Issuer ID: the HIOS ID assigned to the legal entity
- Market: the market in which the products and plans are offered
- Effective Date: the effective date of the change of the Index Rate

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

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

Proposed Rate Increase(s)

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

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

- Single risk pool experience which is more adverse than that assumed in the current rates
- Medical inflation
- Increased utilization
- Prospective changes to benefits covered by the product or successor products
- New taxes and fees imposed on the issuer

- Anticipated changes in the average morbidity of the covered population that is market wide, as opposed to issuer specific morbidity that is reflected in risk adjustment

- Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program

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

Experience Period Premium and Claims

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

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

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

- Separately indicate the earned premium prior to MLR rebates and the amount of MLR rebates refunded (or expected to be refunded) for the market during the experience period. Earned premium should not be reduced for any reductions prescribed when calculating the issuer's MLR, such as taxes and assessments.

- For portions of the experience premium for which the MLR rebate has not been finalized, a best estimate of the rebates is to be included. Describe the methodology used to estimate such rebates.

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

- Worksheet 1, Section I shows the actuary's best estimate of the amount of claims that were incurred during the 12-month experience period. Separately indicate the amount of claims which were processed through the issuer's claim system, processed outside of the issuer's claims system, and the amount that represents the actuary's best estimate of claims incurred but not paid as of the Paid Through Date stated above. This should be provided separately for Incurred Claims in Experience Period and Allowed Claims, as defined and reported on Worksheet 1, Section I.

- Describe the method used for determining Allowed Claims. For example, Allowed Claims could come directly from an issuer's claim records or alternatively could be developed by combining paid claims or capitation payments with member cost sharing.

- Provide support for the estimate of incurred but not paid claims

    - Describe the methodology used to develop the estimate of claims incurred but not paid for both Allowed Claims and Incurred Claims in Experience Period. To the extent that the methodology or completion factors used to estimate incurred but not paid claims on an allowed basis differs from the methodology or completion factors used to estimate incurred claims, describe and support why they are different.

    - Indicate whether the claims used to develop any completion factors reflect the experience period claims for the information submitted or some alternate claims set, such as a larger block of the issuer's experience. If an alternate claims set was used, please provide support for why it is appropriate.

    - If the incurred but not paid claims are unusually high or unusually low relative to the experience period claims paid as of the Paid Through Date, explain what is causing them to be unusually high or unusually low (e.g. introduction of a new claims system, significant employee turnover, etc.)

Benefit Categories

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

Projection Factors

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

Changes in the Morbidity of the Population Insured: Describe any adjustment factors applied to the experience period claims to account for anticipated differences in the average morbidity of the pooled population underlying the experience period and the issuer's population anticipated to be insured in the projection period. These adjustments are shown in the "Pop'l risk Morbidity" column on Worksheet 1, Section II, and are in addition to the anticipated change in claims cost as a result of changes in the average mix by age and gender of the

covered population (which are shown in the "Other" adjustment column). The morbidity of the population could be impacted by items such as guarantee issue, an individual mandate to maintain coverage, expansion of Medicaid programs, and the introduction of a Basic Health Program.

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

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

Changes in Demographics: Describe the development of factors used to adjust the experience period claims to reflect differences between the average mix of the population by age, gender, and region underlying the base period experience and the average mix anticipated to underlie the projection period. These changes are reflected in the "Other" adjustments column on Worksheet 1, Section II. Describe and support the age/gender factors underlying the development of these claims-based demographic adjustment factors.

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

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

- Normalization for changes in age
- Normalization for benefit changes that occurred during the period (Even if allowed claims are used to project trend a normalization adjustment may be warranted to account for the influence that changes in benefits have on utilization.)

- Adjustments for seasonality patterns underlying the claims that may skew calculated trends
- Normalization for any one-time events which are not anticipated to reoccur during the projection period
- Adjustments for anticipated changes in provider contracts that differ from those underlying the experience used
- For prescription drugs, any adjustments made to account for changes in the formulary, expiration of patents, or introduction of new drugs

Credibility Manual Rate Development

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

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

- Multiple years of experience for the market for which rates are being submitted
- The issuer's experience for similar policies nationwide, including rationale for inclusion/exclusion of various blocks of business
- A manual rate developed by a consultant with appropriate supporting documentation as to the underlying source data for development of the manual rate

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

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

Credibility of Experience

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

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

When the base period experience is partially credible and included in experience used to develop the manual rate, the actuary must consider the extent to which the manual rate development double counts the base period experience. If the proposed manual rate lacks sufficient independence from the base period experience, the credibility percentage in the template should be adjusted such that the experience is assigned the appropriate credibility (based on the issuer's credibility formula), taking into consideration the proportion of the manual experience that is from the subject base experience. In this case additional documentation should be included in the actuarial memorandum to demonstrate that the credibility factor applied in the template is consistent with the issuer's credibility formula.

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

Paid to Allowed Ratio

Provide support for the Paid to Allowed Average Factor in Projection Period for the market, shown in Worksheet 1, Section III. Demonstrate that the ratio is consistent with membership projections by plan included in Worksheet 2. The ratio for each plan should be relatively consistent with the metallic actuarial value for the plan to which the actuary is attesting, however it is recognized that they may not be exactly the same due to differences between the issuer's experience and the experience underlying the AV Calculator.

Risk Adjustment and Reinsurance

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

Projected Risk Adjustments PMPM:

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

applying the risk adjustment transfer adjustment factor as a constant multiplicative factor across all plans. The risk adjustment transfer amount should be net of the risk adjustment fees.

In the Part III Actuarial Memorandum issuers must explain how they developed their estimated risk adjustment revenue for all of the plans in the risk pool. Issuers are expected to explain all of their market and plan level assumptions related to the inputs of the HHS payment transfer formula (or alternative state payment transfer formula, if applicable). In other words, issuers must explain their assumptions related to plan and market level risk scores and other relevant cost factor adjustments that are used to calculate payment transfers under the risk adjustment program. Issuers should explain any potential outlier assumptions that have a significant impact on transfers. Issuers may elect to provide supplemental exhibits detailing their plan level transfer calculations in order to demonstrate that their transfer estimates appropriately track with the HHS payment transfer formula.

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

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

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

The Part I Unified Rate Review template requires issuers to report reinsurance payments net of reinsurance contributions. Issuers must describe the underlying experience data and assumptions that they used to develop their estimates of both reinsurance contributions and payments. In particular, issuers should provide an explanation of how they developed an estimate of their claims liability between the reinsurance attachment point and cap. Issuers should describe any key aspects of their enrolled population that significantly impacted their claims assumptions.

Issuers must also describe how they allocated their anticipated reinsurance payments net of reinsurance contributions across the plans in their risk pool (as noted above reinsurance revenue should be allocated proportionally based on premium). Issuers may provide supplemental exhibits that demonstrate how they estimated plan level reinsurance payments in order to demonstrate that they appropriately track with the Federal methodology for calculating reinsurance payments.

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

reinsurance payments. Further, the transitional reinsurance program does not apply to policies renewed under the special transition policy.

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

Non-Benefit Expenses and Profit & Risk

Administrative Expense Load: Provide support for all expenses that do not reflect payments made to providers under the contract for covered medical services. Describe the methodology used for developing the estimate of these non-benefit expenses expected during the projection period for the applicable market, including any allocation of corporate overhead. Discuss how the percentage load varies by product or plan, if applicable. Describe the source data that was used as a basis for the projections and why that data is appropriate.

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

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

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

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

Taxes and Fees: Describe each tax and/or fee and indicate the amount for each, either as a percent of premium or a per member per month amount. Describe only the taxes and fees that may be subtracted from premiums for purposes of calculating MLR. However, do not include any contributions to the Federal transitional reinsurance program or risk adjustment user fees in this amount despite their treatment in MLR calculations, since Federal reinsurance and risk adjustment are expressed in the template net of reinsurance premium and risk adjustment user fees. Any additional taxes and fees should be reflected in the Administrative Expense Load.

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

Exchange user fees should be included in the template in Taxes and Fees. The issuer should provide a narrative verifying the exchange user fees are applied as an adjustment to the Index

Rate at the market level. A description of the process the issuer used to calculate the adjustment should be included. The value should reflect the expected mix of exchange and non-exchange enrollees.

Projected Loss Ratio

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

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

Single Risk Pool

The issuer is required to provide support that the Single Risk Pool for in a particular state and market is established according to the requirements in 45 CFR part 156, §156.80(d). The Single Risk Pool reflects all covered lives for every non-grandfathered product/plan combination for an issuer in a state and market. The Single Risk Pool is specific to the legal entity for the state and market for which it is submitted.

The Single Risk Pool should include transitional products/plans for purposes of base rate experience used to demonstrate the single risk pool. The projection period should reflect experience of transitional policies to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period.

Index Rate

The issuer is required to provide support for the development of the Index Rate in both the experience period and the projection period. The Index Rate is specific to the legal entity for the state and market for which it is submitted. The Index Rate represents the estimated total combined allowed claims experience PMPM in the Single Risk Pool, and should not be adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange user fees.

The Index Rate is to be developed following the specifications of 45 CFR part 156.80(d)(1). The Index Rate is based on the total combined claim costs for providing the EHBs for the Single Risk Pool of that state market. The Index Rate is derived by dividing the total combined EHB allowed claims for the Single Risk Pool by all covered lives in the Single Risk Pool of that state market. Issuers must establish a single Index Rate for all product/plan combinations in the Single Risk Pool.

Issuers are required to provide detailed documentation of the development of the Index Rate in the Actuarial Memorandum.

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

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

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

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

The projected Index Rate must reflect the anticipated claim level of the projection period with respect to trend, benefit and demographics. It must reflect the experience of all policies expected to be in the single risk pool (with all necessary adjustments to reflect the benefits, market rules, etc. applicable to policies upon issue or renewal during the projection period). For transitional policies, the issuer should include those policies anticipated to be enrolled in a fully ACA-compliant during the projection period at a point when the members in these plans move to an ACA-compliant plan. If an issuer wants the renewal rates to increase with trend in the small group market as allowed by the state regulatory authority, the issuer may file the quarterly trend amounts for the twelve month period at one time. The quarterly trend factors applied to the issuer's rates should be included in the Part III Actuarial Memorandum. The Appendix to the Instructions for the Part I Unified Rate Review Template provides further guidance.

The Index Rate may only change at uniform intervals. All issuers are required to set the Index Rate for an effective date of January 1 of each year, and file the Index Rate with the applicable regulatory authority. Subject to state requirements, small group issuers are allowed to file subsequent submissions that reset the Index Rate for the remaining quarters of the calendar year.

For individual and combined market exchanges this will be annually. It is anticipated that Issuers in the small group market will be able to file for quarterly Index Rate changes starting with the third quarter of 2014.

While rate adjustments for the small group market may be filed on a quarterly basis (if permitted by the state), these interim filings could include adjustments for other items, such as new products, more recent experience period claims, etc. However, the rate development for these interim filings must be based on the single risk pool. For example, take an issuer with two cohorts of small employers that files on an interim quarterly basis. The small employers with young enrollees renew in January, while the small employers with older enrollees renew in April. The issuer's Index Rate in the applicable submissions would be derived as follows (assuming the same experience period is used for the two submissions with no projected changes to the population between the experience period and the projection period):

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

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

As described above, small group issuers may have the ability to file Part I Unified Rate Review Templates subsequent to the annual filing that resets the Index Rate for the remaininq quarters of the calendar year. However, the change in the Index Rate is only allowed to occur for the remainder of the calendar year and subsequent submission is required at the beginning of the next calendar year.

> For example, if a small group issuer submits the Part I Unified Rate Review Template for January 1, they may submit a subsequent Part I Unified Rate Review Template that resets the Index Rate effective July 1 of that same year. The Part I Unified Rate Review Template effective July 1 in this example is only allowed to contain a trend increase for

October 1 of that same year. Quarters after October 1 would be included in the next annual submission effective January 1 of the next calendar year.

Market Adjusted Index Rate

Issuers are required to include the Market Adjusted Index Rate.

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

- Federal reinsurance program adjustment (market-wide adjustment)
- Risk adjustment (market-wide adjustment)
- Exchange user fee adjustment (market-wide adjustment)

The issuer is required to provide an explanation of how these modifiers are developed and applied to the Index Rate to develop the Market Adjusted Index Rate. Similar to the Index Rate, the Market Adjusted Index Rate reflects the average demographic characteristics of the single risk pool. In other words, the Market Adjusted Index Rate is not calibrated.

However, the Market Adjusted Index Rate is not included in the Part I Unified Rate Review Template in 2015.

Plan Adjusted Index Rates

The Plan Adjusted Index Rates are included in Worksheet 2, Section IV of the Part I Unified Rate Review Template in 2015.

The Plan Adjusted Index Rate is calculated as the issuer Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules, 45 CFR Part 156, §156.80(d)(2). The following adjustments are allowable under these rules:

- Actuarial value and cost sharing adjustment (plan adjustment)
- Provider network, delivery system and utilization management adjustment (plan adjustment)
- Adjustment for benefits in addition to the EHBs (plan adjustment)

- Impact of specific eligibility categories for the catastrophic plan (plan adjustment)
- Adjustment for distribution and administrative costs (plan adjustment)

The issuer is required to provide an explanation of how these modifiers are developed and applied to the Market Adjusted Index Rate to derive the Plan Adjusted Index Rate. Note, fees and costs are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Exchange User fees, which are applied at the market level to the Index Rate. All other fees must be included in the development of the Plan Adjusted Index Rate, prior to the application of member level rating factors, such as age factors. No additional fees may be charged outside of the development of the Plan Adjusted Index Rate. For example, if it costs an issuer $35 to process an application, that cost must be included in the premium rate development of all policies (new issues and renewals) and subject to the member level rating factors such as age and geographic region factors. The issuer may not, in that example, charge a $35 fee per policy for submission of the application.

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

Similar to the Index Rate and Market Adjusted Index Rate, the Plan Adjusted Index Rates reflect the average demographic characteristics of the single risk pool. In other words, the Plan Adjusted Index Rate is not calibrated.

Calibration

Issuers may need to calibrate the Plan Adjusted Index Rates (which are based on the single risk pool) to apply the allowable rating factors (i.e. age, geography, and tobacco) in order to calculate Consumer Adjusted Premium Rates. The calibration for each allowable rating factor is described below. It is important to note that there is ONLY ONE calibration value which is applied to all Plan Adjusted Index Rates. That is, the calibration may not vary by plan; it must be a common value to all plans in a state and market. Each calibration should be performed using a unique weighting; i.e., the geographic weighting will differ from the age weighting for determining the calibration factor. Once the calibration factor is determined it must be applied uniformly to all plans in a market and state.

Age Curve Calibration

Issuers must provide the approximate weighted average age, rounded to a whole number, associated with the projected single risk pool in the Actuarial Memorandum.

Issuers must provide a detailed explanation of the methodology used in the calibration to the age curve. Specifically, issuers should describe the factors used in the determination of the risk pool weighted average age, a description of data used to weight the factors and a description of the exact calculation. Issuers will need to provide actuarial justification that the methodology employed in the calculation of the average age and the calibration to the age curve complies with the standard age curve methodology and that it conforms with the rating rules specified in 45 CFR 147.102.

A demonstration of how the the Plan Adjusted Index Rate and the age curve are used to generate the schedule of premium rates for each plan should be included in the Actuarial Memorandum. Note, the age curve calibration adjustment is not plan specific. In other words, the same age curve calibration must be applied to all plans in the projected single risk pool.

Geographic Factor Calibration

The issuer is required to include a listing of all geographic rating factors applied to the Plan Adjusted Index Rate in the Actuarial Memorandum.

The issuer must provide the geographic factor calibration that is applied to the projected single risk pool if one is necessary. For example, if the weighted average of the geographic factors does not equal 1.0, calibration may be required.

A detailed description of the development of the geographic rating factors and a demonstration of how these factors are applied to the Plan Adjusted Index Rate is to be included in the Actuarial Memorandum. For example, if the weighted average of the geographic factors does not equal 1.0, the calibration adjustment that is applied should be included in the Actuarial Memorandum along with documentation of the calculation of the calibration adjustment. Note, the geographic calibration adjustment is not plan specific. In other words, the same geographic calibration would be applied to all plans in the projected single risk pool. If an issuer has multiple networks within a given rating area and wants to develop premiums specific for each network, the issuer must have a separate plan for each network with the rating area.

Tobacco Calibration

The issuer is required to include a listing of all tobacco rating factors applied to the Plan Adjusted Index Rate in the Actuarial Memorandum.

If the issuer uses tobacco factors, as allowed, the issuer must provide the tobacco calibration that is applied to the projected single risk pool.

A detailed description of the development of the tobacco rating factors and a demonstration of how these factors are applied to the Plan Adjusted Index Rate should be included in the Actuarial Memorandum. Note, the tobacco calibration adjustment is not plan specific. In other

words, the same tobacco calibration would be applied to all plans in the projected single risk pool.

The calibration adjustments are to be applied uniformly to all plans; plan specific calibration is not allowed.

Calibration adjustments are not found in the Part I Unified Rate Review Template in 2015.

Once the Plan Adjusted Index Rate is calibrated to the age curve using the weighted average age, the entire set of age rates is determined using the standard age factor of each age relative to the standard age factor for the rounded weighted average age. The age factors must be the standard age curve set by HHS or a state specific age curve (if the state requires different age factors than the standard federal age curve).

Issuers that calibrate the Plan Adjusted Index Rate as described in the previous section must calibrate the plans to in the Single Risk Pool consistently; **in other words the calibration cannot vary by plan**.

Issuers must apply these consumer level adjustments as described in §147.102 uniformly to all plans in the Single Risk Pool; **these adjustments cannot vary by plan**.

Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable Market Reform Rating Rules. The Consumer Adjusted Premium Rate is developed by calibrating the Plan Adjusted Index Rate to the age curve as described above, calibrating for geography and tobacco if necessary, and applying the rating factors specified by 45 CFR Part 147, §147.102. The following adjustments are allowable under this rule:

- Whether the plan coverage covers an individual or family (issuers must cover any eligible individual and/or eligible family that requests coverage per the guaranteed issue requirement of the ACA); this is further clarified in regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor
- Rating area
- Age – reflecting the applicable age curve
- Tobacco status

The Actuarial Memorandum should describe how each allowable consumer level adjustment is applied to the Plan Adjusted Index Rate so that the reviewing actuary can readily use the information to approximate Consumer Adjusted Premium Rates filed by the issuer.

The Consumer Adjusted Premium Rates are not included in the Part I Unified Rate Review Template in 2015.

Small Group Plan Premium Rates

If an issuer files small group rates with trend, the Index Rate, the Market Adjusted Index Rate and the Plan Adjusted Index Rate reflect the member weighted average premium over the calendar year (see example in the Appendix of the instructions to the Part I Unified Rate Review Template). As such, in the development of the Consumer Adjusted Premium Rates for small group plans in this case, the Plan Adjusted Index Rate must be adjusted to reflect the appropriate quarter when the consumer level modifiers are applied. Issuers should provide the trend factors that apply to the weighted average Plan Adjusted Index Rates to develop the rates for each effective date included in the submission.

AV Metal Values

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

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

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

AV Pricing Values

For each plan, indicate the portion of the AV Pricing Value that is attributable to each of the allowable modifiers to the Index Rate, as described in 45 CFR Part 156, §156.80(d)(2). If the adjustment for plan cost-sharing includes any expected differences in utilization due to these differences in cost sharing, describe in detail how the difference was estimated and how the methodology ensures that differences due to health status are not included in the adjustment.

Membership Projections

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

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

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

Terminated Products

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

Plan Type

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

Warning Alerts

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

Effective Rate Review Information (optional)

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

Reliance

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

Actuarial Certification

An actuarial certification must be provided for the following:

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

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

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

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

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

1. Identification of the certifying actuary and a statement that he/she is a member of the American Academy of Actuaries

2. A certification that the projected Index Rate is:

    a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),

    b. Developed in compliance with the applicable Actuarial Standards of Practice

    c. Reasonable in relation to the benefits provided and the population anticipated to be covered

    d. Neither excessive nor deficient

3. A certification that the Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

4. A certification that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

5. A certification stating that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans except those specified in the certification. If an alternate methodology was used to calculate the AV Metal Value for at least one plan offered, a copy of the actuarial certification required by 45 CFR Part 156, §156.135 must be included. The certification must be signed by a member of the American Academy of Actuaries, and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies.

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

The actuary may qualify the opinion, if desired, to state that the Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the Index Rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Benefits Map

INSTRUCTIONS AND NOTES ON BENEFIT DOCUMENTATION

1 The purpose of the Benefits Map is to codify the principal elements that define each benefit package offered by the carrier to the Small Group and Individual markets. In most cases, cells have been limited to a pre-determined drop-down menu of selected values to promote uniformity among plan descriptions.

If more than three plans are offered please add additional tabs

2 The term *Cost-Sharing* applies to the mechanism by which member out-of-pocket contribution is determined, according to the type of service being rendered. Basic cost-sharing can be in the form of copayments (i.e. fixed dollar amounts), coinsurance (i.e. a fixed percentage of the cost of services), or front-end deductibles where the member covers 100% of the cost of services up to the defined deductible amount, after which point plan coverage begins. More complex cost-sharing can be in the form of mixed coinsurance and copayments, where minimum and maximum dollar amounts are in place around a base coinsurance amount (e.g. 20% coinsurance with a minimum $15 copayment, or 25% coinsurance with a maximum copayment amount of $300).

3 In some plan designs, reduced cost-sharing is available in the medical coverage if certain preferred facilities are utilized. If this is the case, indicate so by selecting 'Y' (yes) under the column '*Preferred Facility Y or N* ' for the specified service category, and then enter the reduced cost-share ($ or %) in the '*Preferred Facility Copay* ' column beside the 'Y.'

4 For purposes of the Benefits Map, in order to indicate that a certain benefit is **NOT COVERED**, or that the member is in a *Deductible Phase* (as in the case of Rx Coverage with a front-end deductible), the *Member Cost-Share* should reflect COINSURANCE of 100% (i.e. the member pays 100% of the cost).

5 Some plan designs may contain a feature, such as a *Major Medical* rider, which allows the member to submit for reimbursement amounts paid for services rendered by non-participating providers. Some of these riders limit reimbursement to services rendered in Puerto Rico while others include services rendered in the United States. The Benefits Map allows plans to indicate whether they include such a rider, whether or not they cover U.S. services, and whether those services require prior authorization. Typically these riders carry an annual front-end deductible per individual (with a maximum deductible per family covered), followed by cost-sharing based on a defined member coinsurance amount. Often these riders contain a provision which caps member cost-sharing to an annual *Out-of-Pocket Maximum* , defined both at the individual and family contract levels.

6 Plans that cover Dental Services may carry Overall Annual Benefit Limits (*General Annual Limits*) and/or specific *Category Lifetime Limits* (such as for Orthodontia). Please indicate such limits as they may apply in the Dental Coverage section.

7 In the case of Prescription Drug Coverage, plans should indicate which rule applies to the dispensing of brand drugs which have a generic bioequivalent substitution (i.e. Multi-Source Brand Drugs). Select '*Generics Not Mandatory* ' if members are not required to select a generic medication as a first option. Select 'Dispense As Written (D.A.W.)' if the member is required (via a copay penalty) to select generics as a first option, but where such penalty is waived if the physician indicates "Do Not Substitute" on the prescription. Select '$ Penalty + Generic Copay' if members are required to select generics as a first option (regardless of physician indications) or pay a copay penalty (usually the difference in price between the generic and brand versions), plus the amount of the generic copayment. If instead the amount of the penatly is added to the BRAND copay, then select '*$ Penalty + Brand Copay* .'

8 Indicate other features of the Prescription Drug Coverage such as whether Step Therapy and/or Drug Formularies apply, and whether OTC medications are covered, along with the corresponding copay.

9 Since many prescription drug plan designs offer different levels of coverage at different expenditure levels throughout the policy year, the Benefits Map provides for up to three (3) different benefit phases in order to codify such plan designs. For example, a complex plan design may carry a $500 front-end deductible before benefits kick in, later providing benefits at $5 $5 for generics and $15 for brand drugs up until $2,000 in annual expenditures. After that point, the plan design may only cover 50% of the cost of brand drugs, while covering generics with a flat copay of $15. The Benefits Map provides the necessary paramaters to codify this design by indicating 100% coinsurance (no coverage) in *Phase I* from $0 to $500, indicating $5 Generic and $15 Brand in *Phase II* from $500 to $2,000, and finally indicating $15 Generic and 50% coinsurance for Brand in *Phase III* from $2,000 to $99,999. **Note: The limit of $99,999 indicates that the given Rx benefit phase has no limit.**

Attachment 4

Benefits Map

UNIFORM PLAN DESIGN TEMPLATE

General Info

Carrier Name:	
NAIC Company Code:	
OCS Contract Name:	
Product Name:	
Product Type (PPO, POS, HMO):	
Product Effective Date:	
Termination or Change Date:	

Experience

Incurred Experience Period:	
Claims Payment Period:	
Member Months (Incurred Period):	
Earned Premium:	
Gross (Allowed) Claims (before Cost-Sharing):	
Net Paid Claims (after Member Cost-Sharing):	
Member Cost-Share (Gross less Net):	

Medical Coverage

	Member Cost-Share $ or %	Standard Copay / Coins	Preferred Facility Y or N	Preferred Facility Copay
OFFICE VISITS				
Generalist Copay:	$			
Specialist Copay:	$			
Sub-Specialist Copay:	$			
Chiropractic (first visit):	$			
Chiropractic Manipulation:	$			
Physical Therapy:	$			
Respiratory Therapy:	$			
HOSPITAL / ASC FACILITY				
Full Hospital Admission:	$			
Partial Hospital Admission:	$			
Ambulatory Surgical Center (ASC):	$			
EMERGENCY VISITS				
Accident / Trauma				
w/o Nurse Triage Line:	$			
with Nurse Triage Line:	$			
Sickness & Other Urgency				
w/o Nurse Triage Line:	$			
with Nurse Triage Line:	$			
DIAGNOSTIC				
Standard Laboratory:	%			
X-Ray:	%			
MRI:	%			
CT Scan:	%			
PET Scan:	%			
PET/CT:	%			
Endoscopic:	%			
SURGICAL (PROFESSIONAL)				
Hospital Setting:	%			
ASC Setting:	%			
Office Setting:	%			

Major Medical

Does this plan include Major Medical or other Supplemental Coverage?			
If Yes, does the coverage include services rendered in the U.S.?			
If U.S. services are covered, is pre-authorization required?			
Applicable Member Coinsurance:			
		Individual	Family
Per Individual Front-End Deductible & Max Deductible per Family:			
Out-of-Pocket Maximum (Y or N):		OOP Amounts:	

List of Optional Benefits Included in the Premium

Prescription Drug Coverage

Rule for Mandatory Generics:	Generics Not Mandatory
Step Therapy Rule:	No Step Therapy Rule
Prescription Drug Formulary:	No Rx Formulary
OTC Coverage:	If so, OTC Copay:

Rx Benefit Phase I	*FROM:*	$0	*TO:*	$0

		Individual	Family
Per Individual Front-End Deductible & Max Deductible per Family:			
Out-of-Pocket Maximum (Y or N):	OOP Amounts:		

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min & Max	0%	$0	

Rx Benefit Phase II	*FROM:*		*TO:*	

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min Copay	0%	$0	

Rx Benefit Phase III	*FROM:*	$0	*TO:*	$0

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min Copay	0%	$0	

Drop-Down Menu Items

VALUES	*DESCRIPTION*
$	Flat Copay Level
%	Coinsurance Level
Y	Yes
N	No
Flat Copay	Copay Only
Pure Coins	Coinsurance Only
Coins w Min Copay	Coinsurance with a Minimum Copay Amount
Coins w Min & Max	Coinsurance with Minimum and Maximum Copay Amounts
No Benefit Limit	No Dental Limit
General Annual Limit	Overall Benefit Limit per Year
Category Annual Limit	Benefit Limit per Dental Category per Year
Category Lifetime Limit	Benefit Limit per Dental Category per Lifetime
PPO	Preferred Provider Organization (Free Access)
POS	Point of Service Plan (PPO/HMO Hybrid)
HMO	Health Mainenance Organization (Managed Care with Gatekeeper)
Other	Other health care delivery system
Generics Not Mandatory	Generic Dispense is Optional to the Member
Dispense As Written (D.A.W.)	Physician May Indicate 'Do Not Substitute' w/o Penalty to Member
$ Penalty + Generic Copay	Member Pays Difference in Cost (btwn Gen & Brand) plus Generic Copay
$ Penalty + Brand Copay	Member Pays Difference in Cost (btwn Gen & Brand) plus Brand Copay
No Rx Formulary	No Prescription Drug Formulary Applies to this Plan
Formulary Applies	Prescription Drug Formulary Applies to this Plan
No Step Therapy Rule	Step Therapy Not Required
Step Therapy w Waiver	Step Therapy Waived if Utilization Documented in the Last Six (6) Months
$ Penalty + Gen Copay	No Exceptions to Step Therapy Rule

Attachment 4

Benefits Map

UNIFORM PLAN DESIGN TEMPLATE

General Info

Carrier Name:	
NAIC Company Code:	
OCS Contract Name:	
Product Name:	
Product Type (PPO, POS, HMO):	
Product Effective Date:	
Termination or Change Date:	

Experience

Incurred Experience Period:	
Claims Payment Period:	
Member Months (Incurred Period):	
Earned Premium:	
Gross (Allowed) Claims (before Cost-Sharing):	
Net Paid Claims (after Member Cost-Sharing):	
Member Cost-Share (Gross less Net):	

Medical Coverage

	Member Cost-Share $ or %	Standard Copay / Coins	Preferred Facility Y or N	Preferred Facility Copay
OFFICE VISITS				
Generalist Copay:	$			
Specialist Copay:	$			
Sub-Specialist Copay:	$			
Chiropractic (first visit):	$			
Chiropractic Manipulation:	$			
Physical Therapy:	$			
Respiratory Therapy:	$			
HOSPITAL / ASC FACILITY				
Full Hospital Admission:	$			
Partial Hospital Admission:	$			
Ambulatory Surgical Center (ASC):	$			
EMERGENCY VISITS				
Accident / Trauma				
w/o Nurse Triage Line:	$			
with Nurse Triage Line:	$			
Sickness & Other Urgency				
w/o Nurse Triage Line:	$			
with Nurse Triage Line:	$			
DIAGNOSTIC				
Standard Laboratory:	%			
X-Ray:	%			
MRI:	%			
CT Scan:	%			
PET Scan:	%			
PET/CT:	%			
Endoscopic:	%			
SURGICAL (PROFESSIONAL)				
Hospital Setting:	%			
ASC Setting:	%			
Office Setting:	%			

Major Medical

Does this plan include Major Medical or other Supplemental Coverage?	
If Yes, does the coverage include services rendered in the U.S.?	
If U.S. services are covered, is pre-authorization required?	
Applicable Member Coinsurance:	

		Individual	Family
Per Individual Front-End Deductible & Max Deductible per Family:			
Out-of-Pocket Maximum (Y or N):	OOP Amounts:		

List of Optional Benefits Included in the Premium

Prescription Drug Coverage

Rule for Mandatory Generics:	Generics Not Mandatory
Step Therapy Rule:	No Step Therapy Rule
Prescription Drug Formulary:	No Rx Formulary
OTC Coverage:	If so, OTC Copay:

Rx Benefit Phase I	*FROM:*	$0	*TO:*	$0

		Individual	Family
Per Individual Front-End Deductible & Max Deductible per Family:			
Out-of-Pocket Maximum (Y or N):	OOP Amounts:		

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min & Max	0%	$0	

Rx Benefit Phase II	*FROM:*		*TO:*	

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min Copay	0%	$0	

Rx Benefit Phase III	*FROM:*	$0	*TO:*	$0

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min Copay	0%	$0	

Drop-Down Menu Items

VALUES	*DESCRIPTION*
$	Flat Copay Level
%	Coinsurance Level
Y	Yes
N	No
Flat Copay	Copay Only
Pure Coins	Coinsurance Only
Coins w Min Copay	Coinsurance with a Minimum Copay Amount
Coins w Min & Max	Coinsurance with Minimum and Maximum Copay Amounts
No Benefit Limit	No Dental Limit
General Annual Limit	Overall Benefit Limit per Year
Category Annual Limit	Benefit Limit per Dental Category per Year
Category Lifetime Limit	Benefit Limit per Dental Category per Lifetime
PPO	Preferred Provider Organization (Free Access)
POS	Point of Service Plan (PPO/HMO Hybrid)
HMO	Health Mainenance Organization (Managed Care with Gatekeeper)
Other	Other health care delivery system
Generics Not Mandatory	Generic Dispense is Optional to the Member
Dispense As Written (D.A.W.)	Physician May Indicate 'Do Not Substitute' w/o Penalty to Member
$ Penalty + Generic Copay	Member Pays Difference in Cost (btwn Gen & Brand) plus Generic Copay
$ Penalty + Brand Copay	Member Pays Difference in Cost (btwn Gen & Brand) plus Brand Copay
No Rx Formulary	No Prescription Drug Formulary Applies to this Plan
Formulary Applies	Prescription Drug Formulary Applies to this Plan
No Step Therapy Rule	Step Therapy Not Required
Step Therapy w Waiver	Step Therapy Waived if Utilization Documented in the Last Six (6) Months
$ Penalty + Gen Copay	No Exceptions to Step Therapy Rule

Attachment 4

Benefits Map

UNIFORM PLAN DESIGN TEMPLATE

General Info

Carrier Name:	
NAIC Company Code:	
OCS Contract Name:	
Product Name:	
Product Type (PPO, POS, HMO):	
Product Effective Date:	
Termination or Change Date:	

Experience

Incurred Experience Period:	
Claims Payment Period:	
Member Months (Incurred Period):	
Earned Premium:	
Gross (Allowed) Claims (before Cost-Sharing):	
Net Paid Claims (after Member Cost-Sharing):	
Member Cost-Share (Gross less Net):	

Medical Coverage

	Member Cost-Share $ or %	Standard Copay / Coins	Preferred Facility Y or N	Preferred Facility Copay
OFFICE VISITS				
Generalist Copay:	$			
Specialist Copay:	$			
Sub-Specialist Copay:	$			
Chiropractic (first visit):	$			
Chiropractic Manipulation:	$			
Physical Therapy:	$			
Respiratory Therapy:	$			
HOSPITAL / ASC FACILITY				
Full Hospital Admission:	$			
Partial Hospital Admission:	$			
Ambulatory Surgical Center (ASC):	$			
EMERGENCY VISITS				
Accident / Trauma				
w/o Nurse Triage Line:	$			
with Nurse Triage Line:	$			
Sickness & Other Urgency				
w/o Nurse Triage Line:	$			
with Nurse Triage Line:	$			
DIAGNOSTIC				
Standard Laboratory:	%			
X-Ray:	%			
MRI:	%			
CT Scan:	%			
PET Scan:	%			
PET/CT:	%			
Endoscopic:	%			
SURGICAL (PROFESSIONAL)				
Hospital Setting:	%			
ASC Setting:	%			
Office Setting:	%			

Major Medical

Does this plan include Major Medical or other Supplemental Coverage?	
If Yes, does the coverage include services rendered in the U.S.?	
If U.S. services are covered, is pre-authorization required?	
Applicable Member Coinsurance:	

		Individual	Family
Per Individual Front-End Deductible & Max Deductible per Family:			
Out-of-Pocket Maximum (Y or N):	OOP Amounts:		

List of Optional Benefits Included in the Premium

Prescription Drug Coverage

Rule for Mandatory Generics:	Generics Not Mandatory
Step Therapy Rule:	No Step Therapy Rule
Prescription Drug Formulary:	No Rx Formulary
OTC Coverage:	If so, OTC Copay:

Rx Benefit Phase I	FROM:	$0	TO:	$0

		Individual	Family
Per Individual Front-End Deductible & Max Deductible per Family:			
Out-of-Pocket Maximum (Y or N):	OOP Amounts:		

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min & Max	0%	$0	

Rx Benefit Phase II	FROM:		TO:	

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min Copay	0%	$0	

Rx Benefit Phase III	FROM:	$0	TO:	$0

	Type of Rx Cost-Share	% Coins	Min Copay	Max Copay
GENERIC DRUGS				
Non-Preferred Generic:	Flat Copay		$0	
Preferred Generic:	Flat Copay		$0	
MULTI-SOURCE BRAND DRUGS				
Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
Non-Preferred Multi-Source Brand:	Coins w Min & Max	0%	$0	$0
SINGLE-SOURCE BRAND DRUGS				
Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Non-Preferred Single-Source Brand:	Coins w Min Copay	0%	$0	
Specialty/Biotechnological:	Coins w Min Copay	0%	$0	

Drop-Down Menu Items

VALUES	*DESCRIPTION*
$	Flat Copay Level
%	Coinsurance Level
Y	Yes
N	No
Flat Copay	Copay Only
Pure Coins	Coinsurance Only
Coins w Min Copay	Coinsurance with a Minimum Copay Amount
Coins w Min & Max	Coinsurance with Minimum and Maximum Copay Amounts
No Benefit Limit	No Dental Limit
General Annual Limit	Overall Benefit Limit per Year
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PPO	Preferred Provider Organization (Free Access)
POS	Point of Service Plan (PPO/HMO Hybrid)
HMO	Health Mainenance Organization (Managed Care with Gatekeeper)
Other	Other health care delivery system
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$ Penalty + Brand Copay	Member Pays Difference in Cost (btwn Gen & Brand) plus Brand Copay
No Rx Formulary	No Prescription Drug Formulary Applies to this Plan
Formulary Applies	Prescription Drug Formulary Applies to this Plan
No Step Therapy Rule	Step Therapy Not Required
Step Therapy w Waiver	Step Therapy Waived if Utilization Documented in the Last Six (6) Months
$ Penalty + Gen Copay	No Exceptions to Step Therapy Rule

Attachment 4

Plan Cost Summary (All Plan Designs Combined)

DETAIL OF NET COST AND MEMBER COST-SHARE BY SERVICE CATEGORY

Carrier Name:

NAIC Company Code:

	Net Paid Claims	Member Cost-Share	Total Gross Cost	Member Months	Service Count	% Net Claims	% Cost Share	Net Claims PMPM	Cost Share PMPM	Total Cost PMPM	Net Claims Per Serv	Cost Share Per Serv	Total Cost Per Serv
Medical Coverage Experience													
Generalist Office Visits						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Specialist Office Visits						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Sub-Specialist Office Visits						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Chiropractic Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Physical Therapy						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Respiratory Therapy						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Hospital Per Diem Expense						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Other Hospital Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Ambulatory Surgical						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Emergency - Accident/Trauma						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Emergency - Sickness/Urgency						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Standard Laboratory						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
X-Ray Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
MRI Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
CT Scan Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
PET Scan Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
PET/CT Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Endoscopic Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Surgery - Hospital Setting						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Surgery - ASC Setting						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
Surgery - Office Setting						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
All Other Medical Services						0%	0%	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL MEDICAL SERVICES	**$ -**	**$ -**	**$ -**			**0%**	**0%**	**$ -**	**$ -**	**$ -**			
Major Medical Experience													
Services Rendered in PR								$ -	$ -	$ -	$ -	$ -	$ -
Services Rendered in US								$ -	$ -	$ -	$ -	$ -	$ -
TOTAL MAJOR MEDICAL SERVICES								**$ -**	**$ -**	**$ -**			
Prescription Drug Experience													
Generic (Pref & Non-Pref)								$ -	$ -	$ -	$ -	$ -	$ -
Preferred Multi-Source Brand								$ -	$ -	$ -	$ -	$ -	$ -
Non-Preferred Multi-Source Brand								$ -	$ -	$ -	$ -	$ -	$ -
Preferred Single-Source Brand									$ -	$ -	$ -	$ -	$ -
Non-Preferred Single-Source Brand								$ -	$ -	$ -	$ -	$ -	$ -
Specialty/Biotechnological								$ -	$ -	$ -	$ -	$ -	$ -
TOTAL Rx DRUG SERVICES								**$ -**	**$ -**	**$ -**			

Attachment 5

Carrier Name:	
Date of Initial Filing:	
Is this Original or Replacement:	
NAIC Company Code:	
SERFF Tracking Number:	
Market:	

Item	File name and page or worksheet	Carrier verified complete filing (initial)
Unified Rate Review Template (Excel and PDF)		
Public Form of the Rate Filing Information to be Placed on the OCI website (For Increases Greater than 10% this will be the Preliminary Justification Part II)		
Brief description in simple language the reasons why the rate increase is being requested.		
Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary		
Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.		
Actuarial Memorandum meeting the requirements of Puerto Rico and the Federal 2014 Actuarial Memorandum and Certification Instructions 2.0 (Part III)		
General Information		
Company legal name		
HIOS issuer ID		
Market		
Effective date		
Primary contact name, telephone number, email address		
Overview of Rate Increase		
Provide a brief explanation of why a rate increase is being requested and on what policy forms including the names of the policy forms affected.		
Describe the scope and driving factors impacting the rate increase including a description of how the rates were determined.		
Overview of products. This should be a description of type of products, benefits, marketing method, premium classifications, renewability, and underwriting method.		
Historical rate increase for last 3 years.		
Rate increase detailed information such as averages, minimum and maximum		
Effective through date and any rate increase schedule applicable (small group only)		
Include all products which are part of the single risk pool, including those with no proposed rate adjustment		
Base Period Experience		
Explanation of the base period used indicating the basis of the data used, first and last incurred date included.		

Indicate paid through date		
Provide support for the development of the actuary's best estimate of allowed and paid claims incurred during the experience period		
Describe the treatment of large claims and claims pooling, if any.		
Treatment of commercial reinsurance, if any. This is separate from the Transitional Federal Reinsurance program, but is adjustments for commercial reinsurance purchased by the carrier to protect against the risk of large claims.		
Indicate the amount of MLR rebates refunded during experience period		
Exhibit showing current age distribution with those anticipated for projection period		
Capitation Payments		
Describe what is covered by any capitation payments.		
Projection Factors		
Provide documentation of all assumptions and methodologies used in the development of the impact of morbidity and enrollee mix.		
If there were changes in the benefits covered, provide a description of all benefit changes and quantitative support of their impact.		
For each Essential Health Benefit (EHB) not covered previously, the additional cost per-member-per-month (PMPM) with an actuarial explanation of how the additional cost was developed.		
For adjustment factors related to differences in demographics, if applicable, include a description of the source data or assumptions used, why they are appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for issuer specific experience, industry or internal studies, benefit design and credibility.		
If there are other changes impacting rates, provide a description and quantitative documentation of all factors.		
Provide a description of all changes in the rating structure, if any, and provide quantitative support of their impact including all assumptions used.		
Provide quantitative support of the impact due to changes to network, if any.		
Provide quantitative documentation of the trend development including as well as an explanation of the data, assumptions, and periods used.		
Changes in medical cost trend by major service categories for the past three years and future projections.		
Changes in the use of services by major service categories for the past three years and future projections.		
Please explain significant changes from the prior filing assumptions.		
Manual Rate Development, if applicable		
Describe the source data used to develop the manual rate and why such data is appropriate.		
Describe all adjustments made to the data underlying the development of the manual rate to account for differences in demographics, benefits and morbidity/risk to ensure that that resulting manual rate is appropriate for blending with the adjusted experience period claims.		
Credibility		
Indicate the credibility methodology and credibility level of the base period experience.		
Paid to Allowed Ratio		
Provide a quantitative demonstration of the development of the paid to allowed ratio based on company specific projections.		
Non-Benefit Expense Projections		

Administrative Costs		
The methodology used to project administrative expenses, including gain/loss margins, should be explained.		
Identify the main factors that affect changes in administrative costs. Discuss how changes in projected administrative costs are impacting the rate increase and what is driving these changes.		
Actual administrative expenses PMPM for the last three years and explain any changes in administrative expenses from the prior filings.		
Breakdown of projected administrative expenses with any quality improvement costs separated.		
Discuss how and why the percentage administrative load varies by product or plan, if applicable		
Projected Gain/Loss Margins		
Describe the target underwriting gain/loss margin, and any additional risk margin		
To the extent that the target as a percent of premium has changed from the prior submission, provide additional support for why the change is warranted		
Discuss how the percentage load varies by product or plan, if applicable		
Taxes and Fees		
Describe each tax and/or fee and indicate the amount for each, either as a percent of premium or a PMPM amount and a quantitative development.		
Provide an explanation of how taxes and fees were allocated across plans.		
Medical Loss Ratio		
Provide a demonstration of the projected loss ratio using the federal rebate loss ratio formula including the values used.		
Describe how the credibility adjustment was determined, if applicable.		
If the projected loss ratio is less than federal requirement, explain the plan to comply with the Federal MLR requirement.		
Index Rate		
Demonstrate in Excel with formulas how the projected market level index rate was adjusted to arrive at each plan level index rate.		
Provide an example procedure of determining a family rate. Demonstrate that this family rating complies with the federal rating rules of the ACA.		
For the catastrophic plan rate, describe the methodology used to estimate the adjustment reflecting differences in anticipated demographics and morbidity of the catastrophic population as compared to the single risk pool		
AV Metal Values		
The issuer must describe whether the AV Metal Values included were entirely based on the AV Calculator, or whether an acceptable alternative methodology was used to generate the AV Metal Value of one or more plans		
If an alternate methodology was employed to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR Part 156, §156.135		
Provide all AVC screen shots		
Plan-Adjusted Index Rate		
Quantitative development in Excel (with working formulas) of the plan-adjusted index rates starting with the market index rate.		
Membership Projections		
Describe how the membership projections were developed		

Describe any differences between the distribution of projected member months relative to the current membership distribution		
Company Financial Condition		
Describe the financial situation of the company, including surplus, if any. Provide 5 years of RBC ratio levels.		
Provide historic loss ratios.		
Terminated Products		
List the name of each product that will be terminated prior to the effective date including other products that have experience included in the single risk pool during the experience period and any products that were not in effect during the experience but were made available thereafter		
Plan Type		
In the event that the plan types listed in the drop-down box in Worksheet 2, Section I of the Part I Unified Rate Review Template do not describe an issuer's plan exactly and the issuer has selected the closest plan available, per the instructions, please describe the differences between the issuer's plan and the plan type selected.		
Warning Alerts		
Describe any difference between the sum of the plan level projections and the total projected amounts		
Reliance		
If the certifying actuary relied on any information or underlying assumptions provided by another individual, the information relied upon and the name of the individual providing that information may be disclosed.		
For All Small Groups Affected		
Name of group		
Group's average rate increase		
Date of contract renewal		
Effective date of rate increase		
Federal Actuarial Certification		
Puerto Rico Certification Letter		
SERFF Rates Template (Excel)		
Rating Manual (if filed previously indicate date filed)		
Puerto Rico Benefits Maps for each plan (if filed previously indicate date filed)		

Essential Health Benefits and Preventevise Services Checklist

Essential Health Benefits		
Benefit	**Limits**	**Page**
Primary Care Visit to Treat an Injury or Illness	No	
Specialist Visit	No	
Other Practitioner Office Visit (Nurse, Physician Assistant)	Non physician professionals or doctors in odontology including nurse and physician assistant except those required by local law such as: podiatrist, audiologist, optometrist, clinical psychologists and chiropractors.	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Services rendered in an outpatient facility that may be performed in physician's office are not covered.	
Outpatient Surgery Physician/Surgical Services	Excludes: Cosmetic surgery, oral surgery that is dental in origin except those as a result of an accident, mammoplasty (except those required for patients after a breast cancer mastectomy), septoplasty, blepharoplasty, rinoseptoplasty, procedures to re-establish the ability to procreate, organ transplant procedures (OT covered as an optional benefit), induced abortion experimental procedures, skin tags removal, ptosis repair, nail excisions, scalenotomy, Lasik and other surgical procedures to correct refractive defects, surgeries for sexual transformation, surgical assistance services, intravenous analgesia services or analgesia administered though inhalation at the physician or dentist's office, services for the treatment of the temporamandibular articulation syndrome, excision of granulomas or radicular cysts orginated by infection in the tooth pulp; services to correct the vertical dimension or occlusion, removal of exostosis (mandibulary or maxillary).	
Routine Dental Services (Adult)	Dental checkup and cleanning 2 per policy year (every 6 months); bitewings and periapicals no more that one set every 3 years. Orthodontic, Periodontics, Endodontic and prosthetic dental services are not covered. Full mouth reconstructions. (covered as an optional coverage) Fluoride treatment covered to members under age 19. Root canal only to anterior and posterior teeth.	
Routine Eye Exam (Adult)	Refraction exam is covered one per year, per member	
Urgent Care Centers or Facilities	No	

Benefit	Limits	Page
Home Health Care Services	Combined limit. Limit applies to physical, occupational and speech therapy. Covered only if they begin 14 days after member;s discharge from hospital of at least three (3) days and if they are provided for the same condition by he/she was admitted.	
Emergency Room Services	No	
Emergency Transportation/Ambulance	Covered by reimbursement up to $80 per trip	
Inpatient Hospital Services (e.g., Hospital Stay)	Excludes services for personal comfort and or custodial services. Hospitalizations for services or procedures that may be performed in an outpatient services.	
Inpatient Physician and Surgical Services	No	
Bariatric Surgery	Subject to preauthorization, it must be covered the payment of one of the types of the bariatric surgery for life in Puerto Rico, if the services are available. The types of bariatric surgery that must be covered are the following: gastric bypass, adjustable band or sleeve gastrectomy.	
Skilled Nursing Facility	Covered only if they begin 14 days after member's discharge from hospital of at least three (3) days and if they are provided for the same condition by he/she was admitted.	
Prenatal and Postnatal Care	Covered only for mainholder and dependent spouse.	
Delivery and All Inpatiente Services for Maternity Care	Delivery of baby 48 hour minimum length for vaginal delivery and 96 for cesarean delivery. Covered only for main holder and dependent spouse.	
Mental/Behavioral Health Outpatient Services	No limit in accordance to the Mental Health Parity Act.	
Mental/Behavioral Health Inpatient Services	Residential treatment outside service area is not covered. No limit in accordance to the Mental Health Parity Act. Expenses for services resulting from the administration of an employer drug detection program not covered.	
Substance Abuse Disorder Outpatient Services	No limit in accordance to the Mental Health Parity Act. Expenses for services resulting from the administration of an employer drug detection program not covered.	

Benefit	Limits	Page
Substance Abuse Disorder Inpatient Services	No limit in accordance to the Mental Health Parity Act. Partials are included: 2 partial hospital days equivalent to 1 regular day. Residential treatment outside service area is not covered.	
Generic Drugs	Subject to a Drug List, Generics as a first option, Some medications require precertification, Step therapy applies for some drugs.	
Preferred Brand Drugs	Subject to a Drug List, Generics as a first option, Some medications require precertification, Step therapy applies for some drugs.	
Non-Preferred Brand Drugs	Subject to a Drug List, Generics as a first option, Some medications require precertification, Step therapy applies for some drugs.	
Specialty Drugs	Subject to a Drug List, Generics as a first option, Some medications require precertification, Step therapy applies for some drugs.	
Outpatient Rehabilitation Services	20 Physical therapies or manipulations covered under a combined limit per policy year per member. Services not covered include occupational, speech and language therapies, prosthetics and implants. Orthopedics and orthotic devices, cardic rehabilitation. Services limited to physical therapies, except for those covered under home health care benefit.	
Habilitation Services	20 Physical therapies or manipulations covered under a combined limit per year. Services limited to physical therapies, except for those covered under home health care benefit.	
Chiropractic Care	20 Physical therapies or manipulations covered under a combined limit per policy year per member.	

Benefit	Limits	Page
Durable Medical Equipment	Covers with a preauthorization from plan rental or purchase or Oxygen and necessary equipment for its administration/wheelchair/hospital bed. Mechanical respirators and ventilators are covered without limits as required by local law to member's patients under age of 21.	
Diagnostic Test (X-Ray and Lab Work)	No	
Imaring (CT/PET Scans, MRIs)	1 Per policy year per member for Pet & PET/CT, per anatomical region per year for MRI & CT	
Preventive Care/Screening/Immunization	Preventive care that meets recommendations described in ACA	
Routine Foot Care	No	
Routine Eye Exam for Children	1 Visit per year supplemented using FEDVIP.	
Eye Glasses for Children	1 pair of glasses (lenses and frames per year). Supplemented using FEDVIP	
Dental Check-Up for Children	Dental checkup and cleanings 2 per policy year per member (every 6 months); bitewings and periapicals no more than one set every 3 years. Covered under the dental benefit which is offered as an optional benefit.	
Allergy tests	50 Test per policy year. Vaccines not covered.	
Dialysis and hemodialysis	90 Days. Services related to any type of dialysis or hemodialysis, as well as services for any complication that may arise and their corresponding hospital or medical-surgical services, will be covered for the first 90 days form: a) the date in which the member became eligible for the policy during the first time or, b) the date in which he/she received the first dialysis and hemodialysis. This will apply when subsequent dialysis or hemodialysis are related to the same clinical conditions.	
Injectable chemotherapy	No	
Radiation therapy	No	
Intra-articular injections	12 Inyections per policy year per member, up to 2 daily injections	
Cryo-surgery of the uterus	1 procedures per year	
Sterilization	No	
Invasive cardiovascular, non-invasive cardiovascular procedures and tests	Electromiograms covered up to 2 procedures per year	

Benefit	Limits	Page
Nuclear medicine tests	No	
Nerve conduction velocity tests	2 Procedures per policy year	
Gastrointestinal endoscopies	No	
Polysomnography	1 Type of test per lifetime	
Tympanometry	1 Per policy year	
Nutritionist services	4 Per policy year. Limited to morbid, renal and diabetes conditions. Covered by reimbursement up to $20 per visit	
Transplant Services	Medical benefit covers skin, bone and corneal transplants.	
Orthognatic surgery	Expenses related for materials are excluded.	
Lithotripsy	No	
Air ambulance	No. Out of area air ambulance coverage is not covered.	
Out of area coverage (US)	Services are covered for emergency cases or cases that required equipment, treatment and facilities not available in Puerto Rico. Services are subject to preautorization from plan except for an emergency. Elective treatments, not considered as an emergency, are not covered by this policy.	
Biophysical profile	1 Procedures per pregnancy	
MRA	No	
Contraceptive methods	No	
Neurological tests and procedures	No	
All Puerto Rico mandated benefits	No	
Individual		
Covered Preventive Services for Adult		
Benefit	**Limits**	**Page**
Abdominal Aortic Aneurysm	One-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked.	
Alcohol Misuse	Screening and counseling. The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	
Aspirin	Use for men ages 45 to 79 years and for women ages 55 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	
Blood Pressure	Screening for high blood pressure in adults age 18 years and older	

Benefit	Limits	Page
Cholesterol	Screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders. The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease. The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.	
Colorectal Cancer	The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	
Depression	Screening for adults	
Type 2 Diabetes	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	
Diet	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	
HIV	Clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened. Recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	
Immunization	Vaccines for adults-doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphteria, Pertussin, Varicella	
Obesity	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.	

Benefit	Limits	Page
Sexually Transmitted Infection (STI)	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs. The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.	
Tobacco Use	The USPSTF recommends that clinicians ask all adults, about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	
Syphilis	Screening for all adults at higher risk	
Covered Preventive Services for Women, Including Pregnant		
Benefit	**Limits**	**Page**
Anemia	Routine screening for iron deficiency anemia in asymptomatic pregnant women.	
Bacteriuria	screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	
BRCA	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screeing results should receive genetic counseling and, if indicated after counseling, BRCA testing.	
Breast Cancer Mammography	Screening every 1 to 2 years for women over 40. The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.	
Brest Cancer Chemoprevention	Counseling for women at higher risk	
Breastfeeding	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs access to breastfeading equipment and supplies. In conjunction with each birth.	
Cervical Cancer	Screening for sexaully active women. The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years	

Benefit	Limits	Page
Chlamydia Infection	Screening for chlamydial infection in all pregnant women ages 24 and younger and in older pregnant women who are at increased risk. Screening for chlamydial infection in all sexually active, nonpregnant young women ages 24 and younger and in older nonpregnant women who are at increased risk.	
Contraception	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. As prescribed.	
Domestic and interpersonal violence	Screening and counseling for interpersonal and domestic violence.	
Folic Acid	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800pg) of folic acid.	
Gestational diabetes	Screening for gestational diabetes. In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.	
Gonorrhea	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	
Hepatitis B	Screening for pregnant women at their first prenatal visit	
Human Immunodeficiency Virus (HIV)	Clinicians should screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	
Humana Papillomavirus (HPV) DNA Test	High-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.	
Osteoporosis	Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	
RH Incompatibility	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. Also, the USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	

Benefit	Limits	Page
Tobacco Use	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	
Sexually Transmitted Infections (STI)	Counseling on sexually transmitted infections for all sexually active women.	
Syphilis	Screening for all pregnant women or other women at increased risk. The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen persons at increased risk for syphilis infection.	
Well-woman visits	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713. Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors	
Covered Preventive Services for Children		
Benefit	**Limits**	**Page**
Alcohol and Drug Use	Assessment for adolescents	
Autism	Screening for children at 12 and 36 months	
Behavioral	assessment for children of all ages. Ages: 0 to11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	
Blood Pressure	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	
Cervical Dysplasia	Screening for sexually active females	
Congenital Hypothyroidism	Screening for newborns	
Depression	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	
Developmental	Screening for children under age 3, and surveillance throughout childhood	
Dyslipidemia	Screening for children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	
Fluoride Chemoprevention	Supplements for children without fluoride in their water source	
Gonorrhea	preventive medication for the eyes of all newborns	
Hearing	Screening for all newborns	

Benefit	Limits	Page
Height, Weight and Body Mass Index	Measurements for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	
Hemotocrit or Hemoglobin	Screening for children	
Hemoglobinophathies	or sickle cell screening for newborns	
HIV	The USPSTF recommends that clinicians screen for HiV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	
Immunization	Vaccines for children from bith to age 18 - doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus inluenzae type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella	
Iron	Supplements for children ages 6 to 12 months at risk for anemia	
Lead	This USPSTF recommendation addresses screening for elevated blood lead levels in children aged 1 to 5 years who are both at average and increased risk, and in asymptomatic pregnant women.	
Medical History	for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years	
Obesity	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	
Oral Health	risk assessment for young children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.	
Phenylketonuria (PKU)	Screening for this genetic disorder in newborns	
Sexually Transmitted Infection (STI)	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents at increased risk for STIs.	
Tuberculin	testing for children at higher risk of tuberculosis. Ages: 0to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	
Vision	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	
Skin Cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	

COMMONWEALTH OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO FORM FILING CHECK LIST
GENERAL REQUIREMENTS

COMPANY: _____
FORM NUMBER: _____

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Rule XXIV of the Regulations of the Insurance Code of PR	Section 3(A)(1)	Every filing shall be accompanied with a transmittal Letter including the name of the insurer or health services organization making the filing under the signature of an authorized person.	
	Section 3(A)(2)	If it is a new form, the transmittal letter should so indicate, in addition to offering a description of the coverage and the form.	
	Section 3(A)(3)	If it is a revision of a form previously submitted, it should be so indicated in the transmittal letter, adding also the date of approval of the old form and listing the changes.	
	Section 3(A)(4)	The transmittal letter should list all of the forms that are included, their respective titles and form numbers.	
		The transmittal letter should indicate the SERFF tracking number of the Rate filing where the rates applicable to the product were submitted.	
APPLICATION FORM			
Chapter 11 Insurance Code of PR	§ 1107	Application required for insurance.	
Chapter 27 Insurance Code of PR	§ 2725	The application must include the prescribed fraud warning statement.	
Ruling Letter No. N-AV-I-8-38-90 of August 14, 1990 and Section 10.150(F) of the Health Insurance Code		Medical/ Lifestyle questions that should be taken into consideration in life and health applications. Any question of past or present health of any person that refers to a specific disease or general health must be asked "to the best of the applicant's knowledge and belief". Any issuer may require an applicant for group or individual health plan to fill out a medical questionnaire whereby information about preexisting conditions, as well as current prescriptions taken and care received to control a health condition, and the information of the primary care provider treating such condition. *The information provided in such questionnaire shall be used* ***solely and exclusively*** *by the issuer for the purpose of registering the enrollee in an established program to manage diseases*."	
Chapter 14 Health Insurance Code of PR	§ 14.100	A health insurance organization or issuer shall not collect, use or disclose protected health information without a valid authorization from the subject of the protected health information, except as permitted by Section 14.110 of this Code or as required by law or court order. An authorization for the disclosure of protected health information may be obtained for any purpose, provided that the authorization meets the requirements of this Section.	
ADDITIONAL REQUIREMENTS			
Chapter 11 Insurance Code of PR	§ 1114(2)	Every policy to be effective in Puerto Rico shall be offered in the Spanish language and shall be issued in the English language at the option of the proposed insured. In the interpretation of said policies, the text that is of most benefit to the insured shall prevail. The provisions of this subsection shall not apply to such insurance which the Commissioner, through regulations to that effect, may exclude because of its technical nature or volume.	
		The filing shall include the table with copayments, coinsurance and deductibles in the required format.	

As used in the entire checklist the terms insurance, insurer, insured and policy means for HMO's coverage, organization, subscriber and contract, respectivelly.

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Chapter 4 Health Insurance Code of PR	§ 4.060(A)(1)(a)	The filing shall include the formulary (list of prescription drugs) by therapeutic category; Information indicating which prescription drugs, if any, are subject to a management procedure that has been developed and maintained pursuant to this Chapter; and Information on how and what written documentation is required to be submitted in order for covered persons or enrollees, or their authorized representatives, to file a request under the health insurance organization or issuer 's medical exceptions process established pursuant to Section 4.070 of this Chapter.	
		The filing shall include the providers directory.	
		A certification must be included establishing that the language included in the policy/contract related to the Federal Laws ERISA and COBRA complies in its entirety with the dispositions established in the mentioned federal laws. Moreover, the language included in the policy/contract does not contain any additional limitations, conditions or contrary language.	
Circular Letter No. 2007-1775-AV of June 15, 2007		As a requirement, the below certification must be completed, signed and included with the filing.	
Instructions to Submit the filing on SERFF			
		The transmittal letter should be attached in the "Supporting Documentation Tab".	
		Any supporting documentation should be included in the "Supporting Documentation Tab", including evidences of previous approval, the table with copayments, coinsurance and deductibles, certifications, memorandum of variable material, among others.	
		All forms to be approved shall be included in the "Form Schedule Tab"	
		Forms and documents must be saved in a non-protected PDF format so that the file remains searchable and text can be copied from the document.	
		Every communication should be included in SERFF as a "Note to Reviewer" or a "Response Letter". Any other way of communication will not be considered as received.	

CERTIFICATION

I _____ have reviewed or supervised the preparation of the above form(s) and certify that the same comply with all of the applicable requirements of the Puerto Rico Form Filing Check List and that the filing does not contain dispositions previously disapproved or required to be corrected by the Office of the Commissioner of Insurance of Puerto Rico. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of the transmittal letter and enclosures with this filing.

Signature:_____

Date: _____

COMMONWEALTH OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO FORM FILING CHECK LIST
INDIVIDUAL MARKET

COMPANY: _____

FORM NUMBER: _____

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Chapter 16 Insurance Code of Puerto Rico	§ 1602(2)	The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower case unspaced alphabet length not less than one hundred and twenty-point.	
	§ 1602(3)	The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in §§ 1605 to 1628 of this title, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions" or "Exceptions and reductions", except that if an exception or reduction specifically applies to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.	
	§ 1602(4)	Each form shall be identified by a form number in the lower left-hand corner of every page.	
	§ 1604	Except as provided in Section 11.130, each such policy delivered or issued for delivery to any person in Puerto Rico shall contain the provisions as specified in Sections 16.050 through 16.090 inclusive, in the words in which the same appear; except, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded by the applicable caption shown or, at the insurer's option, by such appropriate individual or group caption or sub caption as the Commissioner may approve.	
	§ 1605	Entire Contract Provision	
	§ 1607	Grace Period	
	§ 1608	Reinstatement Provision	
	§ 1609	Notice of Claim Provision *(only applicable for reimbursement purpose)*	
	§ 1610	Claim Forms Provision (only applicable for reimbursement purpose)	
	§ 1611	Proof of Loss Provision (only applicable for reimbursement purpose)	
	§ 1612	Time of Payment of Claims Provision (only applicable for reimbursement purpose)	
	§ 1613	Payment of Claims Provision (only applicable for reimbursement purpose)	
	§ 1615	Civil Actions Provision	
	§ 1629	***Order of Certain Policy Provisions*** The provisions which are the subject of §§ 1605--1628 of this title, inclusive, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the insurer's option, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.	
	§ 1633	Family expenses disability insurance - *Foster child definition*	
HEALTH INSURANCE CODE			
Chapter 4 Health Insurance Code	§ 4.060(A)(1)(B)	Information indicating which prescription drugs, if any, are subject to a management procedure that has been developed and maintained pursuant to this Chapter must be disclosed in the policy or contract.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Chapter 4 Health Insurance Code	§ 4.060(A)(1)(C)	Information on how and what written documentation is required to be submitted in order for covered persons or enrollees, or their authorized representatives, to file a request under the health insurance organization or issuer 's medical exceptions process established pursuant to Section 4.070 of this Chapter.	
	§ 4.060(A)(2)	The policy or contract shall establish that changes in the formulary or other prescription drug management process during the term of the policy, certificate, or contract shall only be made if such change is being made for safety reasons, because the prescription drug cannot be supplied or has been withdrawn from the market by the drug's manufacturer, or if such change entails the inclusion of prescription drugs in the formulary.	
	§ 4.070	The policy or contract must include the Medical Exceptions Approval Process Requirements and Procedures in accordance to Section 4.070.	
	§ 4.100	The policy, certificate, membership booklet, outline of coverage, evidence of coverage, or any other document provided to a covered person or enrollee shall include the disclosures required in Section 4.100.	
	§ 4.120	The policy or contract must establish that when the history of the covered person or enrollee so requires, insofar as it does not jeopardize the patient's health, and at the discretion of the healthcare provider, such healthcare provider may prescribe refills for maintenance drugs up to a term that shall not exceed one hundred eighty (180) days, subject to the limitations of the health plan's coverage.	
Chapter 10 health Insurance Code	§ 10.050(J) § 2.050(D)(3)	The individual health plan issuer shall file with the Commissioner the individual basic health plans in their different metal levels of coverage, following the procedure established in Chapter 11 of the Insurance Code of Puerto Rico and the format provided by the Commissioner through policy letter.	
	§ 10.050(M)	No individual health plan shall deny, exclude or limit the benefits of a covered person based on preexisting conditions, regardless of the age of the enrollee.	
	§ 10.060	An individual health plan issuer shall be renewable or shall continue in force the coverage for the enrollee and his/her dependent, at the option of the enrollee, and in accordance with the applicable Federal regulations and legislation, except in the cases mentioned under this Section.	
	§ 10.080	The policy or contract must include a clause establishing the availability of Coverage in the Individual Market in compliance with Section 10.080.	
Chapter 12 Health Insurance Code	§ 12.040(A)	No policy, contract, certificate or agreement offered or issued in Puerto Rico by a health insurance organization or issuer to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services may contain a provision purporting to reserve discretion to health insurance organizations or issuers to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of Puerto Rico. An adverse determination by a health insurance organization or issuer, as well as disputes or controversies that may arise between a health insurance organization or issuer and a covered person or enrollee, shall be subject to the internal and external review procedures established in this Code.	
Chapter 52 Health Insurance Code	§ 52.040(A)	A health plan that provides coverage for drugs shall provide for the dispensation of any drug covered, regardless of the disorder, injury, illness, condition, or disease for which they were prescribed, provided, that (1) the drug has been approved by the FDA for at least one indication, and (2) the drug is recognized for treatment of the disorder, injury, illness, condition, or disease in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.	
	§ 52.040(B)	Coverage of a drug shall also include medically necessary services associated with the administration of the drug.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Chapter 54 Health Insurance Code	§ 54.050(A)	Health plans that provide coverage for a dependent of a covered person or enrollee shall provide coverage to: (1) A newborn child of a covered person or enrollee from the moment of birth; or (2) A newly adopted child of a covered person or enrollee from the earlier of dates mentioned in this Section.	
	§ 54.050(B)	The coverage for newborn and newly adopted children and children placed for adoption shall meet the following requirements: (1) Include coverage of injury or sickness healthcare services including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and (2) Is not subject to any preexisting condition exclusion.	
	§ 54.060(A)	If payment of a specific premium or subscription fee is required to provide coverage for a **newborn child**, the health plan may require the covered person or enrollee to notify the health insurance organization or issuer of the birth of the child and furnish payment of the required premium or fees within thirty (30) days after the date of birth. If notice and the payment described above are not provided, the health insurance organization or issuer may refuse to continue coverage for the child under the health plan beyond the thirty (30)-day period. However, if within four (4) months after the birth of the child the covered person or enrollee makes all past-due payments, coverage shall be restored. If payment of a specific premium or subscription fee is not required to provide coverage for a newborn child, the health insurance organization or issuer may request notification of the birth of the child, but shall not deny or refuse to continue coverage if the covered person or enrollee does not furnish the notice.	
	§ 54.060(B)	(1) If payment of a specific premium or subscription fee is required to provide coverage for a **newly adopted child or child placed for adoption**, the health plan may require the covered person or enrollee to notify the health insurance organization or issuer of the adoption or placement for adoption and furnish payment of the required premium or fees within thirty (30) days after coverage is required to begin under Section 54.050A(2). (2) If the covered person fails to provide the notice or make the payment described in the preceding paragraph within the thirty (30)-day period, the health insurance organization or issuer shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage.	
Chapter 72 Health Insurance Code	§ 72.040(A)	It is unfairly discriminatory to: (1) Deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health plan, or restrict a health plan coverage or add a premium differential or surcharge to any health plan on the basis of the covered person or enrollee's abuse status; or (2) Exclude, limit coverage, or deny a claim on the basis of the covered person or enrollee's abuse status;	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
OTHER REQUIREMENTS FOR HEALTH SERVICES ORGANIZATIONS			
Chapter 19 of the Insurance Code	§ 1915(1)(c)	The coverage evidence shall be considered as deceptive if, as a whole, and taking into consideration the typography and the format, as well as the language, it leads a person who has no special knowledge of plans and coverage evidence to believe that he has benefits, services, charges or other advantages which do not arise from the coverage evidence or which are not regularly accessible to the subscribers under the health care plan which issues said coverage evidence.	
	§ 1915(4)	No health services organization may use in its name, contract or literature, any of the words "insurance", "contingency", "guaranty", "mutual", or any other word describing insurance, contingency or guaranty business, deceitfully similar to the name or description of any insurance or guaranty corporation doing business in Puerto Rico.	
Puerto Rico Laws			
Act No. 275 September 27, 2012	Section 3(A)(g)	No insurer shall reject or deny any treatment agreed upon and/or included as part of the terms and conditions of the health insurance contract signed by the parties when a medical recommendation to such purposes so require. Physicians, health service organizations, insurers, and providers shall not reject or deny treatment such as hospitalization, diagnosis, and medication to any cancer patient. With regard to cancer survivors, insurers, health service organizations, and healthcare plans providers shall not deny coverage for the treatment and frequent and permanent monitoring of the physical health and emotional wellbeing of the insured.	
	Section 3(E)(c)	Coverage shall include pelvic exams and all types of vaginal cytology that may be required by a physician to detect, diagnose, and treat early stages of abnormalities that may lead to Cervical Cancer.	
	Section 3(E)(d)	Every plan shall provide extended coverage for the payment of breast cancer screening and testing such as visits to specialists, clinical breast exams, mammograms, digital mammograms, magnetic resonance mammography and breast ultrasounds, and treatment including, but not limited to, mastectomy, breast reconstruction after mastectomy, reconstructive surgery of the other breast to achieve symmetry, breast prosthesis, treatment for physical complications at all stages of mastectomy, including lymphedema (swelling that sometimes occurs after breast cancer treatment), any reconstructive surgery after mastectomy that may be needed for the physical and emotional recovery of the patient.	
Act No. 255 September 15, 2012		Health plan shall cover the vaccine against the human papilloma virus (HPV) for males and females; according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC).	
Act No. 239 September 13, 2012		Health plans shall include services provided by psychology professionals trained by education with a master degree or PhD, trainings and experience to provide health care services, duly licensed by the Puerto Rico Board of Psychologist Examiners.	
Act No. 220 September 4, 2012	Section 15	Every plan shall provide coverage for the treatment of autism. This coverage should include, but not limited to, genetics, neurology, immunology, gastroenterology and nutrition; speech, language, psychological, occupational, and physical therapies; and will include physician office visit and the medical tests referred by them.	
Act No. 218 August 30, 2012	Sections 2 and 3	As part of their coverage insurers and HMO's shall include, without this constituting a limitation, access to tests of: Cancer, high blood pressure and cholesterol, diabetes, osteoporosis, and Sexually Transmitted Diseases.	
Act No. 107 June 5, 2012	Section 1	A health plan that provides coverage for treatment of chemotherapy against cancer must also provide coverage of the chemotherapy against cancer in their various methods of administration of the drug, such as intravenous, oral, injectable track or intrathecal route; according to the order of the specialist doctor or oncologist.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Act No. 161 of November 1, 2010	Section 6(i)	Have individual and group healthcare plans cover direct access to gynecology and obstetrics care services without requiring referrals or previous authorization from the plan, insofar as such physician participates in the network of the healthcare providers.	
	Section 6(j)	Have individual or group healthcare plans providing coverage for a minor as a participant or beneficiary allow the parent or tutor of the dependent minor to select a pediatrician as his/her primary care provider, insofar as such pediatrician participates in the network of healthcare providers.	
Act No. 140 of September 22, 2010		Health care plans shall include the medication known as buprenorphine for treatment of opioid dependence in the “Medicaid Preferred Drug List,” or the health plan preferred drug list.	
Act No. 212 of August 9, 2008		Establishes that all health insurance shall provide, subject to preauthorization, coverage for one (1) bariatric surgery per lifetime for the treatment of morbid obesity using one of the following techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy. The intragastric balloon technique is excluded from the law. The health insurance may require a waiting period that shall not exceed twelve (12) months, before cover for the benefits stipulated in this Act. For the preauthorization of these services, the first treatment for the morbid obesity should be dietetic and in changes in the life style. The physician must document the unsuccessful attempt(s) with nonoperative medically supervised weight reduction program(s). For purposes of this Act No., morbid obesity means a body mass index of at least thirty-five (35) kilograms per meter squared, or greater. Bariatric surgery refers to the various surgical procedures performed to treat obesity, which can be practice by the following four techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy or intragastric balloon.	
Act No. 116 of July 17, 2008		Amends Act No. 15 of February 27, 2007, in order to correct the scope of the measure and to extend the term of effectiveness of said Act. Provides that the underwriters of health insurance plans in the Commonwealth of Puerto Rico shall accept, in a family insurance policy, the inclusion as beneficiaries of minors whose custody or guardianship has been granted to the grandparents or other participating family members, and those of legal age who have been declared disabled, whose guardianship has been granted, when the person to whom custody or guardianship has been granted is the primary beneficiary or insured of said policy.	
Act No. 21 February 29, 2008	Section 3	Health plans shall include as part of their coverage, if medically justified, in accordance with the criteria established in the protocol created by virtue of this Act, the rendering of services, including medications, to their subscribers who require tobacco and tobacco by-product use and dependence treatment, up to a maximum of four hundred (400) dollars annually for each subscriber. (**Only applies to HMO's**)	
Act No. 210 of December 14, 2007		Health plans shall provide access to the health services and treatment by a naturopathic physician if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed naturopathic physician, authorized by the Commonwealth of Puerto Rico. Also, the policy or contract must disclose the applicable copay or coinsurance.	
Act No. 127 of September 27, 2007		Health plans shall provide access to the health services and treatment by an audiologist if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed audiologist physician, authorized by the Commonwealth of Puerto Rico. Also, the policy or contract must disclose the applicable copay or coinsurance.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Act No. 125 of September 21, 2007		Health plans must include as part of their coverage, the technological equipment whose use may be necessary to maintain the user alive, a minimum of one (1) daily eight (8) hour shift of nursing services provided by skilled nurses knowledgeable in respiratory therapy or specialists in respiratory therapy with nursing skills, the supplies needed to operate technological equipment and the physical and occupational therapy needed to develop the motor skills of these patients. All of the preceding subject to having the need established by a doctor's order and according to the written home care plan for the patient. For the purposes of this law, a beneficiary shall be understood to be a person under twenty-one (21) years of age who uses medical technology whose functions depend on medical equipment, to wit, mechanical ventilator via tracheotomy, which supplies the vital functions of the human body and which requires the specialized daily care of nurses to prevent death or a greater degree of disability.	
Act No. 165 of August 30, 2006		Establishes that all health insurance companies in the Commonwealth of Puerto Rico are hereby directed to include the vaccine against respiratory syncytial virus as part of their pediatrics coverage.	
Act No. 150 of August 8, 2006		Health plans shall provide access to the health services and treatment by a chiropractor, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed chiropractor, authorized by the Commonwealth of Puerto Rico. Also, the policy or contract must disclose the applicable copay or coinsurance.	
Act No. 311 of December 19, 2003		Any health insurance policy which is available or may be available, renewed, extended, or modified in Puerto Rico by any health insurance company with benefits applicable within the health insurance policy, shall include coverage for initial hearing screening and for any other hearing evaluation within the follow-up care related to the hearing screening described in this Act. As provided by the act, the service shall be rendered in Puerto Rico even though the company is located outside of Puerto Rico. The benefits of the Universal Neonatal Hearing Screening Test to newborn babies, as well as the follow-up care shall be subject to the same co-payment policies and co-insured provisions applicable to any other medical service. With the exception that the benefit of neonatal hearing screening shall be exempted from co-payments or provisions that limit the maximum amount to be paid by the insurer.	
Act No. 148 August 9, 2002	Section 6(d)	Health plans shall provide access to the health services and treatment by a podiatrist, optometrist or psychologist if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed podiatrist, optometrist and clinical psychologist, authorized by the Commonwealth of Puerto Rico. Also, the policy or contract must disclose the applicable copay or coinsurance.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Act No. 383 of September 6, 2000		Establishes that any health insurance companies shall not favor nor instruct its insureds to exclusively contact a medical emergency system other than 9-1-1 during an emergency. It is provided that any entity subject to the provisions of this Act may use a transportation system other than 9-1-1, but cannot prohibit its insured to contact the 9-1-1 system for non-emergency medical cases. No entity subject to the provisions of this Act shall require its insureds or clients to obtain a pre-authorization to contact the 9-1-1 system in case of a medical emergency. In addition, no entity subject to the provisions of this Act may use false or deceitful language in the written material distributed to its insured or clients; or language prohibiting them or making them desist from contacting the 9-1-1 system in case of a medical emergency.	
Act No. 194 August 25, 2000	Section 6	Defines “Health Professional” as any practitioner duly allowed to practice in Puerto Rico, according to the applicable Act and regulations, any of the health and medical care health professions including but not limited to, physicians, surgeons, dentists, pharmacists, nurses and medical technologists, as authorized by the corresponding Act of Puerto Rico.	
	Section 7(a)	All health care plans shall contain a clause providing that in cases in which health care plan coverage is terminated or cancelled, or coverage by a provider is terminated or cancelled, the insurer shall notify the patient of such termination or cancellation thirty (30) calendar days before the date such termination or cancellation becomes effective.	
	Section 7(b)	The policy or contract shall contain a clause providing that subject to payment of premium as required, should the plan or the provider terminate coverage, the patient may continue receiving the benefits thereof for a transitional period of ninety (90) days as of the date the plan or the provider terminates coverage. 1. In those cases in which the patient is hospitalized at the time of the date of said termination of coverage, and the release of the patient from the hospital has been scheduled for a date preceding the date of termination of coverage, the transition period shall be extended from said date to ninety (90) days after the date the patient is released. 2. In those cases in which the patient is in her second trimester of pregnancy as of the date of termination of coverage and the provider has been offering medical treatment pertinent to the pregnancy before the date of termination of coverage, the transitional period concerning pregnancy-related health care shall be extended to the date the mother is released from hospital after childbirth, or the date the newborn is released from the hospital, or both, whichever occurs later. 3. In those cases in which the patient is diagnosed a terminal condition before the date of termination of coverage and the provider has been offering medical treatment pertinent to the condition before said date, the transitional period shall be extended for the remainder of the patient’s life. Providers that continue the treatment of the insured parties or their beneficiaries during said period must accept the payments and rates fixed by the plan as full payment for services rendered, as well as continue providing the plan with all the necessary information required by the plan for purposes of quality control, and surrender or transfer the medical records corresponding to the patients upon termination of said transitional period.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Act No. 194 August 25, 2000	Section 8(c)	All health care plans in Puerto Rico shall provide emergency service benefits with no waiting period. The previous authorization of the insurer shall not be required when providing these emergency services; furthermore, these services shall be provided regardless of whether the provider of such emergency services is a participating provider. In the event that a patient is provided services by a provider not contracted by the insurer, the patient shall not be held liable for the payment of services in an amount exceeding the amount applicable if the patient had received such services from a provider contracted by the insurer. The insurer shall compensate the provider offering the services, and the provider shall be under the obligation to accept said compensation, for an amount not to be less than the agreed with the providers contracted by the insurer to offer the very same services. Moreover, under these circumstances, such emergency services shall be provided regardless of the conditions set forth by the corresponding health care plan.	
	Section 9(c)	All health plans shall contain a provision setting forth that the insurer shall pay the routine medical expenses of any patient suffering from a life-threatening condition for which there is no effective treatment, when the patient is eligible for participating in an authorized clinical treatment study pursuant to the study protocol provisions concerning said treatment, provided the participation of the patient offers a potential benefit to the patient and the physician referring the patient believes that participation in said study is pertinent, or the patient presents evidence of the fact that participation in said study is pertinent. “Routine medical expenses of the patient” shall not be construed to be expenses related to the study, or tests administered to be used as part of the study, or expenses the entity conducting the study is likely to pay.	
Act No. 248 of August 15, 1999		Any insurer that provides maternity benefits shall provide a minimum coverage of forty-eight (48) hours of care in the hospital facilities in benefit of the mother and her newborn child (or children) if it is a natural birth without complications, and a minimum of ninety-six (96) hours if she required a Caesarean section. Any decision that has the effect of shortening the period of time provided above shall have to be determined by the attending purveyor with the acceptance of the patient. If the mother and the newborn are released within a period that is less than what is provided in this Section, but in accordance with the second paragraph, the coverage shall provide for a follow-up visit within the next forty-eight (48) hours. The services shall include, but shall not be limited to the attention and physical care of the child, instruction on the care of the child for both parents, help and training on breast feeding, information regarding home care, and the provision of any treatment, and medical tests for the infant as well as for the mother.	
Federal Laws			
Mental Health Parity Act		The services provided under the policy or contract regarding mental conditions must comply with the "Mental Health Parity Act". There shall be no distinction between a mental disorder and any other medical condition in terms of the access to the services that persons shall need. In addition, the policy or contract may not include any limitations on visits to a psychiatrist, collateral visits, group therapy and residential treatments.	
Patient Protection and Affordable Care Act (PPACA)	§§2704 and 1255 of the PHSA/ §1201 of the PPACA Section 2.050(I) of the Health Insurance Code of PR	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Patient Protection and Affordable Care Act (PPACA)	§ 2712 of the HSA/ §1001 of PPACA 45 CFR §147.128 Section 2.050(J) of the Health Insurance Code of PR	**Prohibit Rescissions** – Coverage may only be rescinded for fraud or intentional misrepresentation of material fact. Notification must be made to the policyholder 30 calendar days prior to cancellation.	
	§2711 of the PHSA/ §1001 of the PPACA Section 2.050 (A)(2) of the Health Insurance Code Act No. 161 of November 1, 2010	**Eliminate Annual Dollar Limits on Essential Health Benefits**	
	§2711 of the PHSA/ §1001 of the PPACA 45CFR §147.126 Section 2.050(A)(1) of the Health Insurance Code	**Eliminate Lifetime Dollar Limits on Essential Health Benefits**	
	§1302 of the PPACA	**Maximum Out of Pocket-** Requires establishment of a maximum cost sharing for Essential Health Benefits	
	§2713 of the PHSA/ §1001 of the PPACA 45 CFR §147.130 Section 2.050(C) of the Health Insurance Code Act No. 161 of November 1, 2010	**Preventive Services** – Requires coverage and prohibits the imposition of cost-sharing for: Services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the "Comité Asesor en Practicas de Inmunización" of the Puerto Rico Health Department. Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. (IN PR 21 YEARS) Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration, including *breast cancer screening, mammography and prevention.*	
	§2714 of the PHSA/ §1001 of the PPACA 26 CFR §§ 144.101, 146.101, 147.100, and 147.120	**Extends Dependent Coverage for Children Until age 26** – If a policy offers dependent coverage, it must include dependent coverage until age 26. (Coverage is not required for children of dependents.) Also, the definition of "Dependent" must comply with Sections 2.030(G) and 10.030(H) of the Health Insurance Code of Puerto Rico.	
	§2719 of the PHSA/ §1001 of the PPACA 45 CFR §147.136	**Appeals Process** – Requires establishment of an internal claims appeal process and external review process. Also, the policy or contract must comply with Chapters 22, 24 and 28 of the Health Insurance Code.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Patient Protection and Affordable Care Act (PPACA)	§2719A of the PHSA/ §10101 of the PPACA 45 CFR § 147.138(b)	**Emergency Services** – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, without imposing any administrative requirement or limitation that is more restrictive than that required for participating provider services, and at the in-network cost-sharing level. In addition to the in-network cost-sharing, an enrollee / insured may be required to pay the excess of the amount a non-participating provider charges over the greater of: (i) The amount the plan pays participating providers for such services; (ii) The amount the plan pays non-participating providers for such services, without reduction for out-of network cost-sharing or; (iii) the amount that would be paid under Medicare. Emergency condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. Emergency service means a medical screening examination (as required under §1867 of the Social Security Act) that is within the capability of the emergency department of a hospital; and within the capabilities of the staff and facilities available at the hospital such further examination and treatment as required under §1867 of the Social Security Act to stabilize the patient. Stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver (including the placenta).	
Circular and Ruling Letters Applicable			
Ruling Letter No. 2011-121-AV of September 1, 2011		Require that health plans must include the meningitis vaccine as part of the basic coverage.	
Ruling Letter No. N-AV-7-8-2001 of July 6, 2001		Require that every Insurer, Health Services Organization and Non-Profit Association that underwrite health insurance in Puerto Rico offer, as part of basic coverage, an annual medical evaluation that includes preventive services required by Act No. 296 of September 1, 2000 without any cost beyond the premium originally established for said plans. The mentioned Act imposes to the Puerto Rico Department of Education the responsibility to ensure that each child received an annual medical evaluation at the beginning of the school year. Said medical evaluation must include physical and mental evaluation, oral hygiene, hearing and visual tests, as well as periodic tests recommended by the American Academy of Pediatrics.	
Ruling Letter No. N-AV-12-111-99 of December 20, 1999		Requires that all health insurance shall estipulate that in such cases in which an insured or subscriber decides to use a private hospital room instead of a semi-private room, he or she will be responsible for the difference in cost that this utilization represents. In addition, all health insurance shall estipulate that unless in the cases of differences in the cost of the hospital rooms, the providers cannot charge to patients in a private rooms different quantities to those that have the rights to charge if said patient was confined in a semi-private room.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Ruling Letter No. N-AV-10-90-97 of November 24, 1997		Establishes that the Health Insurance Portability and Accountability Act (HIPAA) is applicable in our jurisdiction and preempts the Insurance Code of Puerto Rico with regard to the provisions required in the Act, which are not provided in said Code or which are less stringent than the federal requirements.	
Ruling Letter No. N-C-8-71-95 of October 13, 1995		Requires that all health insurance that provides ambulance services in their coverage must estipulate that the ambulance companies that will render the services must be authorized by the Puerto Rico Commission of Public Services.	
Circular Letter No. CC-2014-1848-AS of January 22, 2014		Regarding pregnant women, all insurers or health services organizations are required to cover and will not impose cost-sharing requirements with regard to the following tests included in the most recent recommendations of the "United States Preventive Services Task Force (USPSTF): 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the 28th and 34th week of pregnancy).	
Circular Letter No. 2013-1825-D of March 1, 2013 and Section 2.050(D)(3) of the Health Insurance Code of PR		All insurers and health insurance organizations that provide health insurance to individuals and small groups will have to include in such plans at a minimum essential health services known as Essential Health Benefits (EHB). EHB include benefits and services in at least the following ten categories: 1. Out-patient services 2. Emergency services 3. Hospitalization 4. Laboratory services 5. Maternity and newborn care services 6. Mental health services and for controlled substance use disorder 7. Prescribed medication 8. Rehabilitation and habilitation services and equipment 9. Preventive, wellness, and management of chronic disease services 10. Pediatric services including vision and dental care The EHB Benchmark Plan selected for Puerto Rico was Optimo Plus PPO.1 Exclusively with regard to pediatric vision services, the rule provides for using the coverage of the Federal Employees Dental and Vision Insurance Program (FEDVIP) to define the EHB that must be included in health insurance plans.	
ADDITIONAL REQUIREMENTS			
Chapter 11 Insurance Code of Puerto Rico	Section 11.110(1)	The policy or contract shall include a coordination of benefit provision in compliance with the Coordination of Benefit Model Regulation of the NAIC.	
Rule L of the Regulation of the Insurance Code	§ 17(D)(1)	Notice related to policies or certificates which are not Medicare Supplement Policies.	
	Appendix C	Disclosure Statements. Instructions for use of the disclosure statements for health insurance policies sold to Medicare beneficiaries that duplicate Medicare.	
		The policy shall contain the name and full address of the issuing insurer or health organization on the front cover.	
		The signature of company officer(s) appears prominently on the policy (such as on the cover).	
Circular Letter No. 2007-1775-AV of June 15, 2007		As a requirement, the below certification must be completed, signed and included with the filing.	

REGULATION	REQUIREMENTS	Reference /Page/ Paragraph

CERTIFICATION

I _____ have reviewed or supervised the preparation of the above form(s) and certify that the same comply with all of the applicable requirements of the Puerto Rico Form Filing Check List and that the filing does not contain dispositions previously disapproved or required to be corrected by the Office of the Commissioner of Insurance of Puerto Rico. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of the transmittal letter and enclosures with this filing.

Signature: _____

Date: _____

COMMONWEALTH OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO FORM FILING CHECK LIST
SMALL GROUP MARKET

COMPANY: _____

FORM NUMBER: _____

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Chapter 17 of the Insurance Code	§ 1701(3)	No group disability insurance policy shall be issued for delivery in Puerto Rico, unless it is in agreement with one of the descriptions contained in in § 1401 of this title.	
	§ 1703	Grace Period Provision	
	§ 1706	Issuance of Certificates	
	§ 1707	Conversion provision	
HEALTH INSURANCE CODE			
Chapter 4 Health Insurance Code	§ 4.060(A)(1)(B)	Information indicating which prescription drugs, if any, are subject to a management procedure that has been developed and maintained pursuant to this Chapter must be disclosed in the policy or contract.	
	§ 4.060(A)(1)(C)	Information on how and what written documentation is required to be submitted in order for covered persons or enrollees, or their authorized representatives, to file a request under the health insurance organization or issuer 's medical exceptions process established pursuant to Section 4.070 of this Chapter.	
	§ 4.060(A)(2)	The policy or contract shall establish that changes in the formulary or other prescription drug management process during the term of the policy, certificate, or contract shall only be made if such change is being made for safety reasons, because the prescription drug cannot be supplied or has been withdrawn from the market by the drug's manufacturer, or if such change entails the inclusion of prescription drugs in the formulary.	
	§ 4.070	The policy or contract must include the Medical Exceptions Approval Process Requirements and Procedures in accordance to Section 4.070.	
	§ 4.100	The policy, certificate, membership booklet, outline of coverage, evidence of coverage, or any other document provided to a covered person or enrollee shall include the disclosures required in Section 4.100.	
	§ 4.120	The policy or contract must establish that when the history of the covered person or enrollee so requires, insofar as it does not jeopardize the patient's health, and at the discretion of the healthcare provider, such healthcare provider may prescribe refills for maintenance drugs up to a term that shall not exceed one hundred eighty (180) days, subject to the limitations of the health plan's coverage.	
Chapter 8 Health Insurance Code	§ 8.030(K)	The Small- and Medium-sized Business (PYMES) Employer definition must be in compliance with this Section.	
	§ 8.030(L)	Health plans with waiting periods must define the term 'Waiting Period' as the period of time that must pass before coverage for a covered person or enrollee who is otherwise eligible to enroll under the terms of a health plan can become effective. In no case the waiting period shall exceed ninety (90) days.	
	§ 8.060	The policy or contract shall include the renewal requirements in compliance with this Section.	
	§ 8.070(c)(4)	Health plans shall not deny, exclude or limit benefits for a person due to a preexisting condition regardless of the person's age.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Chapter 12 Health Insurance Code	§ 12.040(A)	No policy, contract, certificate or agreement offered or issued in Puerto Rico by a health insurance organization or issuer to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services may contain a provision purporting to reserve discretion to health insurance organizations or issuers to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of Puerto Rico. An adverse determination by a health insurance organization or issuer, as well as disputes or controversies that may arise between a health insurance organization or issuer and a covered person or enrollee, shall be subject to the internal and external review procedures established in this Code.	
Chapter 52 Health Insurance Code	§ 52.040(A)	A health plan that provides coverage for drugs shall provide for the dispensation of any drug covered, regardless of the disorder, injury, illness, condition, or disease for which they were prescribed, provided, that (1) the drug has been approved by the FDA for at least one indication, and (2) the drug is recognized for treatment of the disorder, injury, illness, condition, or disease in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.	
	§ 52.040(B)	Coverage of a drug shall also include medically necessary services associated with the administration of the drug.	
Chapter 54 Health Insurance Code	§ 54.050(A)	Health plans that provide coverage for a dependent of a covered person or enrollee shall provide coverage to: (1) A newborn child of a covered person or enrollee from the moment of birth; or (2) A newly adopted child of a covered person or enrollee from the earlier of dates mentioned in this Section.	
	§ 54.050(B)	The coverage for newborn and newly adopted children and children placed for adoption shall meet the following requirements: (1) Include coverage of injury or sickness healthcare services including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and (2) Is not subject to any preexisting condition exclusion.	
	§ 54.060(A)	If payment of a specific premium or subscription fee is required to provide coverage for a **newborn child**, the health plan may require the covered person or enrollee to notify the health insurance organization or issuer of the birth of the child and furnish payment of the required premium or fees within thirty (30) days after the date of birth. If notice and the payment described above are not provided, the health insurance organization or issuer may refuse to continue coverage for the child under the health plan beyond the thirty (30)-day period. However, if within four (4) months after the birth of the child the covered person or enrollee makes all past-due payments, coverage shall be restored. If payment of a specific premium or subscription fee is not required to provide coverage for a newborn child, the health insurance organization or issuer may request notification of the birth of the child, but shall not deny or refuse to continue coverage if the covered person or enrollee does not furnish the notice.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Chapter 54 Health Insurance Code	§ 54.060(B)	(1) If payment of a specific premium or subscription fee is required to provide coverage for a **newly adopted child or child placed for adoption**, the health plan may require the covered person or enrollee to notify the health insurance organization or issuer of the adoption or placement for adoption and furnish payment of the required premium or fees within thirty (30) days after coverage is required to begin under Section 54.050A(2). (2) If the covered person fails to provide the notice or make the payment described in the preceding paragraph within the thirty (30)-day period, the health insurance organization or issuer shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage.	
Chapter 72 Health Insurance Code	§ 72.040(A)	It is unfairly discriminatory to: (1) Deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health plan, or restrict a health plan coverage or add a premium differential or surcharge to any health plan on the basis of the covered person or enrollee's abuse status; or (2) Exclude, limit coverage, or deny a claim on the basis of the covered person or enrollee's abuse status;	
	§ 72.040(D)	It is unfairly discriminatory to terminate group coverage for a victim of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the victim of abuse, or the abuser's coverage has terminated voluntarily or involuntarily. Nothing in this subsection prohibits the health insurance organization or issuer or insurance professional from requiring the victim of abuse to pay the full premium for coverage under the health plan or from requiring as a condition of coverage that the victim of abuse reside or work within the health plan service area, if the requirements are applied to all existing or potential covered persons or enrollees. The health insurance organization or issuer may terminate group coverage after the continuation coverage required by this subsection has been in force for eighteen (18) months, if it offers conversion to an equivalent individual plan. The continuation coverage required herein shall be satisfied by coverage required under the 'Consolidated Omnibus Budget Reconciliation Act of 1985' (COBRA), and shall not be in addition to coverage provided under COBRA.	
OTHER REQUIREMENTS FOR HEALTH SERVICES ORGANIZATIONS			
Chapter 19 of the Insurance Code	§ 1915(1)(c)	The coverage evidence shall be considered as deceptive if, as a whole, and taking into consideration the typography and the format, as well as the language, it leads a person who has no special knowledge of plans and coverage evidence to believe that he has benefits, services, charges or other advantages which do not arise from the coverage evidence or which are not regularly accessible to the subscribers under the health care plan which issues said coverage evidence.	
	§ 1915(4)	No health services organization may use in its name, contract or literature, any of the words "insurance", "contingency", "guaranty", "mutual", or any other word describing insurance, contingency or guaranty business, deceitfully similar to the name or description of any insurance or guaranty corporation doing business in Puerto Rico.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Puerto Rico Laws			
Act No. 275 September 27, 2012	Section 3(A)(g)	No insurer shall reject or deny any treatment agreed upon and/or included as part of the terms and conditions of the health insurance contract signed by the parties when a medical recommendation to such purposes so require. Physicians, health service organizations, insurers, and providers shall not reject or deny treatment such as hospitalization, diagnosis, and medication to any cancer patient. With regard to cancer survivors, insurers, health service organizations, and healthcare plans providers shall not deny coverage for the treatment and frequent and permanent monitoring of the physical health and emotional wellbeing of the insured.	
	Section 3(E)(c)	Coverage shall include pelvic exams and all types of vaginal cytology that may be required by a physician to detect, diagnose, and treat early stages of abnormalities that may lead to Cervical Cancer.	
	Section 3(E)(d)	Every plan shall provide extended coverage for the payment of breast cancer screening and testing such as visits to specialists, clinical breast exams, mammograms, digital mammograms, magnetic resonance mammography and breast ultrasounds, and treatment including, but not limited to, mastectomy, breast reconstruction after mastectomy, reconstructive surgery of the other breast to achieve symmetry, breast prosthesis, treatment for physical complications at all stages of mastectomy, including lymphedema (swelling that sometimes occurs after breast cancer treatment), any reconstructive surgery after mastectomy that may be needed for the physical and emotional recovery of the patient.	
Act No. 255 September 15, 2012		Health plan shall cover the vaccine against the human papilloma virus (HPV) for males and females; according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC).	
Act No. 239 September 13, 2012		Health plans shall include services provided by psychology professionals trained by education with a master degree or PhD, trainings and experience to provide health care services, duly licensed by the Puerto Rico Board of Psychologist Examiners.	
Act No. 220 September 4, 2012	Section 15	Every plan shall provide coverage for the treatment of autism. This coverage should include, but not limited to, genetics, neurology, immunology, gastroenterology and nutrition; speech, language, psychological, occupational, and physical therapies; and will include physician office visit and the medical tests referred by them.	
Act No. 218 August 30, 2012	Sections 2 and 3	As part of their coverage insurers and HMO's shall include, without this constituting a limitation, access to tests of: Cancer, high blood pressure and cholesterol, diabetes, osteoporosis, and Sexually Transmitted Diseases.	
Act No. 107 June 5, 2012	Section 1	A health plan that provides coverage for treatment of chemotherapy against cancer must also provide coverage of the chemotherapy against cancer in their various methods of administration of the drug, such as intravenous, oral, injectable track or intrathecal route; according to the order of the specialist doctor or oncologist.	
Act No. 161 of November 1, 2010	Section 6(i)	Have individual and group healthcare plans cover direct access to gynecology and obstetrics care services without requiring referrals or previous authorization from the plan, insofar as such physician participates in the network of the healthcare providers.	
	Section 6(j)	Have individual or group healthcare plans providing coverage for a minor as a participant or beneficiary allow the parent or tutor of the dependent minor to select a pediatrician as his/her primary care provider, insofar as such pediatrician participates in the network of healthcare providers.	
Act No. 140 of September 22, 2010		Health care plans shall include the medication known as buprenorphine for treatment of opioid dependence in the "Medicaid Preferred Drug List," or the health plan preferred drug list.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Act No. 212 of August 9, 2008		Establishes that all health insurance shall provide, subject to preauthorization, coverage for one (1) bariatric surgery per lifetime for the treatment of morbid obesity using one of the following techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy. The intragastric balloon technique is excluded from the law. The health insurance may require a waiting period that shall not exceed twelve (12) months, before cover for the benefits stipulated in this Act. For the preauthorization of these services, the first treatment for the morbid obesity should be dietetic and in changes in the life style. The physician must document the unsuccessful attempt(s) with nonoperative medically supervised weight reduction program(s). For purposes of this Act No., morbid obesity means a body mass index of at least thirty-five (35) kilograms per meter squared, or greater. Bariatric surgery refers to the various surgical procedures performed to treat obesity, which can be practice by the following four techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy or intragastric balloon.	
Act No. 116 of July 17, 2008		Amends Act No. 15 of February 27, 2007, in order to correct the scope of the measure and to extend the term of effectiveness of said Act. Provides that the underwriters of health insurance plans in the Commonwealth of Puerto Rico shall accept, in a family insurance policy, the inclusion as beneficiaries of minors whose custody or guardianship has been granted to the grandparents or other participating family members, and those of legal age who have been declared disabled, whose guardianship has been granted, when the person to whom custody or guardianship has been granted is the primary beneficiary or insured of said policy.	
Act No. 21 February 29, 2008	Section 3	Health plans shall include as part of their coverage, if medically justified, in accordance with the criteria established in the protocol created by virtue of this Act, the rendering of services, including medications, to their subscribers who require tobacco and tobacco by-product use and dependence treatment, up to a maximum of four hundred (400) dollars annually for each subscriber. (**Only applies to HMO's**)	
Act No. 210 of December 14, 2007		Health plans shall provide access to the health services and treatment by a naturopathic physician if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed naturopathic physician, authorized by the Commonwealth of Puerto Rico. Also, the policy or contract must disclose the applicable copay or coinsurance.	
Act No. 127 of September 27, 2007		Health plans shall provide access to the health services and treatment by an audiologist if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed audiologist physician, authorized by the Commonwealth of Puerto Rico. Also, the policy or contract must disclose the applicable copay or coinsurance.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Act No. 125 of September 21, 2007		Health plans must include as part of their coverage, the technological equipment whose use may be necessary to maintain the user alive, a minimum of one (1) daily eight (8) hour shift of nursing services provided by skilled nurses knowledgeable in respiratory therapy or specialists in respiratory therapy with nursing skills, the supplies needed to operate technological equipment and the physical and occupational therapy needed to develop the motor skills of these patients. All of the preceding subject to having the need established by a doctor's order and according to the written home care plan for the patient. For the purposes of this law, a beneficiary shall be understood to be a person under twenty-one (21) years of age who uses medical technology whose functions depend on medical equipment, to wit, mechanical ventilator via tracheotomy, which supplies the vital functions of the human body and which requires the specialized daily care of nurses to prevent death or a greater degree of disability.	
Act No. 165 of August 30, 2006		Establishes that all health insurance companies in the Commonwealth of Puerto Rico are hereby directed to include the vaccine against respiratory syncytial virus as part of their pediatrics coverage.	
Act No. 150 of August 8, 2006		Health plans shall provide access to the health services and treatment by a chiropractor, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed chiropractor, authorized by the Commonwealth of Puerto Rico. Also, the policy or contract must disclose the applicable copay or coinsurance.	
Act No. 311 of December 19, 2003		Any health insurance policy which is available or may be available, renewed, extended, or modified in Puerto Rico by any health insurance company with benefits applicable within the health insurance policy, shall include coverage for initial hearing screening and for any other hearing evaluation within the follow-up care related to the hearing screening described in this Act. As provided by the act, the service shall be rendered in Puerto Rico even though the company is located outside of Puerto Rico. The benefits of the Universal Neonatal Hearing Screening Test to newborn babies, as well as the follow-up care shall be subject to the same co-payment policies and co-insured provisions applicable to any other medical service. With the exception that the benefit of neonatal hearing screening shall be exempted from co-payments or provisions that limit the maximum amount to be paid by the insurer.	
Act No. 148 August 9, 2002	Section 6(d)	Health plans shall provide access to the health services and treatment by a podiatrist, optometrist or psychologist if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed podiatrist, optometrist and clinical psychologist, authorized by the Commonwealth of Puerto Rico. Also, the policy or contract must disclose the applicable copay or coinsurance.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Act No. 383 of September 6, 2000		Establishes that any health insurance companies shall not favor nor instruct its insureds to exclusively contact a medical emergency system other than 9-1-1 during an emergency. It is provided that any entity subject to the provisions of this Act may use a transportation system other than 9-1-1, but cannot prohibit its insured to contact the 9-1-1 system for non-emergency medical cases. No entity subject to the provisions of this Act shall require its insureds or clients to obtain a pre-authorization to contact the 9-1-1 system in case of a medical emergency. In addition, no entity subject to the provisions of this Act may use false or deceitful language in the written material distributed to its insured or clients; or language prohibiting them or making them desist from contacting the 9-1-1 system in case of a medical emergency.	
Act No. 194 August 25, 2000	Section 6	Defines “Health Professional” as any practitioner duly allowed to practice in Puerto Rico, according to the applicable Act and regulations, any of the health and medical care health professions including but not limited to, physicians, surgeons, dentists, pharmacists, nurses and medical technologists, as authorized by the corresponding Act of Puerto Rico.	
	Section 7(a)	All health care plans shall contain a clause providing that in cases in which health care plan coverage is terminated or cancelled, or coverage by a provider is terminated or cancelled, the insurer shall notify the patient of such termination or cancellation thirty (30) calendar days before the date such termination or cancellation becomes effective.	
Act No. 194 August 25, 2000	Section 7(b)	The policy or contract shall contain a clause providing that subject to payment of premium as required, should the plan or the provider terminate coverage, the patient may continue receiving the benefits thereof for a transitional period of ninety (90) days as of the date the plan or the provider terminates coverage. 1. In those cases in which the patient is hospitalized at the time of the date of said termination of coverage, and the release of the patient from the hospital has been scheduled for a date preceding the date of termination of coverage, the transition period shall be extended from said date to ninety (90) days after the date the patient is released. 2. In those cases in which the patient is in her second trimester of pregnancy as of the date of termination of coverage and the provider has been offering medical treatment pertinent to the pregnancy before the date of termination of coverage, the transitional period concerning pregnancy-related health care shall be extended to the date the mother is released from hospital after childbirth, or the date the newborn is released from the hospital, or both, whichever occurs later. 3. In those cases in which the patient is diagnosed a terminal condition before the date of termination of coverage and the provider has been offering medical treatment pertinent to the condition before said date, the transitional period shall be extended for the remainder of the patient’s life. Providers that continue the treatment of the insured parties or their beneficiaries during said period must accept the payments and rates fixed by the plan as full payment for services rendered, as well as continue providing the plan with all the necessary information required by the plan for purposes of quality control, and surrender or transfer the medical records corresponding to the patients upon termination of said transitional period.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
	Section 8(c)	All health care plans in Puerto Rico shall provide emergency service benefits with no waiting period. The previous authorization of the insurer shall not be required when providing these emergency services; furthermore, these services shall be provided regardless of whether the provider of such emergency services is a participating provider. In the event that a patient is provided services by a provider not contracted by the insurer, the patient shall not be held liable for the payment of services in an amount exceeding the amount applicable if the patient had received such services from a provider contracted by the insurer. The insurer shall compensate the provider offering the services, and the provider shall be under the obligation to accept said compensation, for an amount not to be less than the agreed with the providers contracted by the insurer to offer the very same services. Moreover, under these circumstances, such emergency services shall be provided regardless of the conditions set forth by the corresponding health care plan.	
	Section 9(c)	All health plans shall contain a provision setting forth that the insurer shall pay the routine medical expenses of any patient suffering from a life-threatening condition for which there is no effective treatment, when the patient is eligible for participating in an authorized clinical treatment study pursuant to the study protocol provisions concerning said treatment, provided the participation of the patient offers a potential benefit to the patient and the physician referring the patient believes that participation in said study is pertinent, or the patient presents evidence of the fact that participation in said study is pertinent. “Routine medical expenses of the patient” shall not be construed to be expenses related to the study, or tests administered to be used as part of the study, or expenses the entity conducting the study is likely to pay.	
Act No. 248 of August 15, 1999		Any insurer that provides maternity benefits shall provide a minimum coverage of forty-eight (48) hours of care in the hospital facilities in benefit of the mother and her newborn child (or children) if it is a natural birth without complications, and a minimum of ninety-six (96) hours if she required a Caesarean section. Any decision that has the effect of shortening the period of time provided above shall have to be determined by the attending purveyor with the acceptance of the patient. If the mother and the newborn are released within a period that is less than what is provided in this Section, but in accordance with the second paragraph, the coverage shall provide for a follow-up visit within the next forty-eight (48) hours. The services shall include, but shall not be limited to the attention and physical care of the child, instruction on the care of the child for both parents, help and training on breast feeding, information regarding home care, and the provision of any treatment, and medical tests for the infant as well as for the mother.	
Federal Laws			
Mental Health Parity Act		The services provided under the policy or contract regarding mental conditions must comply with the "Mental Health Parity Act". There shall be no distinction between a mental disorder and any other medical condition in terms of the access to the services that persons shall need. In addition, the policy or contract may not include any limitations on visits to a psychiatrist, collateral visits, group therapy and residential treatments.	
	§§2704 and 1255 of the PHSA/ §1201 of the PPACA Section 2.050(I) of the Health Insurance Code of PR	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Patient Protection and Affordable Care Act (PPACA)	§ 2712 of the HSA/ §1001 of PPACA 45 CFR §147.128 Section 2.050(J) of the Health Insurance Code of PR	**Prohibit Rescissions** – Coverage may only be rescinded for fraud or intentional misrepresentation of material fact. Notification must be made to the policyholder 30 calendar days prior to cancellation.	
	§2711 of the PHSA/ §1001 of the PPACA Section 2.050 (A)(2) of the Health Insurance Code Act No. 161 of November 1, 2010	**Eliminate Annual Dollar Limits on Essential Health Benefits**	
	§2711 of the PHSA/ §1001 of the PPACA 45CFR §147.126 Section 2.050(A)(1) of the Health Insurance Code	**Eliminate Lifetime Dollar Limits on Essential Health Benefits**	
Patient Protection and Affordable Care Act (PPACA)	§1302 of the PPACA	**Maximum Out of Pocket-** Requires establishment of a maximum cost sharing for Essential Health Benefits	
	§2713 of the PHSA/ §1001 of the PPACA 45 CFR §147.130 Section 2.050(C) of the Health Insurance Code Act No. 161 of November 1, 2010	**Preventive Services** – Requires coverage and prohibits the imposition of cost-sharing for: Services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the "Comité Asesor en Practicas de Inmunización" of the Puerto Rico Health Department. Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. (IN PR 21 YEARS) Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration, including *breast cancer screening, mammography and prevention.*	
	§2714 of the PHSA/ §1001 of the PPACA 26 CFR §§ 144.101, 146.101, 147.100, and 147.120	**Extends Dependent Coverage for Children Until age 26** – If a policy offers dependent coverage, it must include dependent coverage until age 26. (Coverage is not required for children of dependents.) Also, the definition of "Dependent" must comply with Sections 2.030(G) and 10.030(H) of the Health Insurance Code of Puerto Rico.	
	§2719 of the PHSA/ §1001 of the PPACA 45 CFR §147.136	**Appeals Process** – Requires establishment of an internal claims appeal process and external review process. Also, the policy or contract must comply with Chapters 22, 24 and 28 of the Health Insurance Code.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
	§2719A of the PHSA/ §10101 of the PPACA 45 CFR § 147.138(b)	**Emergency Services** – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, without imposing any administrative requirement or limitation that is more restrictive than that required for participating provider services, and at the in-network cost-sharing level. In addition to the in-network cost-sharing, an enrollee / insured may be required to pay the excess of the amount a non-participating provider charges over the greater of: (i) The amount the plan pays participating providers for such services; (ii) The amount the plan pays non-participating providers for such services, without reduction for out-of network cost-sharing or; (iii) the amount that would be paid under Medicare. Emergency condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. Emergency service means a medical screening examination (as required under §1867 of the Social Security Act) that is within the capability of the emergency department of a hospital; and within the capabilities of the staff and facilities available at the hospital such further examination and treatment as required under §1867 of the Social Security Act to stabilize the patient. Stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver (including the placenta).	
Circular and Ruling Letters Applicable			
Ruling Letter No. 2011-121-AV of September 1, 2011		Require that health plans must include the meningitis vaccine as part of the basic coverage.	
Ruling Letter No. N-AV-7-8-2001 of July 6, 2001		Require that every Insurer, Health Services Organization and Non-Profit Association that underwrite health insurance in Puerto Rico offer, as part of basic coverage, an annual medical evaluation that includes preventive services required by Act No. 296 of September 1, 2000 without any cost beyond the premium originally established for said plans. The mentioned Act imposes to the Puerto Rico Department of Education the responsibility to ensure that each child received an annual medical evaluation at the beginning of the school year. Said medical evaluation must include physical and mental evaluation, oral hygiene, hearing and visual tests, as well as periodic tests recommended by the American Academy of Pediatrics.	
Ruling Letter No. N-AV-12-111-99 of December 20, 1999		Requires that all health insurance shall estipulate that in such cases in which an insured or subscriber decides to use a private hospital room instead of a semi-private room, he or she will be responsible for the difference in cost that this utilization represents. In addition, all health insurance shall estipulate that unless in the cases of differences in the cost of the hospital rooms, the providers cannot charge to patients in a private rooms different quantities to those that have the rights to charge if said patient was confined in a semi-private room.	

REGULATION		REQUIREMENTS	Reference /Page/ Paragraph
Ruling Letter No. N-AV-10-90-97 of November 24, 1997		Establishes that the Health Insurance Portability and Accountability Act (HIPAA) is applicable in our jurisdiction and preempts the Insurance Code of Puerto Rico with regard to the provisions required in the Act, which are not provided in said Code or which are less stringent than the federal requirements.	
Ruling Letter No. N-C-8-71-95 of October 13, 1995		Requires that all health insurance that provides ambulance services in their coverage must estipulate that the ambulance companies that will render the services must be authorized by the Puerto Rico Commission of Public Services.	
Circular Letter No. CC-2014-1848-AS of January 22, 2014		Regarding pregnant women, all insurers or health services organizations are required to cover and will not impose cost-sharing requirements with regard to the following tests included in the most recent recommendations of the "United States Preventive Services Task Force (USPSTF): 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the 28th and 34th week of pregnancy).	
Circular Letter No. 2013-1825-D of March 1, 2013 and Section 2.050(D)(3) of the Health Insurance Code of PR		All insurers and health insurance organizations that provide health insurance to individuals and small groups will have to include in such plans at a minimum essential health services known as Essential Health Benefits (EHB). EHB include benefits and services in at least the following ten categories: 1. Out-patient services 2. Emergency services 3. Hospitalization 4. Laboratory services 5. Maternity and newborn care services 6. Mental health services and for controlled substance use disorder 7. Prescribed medication 8. Rehabilitation and habilitation services and equipment 9. Preventive, wellness, and management of chronic disease services 10. Pediatric services including vision and dental care The EHB Benchmark Plan selected for Puerto Rico was Optimo Plus PPO.1 Exclusively with regard to pediatric vision services, the rule provides for using the coverage of the Federal Employees Dental and Vision Insurance Program (FEDVIP) to define the EHB that must be included in health insurance plans.	
ADDITIONAL REQUIREMENTS			
Chapter 11 Insurance Code of Puerto Rico	Section 11.110(1)	The policy or contract shall include a coordination of benefit provision in compliance with the Coordination of Benefit Model Regulation of the NAIC.	
Rule L of the Regulation of the Insurance Code	§ 17(D)(1)	Notice related to policies or certificates which are not Medicare Supplement Policies.	
	Appendix C	Disclosure Statements. Instructions for use of the disclosure statements for health insurance policies sold to Medicare beneficiaries that duplicate Medicare.	
		The policy shall contain the name and full address of the issuing insurer or health organization on the front cover.	
		The signature of company officer(s) appears prominently on the policy (such as on the cover).	

COMMONWEALTH OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO FORM FILING CHECK LIST
SMALL GROUP MARKET

REGULATION	REQUIREMENTS	Reference /Page/ Paragraph
Circular Letter No. 2007-1775-AV of June 15, 2007	As a requirement, the below certification must be completed, signed and included with the filing.	

CERTIFICATION

I _____ have reviewed or supervised the preparation of the above form(s) and certify that the same comply with all of the applicable requirements of the Puerto Rico Forms Filing Check List and that the filing does not contain dispositions previously disapproved or required to be corrected by the Office of the Commissioner of Insurance of Puerto Rico. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of the transmittal letter and enclosures with this filing.

Signature: _____

Date: _____

Attachment 8

Carrier Name

Tabla de Copagos, Coaseguros y Deducibles	Cubierta Metálica Nombre del Plan	Cubierta Metálica Nombre del Plan	Cubierta Metálica Nombre del Plan
Deducible y Máximo de Bolsillo (MOOP)			
Deducible Anual para Beneficios Medicos			
-Individual			
-Familiar			
Deducible Anual para Medicamentos Recetados			
Especializados, Biotechnicos y Marca No Preferida			
-Individual			
-Familiar			
Deducible Anual para Medicamentos Recetados			
Generico, Bioequivalente o Marca Preferida			
-Individual			
-Familiar			
Gasto Maximo de Bolsillo (MOOP) para Beneficios Medicos			
-Individual			
-Familiar			
Gasto Maximo de Bolsillo (MOOP) para Medicamentos Recetados			
-Individual			
-Familiar			
Beneficios Esenciales de Salud			
Servicios de Emergencia			
-Accidente			
-Enfermedad			
Hospitalización			
-Parcial incluyendo Salud Mental			
-Completa con Pre-Autorización (incluyendo Salud Mental)			
-Completa sin Pre-Autorización (incluyendo Salud Mental)			
-Facilidad de Enfermeria Especializada (Skilled Nursing Facility)			
-Asistencia Quirurgica			
Servicios Ambulatorios			
-Generalista			
-Especialista			
-Sub-Especialista			
-Siquiatria			
-Sicólogo			
-Podiatria			
-Quiropráctico			
-Audiologo			
-Optómetra			
-Facilidad Ambulatoria			
-Procedimientos Diagnósticos y Quirúrgicos en Oficina Medica			
-Procedimientos Endoscopicos			
Servicios de Rehabilitación, Habilitación, y Equipo Medico Duradero			
-Terapia Fisica			
-Terapia Respiratoria			
-Cuidado de Salud en el Hogar			
-Equipo Médico Duradero			
-Manipulaciones de Quiropráctico			
Salud Mental			
-Terapia de Grupo			
-Visitas Colaterales			
Farmacia			
-Generico Bioequivalente			
-Marca Preferida			
-Marca No Preferida			
-Productos Especializados			
-Medicamentos Fuera del Recetario (OTC)			
Programa de Medicamentos Por Correo			
-Generico Bioequivalente			
-Marca Preferida			
-Marca No Preferida			
Servicios de Laboratorios y Rayos X			
-Laboratorio			
-Rayos X			
-PET Scan o PET CT (1 por año)			
Servicios Preventivos, Bienestar y Manejo de Enfermedades Crónicas			
-Servicios Preventivos (incluyendo las de mujer)			
-Inmunizaciones (Vacunas) Preventivas			
-Inmunización (Vacuna) para Virus Respiratorio Sincitial			
Servicios de Visión Pediátrica			
Visión Pediátrica (Lentes de Correción Visual o marcos (frames) para Lentes de Corrección Visual)			
Otros Servicios Cubiertos			
Examen de Refracción (adultos y niños)			
Ambulancia Aerea en Puerto Rico			
Servicios de emergencia en EU			
Servicios en los Estados Unidos de América de casos donde se requiera equipo, tratmiento y facilidades no disponibles en Puerto Rico			
Beneficio de Cirugía Bariátrica para el Tratamiento de Obesidad Mórbida			
Procedimiento de Cirugía Bariátrica			
Programas Inclido como Parte de sus Beneficios			
Nutricionista			
Cubierta Dental			
-Diagnostico y Preventivo			
-Mantenedores de Espacio			