

Health Insurance Rate Review Grant Program Cycle II Quarterly Report Template

October 30, 2013

Organization Information	
State	Arkansas
Project Title	Arkansas Health Insurance Rate Review Program Cycle II
Grant Project Director (Name and Title)	Lowell Nicholas Deputy Commissioner – Rate Review Director
Phone/Email	(501) 683-3638
Grant Authorizing Representative	(Same)
Phone/Email	(Same)

Grant Information	
Date Grant Awarded	September 20, 2011
Amount Granted	\$3,869,076.00
Project Year	2011-2014
Phase (Phase I or Phase II)	Phase II
Project Reporting Period (Example Quarter 1 10/1/2011-12/31/2011)	Quarter 4 (6/30/13-9/30/13)

The purpose of the Cycle II Quarterly Grant Reports are to:

- Provide the Rate Review Grant Program with a better understanding of the States' Department of Insurance Rate Review Program and the rate review initiatives funded through this grant program
- Provide the Rate Review Grant Program with Quarterly Rate Filing Data
- Provide the States participating in the Rate Review Grant Program with the opportunity to share information, highlight successes and reflect upon the progress of their programs

Health Insurance Rate Review Grant Program Cycle II Quarterly Report Template

Grant Performance Period-Cycle II: Date of award through September 30, 2014

Section 1003 of the Affordable Care Act requires the Secretary of the Department of Health and Human Services (HHS), in conjunction with the States, to establish a process for the annual review of health insurance premiums to protect consumers from unreasonable, unjustified and/or excessive rate increases. Section 2974 of the Public Health Service Act (PPACA Section 1003) provides for a program of grants that enable states to improve the health insurance rate review and reporting processes.

The goals of the Cycle II Rate Review Grant Program include:

- Establishing or enhancing a meaningful and comprehensive effective rate review program that is transparent to the public, enrollees, policyholders and to the Secretary, and under which rate filings are thoroughly evaluated and, to the extent permitted by applicable State law, approved or disapproved; as well as
- Developing an infrastructure to collect, analyze, and report to the Secretary critical information about rate review decisions and trends, including, to the extent permitted by applicable State law, the approval and disapproval of proposed rate increases.

States are required to submit quarterly progress reports to CCIIO's Rate Review Grant Program. The quarterly progress report describes significant advancements towards the State's goal of improving its current health insurance rate review and reporting process beginning from the time of approval through completion of the grant period.

Each quarterly report is due thirty days following the end of the Federal fiscal quarter. For example the first Cycle II quarterly report is due by January 31, 2012. All quarterly reports must be submitted electronically through the Health Insurance Oversight System (HIOS).

The following reporting guidelines are intended as a framework and can be modified when agreed upon by the CCIIO Rate Review Grant Program and the State. A complete quarterly progress report must detail how grants funds were utilized, describe program progress, barriers and provide an update on the measurable objectives of the grant program.

PART I: NARRATIVE REPORT FORMAT

Introduction:

The fourth quarter of Cycle II (2013) of the Arkansas HIRRD was a very productive period for the division. Many major accomplishments were achieved.

1. Receipt of Cycle III Grant Award *(Exhibit Four)*
2. Rate Review 'Memorandum of Understanding' *(Exhibit Seven)*
3. Rate Review Manual *(Exhibit Eight)*
4. Completed Phase IV of iRATE (Insurance Rate Analysis and Tracking Engine)

1. Receipt of Cycle III Grant Award

On September 23, 2013, the Arkansas HIRRD was awarded a Cycle III Rate Review grant in the amount of \$3,134,794. The grant consisted of Baseline (\$2,000,000), Performance (\$400,000), and Workload (\$734,794). The Cycle III Grant covers a two year period from 10.1.13 through 9.30.15.

Of the total Cycle III award, \$2,588,025 (83%) is allocated to contracting. The majority of Cycle III contracting is committed to the completion of iRATE (Insurance Rate Analysis Tracking Engine), and the design and implementation of 'All Payers Claims Database' (APCD) within the State of Arkansas.

Arkansas HIRRD's Cycle II and Cycle III overlap in Fiscal Year 2014. Cycle III only is applicable in Fiscal Year 2015. The prior grant history of the Arkansas HIRRD consists of the Cycle I award in the amount of \$1,000,000, and the Cycle II award of \$3,874,098.

2. Rate Review 'Memorandum of Understanding'

Because the implementation of the ACA and the health insurance exchange continued to evolve rapidly, the Arkansas HIRRD had to aggressively adapt and modify its activities in order to comply with its core mission. The appropriate interaction of the Arkansas HIRRD with the Arkansas Health Connector (exchange) and the other Arkansas Insurance Department (AID) divisions lacked clarity. This same knowledge gap seemed to be prevalent in many other states.

HIRRD began writing a Memorandum of Understanding (MOU) to clearly define the obligations of all parties within the Arkansas Insurance Department. After lengthy research and development, the HIRRD created a draft of the MOU and contracted with a national actuarial firm to review and finalize. The HIRRD MOU is well written and will be a very important document for use by the divisions within the Arkansas Insurance Department. The HIRRD MOU is ready for use by the department, by its very nature, in today's environment, cannot be considered "final." HIRRD considers it to be a living document and the HIRRD will edit for updates, modifications, and corrections every ninety days.

3. Rate Review Manual

Another outstanding HIRRD accomplishment was the creation of a Rate Review Manual for the Arkansas Insurance Department. This manual is both functional and comprehensive and will act as a tutorial on rate review in the State of Arkansas. The review of the 'draft' manual was also contracted to a national actuarial firm to review and finalize. Although the Rate Review Manual is ready for use by the department, by its very nature, in today's environment, cannot be considered "final." HIRRD considers it to be a living documents and the HIRRD will edit for updates, modifications, and corrections.

4. Completed Phase IV of iRATE (Insurance Rate Analysis and Tracking Engine)

The continued development of iRATE has created a phenomenal set of future benefits both to the State of Arkansas as well as other states and territories.

Overview

On September 23, 2013, the Arkansas Insurance Department announced premium rates for the 71 qualified health insurance plans that will be sold on the individual market in the new Health Insurance Marketplace. Rates and coverage will go into effect January 1, 2014. The four Qualified Health Plan issuers offering plans in Arkansas are:

- Arkansas Blue Cross and Blue Shield
- Blue Cross and Blue Shield, (Multi-State)
- QCA Health Plans, Inc. d/b/a QualChoice Health Insurance of Arkansas
- Celtic Insurance Company d/b/a Arkansas Health and Wellness Solutions

State Background

The Arkansas Insurance Department has primary regulatory authority over commercial health insurance carriers within the State of Arkansas. The Medicaid program in Arkansas (26% of Arkansans) is administered through the state's Department of Human Services (DHS). Self-insured employer health plans (25% of Arkansans) and Medicare (18% of Arkansans) are regulated by the federal government. Although AID does not regulate self-funded employer health plans in Arkansas, it does regulate the stop-loss (excess loss) policies. Individual, small group plans, and Health Maintenance Organizations (HMOs) are all regulated by AID.

In 2012, there were only three health insurers in Arkansas with more than a 5-percent share in the individual insurance market as well as in the small group market. Based on enrollment figures (number of covered lives, including dependents), the share of the largest insurer in the individual market was 78.8 percent, while the share of the largest insurer in the small group market was 56 percent.

The stated HHS goals of the Cycle II Rate Review Grant Program include:

- Establishing or enhancing a meaningful and comprehensive effective rate review program that is transparent to the public, enrollees, policyholders and to the Secretary, and under which rate filings are thoroughly evaluated and, to the extent permitted by applicable State law, approved or disapproved; as well as
- Developing an infrastructure to collect, analyze, and report to the Secretary critical information about rate review decisions and trends, including, to the extent permitted by applicable State law, the approval and disapproval of proposed rate increases.

The Arkansas HIRRD (Health Insurance Rate Review Division) has not only met these HHS goals but has exceeded them in nearly every category. Additionally, to create an optimal rate review program, the Arkansas HIRRD has also added the following goals and objectives to its strategic planning.

1. To enhance a meaningful and comprehensive effective rate review program that is accurate, timely, and transparent to the public, enrollees, policyholders and to the Secretary, and under which rate filings are thoroughly evaluated and, to the extent permitted by applicable State law, approved or disapproved;
2. To develop an infrastructure to effectively collect, analyze, and report to the Secretary and the Arkansas Exchange (Federal Facilitated Marketplace) critical data/information about rate review decisions and trends, including, to the extent permitted by applicable State law, the approval and disapproval of proposed rate increases.

Since 2010, the HIRRD has been able to establish and continually improve a meaningful and comprehensive effective rate review program that is transparent to the public, enrollees, policyholders and to the Secretary, and under which rate filings are thoroughly evaluated and, to the extent permitted by applicable State law, approved or disapproved;

This goal was met on July 1, 2011. On that date, Steve Larsen, CCIIO Director, officially notified Commissioner Jay Bradford that the Arkansas Department of Insurance (AID) had met the applicable criteria and had been designated an 'Effective Rate Review Program' in all markets. That official CCIIO designation has been successfully maintained through the second quarter of 2013 by constant vigilance and compliance to the applicable ACA rules and regulations. HIRRD has reached effective transparency by:

- a) Complete renovation and updates of the HIRRD web site which is now readily available to the consumer in a user-friendly format.
- b) Actively utilizing the website and public meetings to inform the public about the AID rate review process and all pending and historical rate review requests

HIRRD has planned and implemented an aggressive and innovative effort to improve the infrastructure and accuracy of the AID rate review process. These include, but are not limited to HIRRD's:

- a. Application and subsequent award of Cycle III funding in the amount of \$3,164,794 to ensure long term advancement of our effective rate review process.
- b. Continued development & implementation of iRATE (Insurance Rate Analysis Tracking Engine).
- c. Design and implementation of an Arkansas APCD (All Payers Claims Database)
- d. Production of a professional evaluation of the AID rate review process with comprehensive recommendations which will substantially upgrade the AID process.
- e. Production of an up to date and innovative and comprehensive department training manual, checklists, and job aids for use by AID personnel.
- f. Initiation and funding of numerous and significant actuarial services that could not be funded through the AID operating budget.
- g. Implementation of extensive onsite SERFF training of AID personnel.

Other proposed (or continued) rate review enhancements:

- Expand legal authority for health rate review and approval or disapproval;
- Expand analysis expertise for health rate reviews;
- Enhance technology and programmatic infrastructure to effectively collect, analyze, and report health insurance rate filings and outcomes to diverse stakeholders including the general public, health care insurers, health care providers, and policymakers including state legislators and the Department of Health and Human Services (DHHS) Secretary;
- Create a health insurance education, outreach, and training unit dedicated to information dissemination about health insurance rate approval processes and rate trends to diverse stakeholders including the general public and special consumer populations, policymakers, health insurers, health care providers, and the business community.
- Create a "state of the art" AID internal database which will collect, process, and produce optimal analytics of healthcare data, meeting or exceeding all applicable requirements contained within the ACA augmented by the proposed APCD.

HIRRD goals continue to be to streamline, automate, simplify, and expedite the AID rate review process while providing accuracy, transparency, and "plain language" for the Arkansas consumer. These improvements would facilitate optimal delivery time and accuracy of critical information to the

AID Commissioner. One of the most important goals would be to continue to improve training for current and future AID Life & Health ‘rate review’ employees.

Program Implementation Status:

1. Quarterly Accomplishments to Date:

- **iRATE (Insurance Rate Analysis and Tracking Engine).** The continued development of iRATE has created a phenomenal set of current and future benefits both to the State of Arkansas as well as other states and territories.

To review, iRATE (Insurance Rate Analysis and Tracking Engine) was conceptually created by the Arkansas HIRRD in 2011. The development of iRATE was funded by Cycle II Rate Review grant funds and is therefore available, at no cost, for use by all states and territories. The Arkansas HIRRD produced an iRATE webinar on June 24, 2013 to demonstrate the use and capabilities of iRATE accompanied with a comprehensive user manual. Twenty five states and territories were registered for the webinar and fifteen states and territories have indicated their intent to utilize this “ground breaking” automated SERFF Data Extraction/Retrieval and analytics application. iRATE automates and streamlines the rate filing review process, making it easier and faster to provide an effective rate review. iRATE is a web-based tool that presents data from SERFF (System for Electronic Rate and Form Filing) in a simpler way that is easy to understand. iRATE ensures that the most important data needed to complete an accurate rate review is easily accessible at all times.

In addition, iRATE includes a robust reporting system that helps insurance departments better track reviews and file them for future use. These capabilities and many others make iRATE the best application for performing a fast, effective and accurate rate review. iRATE was released for initial distribution on June 1, 2013.

Further significant development of iRATE is underway. Automated transparency, Plan Management, and the Medical Loss Ratio (MLR) will be incorporated on or before January 1, 2014.

- HIRRD website upgrade has reached 95% of planned enhancements
- Research and development of an All Payers Claims Database (APCD)
- Continued development of detailed rate review manuals, job aids, and checklists.
- Comprehensive on-site training programs for HIRRD and the Life & Health Division regarding:
 - Rate Review Training & Rate Review reporting requirements
 - SERFF
 - HIOS
 - iRATE - Unified Rate Review Template, Medical loss ratio
 - Arkansas healthcare costs and marketplace
 - CMS/CCIIO rules & regulations
 - Health insurance market rules
- Revision of all department manuals to incorporate current ACA rules and regulations
- HIRRD contracted for the creation of a simplified Medical Loss Ratio (MLR) “tracker” which will enable AID to have ‘real time’ measurement (desk top audit) for this important ratio without the complexity or expense of a full blown audit.
- Production of an Arkansas health insurance “cost and market place study”

- Funded and initiated substantial actuarial services that could not be funded through the AID Life & Health operating budget.
 - Engaged Lewis & Ellis Actuaries and Consultants, Inc. (L&E) to review AID's first two small group rate filings. AID had never reviewed a small group rate filing before and needed the review of filings for compliance with AID Bulletin 7-2011.
 - Engaged L&E to create a 'Summary Worksheet' as well as a one-page "short form" actuarial checklist for all future rate requests.
 - Engaged L&E to review existing AID bulletin on 'Small Group' Rate Filings and made necessary changes to the bulletin so that the Department's review would meet all requirements of an 'Effective Rate Review Program'.
 - Engaged L&E to review the two individual rate filings that covered the largest number of individuals. The review helped the Department in reducing the amount to the increases. These filings were the Blue Cross open block of business and the Blue Cross closed block of business.
 - Engaged INS Consultants, Inc. to review L&H's form filing procedures and make recommendations to our procedures so that the Department will be better positioned for implementation of the Affordable Care Act.
 - Engaged INS to produce a comprehensive training manual that will be used to train our staff for future form filing reviews.
 - Engaged L&E to review first ACA filing product which will be sold off the exchange on or after October 1, 2013 for effective date of January 1, 2014
 - Engaged L&E to review rate review manual and memorandum of understanding.

2. Quarterly Progress as, or toward, an Effective Rate Review Program:

- The Department issued Bulletin 9-2013. The purpose of this bulletin was to bring the Department and more specifically its rate review processes into compliance with the revised federal rule, 45 CFR §154.215.
- This revised bulletin added new requirements for state to maintain their "Effective Rate Review Program" status. The bulletin requires carriers to file the Rate Review Justifications with its rate filings. In addition, the bulletin added the new rate filing requirements as set forth in the revised Rule.
- HIRRD contracted with an outside actuary to revise our rate review manual and the checklist used by our analysts.
- AID has maintained its 2011 HHS designation of 'Effective Rate Review Program' in all markets through the present quarter.

3. Challenges and Responses faced this year:

- The greatest challenge has been to meet the continuing ACA mandates and regulations evolving monthly over the last year while simultaneously conducting an efficient rate review process within the State of Arkansas.
- All proposed grant activities were either completed or are ahead of schedule.

4. Describe any required variations from the original Rate Review Work Plan and companion timeline.

NONE

Significant Activities: Undertaken and Planned

Three major HIRRD projects will continue to have the greatest impact on comprehensive rate review for the State of Arkansas:

1. All Payers Claims Database (APCD)
2. iRATE (Insurance Rate Analysis and Tracking Engine)
3. Renovated HIRRD Website

1. All Payers Claims Database (APCD)

Funding for an APCD was approved in the Cycle III funding. The grant funded the Arkansas APCD for FY14 in the amount of \$1,199,038 and \$500,000 in FY15 for a total two year funding of \$1,699,038. HIRRD will measure its progress by completing the following key indicators:

- a) Solicit input and advice from applicable Arkansas stakeholders
- b) Define the purpose and mission of an Arkansas APCD
- c) Identify qualified APCD Vendors
- d) Develop and adopt a realistic governance model that aligns with state and stakeholder goals, capitalizes on available resources, and mitigates actual or apparent conflicts of interest.
- e) Prepare and submit a RFI (Request for Interest) to the qualified Vendors
- f) Determine:
 - Purposes of gathering data?
 - Who will be required to report data?
 - What data are required to be reported?
 - How will the data be submitted and processed?
 - When will the data be required to be submitted?
 - Who will house and analyze the data?
 - Who will have authority to access the data?
 - The technology infrastructure to be utilized
- g) Prepare and submit a RFP (Request for Proposal) to all qualified vendors
- h) Assemble a competent team to evaluate the vendor proposals on a timely basis
- i) Write and issue final regulations.

2. iRATE (Insurance Rate Analysis and Tracking Engine)

With Phase I, II, and III completed, Phase IV of iRATE development has recently begun. This phase will include modifications to enhance transparency between the AID and consumers in the state of Arkansas. Currently, the AID hosts a website to provide consumers with easy to understand information about the reasons for significant rate increases and post justification for the increase. By doing this, the AID expects to bring greater transparency, accountability and help moderate premium increases. Phase IV will integrate information from previous phases into this website to provide even more automated information to the consumer.

Phase IV will include information from the Rating Table Template, Rating Rules Template, Service Area Template, Business Rules Template, and Rates Template. Additionally, this phase will begin the research and analysis of Plan Management for future incorporation into iRATE. The Plan Management feature promises to be a significant addition to the application and the necessary research will begin during this phase.

3. Renovated HIRRD Website

Improvements and additions continue to be made to the website. In an effort to continue providing consumers with basic and helpful information regarding rate review and health insurance costs, the following features which were incorporated into the existing website last quarter continue to be updated.

- Video: The video explains in basic terms how the review process works and how the average premium dollar is spent in Arkansas.
- E-Alerts Sign up: Consumers who register for the updates will receive notifications when a carrier files a request. The registration information will be available on all pages of our site.
- Easy to view rate charts: A web page that contains easy to read charts and a database for current rates being reviewed and recent rates that have been approved or disapproved continues to be updated. For now, staff will manually extract data from the new AFMC developed application and insert the rate data into the charts and meetings were held this quarter to begin the process of automating the insertion of data. In this section of the site, consumers will also be allowed to submit comments. Users submitting comments will complete a form with their first/last name, city/state, and email address. Submitted comments will be saved to the website database and staff can review and post the comments.
- Content Management System (CMS): This feature allows staff to edit content, upload documents and photos, and add links to video files or embed YouTube videos on any page of the website at any time. This quarter, training took place on utilization of the CMS. The goal remains to fortify our online presence and provide consumers with important and useful information.

Operational/Policy Developments/Issues

On February 27, 2013, 78 FR 13436 (Final Rule) implemented the Market Rating Reforms to ensure that individuals and employers will have access to health insurance coverage and greater premium stability. The Market Reforms included are:

- ❖ Fair Health Insurance Premiums;
- ❖ Guaranteed Availability;
- ❖ Guaranteed Renewability;
- ❖ Single Risk Pool.

These Market Reforms apply to non-grandfathered coverage after January 1, 2014. All reforms apply to the Individual and Small Group markets. The guaranteed availability and renewability of coverage applies to the large group market as well. This manual primarily applies to non-grandfathered business. Please see Appendices H, I, and J of new manual for specific guidelines and procedures regarding grandfathered plans. The Arkansas Department of Insurance (AID) issued Bulletin 9-2013 on March 29, 2013 to inform health insurance issuers of the new rate filing procedures adopted to comply with 45 C.F.R. Part 154 and additional reporting requirements that must be met when submitting rate filings to AID for all non-grandfathered plans.

AID required this additional information in accordance with the Commissioner's authority under §23- 79-109 through 110 (amended by Act 1187 of 2013 and Act 1339 of 2013), §23-76-112 and §23-75-111.

AID will use the additional reporting requirements required under the bulletins listed above as well as Bulletin 3B-2013 to evaluate the proposed rate increases of products to make a determination as to whether the increases:

- Comply with the standards set forth in §23-79-109 through 110 (amended by Act 1187 of 2013 and Act 1339 of 2013), §23-76-112 and §23-75-111; and/or

- Are unreasonable pursuant to 45 CFR 154

Pursuant to §23-79-110, in the Individual Market, the AID shall disapprove a premium rate filed if the commissioner finds that the rate is not actuarially sound, is excessive, is inadequate, or is unfairly discriminatory¹. It may also be disapproved if it is not compliant with applicable federal laws or all state laws, regulations, and bulletins.

For all Individual and Small Group filings, a rate filing will be classified into one of the following rate disposition categories², after a statutory rate determination, if applicable:

- **Unreasonable Rate Increase:** the rate increase was determined to be unreasonable.
- **Unreasonable Rate Increase (Modified):** the health insurance issuer modified its proposed rate increase during the review process and the modified rate was still determined to be unreasonable.
- **Unreasonable Rate Increase (Disapproved by State):** the individual market rate increase was disapproved, subject to the requirements of §23-79-109 through 110.
- **Not Unreasonable:** the rate increase was determined not to be unreasonable. For the individual market, the rate increase was approved, subject to the requirements of §23-79-109 through 110.
- **Not Unreasonable (Modified):** the health insurance issuer modified its proposed rate increase during the review process and the modified rate increase was determined to not be unreasonable. For the individual market, the rate increase was approved after modification, subject to the requirements of §23-79-109 through 110.
- **Withdrawn Prior to Determination:** the health insurance issuer elected to withdraw the rate increase prior to the completion of the State's review.

¹ §23-79-110 amended by Act 1187 of 2013(2)(b)(2) (<http://www.arkleg.state.ar.us/assembly/2013/2013R/Bills/SB1071.pdf>)

² Rate Review Instruction Manual (http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf)

Arkansas Legislative Activity.

The Arkansas General Assembly convened on January 14, 2013. During the quarter several bills passed that would affect the rate review process. Below is a brief description of each Act.

- **Act 1187 of 2013.** The Act expands the authority of the Insurance Commissioner over the approval of rates for individual health insurance products. Under prior law the Commissioner could only disapprove rates if the rates were unreasonable to the premium charged. Under Act 1187, the Commissioner may disapprove rates if they are not actuarial sound, excessive, inadequate or unfairly discriminatory. One new factor that the commissioner may take into consideration is the profit generated by the new rate. The Commissioner may disapprove a rate if it is likely to produce a profit that is unreasonably high. In addition the law requires the Commissioner to release to the carrier all of the information used in the rate review process if the rate is disapproved. Under prior law, the Commissioner was not required to release any information. The release will include any documents created by outside actuaries during the rate review process. The HIRRD is currently working on processes and procedures to bring the Department into compliance with this new law.
- **Act 1339 of 2013.** This Act allows the Commissioner to take into consideration the surplus of any non-profit health insurance company when determining if a rate is excessive.

- **Act 1500 of 2013.** This Act creates a state based exchange for Arkansas by July of 2015. Currently Arkansas is a partnership exchange. During the transition process, HIRRD will work closely with the new Arkansas Health Insurance Marketplace Board and its staff in planning for and implementing this new law.
- **Act 1143 of 2013** This Act allows for the Medicaid expansion pursuant to the Affordable Care Act. New Medicaid enrollees would be enrolled in Silver plans in the Exchange and not in a separate Medicaid product. Medicaid would pay the premiums using federal funds. Putting Medicaid recipients into the exchange may impact rates for these plans. This Act complicates the rate review process since this new block of business could greatly impact rates. The Department has no experience in rating Medicaid recipients. Also, some benefits must be altered to meet Medicaid requirements. The HIRRD has been working with the State's Medicaid office on the waiver need to implement this new law.
- ❖ HIRRD continues to utilize outside actuarial services in the rate review process. As an example, expert actuary staff members are being used to train AID staff members on incorporating the Unified Rate Review Template (URRT) into the AID rate review process. Additionally, HIRRD is using the same resources to incorporate the URRT into iRATE.
- ❖ AID has target dates for all rate filings and approval dates. Within the Arkansas Insurance Department, the Life and Health Division, the Exchange Planning Division and the Health Insurance Rate Review Division have had lengthy discussions on the actions each Division must undertake to meet these deadlines.

Public Access Activities

This quarter, focus has remained on the development of the website. The goals are to increase public awareness regarding the rate review program, offer a way for consumers to comment on proposed rates and educate consumers about health care costs. Updates were made this quarter and installation has started on automating the process of uploading data to the rate tables from iRATE. Additionally, content continued to be updated and included during this quarter. The distribution of educational materials such as the FAQ (frequently asked question) brochure continued this quarter at various outreach events.

Collaborative efforts

HIRRD collaborative efforts were intense and successful during the fourth quarter. Collaborative categories were iRATE (Insurance Rate Analysis and Tracking Engine), All Payers Claims Database (APCD), HIRRD Website, state legislation and bulletins, staff training, comprehensive upgrades to rate review manuals and checklists, and satisfactory interface with the Arkansas Health Connector (Exchange).

The collaborative partners for these categories were CMS, CCIIO, SERFF, Arkansas Foundation of Medical Care (AFMC), Life & Health Division of AID, Arkansas Center for Health Improvement (ACHI), L&E Actuaries, APCD Council, and multiple state RR directors.

iRATE was released for initial distribution to all states and territories on June 1, 2013. The Arkansas HIRRD produced an iRATE webinar on June 24, 2013 to demonstrate the use and capabilities of iRATE. A comprehensive iRATE user manual was provided for all webinar attendees. Twenty five states and territories were registered for the webinar and fifteen states and territories have indicated their intent to utilize this "ground breaking" automated SERFF Data Extraction/Retrieval and analytics application.

HIRRD shares adjoining rental space with the Exchange Planning Division (EPD) within the Arkansas Insurance Department (AID). HIRRD has worked closely with the EPD on all matters involving rate review. The two divisions are currently discussing the systems that will be used to transfer rate review information to the Federally Facilitated Exchange for Arkansas. Though the rate review information will be generated by HIRRD, it will be transferred to the FFE by EPD. HIRRD makes its Rate Review Media Center available to EPD, as needed, for meetings and webinars.

Lessons Learned

The ACA deadline of October 1st to begin enrollment placed a great deal of pressure on the HIRRD staff. The HIRRD has learned to maintain maximum flexibility in order to comply.

There continues to be an enormous lack of information in the state related to knowledge in both rate review and general health insurance. Opportunities to impact issues on a positive basis, in both categories by using the HIRRD resources wisely, continue to exist. HIRRD will endeavor to educate, inform, and involve critical constituent groups such as state leaders, legislators, and active affinity stakeholder groups. HIRRD will use the Media Center to its fullest capacity to accomplish these tasks.

Updated Budget

HIRRD is well within its operating budget and projected budget for Cycle II. All budgets have been prepared and reviewed by an outside accounting firm specializing in health care finance.

RATE REVIEW GRANT BUDGET TWENTY ONE MONTHS ACTUAL (SEPTEMBER 2013) CYCLE II
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Category	Spent/ Projected	Budgeted	Variance
Salary	386,822	392,869	6,047
Fringe Benefits	116,751	98,217	(18,534)
Profess. Services/Contracts	1,008,507	1,048,015	39,508
Supplies / Office Expenses	119,413	105,804	(13,609)
Travel	15,938	45,468	29,530
Rental	48,533	72,000	23,467
Capital	16,402	56,725	40,323
Other	--	55,000	55,000
Total	1,712,367	1,874,098	161,731

Updated Rate Review Work Plan and Timeline

HIRRD is on schedule for all segments of the original Rate Review Work Plan and Timeline (See Exhibit One).

Data Collection and Analysis

During the quarter, the Department received 36 new filings. Eighteen of these were for new products to be sold on and off the exchange. Of which three plans submitted rates that were not approved for the Health Insurance Marketplace. All of these products were sent to our outside actuary for a review process.

Individual : 6 plans to be offered

Small Group : 10 plans to be offered

Large Group : 2 plans to be offered

There were a total of eight submissions that had the final disposition processed in this quarter and approved.

1. QUAC-129160688 - Small Grp- PPO Standard – Increase - QLH Grandfathered – Requested 7.7% increase – Negotiated down to 7.1%. 499 policyholders & 887 covered lives.
2. QUAC-129160524 - Small Grp – HMO – Increase - Grandfathered Requested 7.7% increase – Approved. 7,110 policyholders & 11,410 covered lives.
3. QUAC-129072986 - Point-of-Service (POS) – Non-Grandfathered - Requested 17.3% increase – Approved. 3,980 policyholders & 6,934 covered lives. * Increases over 10% must be reported to the Feds. The increase must be justified by a submitting company's actuary and reviewed and approved by AID.
4. HUMA-129103289 - Individual - Preferred Provider (PPO) – Non-Grandfathered - Requested 131.4 Increase – Approved. 504 policyholders & 902 covered lives. * Increases over 10% must be reported to the Feds. The increase must be justified by a submitting company's actuary and reviewed and approved by AID.
5. HLAD-129177380 - Small Grp – Other – Non-Grandfathered – Requested 8% Neutral – Approved. 9,875 policyholders & 16,829 covered lives.
6. ARBB-129179371- Small Grp – PPO - Non-Grandfathered – Requested 8% Increase – Approved. 17,133 policyholders & 30,011 covered lives.
7. AMLC-129152143 – Ind. Hospital/Surgical/Medical Expense – Requested 5% increase. Approved. 42 policy holders and 51 covered lives – Should not have been reported to HHS. Sending e-mail to SERFF asking for assistance in correcting the filing showing that it should not have been reported to HHS.
8. AMLC-129113302 – Ind. Hospital/Surgical/Medical Expense - Requested 5% increase. Approved. 68 policy holders and 89 covered lives Should not have been reported to HHS. Sending e-mail to SERFF asking for assistance in correcting the filing showing that it should not have been reported to HHS.

One challenge the Department faced this past year were the requests that are submitted for very small block of business. In most cases we allowed the carrier to use national numbers to justify a rate increase. Arkansas does require all rate filings to be submitted through SERFF. However, without a database with a reporting capability previously, it was difficult to identify discrepancies in those filings. Our new (I-Rate) database has allowed us to better identify these discrepancies.

Updated Evaluation Plan

In the original evaluation plan described in the Cycle II Rate Review Grant application, measurable objectives, key indicators, and methods to monitor progress were outlined. The applicable updates to those components are described below, beginning with some notable accomplishments.

Overview of HIRRD Accomplishments (2011-13)

- Contracted for comprehensive review and assessment of AID Rate Review by AON Hewitt
- Full adoption of all-inclusive recommendations from AON Hewitt review and assessment
- Direct and major support of AID Life & Health Division in Rate Review analysis
- Awarded and maintained an “Effective Rate Review Program” in all markets
- Created enhanced Rate Review System Evaluation
- Creation and implementation of the ‘Rate Review Media Center’
- Creation and launch of new HIRRD website within the AID website
- Hosted Little Rock National Rate Review Meeting
- Created National Rate Review Communications Platform (RR Listserv)
- Implemented user-friendly education platform for Arkansas Consumers
- Created a formal onsite ‘Rate Review’ training program
- Production of a health insurance “cost and market place study”
- Implementation of a major contract to produce iRATE, a “revolutionary” “Automated SERFF Data Extraction, Retrieval & Analytic Application.”
- Created a comprehensive Rate Review Manual for use by all divisions of the Arkansas Insurance Department (AID).
- Created a detailed ‘Memorandum of Understanding’ for use by all divisions of (AID), especially guidance on interaction between HIRRD and the Arkansas Health Connector.

Progress on meeting HHS Grant Goals

HIRRD has planned and implemented an aggressive and innovative effort to improve the infrastructure and accuracy of the AID rate review process, including but not limited to:

- Initiated a ground-breaking and pioneering contract to automate and analyze the healthcare data extracted from SERFF and applicable federal databases.
- The automatic retrieval and analysis will be used by HIRRD and the AID Life & Health Division (L&H) in compliance and rate review of healthcare information. This has the potential to revolutionize the entire AID rate review process.
- Scheduled and funded extensive onsite SERFF Training of L&H rate review personnel.
- Produced a professional evaluation of the L&H rate review process with recommendations which will substantially upgrade the L&H process.
- Produced an innovative and comprehensive department training manual, checklists, and job aids for use by L&H personnel.

Funded numerous and significant actuarial services that were not fundable through the L&H/AID operating budget.

- a. Engaged Lewis & Ellis (L&E) to review AID’s first two small group rate filings. AID had never reviewed a small group rate filing before and needed the review of filings for compliance with AID Bulletin 7-2011.
- b. Engaged L&E to create a ‘Summary Worksheet’ as well as a one-page “short form” actuarial checklist for all future rate requests.
- c. Engaged L&E to review existing AID bulletin on ‘Small Group’ Rate Filings and made necessary changes to the bulletin so that the Department’s review would meet all requirements of an ‘Effective Rate Review Program’.

- d. Engaged L&E to review the two individual rate filings that covered the largest number of individuals. The review helped the Department in reducing the amount to the increases. These filings were the Blue Cross open block of business and the Blue Cross closed block of business.
- e. Engaged INS to review L&H's form filing procedures and make recommendations to our procedures so that the Department will be better positioned for implementation of the Affordable Care Act.
- f. Engaged INS to produce a comprehensive training manual that will be used to train our staff for future form filing reviews.

HIRRD's continued evaluation shall include, but not be limited to, formal weekly staff meetings in which key indicators, identified in the grant application work plan are discussed and assessed. Each HIRRD staff member has specific areas of responsibilities and will be held accountable for appropriate progress. HIRRD will follow the same successful methodology that it utilized during its Cycle II activities.

Additionally, the HIRRD staff will continue to engage Commissioner Bradford, and the Exchange Planning Director on coordination and planning for Exchange Operations, especially the state responsibilities of AID Rate Review as specified in the ACA.

Finally, the AID HIRRD will meet or exceed all of the CFDA 93.511 "Evaluation" criteria. Additionally, the expertise of competent and credible professional third parties will be fully utilized in the evaluation. HIRRD will fully implement and monitor the very specific assessments, recommendations, and timelines contained in the excellent and comprehensive AON Hewitt reports.

Quarterly Report Summary Statistics:

Please provide the data as available below include activities new this quarter and occurring to date with Rate Review Grant Funds:

- Total Funds Expended to date: **(Cycle II \$1,712,367)**
- Total Staff Hired (new this quarter and hired to date with grant funds): **(0/5)**
- Total Contracts in Place (new this quarter and established to date): **(0/9)**
- Introduced Legislation: **(Yes)**
- Enhanced IT for Rate Review: **(Yes)**
- Submitted Rate Filing Data to HHS: **(Yes)**
- Enhanced Consumer Protections: **(Yes)**
- Consumer-Friendly Website: **(Yes)**
- Rate Filings on Website: **(Yes)**

EXHIBITS

Exhibit 1 - Timeline

Exhibit 2 – Operating Budget

Exhibit 3 – SF-425

Exhibit 4 - Notice of Cycle III Grant Award

Exhibit 5 - PART II: HEALTH INSURANCE RATE DATA COLLECTIONS

Exhibit 6 - Cycle 2 Period Q4 (06/30/2013-9/30/13)

Exhibit 7 – Rate Review Memorandum of Understanding

Exhibit 8- Rate Review Manual

EXHIBIT 1

Timeline

09.23.13	Received Notice of Award for Phase III - Grants to States to Support Health Insurance Rate Review and Increase Transparency in Healthcare Pricing, Cycle III) \$3,134,794.00
09.23.13	Premiums and other details of the private plans that will be offered on Arkansas' Health Insurance Marketplace announced by the AID Commissioner
09.23-27.13	In Person Assister Guide "Phase I Training"
09.06.13	AFMC meeting to discuss next phase IV of I-Rate
08.26.13	APCD Council Meeting
08.01.13	AFMC meeting to discuss next phase IV of I-Rate
07.18.13	APCD Presentation presented by ACHI to both AR Health Connector and HIRR Divisions. The Arkansas Insurance Department (AID) engaged ACHI to study the composition of claims databases such as all-payer claims databases (APCDs)
07.11.13	Presentation AR Health Connector/ Health Insurance Marketplace "Speakers Bureau"
07.09.13	Phase III - Grants to States to Support Health Insurance Rate Review and Increase Transparency in Healthcare Pricing, Cycle III) Submitted.
07.09.13	Cycle III Grant application submitted. (Grants to States to Support Health Insurance Rate Review and Increase Transparency in Healthcare Pricing, Cycle III) .
06.30.13	Deadline for rate and form submission. July 31 st final deadline for all CMS/CCIIO/HIOS submissions.
06.24.13	HIRRD produced national webinar for iRATE (Insurance Rate Analysis & Tracking Engine).
06.20.13	iRATE webinar invitation pre-packet sent out contents (operating manual, screen shots, power point items) as an e-email attachment.
06.03.13	Letter of Intent to Apply for Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing Cycle III – Submitted.
06.01.13	All states and territories notified that the iRATE (Insurance Rate Analysis & Tracking Engine) has been released for distribution.

05.08.13 New (FOA) Funding Opportunity Announcement for Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing”, Cycle III of the Rate Review Grant Program.

05.03.13 iRATE demo ready: afmc.org/I-Rate from AFMC.

04.30.13 iRATE presented to ‘Plan Management’ meeting in Reston, VA.

04.09.13 iRATE presented to Plan Management’ seminar at the NAIC meeting in Houston, TX

03.25.13 HIRRD was placed on the agenda of the ‘Plan Management’ seminar at the NAIC meeting in Houston, TX April 9, to present I-Rate (URRT).

03.15.13 Phase I of the I-Rate development was formally completed. HIRRD and AFMC finalized an I-Rate video which was distributed to other Rate Review Grantee states.

03.13.13 Arkansas State Agency Leaders Meeting.

03.12.13 Sandra McGrew presented two Rate Review Webinar sessions to AID

03.12.13 Health Insurance Exchange – SERFF Plan Management Training

03.11.13 Final day to file Legislation / shell bills. AID did not file any bills this session.

03.07.13 Dave Dillon of L&E Actuaries conducted a two day training seminar on the URRT at AID

02.07.13 Phase 1 I-Rate project closeout

02.01.13 AFMC media center presentation with demo/discussion about AID application of I-RATE

01.28.13 Launch of the “New” HIRRD web site

01.09.13 Presented Aristotle web design for review

01.07.13 Purchased domain name: www.arhealthpremiums.gov.

01.03.13 Final AFMC Rate Review application demo and reporting discussion

12.18.12 Budget reallocation received and accepted by CCIIO

12.11.12 4th quarter report call with CCIIO Rate Review staff

12.10.12 Commissioner Bradford’s AID meeting to discuss legislation

12.6.12 AFMC Rate Review Application Demo and Reporting Discussion

EXHIBIT 2
RATE REVIEW GRANT
TWENTY ONE MONTHS ACTUAL (SEPTEMBER 2013) CYCLE II

Category	Spent/Projected	Budgeted	Variance
Salary	386,822	392,869	6,047
Fringe Benefits	116,751	98,217	(18,534)
Professional Services/Contracts	1,008,507	1,048,015	39,508
Supplies and Other Office Expenses	119,413	105,804	(13,609)
Travel	15,938	45,468	29,530
Rental	48,533	72,000	23,467
Capital	16,402	56,725	40,323
Other	-	55,000	55,000
Total	1,712,367	1,874,098	161,731

ACTUAL										Dec 2011 to Dec 2013	Budgeted Amount	Remaining Balance
	January-13	February-13	March-13	April-13	May-13	June-13	July-13	August-13	September-13			
Monthly Totals	226,724	164,092	301,695	52,443	49,364	83,038	138,876	35,824	35,941	1,712,367	1,874,098	161,731
Regular Salary	20,152	20,152	20,152	20,152	32,381	33,396	23,484	24,322	24,322	386,822	392,869	6,047
Total Fringe Benefits	6,488	6,478	6,361	6,466	9,035	9,258	7,493	7,403	7,403	116,751	98,217	(18,534)
Total	179,061	133,424	266,687	17,815	2,663	3,485	102,328	1,074	1,090	1,008,507	1,048,015	39,508
Total Office Supplies and Other	17,993	1,009	3,173	1,081	2,289	36,699	1,432	1,236	1,925	119,413	105,804	29,039
Total Travel	-	-	2,293	3,899	1,541	199	1,118	279	-	15,938	45,468	29,530
Total Rental	3,031	3,031	3,031	3,031	1,456	-	3,021	1,511	1,201	48,533	72,000	23,467
Capital			-					-	-	16,402	56,725	40,323
Total Other										-	55,000	55,000

FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted DHHS-CC110		2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment) 6PRPPR120006-01-01		Page 1	of 1 pages																								
3. Recipient Organization (Name and complete address including Zip code) ARKANSAS INSURANCE DEPARTMENT 1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201																													
4a. DUNS Number 810501558	4b. EIN 71-0847443	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Final	7. Basis of Accounting <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual																									
8. Project/Grant Period From: (Month, Day, Year) 10/01/2011			To: (Month, Day, Year) 09/30/2014																										
9. Reporting Period End Date (Month, Day, Year) 09/30/2013																													
10. Transactions																													
Cumulative																													
(Use lines a-c for single or multiple grant reporting)																													
Federal Cash (To report multiple grants, also use FFR Attachment):																													
a. Cash Receipts					1,706,972.13																								
b. Cash Disbursements					1,685,003.87																								
c. Cash on Hand (line a minus b)					21,968.26																								
(Use lines d-o for single grant reporting)																													
Federal Expenditures and Unobligated Balance:																													
d. Total Federal funds authorized					3,874,098.00																								
e. Federal share of expenditures					1,685,003.87																								
f. Federal share of unliquidated obligations																													
g. Total Federal share (sum of lines e and f)					1,685,003.87																								
h. Unobligated balance of Federal funds (line d minus g)					2,189,094.13																								
Recipient Share:																													
i. Total recipient share required																													
j. Recipient share of expenditures																													
k. Remaining recipient share to be provided (line i minus j)					0.00																								
Program Income:																													
l. Total Federal program income earned																													
m. Program income expended in accordance with the deduction alternative																													
n. Program income expended in accordance with the addition alternative																													
o. Unexpended program income (line l minus line m or line n)					0.00																								
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%;">11. Indirect Expense</th> <th style="width:10%;">a. Type</th> <th style="width:10%;">b. Rate</th> <th style="width:10%;">c. Period From</th> <th style="width:10%;">Period To</th> <th style="width:10%;">d. Base</th> <th style="width:10%;">e. Amount Charged</th> <th style="width:10%;">f. Federal Share</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="8" style="text-align: right;">g. Totals:</td> </tr> </table>						11. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share									g. Totals:							
11. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share																						
g. Totals:																													
12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:																													
13. Certification: By signing this report, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)																													
a. Typed or Printed Name and Title of Authorized Certifying Official Jay Bradford State Insurance Commissioner				c. Telephone (Area code, number and extension) 501-371-2621																									
b. Signature of Authorized Certifying Official 				d. Email address jay.bradford@arkansas.gov																									
e. Date Report Submitted (Month, Day, Year) 10/21/13				14. Agency use only:																									

Standard Form 425
 OMB Approval Number: 0348-0061
 Expiration Date: 10/31/2011

Paperwork Burden Statement
 According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is 0348-0061. Public reporting burden for this collection of information is estimated to average 1.5 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0060), Washington, DC 20503.

EXHIBIT FOUR

Notice of Cycle III Grant Award

1. DATE ISSUED MM/DD/YYYY 09/23/2013	2. CFDA NO. 93.511	3. ASSISTANCE TYPE Project Grant
1a. SUPERSEDES AWARD NOTICE dated except that any additions or restrictions previously imposed remain in effect unless specifically rescinded		
4. GRANT NO. 1 PRPPR140042-01-00 Formerly	5. ACTION TYPE New	
6. PROJECT PERIOD From MM/DD/YYYY 10/01/2013	Through MM/DD/YYYY 09/30/2015	
7. BUDGET PERIOD From MM/DD/YYYY 10/01/2013	Through MM/DD/YYYY 09/30/2015	

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
7500 Security Boulevard
Baltimore, MD 21244-1850

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)
Section 2794 of the Public Health Service Act (Section 1003 of the
Affordable Care Act)

8. TITLE OF PROJECT (OR PROGRAM) Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care	
9a. GRANTEE NAME AND ADDRESS Arkansas Insurance Department 1200 W 3rd St Administration-DUP Little Rock, AR 72201-1904	9b. GRANTEE PROJECT DIRECTOR Dr. Lowell Nicholas 1200 W 3rd St Little Rock, AR 72201-1904 Phone: 501-683-3638
10a. GRANTEE AUTHORIZING OFFICIAL Ms. Lesia Carter 1200 West Third Street Administration Little Rock, AR 72201-1904 Phone: 501-683-1299	10b. FEDERAL PROJECT OFFICER Ms. Sarah Norman 200 Independence Ave Sw Rm 738-G null Washington, DC 20201-0004 Phone: 301-492-4185

ALL AMOUNTS ARE SHOWN IN USD	
11. APPROVED BUDGET (Excludes Direct Assistance)	
I Financial Assistance from the Federal Awarding Agency Only	
II Total project costs including grant funds and all other financial participation	
a. Salaries and Wages	299,301.00
b. Fringe Benefits	92,661.00
c. Total Personnel Costs	391,962.00
d. Equipment	23,750.00
e. Supplies	16,356.00
f. Travel	0.00
g. Construction	0.00
h. Other	114,701.00
i. Contractual	2,588,025.00
j. TOTAL DIRECT COSTS	3,134,794.00
k. INDIRECT COSTS	0.00
l. TOTAL APPROVED BUDGET	3,134,794.00
m. Federal Share	3,134,794.00
n. Non-Federal Share	0.00

12. AWARD COMPUTATION			
a. Amount of Federal Financial Assistance (from Item 11e)	3,134,794.00		
b. Less Unobligated Balance From Prior Budget Periods	0.00		
c. Less Cumulative Prior Award(s) This Budget Period	0.00		
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	3,134,794.00		
13. Total Federal Funds Awarded to Date for Project Period	3,134,794.00		
14. RECOMMENDED FUTURE SUPPORT (Subject to the availability of funds and satisfactory progress of the project):			
YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:	
a. COLLECTION	b
b. ADDITIONAL COSTS	
c. MATCHING	
d. OTHER RESEARCH (Add / Deduct Option)	
e. OTHER (See REMARKS)	

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARDING AGENCY OR THE ABOVE FIELD PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:

- a. The grant program legislation.
- b. The grant program regulations.
- c. The award notice including terms and conditions, if any, noted below under REMARKS.
- d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - ☒ Yes ☐ No)
Refer to the following Award Attachments: 1) Standard Terms and Conditions 2) Programmatic Terms and Conditions

GRANTS MANAGEMENT OFFICER: Michelle Feagins, Grants Management Officer

17. OBJ CLASS 4115	18a. VENDOR CODE 1716006766A1	18b. EIN 710847443	19. DUNS 081501558	20. CONG. DIST. 02
21. a. 3-5992933	b. PRPPR0042A	c. ADMINISTRATIVE CODE IPR	d. AMT ACTION FIN ASST \$3,134,794.00	e. APPROPRIATION 75140112
22. a.	b.	c.	d.	e.
23. a.	b.	c.	d.	e.

EXHIBIT 5

PART II: HEALTH INSURANCE RATE DATA COLLECTION

The data for Tables A-E (provided below) and the Rate Filing Detailed Data Elements will be submitted through the Health Insurance Oversight System (HIOS). The rate filing data can either be downloaded through the SERFF system or uploaded directly by the States (for states not employing SERFF) into the HIOS system.

Table A. Rate Review Volume

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Number of submitted rate filings	12	9	20	36	77
Number of policy rate filings requesting increase in premiums	10	9	4	6	29
Number of filings reviewed for approval, denial, acceptance etc.	10	8	7	23	48
Number of filings approved	5	4	7		36
Number of filings denied	5	4	0		9
Number of filings deferred	0	0	0		3

Table B. Number and Percentage of Rate Filings Reviewed – Individual Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Product Type (PPO, HMO, etc.)	ALL	OTH/PPO	OTH/PPO	OTH/POS/PPO	ALL
Number of Policy Holders	5,071	1,045	12	4,594	10,722
Number of covered lives affected	8,614	1,782	2,233	7,976	20,605

Table C. Number and Percentage of Rate Filings Reviewed – Small Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Product Type (PPO, HMO, etc.)	ALL	FFS/HDHP HSA/PPO	HMO/OTH POS/PPO		ALL
Number of Policy Holders	34	466	963	34,618	36,081
Number of covered lives affected	270	4,060	16,803	59,137	80,270

Table D. Number and Percentage of Rate Filings Reviewed – Large Group

State	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Product Type (PPO, HMO, etc.)	N/A	PPO	HMO/OTH	N/A	HMO/OTH PPO
Number of Policy Holders	N/A	39	5	N/A	44
Number of covered lives affected	N/A	52	1,498	N/A	1,550

Table E. (SERFF Users): Number and Percentage of Rate Filings Reviewed –Combined

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Product Type (PPO, HMO, etc.)	N/A	HSA/PPO	N/A	N/A	HSA/PPO
Number of Policy Holders	N/A	28	N/A	N/A	28
Number of covered lives affected	N/A	326	N/A	N/A	326

Rate Filing Detailed Data Elements: Please refer to the Enclosure for the updated **Rate Filing Detailed Data Elements**. Please note all the data collected for the Rate Filing Detailed Data Elements will be collected at the level of the *rate filing*.

EXHIBIT 6

Cycle 2 Period Q4 07/01/2013-09/30/2013

State: Arkansas

Generated: 10/01/2013 12:53:03

Submitted

HIPR Table A - Summary

Rate Filings For This Period (A1)	36
Rate Increases For This Period (A2)	6
Reviewed (A3)	23
Approved (A4)	20
Denied (A5)	0
Deferred (A6)	3

HIPR Table B (Individual) - Summary

Product Type	Policy Holders	Covered Lives
EPO	0	0
FFS	0	0
HDHP	0	0
HMO	0	0
HSA	0	0
OTH	110	140
POS	3980	6934
PPO	504	902

HIPR Table C (Small Group) - Summary

Product Type	Policy Holders	Covered Lives
EPO	0	0
FFS	0	0
HDHP	0	0
HMO	7110	11410
HSA	2169	4135
OTH	0	0
POS	9435	16043
PPO	15904	27549

HIPR Table D (Large Group) - Summary

Product Type	Policy Holders	Covered Lives
EPO	0	0
FFS	0	0
HDHP	0	0
HMO	0	0
HSA	0	0
OTH	0	0
POS	0	0
PPO	0	0

HIPR Table E (Small and Large Group) - Summary

Product Type	Policy Holders	Covered Lives
EPO	0	0
FFS	0	0
HDHP	0	0
HMO	0	0
HSA	0	0
OTH	0	0
POS	0	0
PPO	0	0

EXHIBIT 7

Arkansas Insurance Department

Mike Beebe
Governor



Jay Bradford
Commissioner

October 21, 2013

Jay Bradford
Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Dear Commissioner Bradford:

The Health Insurance Rate Review Division (HIRRD) seeks to coordinate responsibilities and facilitate the exchange of information with the other divisions of the Arkansas Insurance Department (AID). The purpose of this letter is to memorialize the agreed upon matrices of duties.

Attached to this letter is a Matrix of Duties for each division. The RACI Matrix will identify which party is **Responsible**, **Accountable**, **Consulted** and **Informed** for each task:

- **Responsible:** this is a person/organization that performs a task or work, and he/she is responsible for the work.
- **Accountable:** primarily the person/organization in charge of the task or work.
- **Consulted:** person/organization who gives feedback, contribute as and when required.
- **Informed:** Person/organization in charge that needs to know the action or decision taken

These matrices are mutually agreeable by HIRRD and the divisions.

HIRRD and the divisions will continue to work with the other in a fair and transparent manner, assist one another in the duties outlined in the matrices, and will keep one another informed of the progress made implementing the various aspects of the Affordable Care Act. Relevant reports and information consonant with Federal and Arkansas privacy and public record laws shall be shared between the divisions.

Sincerely,

Lowell Nicholas
Deputy Commissioner, Health Insurance Rate Review Division

Attachments

LEGAL DIVISION

Matrix of Duties

Duties	HIRRD	Legal
In the event that an issuer appeals a plan non-certification due to an adverse rate increase determination by HIRRD, coordinate with HBEPD and Legal Divisions to support the hearing process to defend the rate increase determination.	C	A
Notify HIRRD of any complaint, investigation, or legal action related to Qualified Health Plans (QHPs) and provide ongoing updates of cases relating to such plan.	I	A
Coordinate with other divisions (such as Finance and Consumer Services) to conduct independent examinations and/or formulate corrective action plans related to potential statutory violation and/or noncompliance of QHPs in licensing, finance, or market conduct requirements and notify HIRRD of any legal or investigative action pertaining to these plans.	I	A
In the event that a plan is decertified or non-certified and the issuer appeals the decision, formulate hearing notices to support the hearing process as outlined in Ark. Code Ann. §23-61-303. Non-certification means that the issuer submitted a Qualified Health Plan application and was issued a non-certification decision by AID.	I	A
Investigate complaints related to discriminatory practices and verify that QHPs comply with state laws and regulations regarding marketing by health insurance issuers, including Arkansas Insurance Code Title 18§23 Unfair Methods of Competition and Unfair or Deceptive Acts or Practices defined in <i>Title 18 Regulation 1302 Accident and Sickness Insurance Advertisements</i> .	I	A

- **Responsible:** this is a person/organization that performs a task or work, and he/she is responsible for the work.
- **Accountable:** primarily the person/organization in charge of the task or work.
- **Consulted:** person/organization who gives feedback, contribute as and when required.
- **Informed:** Person/organization in charge that needs to know the action or decision taken.

HEALTHCARE BENEFITS EXCHANGE PARTNERSHIP DIVISION

Matrix of duties

Duties	HIRRD	HBEPD
Develop an infrastructure to effectively collect, analyze, and report to the Secretary and the Arkansas Exchange critical data/information about rate review decisions and trends.	A	C
Receive Justification Information for Rate Increase; Coordinate with the Health Insurance Rate Review Division to analyze rate increases; Approve and Update QHP Rate and Benefit data in issuer account.	C	A
Notify HIRRD when Qualified Health Plan (QHP) application materials have been received through SERFF.	I	A
Receive and review final QHP Issuer Application Submission including attestations for accreditation, licensure and solvency, and network adequacy.	I	A
Receive and review final QHP Form and Rate Application Submission including attestations compliance with EHB standards and nondiscrimination, marketing standards.	I	A
In the event that a QHP meets decertification criteria, HBEPD notifies CCHIO, HIRRD, Finance Division, Consumer Services Division, and Legal Division, <i>prior</i> to plan decertification.	I	A
Conduct oversight and monitoring of plan-level compliance Issues with QHP certification requirements; support oversight and monitoring process by providing rate and benefit data as needed.	I	A

- **Responsible:** this is a person/organization that performs a task or work, and he/she is responsible for the work.
- **Accountable:** primarily the person/organization in charge of the task or work.
- **Consulted:** person/organization who gives feedback, contribute as and when required.
- **Informed:** Person/organization in charge that needs to know the action or decision taken.

LIFE AND HEALTH DIVISION Matrix of Duties

Duties	HIRRD	Life and Health
Enhance current processes for reviewing health insurance premium increases.	A	C
Enhance a meaningful and comprehensive effective rate review program that is accurate, timely, and transparent to the public, enrollees, and policyholders.	A	C
Create detailed and comprehensive rate review manuals, job aids, and checklists.	A	C
Provide an optimal training system for current and future AID Life & Health 'rate review' employees.	A	C
Receive Justification Information for Rate Increase; Coordinate with the Health Insurance Rate Review Division to analyze rate increases; Approve and Update QHP Rate and Benefit data in issuer account.	C	A
Review plan rates for Qualified Health Plan (QHP) applicants during the applications and/or recertification process if the premium rate represents an increase.	C	A
Notify issuer of any company issues or concerns with QHP form/rate application and communicate with issuer to resolve.	I	A
Review plan form filings for compliance with QHP certification standards including, but not limited to: Compliance with Essential Health Benefits standards, state-mandated benefits, discriminatory benefit design, market reform rules, network adequacy, rating areas and actuarial value, service areas, and plan rates and benefits.	I	A
Coordinate with the Life and Health Division to notify issuers of issues with plan rates or non-approval of rate increases.	I	A

- **Responsible:** this is a person/organization that performs a task or work, and he/she is responsible for the work.
- **Accountable:** primarily the person/organization in charge of the task or work.
- **Consulted:** person/organization who gives feedback, contribute as and when required.
- **Informed:** Person/organization in charge that needs to know the action or decision taken.

FINANCE DIVISION

Matrix of Duties

Duties	HIRRD	Finance
Evaluate and certify that an issuer is properly licensed, in good standing to offer health insurance coverage in Arkansas, and in compliance with all state financial solvency requirements.	I	A
While maintaining the confidentiality of issuer financial and solvency information, communicate, give status updates and/or make recommendations to HIRRD during the QHP application process, and convey any deficiencies in documentation or solvency requirements and/or compliance issues during the evaluation/certification process; Receive and evaluate responses and resolutions submitted by the issuer.	I	A
Evaluate financial solvency of new companies and co-op plans; prioritize solvency review of companies applying for QHP certification to ensure financial solvency reviews of new companies will be completed in a timely manner if the company submitted the QHP application prior to the application deadline.	I	A
New issuers coming into the Arkansas market (or current issuers offering new lines of business should go through a financial examination as required by Ark. Code Ann. §23-61-201.	I	A

- **Responsible:** this is a person/organization that performs a task or work, and he/she is responsible for the work.
- **Accountable:** primarily the person/organization in charge of the task or work.
- **Consulted:** person/organization who gives feedback, contribute as and when required.
- **Informed:** Person/organization in charge that needs to know the action or decision taken.

INFORMATION SYSTEMS DIVISION

Matrix of Duties

Duties	HIRRD	IS
In collaboration with other divisions, develop reporting infrastructure and processes to report on data related to rate increases, health plans, compliance data, and other data as collected in AID software tools.	A	R
Coordinate compliance monitoring of AID software tools to ensure compliance with HHS Information Technology Guidance, including Privacy and Security standards set forth in 45 CFR 155.260(a)-(g).	A	R
Support the development, integration, or establishment of software and/or IT processes necessary to interface with the iRate and external systems such as SERFF.	C	A
General IT support such as setting up printers, internet access, active directory and email account administration, remote login infrastructure, training lab, etc.	C	A
Create, develop, and implement iRATE (Insurance Rate Analysis and Tracking Engine). iRATE includes a robust reporting system that helps insurance departments better track reviews and file them for future use.	A	C

- **Responsible:** this is a person/organization that performs a task or work, and he/she is responsible for the work.
- **Accountable:** primarily the person/organization in charge of the task or work.
- **Consulted:** person/organization who gives feedback, contribute as and when required.
- **Informed:** Person/organization in charge that needs to know the action or decision taken.

EXHIBIT 8

Health Insurance Rate Review Division Arkansas Insurance Department

Rate Filing Review Manual

Health Insurance Coverage in the Small Group or Individual Markets

Prepared by: Lewis & Ellis, Inc.

October 9, 2013

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal Arkansas Department of Insurance 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.

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SECTION 1: Introduction

On February 27, 2013, 78 FR 13436 (Final Rule) implemented the Market Rating Reforms to ensure that individuals and employers will have access to health insurance coverage and greater premium stability. The Market Reforms included are:

- ❖ Fair Health Insurance Premiums;
- ❖ Guaranteed Availability;
- ❖ Guaranteed Renewability;
- ❖ Single Risk Pool.

These Market Reforms apply to non-grandfathered coverage after January 1, 2014. All reforms apply to the Individual and Small Group markets. The guaranteed availability and renewability of coverage applies to the large group market as well. This manual primarily applies to non-grandfathered business. Please see Appendices H, I, and J for specific guidelines and procedures regarding grandfathered plans.

The Arkansas Department of Insurance (AID) issued Bulletin 9-2013 on March 29, 2013 to inform health insurance issuers of the new rate filing procedures adopted to comply with 45 C.F.R. Part 154 and additional reporting requirements that must be met when submitting rate filings to AID for all non-grandfathered plans. AID required this additional information in accordance with the Commissioner's authority under §23-79-109 through 110 (amended by Act 1187 of 2013 and Act 1339 of 2013), §23-76-112 and §23-75-111.

AID will use the additional reporting requirements required under the bulletins listed above as well as Bulletin 3B-2013 to evaluate the proposed rate increases of products to make a determination as to whether the increases:

- Comply with the standards set forth in §23-79-109 through 110 (amended by Act 1187 of 2013 and Act 1339 of 2013), §23-76-112 and §23-75-111; and/or
- Are unreasonable pursuant to 45 CFR 154

Pursuant to §23-79-110, in the Individual Market, the AID shall disapprove a premium rate filed if the commissioner finds that the rate is not actuarially sound, is excessive, is inadequate, or is unfairly discriminatory¹. It may also be disapproved if it is not compliant with applicable federal laws or all state laws, regulations, and bulletins.

¹ §23-79-110 amended by Act 1187 of 2013(2)(b)(2)
(<http://www.arkleg.state.ar.us/assembly/2013/2013R/Bills/SB1071.pdf>)

For all Individual and Small Group filings, a rate filing will be classified into one of the following rate disposition categories², after a statutory rate determination, if applicable:

1. **Unreasonable Rate Increase:** the rate increase was determined to be unreasonable.
2. **Unreasonable Rate Increase (Modified):** the health insurance issuer modified its proposed rate increase during the review process and the modified rate was still determined to be unreasonable.
3. **Unreasonable Rate Increase (Disapproved by State):** the individual market rate increase was disapproved, subject to the requirements of §23-79-109 through 110.
4. **Not Unreasonable:** the rate increase was determined not to be unreasonable. For the individual market, the rate increase was approved, subject to the requirements of §23-79-109 through 110.
5. **Not Unreasonable (Modified):** the health insurance issuer modified its proposed rate increase during the review process and the modified rate increase was determined to not be unreasonable. For the individual market, the rate increase was approved after modification, subject to the requirements of §23-79-109 through 110.
6. **Withdrawn Prior to Determination:** the health insurance issuer elected to withdraw the rate increase prior to the completion of the State's review.

² Rate Review Instruction Manual (http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf)

SECTION 2: Arkansas Rate Review Initial Procedures

A health insurance issuer submits all required Arkansas filings through SERFF. Once submitted, all filings are received by AID administrative staff and sent to the appropriate compliance officer. The life and health compliance officer (reviewer) is assigned small group and individual health insurance filings, which this manual addresses. Once assigned, the reviewer will enter the filing into a preliminary tracking tool. This tracking tool is to ensure all filings are accounted for and to manage calendars. The main tracking (what's happening on a day-to-day basis) will be monitored through the SERFF system.

An issuer must also submit the Rate Filing Justification to CMS for small group and individual health insurance filings that include a rate increase. The justification is filed through the Health Insurance Oversight System (HIOS). The requirements are defined in Federal Regulation 45 C.F.R. § 154.215.

Arkansas will receive email notifications for all rate increases reported in the HIOS. This notification will be automatically generated and sent to AID staff as defined in the HIOS under the State General Info page. As the filing was already filed through SERFF, the reviewer will note in the Excel log that the notification from HIOS was received. The Arkansas reviewer should notify CMS of any applicable rate increases filed in the State and not reported by issuers in HIOS.

Initial Review

The reviewer will do a preliminary check of the contents of the filings. This check is to verify the filer has included all data required by AID bulletins along with rate sheets/methodology. An Excel checklist will be utilized to ensure issuer has submitted all information required by Arkansas regulations and bulletins. Checklists differ for new versus renewal business. If any omissions are found, the reviewer will submit an objection letter to the issuer via SERFF. The reviewer should give a respond-by date that takes into consideration the complexity of the requested changes, the filing date and the date the rates will be implemented:

- ❖ Missing SERFF data from the General or Rate/Rule Schedule tab or missing actuarial certification—2 days to 1 week response time
- ❖ Missing data from Rate Filing Justification requirements or missing data prescribed by bulletins—1 week response time

Due to statutory limitations on total review time, the required response times for each inquiry letter should be shortened if the filing submission date is greater than 30 days old or the implementation date is within 60 days. Other factors may affect the allowed response time as well—complexity of request, vacation schedules, etc.

With any objection, a statement regarding required complete filings and Ark. Code Ann. § 23-79-109(1)-(5) should be included. This statement should make it clear that the rate review period will not begin until the filing is complete as determined by the reviewer and that the review period can be increased an additional 30 days. Also, it is suggested to put in a statement such as, "If your response to this objection or a request for an extension is not received by the respond-by date, your filing will be Disapproved or deemed Unreasonable, as applicable".

The reviewer will do a secondary check that should determine if enough detail is given in the filing to verify trends, loss ratios and all changes the issuer is requesting. This includes premiums, claims, trend,

rates and changes from previous filed rates.

The reviewer will look at the contents of the filing to verify that all changes are documented and information in Parts I, II and III are given. This check will also include verification that all data is included to calculate a rate and the total annual increase (including trending and any other factor changes). The checklists should be used. An objection requesting any missing data or clarification of data should be submitted to the issuer with a response time of one week.

If the basic and secondary reviews have been deemed complete, and the issuer has responded to all the reviewer's objections in a timely manner, an advanced review should be done. An advanced review may be omitted and the filing expedited under the following circumstances:

- ❖ The filing has a small number of Arkansas policyholders (under 50) and
- ❖ The rate increases are small (under 5% annually) and
- ❖ No other changes are made (benefit relativities, area factors, demographic tables, etc.) and
- ❖ A defensible determination can be made to the issuer and the Commissioner, either:
 - Disapproval or approval, as applicable:
 - Unreasonable or not unreasonable, as applicable.

Factors to be Considered in Reviewing Rate Filings

Factors considered in a rate filing are discussed in detail in the following sections.

Responses to objections in this section may take longer due to the data requested. Often a one- to two-week respond-by date is required.

New Business

New business requires different and additional checks. New business includes new blocks of business for an existing issuer (generally for Individual or Association coverage only), an existing issuer offering either Individual or Small Group coverage for the first time, or a new issuer wishing to offer coverage in Arkansas for the first time.

New business checks should include review of all basic information as outlined previously plus appropriate checks for new products. Advanced checks should include proposed trend and target loss ratios, including lifetime loss ratios for underwritten individual business (as appropriate). Information regarding the basis for pricing assumptions should be included. The following are generally considered actuarially sound pricing bases:

- ❖ Nationwide experience for proposed product appropriately adjusted for Arkansas specific characteristics.
- ❖ Current experience on any similar existing Arkansas product
- ❖ Rates developed using a large existing consultant database or current nationwide studies (Milliman Healthcost Database, national trend studies, etc.) appropriately adjusted for Arkansas specific characteristics.

For existing issuers filing a new product, a preliminary check against current products for reasonableness should be done. In other words, an examination of whether the new products are priced consistently with the current blocks of business. Additional information should be requested if there are inconsistencies that are not addressed by the filing.

New issuers coming into the Arkansas market (or current issuers offering new lines of business) should go through a financial examination as required by Ark. Code Ann. § 23-61-201. After examination, the basic and advanced checks should be done as stated above. When all objections have been answered, an outside actuarial review is recommended. The Commissioner should be informed of the examination's financial audit on the issuer (reserves, surplus, reinsurance etc.), actuarial recommendations and reviewer's assessment before rendering a decision.

Disposition of the Filing

When the filing is considered complete by the reviewer, AID will post on its website the Unified Rate Review Template (Part I), written description justifying the Rate Increase (Part II), and Actuarial Memorandum (Part III)—Public version. Parts I, II and III are also available on the healthcare.gov website.

Parts I, II and III should be pulled directly from SERFF. Manual entry or a program can be used to pull in the appropriate data for a summary from the SERFF general information and rate/rule schedule tab. All items will be downloaded onto the AID website. Consumers will then have 30 days to comment about the rate changes either by mail, email or telephone. The Actuarial Memorandum cannot be pulled from SERFF unless the company has been requested to file a public version.

Appropriate comments submitted by consumers regarding rate filings will be posted on the AID website and made part of the rate filing.

After the evaluation of the filing is complete, the issuer has responded to all objections and questions and consumer input has been incorporated, a final disposition will be recommended to the Commissioner. A summary should be developed for the Commissioner with information necessary for the Commissioner to make an informed decision. For any filing that exceeds the subject to review threshold, the CMS summary required in 45 C.F.R. § 154.210(b) (2) should also be included. The reviewer should make a note on the preliminary tracking sheet of the date the filing was sent to the Commissioner for review.

- ❖ After assessments and discussions with the filing carrier, if the reviewer is still not convinced of the filing's merits, the reviewer should request that the filing be Disapproved or considered Unreasonable, as applicable.
- ❖ If the reviewer believes the increase appears to be considered not unreasonable:
 - If the increase is under the "subject to review" threshold, the summary information should be sent to the Commissioner, along with the reviewer's (and actuaries', if applicable) suggested action.
 - If the increase is over the "subject to review" threshold, a thorough, written description of the filing, as required to be submitted to CMS, along with the summary information, should be sent to the Commissioner. The reviewer's suggestion to approve as well as any analysis done by the reviewer or outside actuaries should also be sent.
- ❖ If the reviewer believes that negotiations for a lower increase are appropriate, summary information and additional information should be supplied to the Commissioner. An analysis (from the reviewer and/or actuary) should be developed to show the increase requested versus what the reviewer/actuary considers appropriate. A write-up describing any other factors to aid in the decision making or to help the Commissioner in any further negotiations

should also be completed. This should include: past increases, loss ratio history, consumer complaints/input, impact on the market, competitive information (if available) along with any actuarial write-up that was done.

The Commissioner may also review other aspects of the rate change that are not actuarial in nature, such as:

- ❖ Effect on the policyholders
- ❖ Effect on the issuer's solvency
- ❖ Consumer Input
- ❖ Competition in the market place
- ❖ Any other factor the Commissioner deems practical

The Commissioner should rely on others to gather any information s/he considers necessary—finance, accounting, consumer advocates, competitive practices, etc.

The Commissioner will be given the filing date, implementation date, the date the filing was deemed complete (last objection answered) and the deemer date (60 days after complete filing received). For non-negotiated determinations, the Commissioner shall render the final determination at least one week before the deemer date. If the Commissioner decides to negotiate a different change from the one proposed, an objection with the AID's proposed premium changes should be written up and submitted in SERFF. The Commissioner should allow more time (2-3 weeks) before the deemer date to allow for the negotiations. The Commissioner will be kept informed by the reviewer of the issuer's responses to the Commissioner's request. The Commissioner may also communicate directly with the issuer as he/she sees fit. However, the reviewer will request that the issuer submit all final rates through SERFF.

These are only suggested courses of action. The Commissioner has the final authority on all rate filing dispositions.

SECTION 3: Rate Filing Submission Requirements & Evaluation Steps

For filings of plans with effective dates of January 1, 2014 and later, any new product or a product subject to a rate increase requires the issuer to submit Rate Filing Justification for all products in the Single Risk Pool, in accordance with Arkansas Bulletin 3B-2013. The Rate Filing Justification must consist of³:

- ❖ Part I: Unified Rate Review Template;
- ❖ Part II: Consumer-friendly written narrative justifying the rate increase;
- ❖ Part III: Rating Filing Justification.

Federal Regulations require issuers must submit Parts I and III for all rate filings. Part II is submitted if the rate increase is higher than 10% to HHS or if the State requires the documentation for all rate increases. Arkansas requires Parts I, II, and III for all rate increases per Arkansas Bulletin 09-2013.

Part I – Unified Rate Review Template

The Unified Rate Review Template includes:

- ❖ Historical and projected claims experience;
- ❖ Trend projections related to utilization, and service or unit cost;
- ❖ Any claims assumptions related to benefit changes;
- ❖ Allocation of the overall rate increase to claims and non-claims costs;
- ❖ Per enrollee per month allocation of current and projected premium;
- ❖ Three year history of rate increases for the product associated with the rate increase⁴.

The Excel file “Final Unified_Rate_Review_Template – April 2013.xls” used by the carriers can be obtained through HIOS.

Part II – Written Justification

The written description of the rate increase must include a simple narrative of the data and assumptions used to develop the rate increase⁵. This narrative must be easy to understand and consumer-friendly. The justification must include:

- ❖ Explanation of the most significant factors causing the rate increase;
- ❖ Description of the overall experience of the policy, including historical and projected expenses and loss ratios.

Part III – Rating Filing Justification

The rate filing justification must include an Actuarial Memorandum that contains the details and assumptions supporting the rate increase⁶. HHS has provided guidance on the structure of the Actuarial Memorandum. The HHS Actuarial Memorandum is outlined and explained in Section 6 of this manual.

Evaluation of the Rate Filing

Parts I and III must provide sufficient information to conduct an evaluation of the proposed rate or rate

³ 45 CFR § 154.215 – Submission of rate filing justification

⁴ 45 CFR § 154.215(d) – Unified Rate Review Template

⁵ 45 CFR § 154.215(e) – Written Description

⁶ 45 CFR § 154.215(f) – Content of rate filing documentation

increase.

Pursuant to Bulletin 09-2013, AID may take into consideration the following criteria, to the extent applicable, to review the filing:

- ❖ The impact of utilization changes by major service categories;
- ❖ The impact of cost-sharing changes by major service categories;
- ❖ The impact of benefit changes;
- ❖ The impact of changes in enrollee risk profile;
- ❖ The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increases;
- ❖ The impact of medical trend changes by major service categories;
- ❖ The impact on the actuarial value of the health plan in relation to the changes in cost sharing;
- ❖ The impact of changes in reserve needs;
- ❖ The impact of changes in administrative costs related to programs that improve health care quality;
- ❖ The impact of changes in other administrative costs;
- ❖ The impact of changes in applicable taxes, licensing or regulatory fees;
- ❖ Medical Loss Ratio and other standardized ratio tests;
- ❖ The carrier's capital and surplus;
- ❖ Consumer comments regarding the rate filing;
- ❖ The impact of changes on pricing, including the limitations on age and tobacco use;
- ❖ The impacts of geographic factors and variations;
- ❖ The impact of changes within a single risk pool to all products or plans within the risk pool;
- ❖ The impact of Federal reinsurance and risk adjustment payments and charges; and
- ❖ The impact of the changes on the plan's essential benefits and non-essential health benefits.

Review of Requirements and the Factors for Rate Evaluation

AID will use reporting requirements to evaluate whether the proposed rates:

- Comply with the standards set forth in §23-79-109 through 110 (amended by Act 1187 of 2013 and Act 1339 of 2013), §23-76-112 and §23-75-111; and/or
- Are unreasonable pursuant to 45 CFR 154

In the Individual Market, the AID shall disapprove a premium rate filed if the commissioner finds that the rate is not actuarially sound, is excessive, is inadequate, or is unfairly discriminatory⁷. It may also be disapproved if it is not compliant with applicable federal laws or all state laws, regulations, and bulletins.

Pursuant to §23-79-110, statutory review determinations for the Individual Market are defined as:

- ❖ A rate is actuarially sound if it is:
 - Supported by an actuarial analysis made by a member of the American Academy of Actuaries; and
 - Based on generally accepted actuarial principles and methodologies that show the rate to be reasonable.
- ❖ A rate is excessive if it is:
 - Likely to produce a profit that is unreasonably high in relation to past and prospective loss experience for the form which the filing affects or if expenses are unreasonable high in relation to services given.
- ❖ A rate is not unfairly discriminatory if:
 - It shows equitably the differences in expected losses and expenses; or
 - Different premiums result for policyholders with like loss exposures but different expense factors or with like expense factors buy different loss exposures, if the rates show the differences with reasonable accuracy.
- ❖ A rate is inadequate if:
 - The investment income attributable to the rate fails to satisfy projected losses and expenses for the form which the filing affects.

⁷ §23-79-110 amended by Act 1187 of 2013(2)(b)(2)
(<http://www.arkleg.state.ar.us/assembly/2013/2013R/Bills/SB1071.pdf>)

For all Individual and Small Group filings, a rate filing will be classified into one of the following rate disposition categories⁸, after a statutory rate determination, if applicable:

1. **Unreasonable Rate Increase:** the rate increase was determined to be unreasonable.
2. **Unreasonable Rate Increase (Modified):** the health insurance issuer modified its proposed rate increase during the review process and the modified rate was still determined to be unreasonable.
3. **Unreasonable Rate Increase (Disapproved by State):** the individual market rate increase was disapproved, subject to the requirements of §23-79-109 through 110.
4. **Not Unreasonable:** the rate increase was determined not to be unreasonable. For the individual market, the rate increase was approved, subject to the requirements of §23-79-109 through 110.
5. **Not Unreasonable (Modified):** the health insurance issuer modified its proposed rate increase during the review process and the modified rate increase was determined to not be unreasonable. For the individual market, the rate increase was approved after modification, subject to the requirements of §23-79-109 through 110.
6. **Withdrawn Prior to Determination:** the health insurance issuer elected to withdraw the rate increase prior to the completion of the State's review.

Pursuant to §23-79-109, if the commissioner disapproves a rate, the insurer may request that the commissioner provide the insurer with the filing an actuarial analysis, interpretation of statistical data, and other methodology that was reviewed by the commissioner or his or her staff.

⁸ Rate Review Instruction Manual (http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf)

Criteria to Analyze in the Evaluation of a Proposed Rate

As outlined in Section 4, AID is responsible for reviewing the 19 criteria, to the extent applicable, for each filing under review. The following narratives provide some review considerations for each of the criterion.

1. The impact of utilization changes by major service categories

❖ **Utilization Changes:** This item refers to changes in statistics such as admits per 1,000 members or days per 1,000 members for Inpatient, scripts per 1,000 members for Prescription Drugs, and services per 1,000 members for all other major categories.

❖ **Additional Considerations:**

- Issuers should disclose if the following factors were used in their utilization trend determination:
 - Medical technology
 - Cost share utilization disincentive, e.g. migration to higher cost-sharing to incentivize less use of medical services
 - Anti-selection from losing healthy insureds as a block of policies age

2. The impact of cost-sharing changes by major service categories

❖ **Cost-Sharing Changes:** Since Arkansas requires all factor changes to be submitted for review, there are three possible types of reviews under this provision that may be considered.

- 1) Benefit changes resulting from changes in cost sharing under the plan. (e.g., unilaterally increasing deductibles or copays).
- 2) Benefit relativity factors are reviewed for reasonableness.
- 3) Review the AV calculation.

3. The impact of benefit changes

❖ **Benefit Changes:** There are two possible types of reviews under this provision that may be considered.

- 1) Verification that the historical experience has been adjusted to current benefit levels.
 - It should be determined whether the experience used to develop trend estimates have been normalized for the impact of benefit changes.
- 2) Evaluation of cost adjustments applied to reflect newly mandated benefits, e.g. EHB, as well as reductions in the scope of services covered under the health plan.

4. The impact of changes in enrollee risk profile

❖ **Risk Profile Changes:** This provision requires that historical experience upon which projected has been adjusted to reflect a normalized enrollee risk profile.

❖ **Considerations:**

- An evaluation should be performed to ensure that the experience used to develop trend estimates has also been normalized for underlying changes in the risk profile.
 - This would include risk profile items that can be separately adjusted through the rating process (e.g., age and geography).
- Since many health insurance issuers do not currently employ sophisticated, if any, risk adjustment models, it is likely that changes in average rating factors (rather than a risk adjustment) would be used to adjust the experience.
- There will be variation among carriers when quantifying the impact of the uninsured population entering the insured markets. There is not a primary source available to a carrier that discusses the impact of the uninsured population. It is unclear which uninsured individuals will obtain coverage and what their utilization patterns will look like. There is likely to be a wide variation of estimated impacts made by carriers. Therefore, discussion among reviewers will help in determining what appears to be a reasonable assumption for this review consideration.

5. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increases

- ❖ **Impact of Trend Estimates:** This provision refers to a rate increase update as a result of inaccuracies in prior trend estimates.
- ❖ **Considerations:** This provision would be evaluated by assessing the issuer's actual-to-expected analysis.

6. The impact of medical trend changes by major service categories;

- ❖ **Major Service Category:** The Unified Rate Review Template (URRT) requires a breakdown of services into the following categories: Inpatient, Outpatient, Professional, Prescription Drugs, Other, and Capitation.
- ❖ **Medical Trend Changes:** Since utilization changes are presented as a separate review item, this item refers to either the change in total cost PMPM or the change in cost per service.
- ❖ **Additional Considerations:**
 - Trend analysis performed by carriers will typically be based on data that has been normalized for the effects of changes in demographics, benefits, other rating factors, large claims, and seasonality.
 - Check the trend to determine if it exceeds the national average by 2%. If it does, then additional information should be requested from the issuer. This review can be done with various annual trend surveys. Please note that surveys represent nationwide trends, and many are retrospective trends and, therefore, should only be used as an estimated benchmark. Periodically, new benchmark assumptions should be obtained.
 - In addition to unit cost and utilization effects, the issuers may need to disclose if the following factors were utilized in their trend determination:
 - Deductible leveraging
 - Benefit buy-down impact
 - Future/new benefits and/or mandates
 - Risk profile changes

- Aging of population (both utilization & mix of service changes)
 - Increased portion of pool from conversion policies
 - Changes in gender and other demographic characteristics
 - Mandate changes
- Since detailed trend analysis may only be credible for the largest of issuers, the URRT may show the same trend factor for each type of service.

Even if a company does not have experience in a particular market, trend assumptions are still used in the development of a manual rate. Therefore, a trend review may still be required in this case.

7. The impact of actuarial value of the health plan in relation to the changes in cost sharing

❖ **Actuarial Value:** The Actuarial Value should be calculated by the AV Calculator. The AV Calculator does not account for all cost sharing provisions, and a separate analysis should be performed by the issuer to account for these provisions.

❖ **Considerations:**

- Perform independent calculation using the AV Calculator.
- Review the screenshots provided by the issuer and compare with independent calculation.
- Understand the additional adjustments made for the cost sharing provisions that are not included in the AV Calculator. Use the Calculator to help determine reasonableness of the assumptions.

For example, if a plan allows for a waiver of ER copay for the first 3 visits, use the Calculator to show the difference in the metal value calculated when there is no copay for all ER visits and when there is a copay for all ER visits. The adjustment should fall in the middle. If not, then questions should be asked about the adjustment made.

8. The impact of changes in reserve needs

❖ **Reserve Needs:** This provision refers to an analysis of the reserves included in a health insurance issuer's incurred claim estimates.

❖ **Considerations:**

- This type of review would ensure that the claims unpaid provision inherent in the issuer's incurred claim estimate used in developing rates is not excessive.
- Health insurance issuers utilize a margin for adverse deviation in calculating reserve needs for statutory reporting purposes; however, claims unpaid estimates for pricing purposes should not include significant margins, if any.

9. The impact of changes in administrative costs related to programs that improve health care quality

❖ **Quality Improvement Expenses:** This provision refers to a review of any expenses related to quality improvement programs that may affect projected future claims.

❖ **Considerations:**

- Since the statutory statement has been revised to include the Supplemental Health Care Exhibit for purposes of calculating the federal MLR, AID could request insurers

to compare base period and projected expenses included in the rate filing with those in the carrier's most recent Supplemental Health Care Exhibit.

10. The impact of changes in other administrative costs

- ❖ **Other Administrative Expenses:** This provision refers to a review of any expenses, such as general administrative expenses and commissions, to determine whether these amounts are consistent with prior financial results and whether projected changes are fully supported.
- ❖ **Considerations:**
 - The URRT provides the expected expense load. The detailed information provided in Part III should be reviewed.

11. The impact of changes in applicable taxes, licensing or regulatory fees

- ❖ **Taxes and Fees:** This provision refers to a review of any expenses directly related to taxes, licensing, or regulatory fees to determine whether these amounts are consistent with prior financial results and whether projected changes are fully supported.
- ❖ **Considerations:**
 - The transitional reinsurance program items in the URRT should be reviewed.

12. The medical loss ratio and other standardized ratio tests

- ❖ **Medical Loss Ratio:** The medical loss ratio should be reviewed for compliance with Arkansas specific loss ratio requirements (e.g. for Individual business) and compliance with federal adjusted MLR requirements.
- ❖ **Considerations:**
 - If the projected aggregate medical loss ratio is less than projected federally-adjusted medical loss ratio, then the health insurance issuer must provide justification for the relationship between the medical loss ratio figures.
 - Review the historical loss ratio if provided. This should be compared to the target loss ratio.

13. The carrier's capital and surplus

- ❖ **Financial Performance:** This provision refers to the relationship of the rate increase relative to the financial performance of the issuer. The review could address whether RBC levels, or other financial indicators, are too low or too high relative to the requested rate increase.
- ❖ **Considerations:**
 - A benchmark between 200 – 300% of Authorized Control Level (ACL) under the NAIC Risk-Based Capital System would be appropriate to trigger further examination to ensure that the risk-based capital is not inadequate after the implementation of the proposed rate increase.
 - If the RBC ratio falls above 700%, further scrutiny of the rate increase may be necessary; however, there are no national standards for excessive RBC levels. Therefore, caution should be utilized in evaluating whether an issuer's capital and surplus appears excessive after the implementation of the proposed rate increase.

- If financial indicators imply that a carrier's solvency is threatened without rate increase action, this can be taken into consideration in determining whether or not the rates are unreasonable.

14. Consumer comments regarding the rate filing

- ❖ **Consumer Comments:** Bulletin 09-2013 requires that consumer comments be considered before a rate determination is made.
- ❖ **Considerations:**
 - An evaluation of any public comments about a proposed rate filing should be peer reviewed before it is used in the rate determination.

15. The impact of changes on pricing, including the limitations on age and tobacco use

- ❖ **Age:** Age is limited to 3:1 age band as prescribed by HHS. This was adopted by Arkansas in Bulletin 3B-2013.
- ❖ **Tobacco:** Tobacco is limited to a 20% load and was prescribed by Arkansas in Bulletin 3B-2013.
- ❖ **Considerations:**
 - The minimum and maximum rate changes for policyholders should be evaluated to determine how they will be affected.
 - Review how the rates were adjusted for these required changes.

16. The impacts of geographic factor and variations

- ❖ **Geographic Areas:** There is no specification on the allowable rating factors, but the factors must be actuarially justified. The differences in factors between rating areas must not be based on the health status of the population in the area.
- ❖ **Considerations:**
 - Did the issuer use only the allowable areas?
 - Is there any indication that the differences in area are due to the health status of the population in that area?
 - Has the carrier changed the geographic areas from previous filings? Compare the value of the factors.
 - What is the range of the low to high factor?

17. The impact of changes within a single risk pool to all products or plans within the risk pool

- ❖ **Single Risk Pool:** Non-grandfathered experience is required to be pooled for the Single Risk Pool by market.
- ❖ **Considerations:**
 - Verify that all experience for the Single Risk Pool is shown in the URRT.
 - Verify that all changes were allowable. Ensure that only the allowable rating factors were used, etc.

18. The impact of Federal reinsurance and risk adjustment payments and charges

❖ *Risk Adjustment:*

Calculation of Plan Average Actuarial Risk

Once the individual risk scores are calculated, the plan average risk score is calculated and adjusted. The plan average risk score is adjusted for normalization, AV, and rating adjustment.

Risk Scores predict how a plan's liability will differ from the State average due to the overall health status of its enrollees. The State average is based on a national sample that is adjusted to the State level⁹.

Plan Actuarial Value differences impact the plan liability risk scores. For example, Gold plans have higher risk scores than Bronze plans. The risk scores need to be adjusted to ensure that AV differences do not affect the payment transfers.

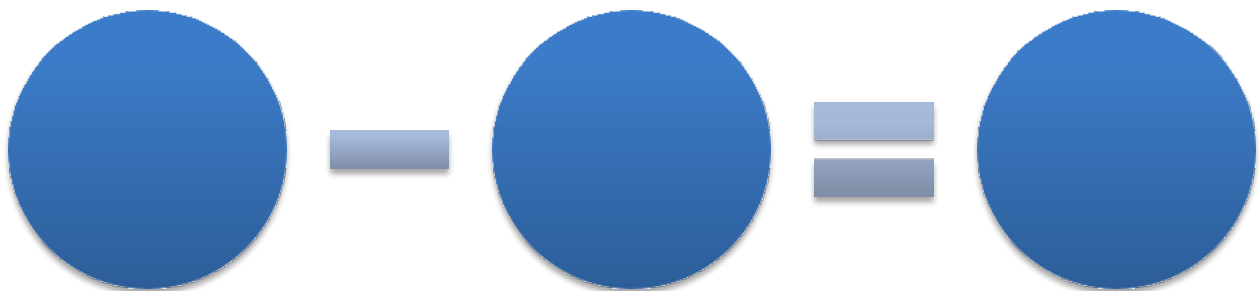
Additionally, payment transfers should not compensate for allowable rating factors, such as Age, Tobacco, Family Size, and Geography.

Calculation of Payments and Charges

Payments are calculated separately for individual, Small Group, and catastrophic plans¹⁰. The model is "zero-sum," meaning that funds are transferred within a risk pool within a market with in a State.

Payment transfer is meant to represent the difference between premiums based on actual risk exposure and premiums plans would charge based on prohibited rating factors, such as gender, health status, industry, etc. The payment transfer formula is:

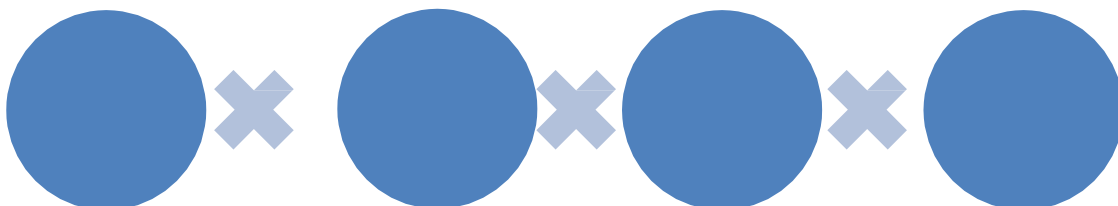
- Product of State Average Premium, Plan Risk Scores, and Other Cost Factors, less
- Product of State Average Premium and Plan Premium Factors.



⁹ CCIIO Risk Adjustment Methodology Overview Presentation (<http://cciio.cms.gov/resources/files/hie-risk-adjustment-methodology.pdf>)

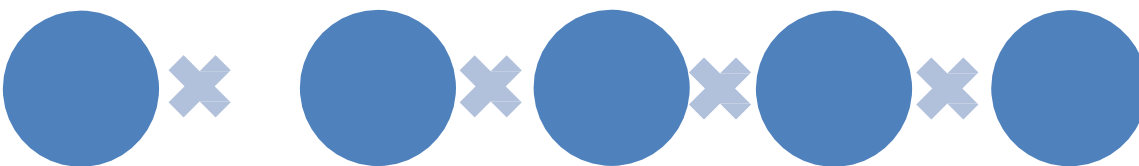
¹⁰ Academy of Actuaries Risk Adjustment Presentation (<https://regulationreview.lmi.org/RegulationReview/VideoStream.aspx?vid=Mod130Wifi.mp4>)

The first part of the formula is the State Average Premium normalized for Plan Average Risk Score, Geographic Cost Factor, and Induced Demand Factor.



The State Average Premium is calculated as the enrollment-weighted average of all plan average premiums of risk adjustment covered plans in the applicable risk pool in the applicable market in the State. The Plan Average Risk Score accounts for the health status of the plan. The Induced Demand Factors account for the differences in utilization in the various metal plans. The factors are the standard factors found in 45 CFR Part 153.

The second part of the formula State Average Premium is normalized for Plan Actuarial Value, Allowable Rating Factor (Age only), Geographic Cost Factor, and Induced Demand Factor.



The Plan AV is the standard Actuarial Value for the plan's metal level (for example, Gold plan AV = 0.80). This is not the value determined by the Actuarial Value Calculator. The Age Rating Factor would be calculated as the enrollment-weighted average of the age factor, based on the applicable standard age curve, across all of a plan's enrollees. The Area Cost Factor is calculated based on the observed Silver plan premiums in an area relative to the statewide average silver plan premium. These premiums are

standardized by age¹¹.

19. The impact of the changes on the plan's essential benefits and non-essential health benefits

- ❖ **EHB:** Benefits required by the ACA and any additional benefits.
- ❖ **Considerations:**
 - Evaluation of cost adjustments applied to reflect newly mandated benefits, e.g. EHB, as well as reductions in the scope of services covered under the health plan.

¹¹ Academy of Actuaries Risk Adjustment Presentation
(<https://regulationreview.lmi.org/RegulationReview/VideoStream.aspx?vid=Mod130Wifi.mp4>)

SECTION 4: Actuarial Memorandum - Review Considerations¹²

A Part III Actuarial Memorandum, including a corresponding Actuarial Certification, must be submitted with each Part I Unified Rate Review Template, pursuant to Bulletin 09-2013. Please see the instructions for completing the Part I Unified Rate Review Template (URRT) for circumstances in which the template must be completed and for which products.

The purpose of the Actuarial Memorandum is to provide certain information related to the submission, including support for the values entered into the Part I Unified Rate Review Template, which supports compliance with the market rating rules and reasonableness of applicable rate increases. It should be noted that the URRT was designed to be a reporting tool and not necessarily used by a carrier as an actuarial rating tool. Therefore, the Actuarial Memorandum should support all aspects of the premium rate development that may or may not be included in the URRT.

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 Benefits portion of premium upon which advanced payment of premium tax credits (APTCs) are based,
- ❖ the Index Rate developed in accordance with federal regulations and that the Index Rate along with allowable modifiers are used in the development of plan specific premium rates

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

¹² HHS “Part III Actuarial Memorandum and Certification Instructions,” March 18, 2013

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:** The following information that uniquely identifies the issuer submitting the memorandum. The information must be the same as the entries in the general information section of Worksheet 1 of the Part I Unified Rate Review Template (see the instructions for the Part I Unified Rate Review Template for additional definition of these fields):
 - Company Legal Name: the organization's legal entity name associated with the HIOS Issuer ID
 - State: the state that has regulatory authority over the policies
 - HIOS Issuer ID: the HIOS ID assigned to the legal entity
 - Market: the market in which the products and plans are offered
 - Effective Date: the latest effective date for which rate increases are being submitted
- ❖ **Company Contact Information:** The information detailing how the reviewing regulator should contact the company in the case additional information is needed.
 - Primary Contact Name: The name of the person at the company who will serve as the primary contact for the submission. This person should be contacted if there are questions related to the information submitted, or if additional information is needed.
 - Primary Contact Telephone Number: The phone number for the primary contact
 - Primary Contact Email Address: The email address for the primary contact

Proposed Rate Change(s)

In this section, the Actuary must provide information related to the proposed rate or rate change(s). If the proposed rate adjustment varies by product, the information provided should clearly identify which proposed adjustments apply to which products. 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 should be included. The information that must be provided includes the following items:

Reason for Rate Change(s): A narrative description of all significant factors driving a proposed rate change. 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
 - *Comment:* Adverse experience can be demonstrated in a loss ratio report or an actual-to-expected analysis. The complete experience, including earned premiums and incurred claims, will be presented and compared to the estimates and assumptions made during the original pricing of the product.
Note that the URRT only includes experience for the most recently completed calendar year. The carrier may provide additional experience to support any adjustments. If not provided, this may be requested.
- ❖ **Medical inflation**
 - *Comment:* Medical inflation is a primary component of trend. A trend analysis will be provided to show how the cost of medical services has changed. In a trend analysis, the data must be normalized to exclude external factors that would imply an increase in

claim costs. These factors could include age of the population, location of the population, etc.

- ❖ **Increased utilization**
 - *Comment:* Utilization refers to the frequency of use of medical services. This is the second primary component of trend. Similar to medical inflation, a trend analysis will be provided.
- ❖ **Prospective changes** to benefits covered by the product or successor products
- ❖ **New taxes and fees imposed** on the issuer, e.g. Exchange user fees
- ❖ **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
 - *Comment:* A change in the average morbidity of the covered population refers to a change in the average allowed claims per member per month (PMPM) that will occur to the entire population and all products. This change could be triggered by the introduction of a new medical procedure or medical cure, individual mandate requiring coverage, etc., where a significant cost savings or cost increase would result.
- ❖ **Reinsurance:** Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program

If the requested rate change is not the same across all products and plans, a narrative should be provided to explain why the rate changes vary by product or plan given they are based on the same Single Risk Pool of experience for the market.

Comment: It is expected that many rate changes will be uniform across the entire risk pool and market. There must be significant support to warrant rate changes that vary by product or plan.

Some Review Considerations

1. Evaluate which forms will be affected by which rate change submitted in the filing. The health insurance issuer may submit multiple rate requests for multiple policy forms; however, all information regarding each product or plan must be provided in each URRT due to the Single Risk Pool requirement.
2. Generally, for major medical plans, the rates are assumed to be effective for 12 months; however, issuers may submit a rate change for an extended period.
 - For plans that have a renewal date in 2013, issuers may request a larger rate increase due to an extended renewal period in order to postpone the effects of the reforms.
3. What is the range of possible rate changes?
 - Who is impacted and to what degree?
 - What is the minimum and maximum rate change?
 - What is the median rate change? How skewed is the range of changes versus the average change?
4. What is the relationship between the experience period and the effective date for the proposed rate change?
5. Are there significant differences or fluctuations over time in the proposed rate change to historical rate changes?
6. Evaluate the range of the maximum and minimum rate change around the overall average amount.
 - Does the issuer adequately document the reasons for the variation applied to the assumed population distribution?
7. Evaluate the number of affected policyholders for the minimum and maximum rate changes.

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:** The date through which payments have been made on claims incurred during the experience period.

- *Comment:* Particularly in health insurance, there is a significant lag in the reporting and payment of claims. Payments are often made several months or years after the service was performed. The delay is due to various factors, including slow reporting by doctors, negotiations between providers and carriers to determine appropriate cost sharing, etc. A common industry practice is to have a paid through date that is at least 3 months after the end of the experience period. Most claims are reported and paid within 3 months of service. Some estimation still occurs, but it is significantly reduced at the 3 month mark.

If earlier paid through dates are used (i.e.: less than 3 months after the experience period), then the incurred claims have a greater volatility. Therefore, the development of these claims should be scrutinized more thoroughly.

This will be highly dependent on the date of submission versus the required calendar year experience period.

- ❖ **Premiums (net of MLR Rebate) in Experience Period:** This illustrates how the amount of premium earned during the experience period, net of MLR rebates to policyholders, was developed.

- 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 should be separately indicated. 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. The methodology used to estimate such rebates must be described.

- ❖ **Allowed and Incurred Claims Incurred During the Experience Period:** The development of the Actuary's best estimate of allowed and paid claims incurred during the experience period must be supported.

- Worksheet 1, Section I shows the Actuary's best estimate of the amount of claims that were incurred during the 12-month experience period. This includes 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.

- *Comment:* The carrier is required to provide the paid amounts during the experience period as well as the estimated claims that have not been reported or paid. As discussed earlier, the amount of time between the experience period and the paid through date lessens the magnitude of the estimations.
- The method used for determining Allowed Claims must be described. 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.
- Support for the estimate of incurred but not paid claims must be provided.
 - The methodology used to develop the estimate of claims incurred but not paid for both Allowed Claims and Incurred Claims in Experience Period must be provided. 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, support for the differences should be described.
 - An indication 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, support for why it is appropriate should be provided.
 - 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, an explanation of what is causing them to be unusually high or unusually low (e.g. introduction of a new claims system, significant employee turnover, etc.) should be provided.
 - *Comment:* The most common methods for estimating claims incurred but not paid are the completion factor method, the PMPM method, and the loss ratio method.

The completion factor method (lag method) uses claim payment patterns from earlier time periods or similar blocks of business to develop the factors. The factors are then used to increase the paid claims amounts in the early months. The completion factor method is most useful for blocks of business that have consistent claim payment patterns and a credible source to derive the factors from.

The PMPM method takes an average size of claim per member per month and applies this amount to the number of members in that month. This method is useful when closed claims accurately reflect a fully paid block of business.

The loss ratio method is based on the earned premium of the block and

uses a loss ratio for determining the incurred claims. This method is generally used on a block where there is no credible information available or the block of business is highly volatile. Therefore, some carriers will use this method to estimate the most recent months incurred claims because most health claims are not reported immediately after service.

Benefit Categories

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

Comment: Benefit Categories include:

- ❖ Inpatient Hospital
- ❖ Outpatient Hospital
- ❖ Professional
- ❖ Other Medical
- ❖ Capitation
- ❖ Prescription Drug

Some Review Considerations

1. For all benefit categories, review the development of the projected allowed costs for reasonableness and appropriateness.
 - Review the supporting documentation that is required, e.g., the product narrative, credibility assumptions, base period experience and assumptions, and manual rate development experience
2. Is the base period experience appropriate given the level of credibility?
3. When a manual rate is blended with the experience:
 - Is the source population of the manual rate appropriate for the type of plan?
 - Are a product’s plan benefit characteristics taken into account in the manual rate?
 - Is the distribution of costs by service category reasonable?
 - If the issuer used nationwide experience, was there a logical explanation for why nationwide experience was used and were reasonable adjustments made to reflect Arkansas specific utilization, price levels or other regional specific attributes?
4. Has there been a change in the source of the data used in the rate development from the most recently approved rate filing?
 - For example, if the insurer used product specific experience for the base rate development in the prior filing, but in this filing is using a blend of the manual rate and the product experience.
5. Determine if smoothing techniques that shift projected allowed costs to a different reporting category affect the experience pmpm.

- For example, are cost and utilization trends that typically vary significantly by service category inappropriately combined into a single factor?
- 6. Is there evidence supporting how the assumptions were determined?
- 7. For each rating factor, is the documentation provided:
 - Complete;
 - Adequately detailed; and
 - Clear?
- 8. Assess whether assumptions are reasonable individually as well as in the aggregate.
- 9. Evaluation of the health insurance issuer's aggregation of experience data, e.g. across product line and geographic locations.
- 10. Evaluate the base period allowed costs on a pmpm basis by service category versus other products in marketplace.

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, support for the following factors should be included:

- ❖ **Changes in the Morbidity of the Population Insured:** 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 must be provided. 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, the individual mandate to maintain coverage, and the expansion of Medicaid programs.
- ❖ **Changes in Benefits:** 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, should be provided and supported. 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:** 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 must be provided. These changes are reflected in the "Other" adjustments column on Worksheet 1, Section II. The age factors underlying the development of these claims-based demographic adjustment factors must be supported.
- ❖ **Other Adjustments:** 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, must be discussed and supported.

❖ **Trend Factors (cost/utilization):** The source claims data used and methodology used for developing the cost and utilization projection factors, including all adjustments made to the data must be provided. The adjusted source data that is applicable to the Single Risk Pool should be explained. 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

Some Review Considerations

1. Are the factors consistent with changes described in the reporting requirements:
 - True inflation in unit prices of medical services (most comparable to Medical CPI)
 - Deductible leveraging, e.g. higher deductible plans tend to have higher trend levels
 - Risk profile changes
 - Aging of population (both utilization & mix of service changes)
 - Changes in gender and other demographic characteristics
 - Increased portion of pool from conversion policies
 - Benefit changes, e.g. benefit buy-down impacts for employers
 - Expected enrollment changes
 - Marketing
 - Changes in delivery system and provider contracting
 - Utilization changes
 - Medical technology cause of increased utilization
 - Anti-selection from losing healthy insureds as block of policies age (e.g. anti-selection spiral)
 - Loss of initial policy year's lower-than-normal claims costs (primarily for individual business with underwriting)
 - Changes in claims procedures.
2. Request and review required supporting documentation for the development of the projection assumptions entered in Part I to determine if the factors are supported.
3. Are cost and utilization trends that typically vary significantly by service category inappropriately combined into a single factor?
4. Determine that the information is not distorted by the shifting of projected allowed costs among service categories.
5. Analyze impact of any overestimate or underestimate of medical trend for prior years related to the rate increase.
 - The impact of the over/understatement of prior rates can be developed by recalculating the expected revenue requirement for the prior period using the most recent claim experience and updated pricing assumptions
 - If the overstatement or understatement of prior rates is a significant driver of the proposed rate increase, an additional actual-to-expected analysis on historical claims could be requested for review.

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:** The source data used to develop the manual rate and why such data is appropriate must be discussed. 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

Some Review Considerations

1. Carriers must demonstrate that the manual rate includes EHB.

- ❖ **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. 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 must be described.
 - *Comment:* The purpose of the adjustments to the data is to ensure that the population being priced is well represented by this manual rate. If the manual is not representative of the population and product being priced, then the final rates will not be accurate.

If a carrier used nationwide experience they should provide a logical explanation for why nationwide experience was used and if reasonable adjustments were made to reflect Arkansas specific utilization, price levels or other regional specific attributes.

- ❖ **Inclusion of Capitation Payments:** If some of the services in the projection period will be provided under a capitation arrangement, a description of how these payments were accounted for in the development of the credibility manual should be included.
 - *Comment:* A capitation payment is when an insurer pays a provider a fixed amount per month to perform a service. This payment structure can introduce a different claim and utilization that would be different than traditional payment methods.

Credibility of Experience

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

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

When the base period experience is partially credible and included in experience used to develop the manual rate, the Actuary must consider the extent to which the manual rate development double counts the base period experience. (See —The Complement of Credibility by Joseph A. Boor, Proceedings of the Casualty Actuarial Society, May 1996, Volume LXXXIII.) If the proposed manual rate lacks sufficient independence from the base period experience, the credibility percentage in the

template should be adjusted such that the experience is assigned the appropriate credibility (based on the issuer's credibility formula), taking into consideration the proportion of the manual experience that is from the subject base experience. In this case, additional documentation should be included in the Actuarial Memorandum to demonstrate that the credibility factor applied in the template is consistent with the issuer's credibility formula. See the example in the comments section.

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."

Some Review Considerations

Most of the time, credibility is based on membership. CMS uses a credibility formula where 24,000 member months is considered to be fully credible for Medicare Advantage Plans. Partial credibility is calculated to be the square root of the number of member months divided by 24,000. The State of Colorado uses 2,000 life years and 2,000 claims each year as fully credible.

An example for a carrier who avoids double counting the base period experience in the manual rate is:

If a partially credible plan had 8,000 member months and was weighted with a population that had 50,000 member months (including the partial credible plan), then the original credibility percentage would be $(8,000/12,000)^{0.5} = 81.650\%$. The manual rate would then have a credibility applied of $100\% - 81.650\% = 18.350\%$.

However, the manual rate is composed of $8,000/50,000 = 16\%$ of the partially credible plan's experience. In order for the combined experience of the partially credible plan and the manual rate to have a contribution of the partially credible plan equal to 81.650% overall, then Q = the new credibility would have to satisfy this formula:

$$Q + (1-Q) * (MM/TM) = C,$$

Where MM = the number of member months for the partially credible plan;

TM = the total number of member months in the manual rate experience (including the member months of the partially credible plan); and C = the original credibility of the partially credible plan = $(MM/12,000)^{0.5}$

Solving for Q,

$$Q = \frac{C - (MM/TM)}{1 - (MM/TM)}$$

In our numerical example, $Q = (81.650\% - (8,000/50,000)) / (100\% - (8,000/50,000))$;
 $Q = 78.15\%$

Paid to Allowed Ratio

The Paid to Allowed Average Factor in Projection Period for the market, shown in Worksheet 1, Section III should be supported. The ratio must be 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.

Some Review Considerations

1. This amount 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. This value does not come from the AV Calculator.
2. This amount reflects the average benefit level anticipated, which means that it should indicate the anticipated metal level for the projection period for a particular product¹³.

Risk Adjustment and Reinsurance

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

❖ Projected Risk Adjustments PMPM:

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

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

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

Some Review Considerations

1. Has the issuer provided a detailed exhibit showing their risk adjustment calculation?

¹³ Part I Unified Rate Review Template Instructions (March 18, 2013)

2. How were the risk scores for the risk pool developed?
3. Were the payment transfers allocated by premium amounts?

❖ **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium (Individual Market 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.

Some Review Considerations

1. Section 5, Number 15 of this report explains how the reinsurance payments are calculated. These calculations should be reviewed.
2. The reviewer may request the reinsurance amount published in the Annual Notice of Benefit and Payment Parameters to verify that the assessment is accurate.
3. Issuers may describe the data used to calculate the estimates, and the reviewer could confirm the plan characteristics of the reinsurance, including the attachment point, etc.
4. Confirm that the calculation was based on an incurred claims basis, not an allowed claim basis.

Non-Benefit Expenses and Profit & Risk

- ❖ **Administrative Expense Load:** All expenses that do not reflect payments made to providers under the contract for covered medical services should be supported. 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 should be described. If the percentage load varies by product or plan, it should be explained. The source data that was used as a basis for the projections and why that data is appropriate should be provided.

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.

The issuer should maintain documentation of the expense allocation methodology, including expenses identified by function and whether they are fixed or variable. This could be requested by the reviewer.

Some Review Considerations

1. Review the supporting documentation for administrative expense development:
 - Determine if there is a justification for the level of administrative costs, including services provided under administrative agreements with related or non-related parties.
 - Look at the distribution by expense category.
2. Are changes from the actual reporting period to the projection period reasonable?
 - Review the supporting documentation for a description of changes since the experience period that may explain the deviation of the projected from actual, e.g. enrollment, contractual arrangements, allocation methodology, etc.
 - Consider the exposure basis, i.e. credibility, associated with actual versus projected values.
3. Consider if the product was a new plan in the experience period.
4. Consider that administrative expenses such as overhead expenses may be more reflective of the overall operations of the health insurance issuer rather than the specific product.
5. Evaluate the impact of changes in administrative costs related to programs that improve health care quality.
6. Evaluate the overall level of commission/distribution costs and any changes for the projection period.

7. Evaluate the base period allowed costs on a pmpm basis by service category versus other products in marketplace.
8. Evaluate the basis for new expense items e.g. user Exchange fees.

❖ **Profit (or Contribution to Surplus) & Risk Margin:** The target underwriting gain/loss margin and any additional risk margin should be described. To the extent that the target as a percent of premium has changed from the prior submission, additional support for why the change is warranted will be provided. If the percentage load varies by product or plan, it should be explained.

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.

Some Review Considerations

1. The profit should be assessed on both a percent of premium basis and a pmpm basis.
2. Projected margin levels should be relatively consistent on a year-by-year basis. Significant annual variations should be supported.
3. For products with projected negative margins, the issuer must demonstrate that this is not anti-competitive behavior.
4. Projected profit can be compared to actual levels reported in statutory financial statements.
5. Does the documentation provide adequate narrative and quantitative support for variations in margin due to differences in the degree of risk or surplus requirements for the particular product line?
6. Consider if the plan's projected gain load includes a contingency margin that correlates to the "risk" in the product.
 - For example, a product with low inpatient cost sharing may be an indicator of the "richness" of the plan. A plan with "richer" benefits might attract enrollees with anti-selective behavior.
7. Is the proposed rate increase necessary for the issuer to stay solvent?
8. Is the proposed rate increase necessary to maintain rate stability and prevent excessive future rate increases?
9. How sensitive is the level of company surplus to different rate increase scenarios?
10. Are there any transactions between affiliates that could distort profit levels or surplus levels?
11. How material is the impact of the health issuer's investment income?

❖ **Taxes and Fees:** Each tax and/or fee should be described and the amount for each, either as a percent of premium or a per member per month amount, should be provided. Only the taxes and fees that may be subtracted from premiums for purposes of calculating MLR will be described. However, any contributions to the Federal transitional reinsurance program in this amount despite their treatment in MLR calculations, since Federal reinsurance is expressed in the template net of reinsurance premium, should not be included. 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.

Some Review Considerations

1. How were the Exchange user fees PMPM calculated?
2. How were these amounts applied as an adjustment to the market?

Projected Loss Ratio

The projected loss ratio using the federally prescribed MLR methodology should be provided. If the projected loss ratio is less than 80%, the issuer needs to explain its plan to comply with the Federal MLR requirement found in PHSA 2718.

A demonstration of the MLR calculation should be included.

Some Review Considerations

1. Lifetime Loss Ratio Analysis (Individual only)
 - Review lapse assumptions;
 - Assess the impact of underwriting by policy duration and overall;
 - What is the anticipated loss ratio before and after implementation of proposed rate increase?
 - Assess the reasonableness of projection/calculation method;
 - Assess the impact of the credibility level assigned to base period data;
 - What is the basis for the interest rate assumption;
 - Evaluate the change in lifetime loss ratio since the last rate filing.
2. Additional Loss Ratio Analysis
 - Does the projected loss ratio appear reasonable in light of the historical loss ratio and the level of the projected rate increase?
 - Is the projected aggregate medical loss ratio less than projected federally-adjusted medical loss ratio?
 - Does the relationship between the medical loss ratio and federally-adjusted medical ratio appear reasonable based on the justification provided
 - How does the calculated value, $\text{Estimated Rate Change} = \frac{\text{Historical Loss Ratio}}{\text{Target Loss Ratio}} - 1$, compare to the proposed rate change?
 - Are differences between these two amounts adequately explained by changes in other factors, such as benefit changes, age and gender factors?
 - If the projected medical loss ratio is significantly greater than historical medical loss ratios, but the carrier is requesting a large rate increase, then there may be an inconsistency in the filing that requires additional inquiry.
3. Federally Adjusted Loss Ratio

- Does the issuer provide enough detail to understand how the federally adjusted loss ratio was developed?
- Is the federally adjusted loss ratio targeted at 80%? Is the issuer planning to file rebates?

Index Rate

The Index Rate in both the experience period and the projection period must be included. It is the legal entity-specific rate for the State and market that is being submitted. The Index Rate represents the estimated total combined allowed claims experience PMPM of all non-grandfathered plans for Essential Health Benefits (EHB) within a market and State, and should not be adjusted for payments and charges under the risk adjustment and reinsurance programs, or for Exchange user fees. It is simply allowed claims PMPM for Essential Health Benefits.

The difference between the total allowed claims PMPM and the Index Rate should be described. For example, any covered benefits in excess of Essential Health Benefits that are included in allowed claims but excluded from the Index Rate should be identified and explained.

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, the methodology used to develop the reported Index Rate of Experience Period must be provided. The development of the Index Rate should explain 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 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, 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. The projected trended Index Rate for each effective date in the submission will be provided.

The projected Index Rate must reflect the anticipated claim level of the projection period with respect to trend, benefit and demographic differences. It must reflect the experience of all policies expected to be in the Single Risk Pool (with all necessary adjustments to reflect the benefits, market rules, etc. applicable to policies upon issue or renewal during the entire projection period) of the applicable market regardless of the renewal date of the policies.

For example, for policies issued on July 1, 2013 the experience of these policies should be included in projecting the January 1, 2014 Index Rate, and adjusted to reflect benefits, trend, market rules, etc. as if the policies were going to be renewed on January 1, 2014 with rates

effective through December 31, 2014, despite the actual renewal not being scheduled to occur until July 1, 2014.

If an issuer wants the renewal rates to increase with trend in the Small Group market, the issuer may file the quarterly trend amounts for the twelve month period at one time. The quarterly trend factors applied to the issuer's rates should be included in the Part III Actuarial Memorandum. The Appendix to the Instructions for the Part I Unified Rate Review Template provides further guidance.

For qualified health plans (QHPs) offered in an exchange, the rates may only change at the uniform interval permitted by the Exchange. For individual market exchanges, this would generally be annually. It is anticipated that issuers may be able to file for rate increases in the Small Business Health Options Programs (SHOPs) on a more frequent basis, such as quarterly, for example. While rate adjustments may be filed on a more frequent basis than annually (such as quarterly), these interim filings could include adjustments for other items, such as new products, more recent experience period claims, etc.

The rate development for these 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).

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

- ❖ The Actuarial Value and cost-sharing design of the plan
- ❖ The plan's provider network, delivery system characteristics, and utilization management practices
- ❖ The benefits provided under the plan that are in addition to the Essential Health Benefits. These additional benefits must be pooled with similar benefits within the Single Risk Pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to Essential Health Benefits
- ❖ Administrative costs, excluding Exchange user fees
- ❖ With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans

Specifically for the catastrophic plan rate, 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 should be described.

Some Review Considerations

1. Does this Index Rate represent the average allowed claim cost per member per month for coverage of EHB for the market?
2. Does it exclude adjustments for payments and charges under the risk adjustment and transitional reinsurance programs?
3. Were allowed or paid claims used as a basis for developing the Index Rate? If paid claims were used, how were these claims adjusted to reflect the allowed claims?
4. How was the projected claims experience and manual rate combined to reflect the credibility blended experience?
5. Did the issuer adjust the Index Rate for prohibited rating factors, such as anticipated morbidity?
6. Is there support for the market-wide risk transfer payment or charge? How was it calculated? Is there history available for the previous risk transfer payments?

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.

Some Review Considerations

1. What adjustments were made to the Index Rate to account for differences in Actuarial Value and cost-sharing? How were these adjustments calculated?
2. Are there any of difference due to changes in provider network, delivery system characteristics, or utilization management?
3. What additional benefits are included?

AV Pricing Values

The fixed reference plan selected as the basis for the AV Pricing Values should be provided. The reference plan is described further in the instructions for the Part I Unified Rate Review Template. For each plan, 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), should be provided. If the adjustment for plan cost-sharing includes any expected differences in utilization due to these differences in cost sharing, a description of how the difference was estimated and how the methodology ensures that differences due to health status are not included in the adjustment must be provided.

Some Review Considerations

1. Differences versus the AV Metal Value calculation could include:
 - a. Area-specific population versus the standard population
 - b. Differences in age
 - c. Network/discounts
 - d. Excess benefits (beyond EHB – this could vary by product)
 - e. OON benefits
 - f. Administrative Expenses

Membership Projections

A description of how the membership projections found in Worksheet 2 of the Part I Unified Rate Review Template were developed must be included. 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.

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

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

Some Review Considerations

1. Is the projected membership in line with previous years? If not, have the differences be quantified and explained?
2. How were the members eligible for the cost sharing reduction subsidies split out and identified?

Terminated Products

The name of each product that will be terminated prior to the effective date will be listed. 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 will be included.

Some Review Considerations

1. Were the terminated products included in the URRT as required by the Single Risk Pool guidance?

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, the instructions require that the issuer explain the differences between the issuer's plan and the plan type selected.

Warning Alerts

In the event of Warning Alerts in Worksheet 2, the issuer will describe any difference between the sum of the plan level projections in Worksheet 2 and the total projected amounts found on Worksheet 1.

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).

If this information is not provided, it is suggested that all additional elements be requested to facilitate the review.

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 should 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 Benefits 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 is used in the development of plan specific premium rates.

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.

The reason an alternate methodology was used must be included. The description of the process that was used to develop the AV metal value should be included also.

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.

Some Review Considerations

1. The objective of obtaining an Actuarial Certification is to place greater responsibility on the Actuary's professional judgment and to hold the Actuary accountable for the reasonableness of the assumptions and projections.
2. AID could verify in the actuarial directory, www.actuarialdirectory.org, that the Certifying Actuary is a member of the American Academy of Actuaries (AAA) and compliant with professional continuing education requirements.
3. It should be noted that not all members of the AAA are qualified to perform all actuarial tasks. Certifying actuaries must be qualified under Precept 2 of the Code of Professional Conduct and thus must also have pricing experience in order to do rate filings.
4. If the reviewer has reason to doubt the Actuary's qualifications, the reviewer can contact the Actuarial Board for Counseling and Discipline (ABCD), www.abcdboard.org. The reviewer can request the ABCD to investigate the Certifying Actuary's qualifications in accordance with its Rules of Procedure.
5. An important step in evaluating the Actuarial certification is to carefully read the language used to determine whether it is a clean opinion or a qualified opinion.
6. A qualified opinion would typically use wording such as the following: "except for the issue referred to in the preceding paragraph...". This is an indication that the information provided modifies the Actuary's opinion and in some manner weakens the Actuarial Certification.
7. The reviewer should carefully read any apparent qualifying language and discuss the specific meaning of the qualification with the Certifying Actuary.
8. If the qualification is deemed significant, it may be that the health insurance issuer has not complied with the requirements of Bulletin 3B-2013.

APPENDIX A: Arkansas Geographic Rating Areas¹⁴

Region	Counties
Central	Cleburne, Lonoke, Pulaski, Yell, Conway, Perry, Saline, Faulkner, Pope, Van Buren, Grant, White
Northeast	Clay, Fulton, Jackson, Randolph, Woodruff, Craighead, Greene, Lawrence, Sharp, Crittenden, Independence, Mississippi, St. Francis, Cross, Izard, Poinsett, Stone
Northwest	Baxter, Madison, Washington, Benton, Marion, Boone, Newton, Carroll, Searcy
South Central	Clark, Pike, Garland, Hot Spring, Montgomery
Southeast	Arkansas, Cleveland, Jefferson, Phillips, Ashley, Dallas, Lee, Bradley, Desha, Lincoln, Chicot, Drew, Monroe
Southwest	Calhoun, Lafayette, Ouachita, Columbia, Little River, Sevier, Hempstead, Miller, Union, Howard, Nevada
West Central	Crawford, Scott, Polk, Franklin, Sebastian, Johnson, Logan

¹⁴ AR [Bulletin](#) 03A-2013

APPENDIX B: HHS Default Standard Age Curve¹⁵

Age	Premium Ratio	Age	Premium Ratio	Age	Premium Ratio
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and Older	3.000

¹⁵ “Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting” dated February 25, 2013 (<http://cciio.cms.gov/resources/files/market-reforms-guidance-2-25-2013.pdf>)

APPENDIX C: Technical Issues with the Actuarial Value Calculator

Several technical issues and inconsistencies have been noted with the Actuarial Value Calculator. Discovered issues include:

- ❖ Using \$0 copay produces a different AV than checking the subject to deductible and subject to coinsurance boxes
- ❖ If the Rx coinsurance is 50% and check the "subject to deductible" box, you get a different result than if the input is 50% in the separate coinsurance column.
- ❖ The AV calculator cannot handle copays for "Outpatient Facility Fee (e.g., Ambulatory Surgery Center)" and "Outpatient Surgery Physician/Surgical Services." The plan will need to estimate the value of the copay as if it were coinsurance.
- ❖ A coinsurance percentage of 99.99% produces a 2% difference in AV compared to 100.00% coinsurance. The 99.99% coinsurance more closely resembles the AV resulting from typing in 100.00% coinsurance into the "Coinsurance, if different" boxes.

APPENDIX D: Unified Rate Review Template¹⁶

The Part I Unified Rate Review Template (URRT) is required to be submitted by all issuers in the individual or small group markets that are proposing a rate increase on any non-grandfathered product. In addition, all issuers applying for at least one QHP in the State must submit the template for the applicable market in which the QHP would be offered. Quarterly rate increases for the small group market will be allowed.

The URRT is considered to be a reporting tool, not a rating tool. Be sure to review the Actuarial Memorandum for the pricing assumptions and methodologies.

The Purpose of the URRT

The URRT consists of 2 worksheets in an Excel file. Issuers are required to fill out a URRT with each rate filing submission that includes all products in the Single Risk Pool.

The purpose of Worksheet 1 is to capture information at the market level, consistent with the requirement to set premium rates using a single risk pool, as defined in 45 CFR Part 156, §156.80.

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.

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.

Technical Considerations

HHS has released the URRT and does not plan to update it until 2014. Several technical issues and inconsistencies have been noted with the URRT. Discovered issues are included in Appendix D as they are found.

Below is a list of issues and possible examples as solutions for entering the data:

- ❖ Worksheet 1
 - Section I
 - For new products, the template does not allow blanks for any of the data cells.
 - Also, it does not allow zero dollar inputs for premiums (F14), incurred claims (F15), allowed claims (F16) or member months (F18). However, it does allow for a zero dollar index rate.
 - For individual and combined market products, the date of the beginning of the experience period (E12) should be January 1 of the most recently completed calendar year. For small group products, the date must be

¹⁶ HHS “Part I Unified Rate Review Template Instructions,” March 18, 2013

the first date of a calendar quarter, e.g., January 1, April 1, July 1 or October 1.

- Section II
 - The template does not allow for blanks for any of the utilization per 1,000 (F24:F29), average cost/service (G24:G29), projection factors (J24:M29) or manual rates (R24:S29). However, it does allow the user to leave the utilization descriptions blank (E24:E29).
 - These entries are restricted to non-negative values. Therefore, the template allows inputs of zero amounts.
- Section III
 - The template does not allow blanks for any of the data cells.
 - The following data restrictions are enforced:
 - (Q32) Credibility: 0.00% - 100.00%
 - (V33) Paid to Allowed factor: 0.000 - 1.000
 - (T40:T42) Admin, Margin & Taxes % of Premium: 0.00% - 100% (Admin can take any non-negative value)
 - (V44) Projected Index Rate PMPM: non-negative values
 - (X47) Projected Member Months: non-negative values

❖ Worksheet 2

- Section I
 - For new products:
 - Historical rate increase information can be left blank (21:23).
 - Rate Change % (25) should be entered as 0.00%.
 - Cumulative rate change % (26) should be entered as -999.00%.
- Section II
 - For new products:
 - Components of premium increase (33:41) and member cost share increase (43) should be entered as zero.
 - Average current rate PMPM (46) should equal the projected rate on WS 1 (V43).
 - For existing products:
 - For each plan, (average current rate + total rate increase) = (line 46 + line 42) = line 80 = average projected rate. However, the totals (Col F) will never be consistent unless the current member months equal projected member months.
- Section III
 - For new products, all entries should be left blank.
- Section IV
 - The section should be completed so that the relationships listed in the next section are valid.
 - Net amount of reinsurance (95) can be left blank for small group products.

Relationships within the URRT

Assuming that only non-grandfathered business is reported in Worksheet 2 (WS2) of the URRT, there are several relationships between Worksheet 1 (WS1) and Worksheet 2 that may help review and understand that information.

- ❖ Assuming only non-grandfathered experience reported on Worksheet 2 for existing products:
 - $WS2\ F54 = WS1\ G14$
 - $WS2\ F55 = WS1\ F18$
 - $WS2\ F56 = WS1\ F14$
 - $WS2\ F60 = WS1\ F16$
 - $WS2\ F64 = WS1\ (F16 - F15)$
 - $WS2\ F67 = WS1\ F15$
 - $WS2\ F72 = WS1\ G15$
 - $WS2\ F73 = WS1\ G16 = WS1\ H30$
 - $WS2\ F74 = WS1\ G17$
- ❖ Assuming only non-grandfathered experience reported on Worksheet 2 for new and existing products:
 - $WS2\ F47 = WS2\ F81 = WS1\ X47$
 - $WS2\ F80 = WS1\ V43$
 - $WS2\ F82 = WS1\ X43$
 - $WS2\ F86 = WS1\ (V32 - V35 - V37) * X47$
 - $WS2\ F90 = WS1\ (X32 - X34)$
 - $WS2\ F93 = WS1\ X38$
 - $WS2\ F95 = WS1\ X37$
 - $WS2\ F96 = WS1\ X35$
 - $WS2\ F98 = WS1\ V38$
 - $WS2\ F100 = WS1\ V44$
 - $WS2\ F99 \neq WS1\ V32$
 - Although the template checks whether these values are consistent, these values will never be equal unless the risk adjustment PMPM (V35) and reinsurance recoveries PMPM (V37) on WS1 are zero. The correct relationship is described below:
 - $WS2\ F99 = WS1\ (V32 - V35 - V37)$

APPENDIX E: Federal Requirements – Market Reforms

On February 27, 2013, the Department of Health and Human Services released 78 FR 13436 (Final Rule)¹⁷. The Final Rule implements the rating provisions with regards to fair health insurance premiums.

Market Rating Reforms

The Final Rule implemented the Market Rating Reforms to ensure that individuals and employers will have access to health insurance coverage and greater premium stability.¹⁸ The Market Reforms are:

- ❖ Fair Health Insurance Premiums;
- ❖ Guaranteed Availability;
- ❖ Guaranteed Renewability;
- ❖ Single Risk Pool.

These Market Reforms apply to non-grandfathered coverage after January 1, 2014. All reforms apply to the Individual and Small Group markets.

Fair Health Insurance Premiums

The Final Rule states that the premium rates in the Individual and Small Group markets may only be based on rating area (geography), age, tobacco usage, and family size¹⁹.

Rating Area (Geography)

Each state must set the number of rating areas based on the certain geographic boundaries, such as counties, three-digit zip codes, or metropolitan statistical areas (MSAs) and non-MSAs.²⁰ Arkansas established 7 rating areas based on its counties for rating purposes.²¹ There is no specification on the allowable geographic rating factors, but the factors must be actuarially justified. The differences in factors between rating areas must not be based on the health status of the population in the area. Appendix A lists the Arkansas approved rating areas.

Age

The federal requirements state that issuers may vary rates by age, but the variance cannot exceed a 3:1 band for adults who are age 21 and older. The Final Rule established a uniform age curve for children, adults, and older adults.²² The child age band allows for a single age factor for individuals age 0 to 20, and the older adult's age factor is the same for all individuals age 64 and older. The adult age band allows for 1 year factor increases from ages 21 to 63 with a limitation that the ratio of the low to highest rate factor being no more than 3:1. Arkansas adopted the federal requirements for age in Bulletin 3B-2013. The federal standard default age curve can be found in Appendix B.

Tobacco Usage

In the Individual and Small Group markets, the federal requirements also allow issuers to vary rates

¹⁷ 78 FR 13436 (<http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf#page=32>)

¹⁸ Health Insurance Market Rules Presentation (<http://cciio.cms.gov/resources/files/market-rules-2-27-2013.pdf>)

¹⁹ ACA Section 2701 – Fair Health Insurance Premiums

²⁰ 45 CFR § 147.102(b) Rating Area (<http://www.ecfr.gov/cgi-bin/text-idx?SID=64841d70dd50be06050eb7ebb598f05a&node=20130227y1.46>), Amended February 27, 2013

²¹ CCIIO Rating Areas (<http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/ar-gra.html>) and QHP Rating Area (AR Bulletin 3A-2013- Rating Area section and Appendix C)

²² 45 CFR § 147.102(d) – Uniform Age Bands

based on tobacco usage. The federal requirements limit carriers to a maximum 50% load. States are allowed to implement more restrictive limits. Arkansas instituted a maximum tobacco usage load of 20% as prescribed in Bulletin 3B-2013. Issuers have discretion to vary the tobacco load by age as long as it does not exceed 20%.

For the purposes of rating, tobacco use is defined as using tobacco on average four or more times per week within in the last 6 months.²³

In the Final Rule, tobacco usage may be rated in the Small Group market if the issuer also offers a tobacco cessation program that would allow tobacco users to reduce their premiums to non-tobacco user levels when they participate in the program.²⁴

Family Size

The Final Rule states that issuers may vary rates based on whether a plan covers an individual or a family. In general, family premiums are determined by adding up the separate premiums of each family member, not to exceed more than the three oldest children.²⁵ Each individual within a family may be rated based on age and tobacco usage. Arkansas adopted the federal requirements for family rating in Bulletin 3B-2013.

Within in the Small Group market, the premiums for all covered participants and beneficiaries are aggregated for the entire group.

Prohibited Rating Factors

The Final Rule states that the premium rates in the Individual and Small Group markets may only be based on rating area (geography), age, tobacco usage, and family size. Examples of common rating factors that are no longer allowable include:

- ❖ Health Status;
- ❖ Medical History;
- ❖ Pre-Existing Conditions;
- ❖ Gender;
- ❖ Industry;
- ❖ Block or Product.

Guaranteed Availability

Issuers will no longer be able to deny coverage to individuals if they apply for coverage. This guarantee issue environment will significantly impact the Individual market because issuers will be required to accept every employee and individual that applies for coverage²⁶.

It is expected that there will be industry challenges in determining the morbidity impact of the currently uninsured population and the impact of the individual mandate that requires all people to have health insurance coverage or face a tax penalty.

Carrier estimates for the impact of guaranteed availability will significantly affect the proposed rates for a given product; therefore, this is one of the key assumptions that must be thoroughly assessed.

Guaranteed Renewability

²³ 45 CFR § 147.102(a)(1)(iv) – Tobacco Usage

²⁴ 78 Final Rule 13406, February 27, 2013, page 30

²⁵ 45 CFR § 147.102(c) – Family Coverage

²⁶ Public Law 111-148 (Mar. 23, 2010) Sec. 2702 – Guaranteed Availability of Coverage
(<http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>)

Issuers must renew or continue coverage at the option of the plan sponsor or individual. Exceptions to this rule include:

- ❖ Nonpayment of premiums;
- ❖ Fraud;
- ❖ Violation of participation/contribution rates (group market only);
- ❖ Enrollees' movement outside service area;
- ❖ Loss of association membership.

Issuers may terminate a product, but the individual or group must be offered other products. Issuers may also exit the individual or group market, as permitted by the State²⁷.

Single Risk Pool

The Final Rule requires issuers to maintain a Single Risk Pool for the Individual market and a Single Risk Pool for the Small Group market, unless a state merges the markets into one Single Risk Pool²⁸. Arkansas is not merging the Individual and Small Group markets into a Single Risk Pool²⁹. All non-grandfathered plans in each Single Risk Pool must be pooled together for rating purposes.

Within each Single Risk Pool, an Index Rate is established for each plan or policy year³⁰. The Index Rate is the total combined claims costs for providing Essential Health Benefits (EHBs). Once the index rate is calculated, it must be then adjusted for market-wide payments under the risk adjustment program and reinsurance program.

Plans within the Single Risk Pool may vary according to the permitted plan-level adjustments³¹. These adjustments to the market-wide adjusted index rate include:

- ❖ Actuarial Value and cost-sharing design of the plan;
- ❖ Plan's provider network, delivery system characteristics, and utilization management practices;
- ❖ Additional benefits beyond EHBs;
- ❖ Administrative Costs;
- ❖ Other adjustments specific to catastrophic plans.

The information on the Unified Rate Review Template (URRT) does not explicitly detail how the Index Rate and adjustments are calculated. Carriers must document the methods for calculating these items within the supporting Actuarial Memorandum. Both the URRT and Actuarial Memorandum are discussed in later sections.

Essential Health Benefits

The Essential Health Benefits are defined as³²:

- ❖ Ambulatory patient services;
- ❖ Emergency services;
- ❖ Hospitalization;
- ❖ Maternity and newborn care;
- ❖ Mental health and substance use disorder services, including behavioral health treatment;
- ❖ Prescription drugs;

²⁷ Health Insurance Market Rules Presentation (<http://cciio.cms.gov/resources/files/market-rules-2-27-2013.pdf>)

²⁸ 78 Final Rule 13406, February 27, 2013, page 2; ACA Sec. 1312(c)

²⁹ AR Bulletin 03A-2013

³⁰ 45 CFR § 156.80(d) – Index Rate

³¹ 45 CFR § 156.80(d) (2)– Permitted plan-level adjustments

³² ACA Sec. 1302 - Essential Health Benefits Requirements

- ❖ Rehabilitative and habilitative services and devices;
- ❖ Laboratory services;
- ❖ Preventive and wellness services and chronic disease management;
- ❖ Pediatric services, including oral and vision care.

These benefits are required to be covered on all non-grandfathered health plans in the Small Group and Individual markets both inside and outside the Exchanges. Each State must select a benchmark plan that serves as a reference plan.³³

For Arkansas, the EHB Benchmark Plan is the Blue Cross Blue Shield Health Advantage Point of Service Small Group plan³⁴. Additionally, this was supplemented with the Pediatric Vision and Dental benefits from the Arkansas CHIP plan.

All non-grandfathered plans must offer benefits and coverage limits that are substantially equal to the benchmark plan's EHB offerings. Benefit substitutions within the same category are permitted if the substitution is actuarially equivalent. The Actuarial Certification in the Actuarial Memorandum must specifically address the actuarial equivalence of the substitution. No substitutions are allowable for prescription drug.

A carrier is allowed to offer benefits in excess of the EHB. Note these excess benefits would not be included in the Actuarial Value calculation.

Actuarial Value and Actuarial Value Calculator

Each plan must meet an Actuarial Value (AV), which indicates the plan's level of coverage. Each plan's level of coverage must be actuarially equivalent to a specific metal level that represents a percentage of the full actuarial value of the benefits provided in the plan. The metal levels are³⁵:

- ❖ Bronze Level: 60%;
- ❖ Silver Level: 70%;
- ❖ Gold Level: 80%;
- ❖ Platinum Level: 90%.

The Actuarial Value is based only on the EHBs for the plan and the cost-sharing provisions for a set of benefits.³⁶ The AV is calculated by computing a standard population's ratio of:

- ❖ Total Expected Payments by the plan for EHBs, accounting for the plan's cost-sharing rules (i.e.: deductibles, coinsurance, copays, etc.) divided by
- ❖ Total Costs for the EHB without any cost-sharing provisions.

The AV measure is designed to help consumers quickly compare plans that have different cost-sharing provisions. As an example, a plan with an 80% AV would be expected to pay, on average, 80% of the expected medical expenses for the EHB at the Gold level. The individual would be responsible for the remaining 20% of the expenses.

³³ Essential Health Benefits Bulletin, Dec. 16, 2011

CCIIO http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf ³⁴ AR Directive 1-2013

³⁵ ACA Sec. 1302(d) - Levels of Coverage; AR Bulletin 3A-2013

³⁶ Actuarial Value and Cost-Sharing Reductions Bulletin (<http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>) and 45 CFR § 156.140 – Levels of Coverage

A plan is allowed a variation of +/-2% of the metal value. This is known as a de minimis variation.³⁷ In the example above, a plan is still determined to be a Gold metal level if the calculated AV is between 78% to 82%.

To calculate AVs, HHS developed the Actuarial Value Calculator. All issuers must use the AV Calculator, unless the health plan's design is not compatible with the AV Calculator³⁸. In the event that the provided AV Calculator is not used for any other reason, the Actuary must use the AV Calculator to compare to the alternative method used. In situations where the HHS calculator is not used, an Actuarial Certification is required to be submitted to support the calculations.

The AV Calculator is an Excel based model that allows the user to input cost-sharing provisions of each plan. Please note the following regarding the AV calculator:

- ❖ It uses a national standard population without geographic variations.
- ❖ It only considers In-Network benefits for the EHBs.
- ❖ The Calculator is able to handle HRA and HSA contributions within the model by treating the contributions as first dollar coverage benefits.
- ❖ The model does not support copays in conjunction with coinsurance.
- ❖ It also does not allow copays for Outpatient facility or Outpatient professional services.
- ❖ Cost-sharing provisions are limited in the model based on the IRS limitations from 223(c) (2) (A) (ii). In 2014, the maximum out of pocket allowable is \$6,500.

The AC calculator uses separate tables by desired metal level due to differences in induced utilization. Induced utilization accounts for different claim patterns based on a plan's benefit richness. The user must select the desired metal level so the appropriate continuance table is used in the calculations.

If the AV Calculator produces a percentage that represents a different metal level, then the user must select the correct continuance table. For example, if a user selects a Gold plan as the desired metal level, the Gold plan continuance tables are used. If the resulting AV is not within 78% and 82%, then the user would have to change the benefits or select another metal level continuance table as their desired metal level. In order for an AV to be valid, both the chosen desired metal level and calculated AV metal level must match.

Several technical issues and inconsistencies have been noted with the AV Calculator. Discovered issues are included in Appendix C as they are found.

Minimum Loss Ratio Requirements

Health benefit plans are required to meet minimum loss ratios for each market.³⁹ The following are the required minimum medical loss ratios by market:

- ❖ Large Group: 85%;
- ❖ Small Group: 80%;
- ❖ Individual: 80%.

If a carrier does not meet these minimum loss ratios in a given market, the carrier must issue rebates back to the individuals or groups in order to meet these minimums. When calculating the medical loss ratio for rebate purposes, adjustments may be made for:

- ❖ Credibility,

³⁷ 45 CFR § 156.140(c) – De minimis variation

³⁸ 45 CFR § 156.135(a) & (b)(2) & (3) – AV Calculation for determining level of coverage

³⁹ 45 CFR § 158.210 – Minimum Medical Loss Ratio

- ❖ Quality improvements,
- ❖ Taxes and fees,
- ❖ Payments for risk adjustment, risk corridors, and reinsurance.⁴⁰

The rebates are required to be filed in June for the prior year at the market level, and the payments are due in August. Estimated prospective impacts will have to be included at the time of the rate filing.

Arkansas bulletins do not have minimum loss ratio requirements. The federal MLR can be used as a guide. It can be expected that projected loss ratios in the rate filing can be as much as 7% lower than the rebating MLR guidelines due to quality improvement activities and behavioral uncertainties. Also, credibility may affect the loss ratio by a substantial amount.

The calculation of the federally applied MLR would require information that may not be contained in a single filing. Often blocks of business are aggregated and credibility adjustments may be used. Reviewers may need to ask for the detailed calculations to ensure that the company is complying.

⁴⁰ 45 CFR § 158.221 – Formula for calculating an issuer’s medical loss ratio

APPENDIX F: Federal Requirements – Premium Stabilization Programs

The ACA established several programs to stabilize premiums in the Individual market to minimize the effects of adverse selection. These programs include⁴¹:

- ❖ Transitional Reinsurance,
- ❖ Temporary Risk Corridors,
- ❖ Permanent Risk Adjustment.

Of the 3Rs, the Transitional Reinsurance and Risk Adjustment Programs will affect the premium rates submitted by carriers.

Transitional Reinsurance

This mandatory reinsurance program was developed to stabilize premium volatility while all healthcare reform changes are being implemented. The program is effective from 2014 to 2016. All group and individual issuers and third party administrators (TPAs), who provide major medical coverage, are required to contribute to the State's reinsurance entity for the plan year⁴². The contribution amounts are \$5.25 per enrollee per month for 2014 and will be based on total market share.

The aggregate national contributions for reinsurance payments will be \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016. This program phases out after 2016⁴³. During the first year, the program will help reduce premium rates by 10% to 15%, according to HHS. Note that as the reinsurance contributions over the three year period decrease, premium rates will likely increase to compensate for the loss of the reinsurance subsidies.

The reinsurance payments are based on a coinsurance rate applied to an issuer's paid claims costs that are above an attachment point and below the reinsurance cap for the benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for reinsurance payments. The reinsurance cap is the threshold dollar amount where the issuer is no longer eligible for reinsurance payments.⁴⁴ In 2014, the coinsurance rate is 80% of the attachment point of \$60,000 with a reinsurance cap of \$250,000.⁴⁵

HHS plans to provide quarterly estimates of reinsurance payments. This will help provide funding to compensate for individuals with high claims costs throughout the year.⁴⁶ These payments will begin in May 2014. Payments will be prorated based on received contributions to ensure that payments do not exceed the available funds.

In 2015, the annual payment reconciliation will begin. Each quarter, an amount will be withheld and allocated toward the annual reconciliation. Amounts are withheld from the quarterly payments for plans that become eligible for reinsurance payments later in the year. This process prevents the funds from being exhausted before some plans hit the attachment point. The annual reconciliation pays out

⁴¹ Bulletin on the Risk Adjustment Program (<http://cciio.cms.gov/resources/files/ppfm-risk-adj-bul.pdf>)

⁴² ACA Sec. 1341 - Transitional Reinsurance Program for Individual and Small Group Markets in each State

⁴³ CCIIO Reinsurance Presentation (<http://cciio.cms.gov/resources/files/hie-ro-hhs-or.pdf>)

⁴⁴ 45 CFR § 153.20 & 45 CFR § 156.230 – Reinsurance Program and Calculation of Reinsurance Payments

⁴⁵ Buck Consultants' fyi "Transitional reinsurance program results in significant new costs for group health plans" (<http://www.buckconsultants.com/portals/0/publications/fyi/2012/fyi-2012-1206-Transitional-reinsurance-program-results-in-new-costs.pdf>)

⁴⁶ Bulletin on the Transitional Reinsurance Program (<http://cciio.cms.gov/resources/files/reinsurance-program-bulletin-5-31-2012.pdf>)

withholds throughout the year and any unpaid quarterly payments.

Risk Adjustment

Since the ACA limits issuers from rating individuals or small groups based on health status, the Risk Adjustment Program was established to help stabilize premiums and mitigate these risks. The Risk Adjustment program's goal is to transfer money between health plans to cover the actual risk exposure beyond what the issuers can charge through premiums⁴⁷.

In Arkansas, HHS will run the program.

Unlike the reinsurance program, the risk adjustment program is permanent. This program applies to non-grandfathered Individual and Small Group plans inside and outside the Exchange.

Payments are provided to issuers that disproportionately attract higher risk populations⁴⁸. The program is designed to transfer funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection.

HHS has established a Federal methodology for risk adjustment calculations, which will be used in Arkansas⁴⁹.

The Final Rule defines the risk adjustment methodology⁵⁰:

- ❖ Risk Adjustment Model;
- ❖ Calculation of Plan Average Actuarial Risk;
 - Includes removing rating variation for age, geography, smoking, and family status
- ❖ Calculation of Payments and Charges;
- ❖ Data collection approach;
- ❖ Schedule for implementation.

Risk Adjustment Model

The HHS Risk Adjustment Model predicts the health care costs based on the relative actuarial risk of enrollees in risk adjustment covered plans⁵¹. In HHS-run States, this model calculates individual risk scores that are used to develop the plan average actuarial risk. The risk scores predict plan liability and not the total expenditures. Each enrollee's risk score is based on the individual's demographic and health status information. The risk scores are calculated on a concurrent basis, meaning that the current year diagnoses predict current year costs. The model also addresses the newly insured population, plan metal level differences, and the need for risk adjustment transfers that net to zero⁵².

The Risk Adjustment methodology is based on 15 separate risk adjustment models – one for each combination of:

- ❖ Metal Level – Platinum, Gold, Silver, Bronze, Catastrophic
- ❖ Age Group – Adult, Child, Infant.

⁴⁷ ACA Sec. 1343 – Risk Adjustment

⁴⁸ CCIIO Reinsurance, Risk Corridors, and Risk Adjustment Final Rule Presentation (<http://cciio.cms.gov/resources/files/3rs-final-rule.pdf>)

⁴⁹ 45 CFR § 153.320 – Federally certified risk adjustment methodology

⁵⁰ Bulletin on the Risk Adjustment Program (<http://cciio.cms.gov/resources/files/ppfm-risk-adj-bul.pdf>)

⁵¹ CCIIO Risk Adjustment Methodology Overview Presentation (<http://cciio.cms.gov/resources/files/hie-risk-adjustment-methodology.pdf>); 45 CFR § 153.20 – Definitions

⁵² HHS Risk Adjustment Model Algorithm Instructions (http://cciio.cms.gov/resources/files/ra_instructions_proposed_1_2013.pdf)

The risk score is calculated at the diagnosis level, using ICD-9 codes, and each person is assigned Hierarchical Condition Categories (HCCs). Demographic and interaction factors are also added to the risk scores. HHS intends to use diagnoses in the current year to predict the expenditures in the current year. HCCs are additive for unrelated disease categories. The interaction factors occur when an individual with at least one of the HCCs that comprises the severity illness indicator variable and at least one of the HCCs interacted with the severity illness indicator variable would be assigned an interaction factor.

Schedule for implementation

Issuers will provide data for the risk adjustment calculations by April 30th of the year following the benefit year (for example, by April 30, 2015 for benefit year 2014). HHS will notify issuers of payments owed or charges due no later than June 30th of the year following the benefit year (for example, by June 30, 2015 for benefit year 2014).

Risk Adjustment Estimation for Filings

Each filing will include an estimated pmpm impact as a result of risk adjustment. In determining the pmpm impact, a risk adjustment value of 1.0 means that the individual or group population is assumed to be an average risk. A value greater than 1.0 will indicate a riskier individual or group population and the carrier will receive risk adjustment payments. A value less than 1.0 will indicate a better risk individual or group population and the carrier will be charged risk-adjustment payments.

- ❖ Carrier estimates in the URRT will be on a pmpm basis. The carriers will subtract the difference in the estimated market risk score versus the estimated single risk pool risk score. This difference would then be multiplied by the allowed cost pmpm.

APPENDIX G: Arkansas Checklist

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
Cover Letter	Include the legal name and address of the submitting company, toll-free number and valid email address of the filer, unique identifying form number of each form submitted and its descriptive title, whether the form is new or a form revision, and identify for any revised forms the form being replaced by its form number, assigned tracking number and approval date.				
SERFF Rate Review Detail	Complete the Rate Review Detail screen within SERFF. Include supporting documentation of the calculation within the Supporting Documentation tab of SERFF.				
Rate Schedule	A schedule of rates for the filed effective date for all products and plans which are part of the single risk pool must be submitted. Include all products and plans regardless of whether or not a rate increase is being requested.				
Federal Part I Unified Rate Review Template	A Federal Part I Unified Rate Review Template must be submitted with all rate filings which include at least one product that is subject to a rate increase in Arkansas.	45 CFR 154.215(a) and (b), AR Bulletin 09-2013			
Federal Part II Written Description	A Federal Part II written description must be submitted for all rate increases in Arkansas.	45 CFR 154.215(a), (b), and (e), AR Bulletin 09-2013			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
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Federal Part III Actuarial Memorandum Requirements	A Federal Part III Actuarial Memorandum requirements must be provided with each filing and must follow the Actuarial Memorandum structure as guided by CMS.	45 CFR 154.215(a) and (b), AR Bulletin 09-2013			
Company Legal Name	The Company's legal name associated with the HIOS issuer ID	Federal Part III Actuarial Memorandum			
HIOS Issuer ID	The HIOS ID assigned to the legal entity	Federal Part III Actuarial Memorandum			
NAIC Number	The NAIC Company Code assigned to the legal entity	Federal Part III Actuarial Memorandum			
Primary Contact Name	Name of person at the company who will serve as the primary contact for the filing	Federal Part III Actuarial Memorandum			
Primary Contact Number	Phone number for the primary contact	Federal Part III Actuarial Memorandum			
Primary Contact Address	Address for the primary contact	Federal Part III Actuarial Memorandum			
Scope and Purpose	The scope and purpose of the filing, including all laws the filing is intended to comply with. List the proposed changes to the base rates or rating factors	ASOP #8			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
Market	The market in which the products are offered	Federal Part III Actuarial Memorandum			

Inside or Outside the Exchange	Indicate whether the products are to be sold inside the Exchange, outside the Exchange, or both.				
Policy forms	List all policy form numbers including HIOS Product Codes and Product Names	Federal Part III Actuarial Memorandum			
Description of Benefits	A narrative description of the benefits that will be provided by the policy forms included in the filing.	Federal Part III Actuarial Memorandum			
Marketing Method	A description of the marketing methods used to inform consumers of the availability of the policies and whether policies are to be offered on the government exchange.	Federal Part III Actuarial Memorandum			
History of Rate Adjustments	The month, year and percentage amount of all previous rate revisions.				
Effective Date and Implementation of Proposed Rate Adjustment	The month and year that the rate revision is scheduled to be implemented, and the implementation method, such as the next policy anniversary date, etc.	Federal Part III Actuarial Memorandum			
Months of Rate Guarantee	The number of months that the rate will be guaranteed to an individual policyholder.				

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
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Proposed Percentage Rate Adjustment	The requested rate adjustments for each product and plan, including an explanation and actuarial justification of the apportionment of the aggregate rate revision within each policy form or between policy forms.	Federal Part III Actuarial Memorandum			
Maximum Rate Change Requested	The maximum rate change that could be applied to a policyholder based on changes to the base rate and rating factors.				
Minimum Rate Change Requested	The minimum rate change that could be applied to a policyholder based on changes to the base rate and rating factors.				
Distribution of Rate Changes	Anticipated distribution of rate changes due to changes in base rates, plan relativities, and rating factors.				
Description of How Rates Were Determined	The type of rating methodology used and a description of how rates were determined to be reasonable relative to the level of benefits provided, and not excessive, inadequate, or unfairly discriminatory				
Reason for Rate Adjustment	A narrative description of the significant factors driving the change in rates.	Federal Part III Actuarial Memorandum			
Percentage of Rate Adjustment Attributable to Experience	The portion of the rate adjustment for each plan that is attributable to experience.				

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
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Average Annual Premium	The average annual premium for Arkansas, before and after the proposed rate adjustment.	Federal Part III Actuarial Memorandum			
Number of Policyholders and Covered Lives	The number of Arkansas policyholders and covered lives affected by the proposed rate increase.				
Dates of Service for the Experience Period Used to Develop Rates	The dates or service of claims representing the base period experience used to develop the index rate for the single risk pool.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(vx)			
Date Through Which Claims Were Paid	The date through which claim payments were made on claims incurred during the experience period.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(vx)			
Estimated Allowed Claims During the Experience Period Used to Develop Rates	The actuary's best estimate of allowed claims for the single risk pool during the experience period that were used as a basis for developing the projected index rate.	45 CFR 154.301(a)(3)(i) and (iv); ASOP #8			
Method for Determining Allowed Claims	The method that was used to determine allowed claims (e.g. directly from claims system, paid claims plus required cost sharing)	45 CFR 154.301(a)(3)(i) and (iv)			
Incurred but Not Paid Claims	Support for the method used to develop the incurred but not paid claims on an allowed basis	45 CFR 154.301(a)(3)(i) and (iv)			
Premium in Experience Period (Net of MLR Rebate)	The best estimate of premium earned during the experience period, both before and after MLR rebates.	45 CFR 154.301(a)(3)(i); ASOP #8			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
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Adjustments to Allowed Claims During the Experience Period	Description and numerical support for adjustments made to the experience period allowed claims for the single risk pool that were used as a basis for developing the projected index rate to adjust for the potential volatile nature of the experience.	45 CFR 154.301(a)(3)(i) and (iv)			
Changes in Benefits	A description of average benefit changes (i.e. changes to covered services) between the experience period and the projection period, and a description of and support for the impact of each change on rates.	45 CFR 154.301(a)(4)(iv); Federal Part III Actuarial Memorandum; ASOP #8			
Trend Factors (Cost and Utilization)	A description of how trend is developed and a detailed trend analysis supporting the factor used.	45 CFR 154.301(a)(4)(i); Federal Part III Actuarial Memorandum; ASOP #8			
Projected Changes in the Demographics of the Population Insured	A description and support for the development of factors used to reflect differences in the average demographics of the population covered in the experience period and the population anticipated to be covered in the projection period.	45 CFR 154.301(a)(4)(v); ASOP #8			
Projected Changes in the Morbidity of the Population Insured	A description and support for the development of factors used to adjust the experience period claims to reflect differences in the average morbidity of the population covered in the experience period and the population anticipated to be covered in the projection period.	45 CFR 154.301(a)(4)(v) and (xv); ASOP #8			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
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Other Projected Changes	A description and support for the development of any other factors used to adjust the experience period claims to reflect differences between the experience period and the population anticipated to be covered in the projection period.	45 CFR 154.301(a)(4)(v) and (xv); ASOP #8			
Methodology Used to Develop the Credibility Manual Rate	A description of the methodology used to develop the credibility manual index rate, if applicable.	ASOP #25			
Source and Appropriateness of Experience Used to Develop the Credibility Manual Rate	A description of the source data used to develop the credibility manual index rate and support that the data is appropriate, if applicable.	ASOP #25			
Adjustments Made to Data Used to Develop the Credibility Manual Rate	A description and support for each adjustment made to the experience used to develop the credibility manual index rate, if applicable.	ASOP #25			
Inclusion of Capitation Payments in Developing the Credibility Manual Rate	A description of how capitated services were accounted for in developing the credibility manual index rate, if applicable.	ASOP #25			
Credibility Method	Description of the methodology used to determine the credibility of the base period experience.	ASOP #25			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
Credibility Level(s)	The credibility level assigned to the base period	ASOP #25			

	experience.				
Covered Services - Essential Health Benefits	Description and percent of claims represented by newly added benefits which are Essential Health Benefits.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iv)			
Covered Services - State Mandated Benefits Which are Not Essential Health Benefits	Description and percent of claims represented by benefits which are Arkansas state mandated benefits but are Not Essential Health Benefits.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iv)			
Covered Services - Eliminated Benefits	Description and percent of claims represented by benefits which are currently covered but will not be covered in the projection period.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iv)			
Covered Services - Additional Mandatory Supplemental Benefits	Listing of benefits that will be covered on a mandatory basis in the projection period but are Not an Essential Health Benefit.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iv)			
Covered Services - Changes in the Level of Covered Services	Description of benefits which are currently covered but will be covered at a different level in the projection period (e.g. change in the number of visits covered).	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iv)			
Covered Services - EHB Substitutions	Description and support for any benefits substituted for Essential Health Benefits.	45 CFR 156.115(b)			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
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Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost-sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.				
Plan Relativities	For rate increase filings, if the rate increase is not uniform for all plan designs, provide support for all requested rate increases by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders. For initial filings, provide the derivation of any new plan factors.				
Credibility Adjusted Projected Claims	Estimated claims for the projection period, after adjusting for credibility, including appropriate support.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(xv)			
Projected Index Rate	Estimated index rate for the projection period, representing the EHB portion of the credibility adjusted projected claims.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(xv)			
Risk Transfer Payments	Demonstration of the calculation of the estimate of the risk adjustment payments during the projection period.	45 CFR 154.301(a)(3)(iii); 45 CFR 154.301(a)(4)(xvi)			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
Transitional Reinsurance	Demonstration of the calculation of the estimate of the transitional reinsurance payments during the projection period.	45 CFR 154.301(a)(3)(iii); 45 CFR 154.301(a)(4)(xvi)			

Plan Level Adjusted Index Rate	Demonstration of how the index rate was adjusted for the allowable plan level adjustments outlined in 45 CFR 154.80(d) (2).	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iii)			
AV Metal Values	Description of how the AV Metal Values for each of the plans was calculated, and support for use of alternate methodologies other than the AV calculator.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iii)			
AV Pricing Values	Description of how the AV Pricing Values for each of the plans was calculated and identification of a reference plan.	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iii)			
Paid to Allowed Ratio	Provide support for the average paid to allowed ratio during the projection period	Federal Part I Unified Rate Review Template and Part III Actuarial Memorandum			
Projected Non-Benefit Expenses, Risk and Profit	Support for proposed non-benefit expenses, risk margins and profit margins.	45 CFR 154.301(a)(4)(vii), (ix) and (x)			
Comparison of Current and Proposed Non-Benefit Expenses, Risk and Profit	A comparison of the amounts by prescribed expense category as a percent of premium and on a PMPM basis for both the current and proposed rates.	45 CFR 154.301(a)(4)(vii), (ix) and (x)			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
Varying Non-Benefit Expenses by Plan	Support for non-benefit expense loads as a percent of premium that vary by plan.	45 CFR 154.301(a)(4)(vii), (ix) and (x)			
Age Factors	Confirm the prescribed standardized factors were used.	45 CFR 154.301(a)(4)(v)			
Geographic Factors	Proposed factors for use with the State defined geographic rating regions and	45 CFR 154.301(a)(4)(xiv)			

	support any changes				
Tobacco Factors	Proposed tobacco status categories and corresponding factors and support any changes.	45 CFR 154.301(a)(4)(v)			
Family Composition	Proposed family composition factors/methodology and demonstration that the premium developed is consistent with the premium developed using the methodology described in 45 CFR 147.102(c)(1) and (2)	45 CFR 154.301(a)(4)(iv)			
Development of Rate Tables	Description of how the plan level adjusted index rate was normalized to the carrier's reference plan for use in developing age, geographic and tobacco status specific rates.	45 CFR 154.301(a)(4)(v) and (xiv)			
Wellness Programs	Describe any wellness programs included in the filing	PHS Act Section 2705(j)			
Projected Contribution to Profit/Surplus	Description of the carrier's expected contribution to profit/surplus for the products filed.	45 CFR 154.301(a)(4)(xii)			
Loss Ratio Requirements	List the appropriate standard from NAIC Model # 134 "Guidelines for Filing of Rates for Individual Health Insurance Forms".	45 CFR 154.301(a)(4)(xi)			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
Projected Federal MLR	Demonstration of the anticipated Federal MLR during the projection period	45 CFR 154.301(a)(4)(xi)			

Reliance	Disclosure of any information developed by other individuals that the actuary relied on in the development of rates.	ASOP #8; Federal Part III Actuarial Memorandum			
Identification of the Certifying Actuary	The certifying actuary must identify himself/herself and indicate they are a member of the American Academy of Actuaries	Federal Part III Actuarial Memorandum			
Certification of the Index Rate	Certification that the index rate was calculated appropriately and in compliance with applicable laws and Actuarial Standards of Practice	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(xv)			
Certification of the Plan Level Rates	Certification that plan level rates were developed using the index rate and only adjusting for allowable factors	45 CFR 154.301(a)(3)(iv); 45 CFR 154.301(a)(4)(iii)			
Certification of Metal AV	Certification that the standard AV Calculator was used to determine the metal AV for each plan or if an alternate methodology is consistent with the AV Calculator.	Federal Part III Actuarial Memorandum			
Certification of EHB Substitutions	Certification that EHB substitutions meet the requirements of 45 CFR 156.115(b)	45 CFR 156.115(b)			

Required Item	Description of Review Requirement	Reference(s)	Location in the Filing	Document Name / Exhibit Name or Number	Filer's Notes
Certification of Geographic Factors	Certification that geographic factors reflect only differences in the costs of delivery (including both unit costs and provider practice patterns) and do NOT reflect differences in morbidity.	45 CFR 154.301(a)(4)(xiv)			

Compliance with Applicable State and Federal Laws and Regulations and Actuarial Standards of Practice	Certification that the proposed rates are in compliance with applicable Arkansas and Federal laws and regulations and applicable Actuarial Standards of Practice.				
Additional Requirements for Stand-Alone Dental Filings	Provide the following for stand-alone dental plan filings: <ul style="list-style-type: none"> - Identification of the level of coverage (i.e. low or high), including the AV of the plan - Certification of the level of coverage by a member of the American Academy of Actuaries, and - Demonstration that the plan has a reasonable annual limitation on cost-sharing. 				

APPENDIX H: Grandfathered Plans

Arkansas Department of Insurance (AID) Bulletin 9-2013 specifies that the filing provisions in Bulletins 6A-2011, 7-2011 and 7A-2011 will still apply to grandfathered plans.

AID will use the additional reporting requirements required under the bulletins listed above to evaluate the proposed rate increases of products to make a determination as to whether the increases:

- Comply with the standards set forth in §23-79-109 through 110 (amended by Act 1187 of 2013 and Act 1339 of 2013), §23-76-112 and §23-75-111; and/or
- Are unreasonable pursuant to 45 CFR 154

Pursuant to §23-79-110, in the Individual Market, the AID shall disapprove a premium rate filed if the commissioner finds that the rate is not actuarially sound, is excessive, is inadequate, or is unfairly discriminatory⁵³. It may also be disapproved if it is not compliant with applicable federal laws or all state laws, regulations, and bulletins.

ACA Applicability to Grandfathered Plans

Most plans that existed on or before March 23, 2010 are exempt from certain ACA requirements. A grandfathered health plan is not required to comply with some of the provisions that apply to non-grandfathered plans⁵⁴.

ACA Provisions that Apply to Grandfathered Plans

- ❖ Prohibited from applying lifetime dollar limits to key health benefits;
- ❖ Not permitted to cancel insurance coverage solely because of an honest mistake that an insured or employer made on the insurance application;
- ❖ Must extend dependent coverage to adult children until they reach 26 years of age.

Grandfathered *individual* health insurance policies are not required to:

- ❖ Remove annual dollar limits on key benefits; or
- ❖ Eliminate pre-existing condition exclusions for children under 19 years of age.

Rate Review Procedures & Rate Filing Submission Requirements

Section 2 of this manual outlines the procedures a compliance officer or reviewer needs to follow once a filing has been submitted. These procedures apply to both non-grandfathered and grandfathered business.

Bulletins 6A-2011 & 7A-2011 outline the reporting requirements required with each submission of a proposed rate change or proposed rate increase to AID.

⁵³ §23-79-110 amended by Act 1187 of 2013(2)(b)(2) (<http://www.arkleg.state.ar.us/assembly/2013/2013R/Bills/SB1071.pdf>)

⁵⁴ U.S Department of Health & Human Services
(<http://www.hhs.gov/healthcare/insurance/grandfather/>)

All health insurance issuers shall submit the following information for Individual Major Medical Policies⁵⁵:

1. A description of the policy or contract form number affected by the rate filing.
2. For all rate filings that represent a rate increase, a rate summary worksheet, and a written description justifying the rate increase.
3. A statement of the approximate number of persons in Arkansas affected by the rate increase.
4. An Actuarial Certification indicating that, in the belief of the actuary, the proposed rate or rate revision does not discriminate unfairly between policyholders or contract holders.
5. The Medical Loss Ratio as calculated under federal guidelines including the actual data elements used in the MLR calculation.

The following requirements shall apply to all health insurance issuers for Small Group Major Medical Policies⁵⁶:

1. Each year on September 1, issuers must file with the Commissioner its schedule of rates or methodology for determining rates. Any changes or new rates must be approved before implementation.
2. Either a specific schedule of rates or a methodology for determining rates shall be established in accordance with actuarial principles for various categories of enrollees.
3. A certification by a qualified actuary as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with the adequate supporting information.
4. Carriers must include the Medical Loss Ratio for the small employer group filing.

Bulletins 6A-2011 and 7-2011 outline the reporting requirements required with each submission of a proposed rate change or proposed rate increase to AID.

All health insurance issuers shall submit the following information:

- ❖ Exhibit 1: Rate Summary Worksheet;
- ❖ Exhibit 2: Written Explanation of the Rate Increase; and
- ❖ Exhibit 3: Rating Filing Justification.

The information contained in Exhibits 1, 2 and 3 serve as the Preliminary Justification and will be posted on the AID website. AID may request part or all of the data included in Exhibit 3 as part of the review of any rate filing. Consumers will be encouraged to submit comments on the proposed rate filing.

Exhibit 1 – Rate Summary Worksheet

Carriers must use the standardized Excel worksheet for completing Exhibit 1 of the Preliminary Justification. The Rate Summary Worksheet includes⁵⁷:

- ❖ Historical and projected claims experience by service category;
- ❖ Overall medical trend split by service category;
- ❖ Enrollee cost sharing portion of the historical and projected claims experience;
- ❖ Allocation of the overall rate increase to claims and non-claims costs;
- ❖ Per enrollee per month allocation of current and projected premium;
- ❖ Range and scope of the proposed increase; and
- ❖ Three year history of rate increases for the product associated with the rate increase.

A sample of a completed version of the worksheet is provided in Appendix I.

Exhibit 2 – Written Explanation of the Rate Increase

The written explanation of the rate increase must provide a brief, non-technical description of why the issuer is requesting this rate increase⁵⁸. This explanation must be easy to understand and is intended to help consumers interpret the rate

⁵⁵ Bulletin 6A-2011

⁵⁶ Bulletin 7-2011, 7A-2011

⁵⁷ Bulletin 6A-2011, 7-2011 – Exhibit 1

⁵⁸ Bulletin 6A-2011, 7-2011 – Exhibit 2

summary data provided in Exhibit 1. The explanation must be submitted as a Microsoft Word file and should include information on the following components related to the rate increase:

- ❖ Scope and range of the rate increase;
- ❖ Financial experience of the product and how the rate increase will affect the projected financial experience;
- ❖ Description of changes in medical service costs and how they contribute to the overall rate increase;
- ❖ Description of any changes in benefits and how those changes affect the rate increase⁵⁹; and
- ❖ The resulting impact of changes in administrative costs and anticipated profits on the rate

increase. Exhibit 3 – Rating Filing Justification

Health Insurance carriers are required to complete Exhibit 3 of the Preliminary Justification for any rate approval.

Issuers have the discretion to select the format in which they present the following reporting elements:

- ❖ Description of the type of policy, benefits, renewability, general marketing method and issue age limits;
- ❖ Scope and reason for the rate increases;
- ❖ Average annual premium per policy, before and after the rate increase;
- ❖ Past experience, and any other alternative or additional data used;
- ❖ A description of how the rate increase was determined, including the general description and source of each assumption used;
- ❖ The cumulative loss ratio and a description of how it was calculated;
- ❖ The projected future loss ratio and a description of how it was calculated;
- ❖ The projected lifetime loss ratio that combines cumulative and future experience, and a description of how it was calculated;
- ❖ The Federal medical loss ratio (MLR) standard in the applicable market to which the rate increase applies, accounting for any adjustments allowable under Federal law;
- ❖ A justification if the projected future loss ratio is less than the Federal MLR standard.

A checklist of the detailed Exhibit 3 requirements listed in Bulletins 6A-2011 and 7-2011 is provided for the reviewer in Appendix J.

⁵⁹ Benefit changes are limited under ACA grandfathering provisions
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Evaluation of the Rate Filing

Exhibits I and III must provide sufficient information to conduct an evaluation of the proposed rate or rate increase.

Pursuant to Bulletins 6A-2011 and 7-2011, AID may take into consideration the following criteria, to the extent applicable, to review the filing:

- ❖ The impact of medical trend changes by major service categories;
- ❖ The impact of utilization changes by major service categories;
- ❖ The impact of cost-sharing changes by major service categories;
- ❖ The impact of benefit changes;
- ❖ The impact of changes in enrollee risk profile;
- ❖ The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increases;
- ❖ The impact of changes in reserve needs;
- ❖ The impact of changes in administrative costs related to programs that improve health care quality;
- ❖ The impact of changes in other administrative costs;
- ❖ The impact of changes in applicable taxes, licensing or regulatory fees;
- ❖ Medical Loss Ratio;
- ❖ The carrier's capital and surplus; and
- ❖ Consumer comments regarding the rate filing;

These criterion were discussed in detail in Sections 3 and 4 of this manual.

Rate Review Determination

The Commissioner, within a reasonable period, shall approve any schedule of rates or methodology, if applicable, for determining rates based on the requirements in Bulletins 6A-2011 and 7-2011. If the Commissioner does not disapprove any schedule of rates filing within 60 days of the filing and the period has not been extended by mutual agreement, the schedule of rates shall be deemed approved. The Commissioner may require the submission of additional information he or she deems relevant in the evaluation of a rate filing.

For all Individual and Small Group filings, a rate filing will be classified into one of the following rate disposition categories⁶⁰, after a statutory rate determination, if applicable:

1. **Unreasonable Rate Increase:** the rate increase was determined to be unreasonable.
2. **Unreasonable Rate Increase (Modified):** the health insurance issuer modified its proposed rate increase during the review process and the modified rate was still determined to be unreasonable.
3. **Unreasonable Rate Increase (Disapproved by State):** the individual market rate increase was disapproved, subject to the requirements of §23-79-109 through 110.
4. **Not Unreasonable:** the rate increase was determined not to be unreasonable. For the individual market, the rate increase was approved, subject to the requirements of §23-79-109 through 110.
5. **Not Unreasonable (Modified):** the health insurance issuer modified its proposed rate increase during the review process and the modified rate increase was determined to not be unreasonable. For the individual market, the rate increase was approved after modification, subject to the requirements of §23-79-109 through 110.
6. **Withdrawn Prior to Determination:** the health insurance issuer elected to withdraw the rate increase prior to the completion of the State's review.

Rate Review Considerations

⁶⁰ Rate Review Instruction Manual (http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf)

The following narratives provide some review considerations for each portion of the filing requirements required for grandfathered business.

Product and Filing Description

This review is to identify the key reasons for the filing before further analysis commences.

Some Review Considerations

1. Evaluate which forms will be affected by which rate increase submitted in the filing. The health insurance issuer may submit multiple rate requests for multiple policy forms.
2. Generally, for major medical plans, the rates are assumed to be effective for 12 months; however, issuers may submit multiple month rate increases to be implemented successively.
 - The issuer may request a 5% rate increase to be effective on 7/1 and an additional 5% to be effective on 10/1.
3. Are there any changes to the underwriting process which could have a corresponding pricing impact?
 - For example, the implementation of additional health questionnaires which could potentially modify the underlying claim costs.
4. What is the relationship between the experience period and the effective date for the proposed rate increase?
5. Are there significant differences or fluctuations over time in the proposed rate change to historical rate changes?

Range and Scope of Proposed Increase

Review the range of rate increases across all covered individuals and compare the overall rate increase versus the overall premium increase.

Some Review Considerations

1. What is the range of possible rate increases?
 - Who is impacted and to what degree?
 - What is the minimum and maximum rate change?
2. Is the proposed increase subject to review threshold (Section F of Part I) materially different than the overall projected premium increase (Section C of Part I)?
 - Is the difference between the two amounts adequately supported by the factors such as aging, moves across different geographic rating zones, population changes, benefit changes, or even changes in employer contribution levels?
 - If the amounts are equal, does the issuer's documentation appropriately demonstrate that there are no changes to the rate structure of the product.
3. Evaluate the range of the maximum and minimum rate increase around the overall average amount.
 - Does the issuer adequately document the reasons for the variation, such as changes to gender and area factors, applied to the assumed population distribution?
4. Evaluate the number of affected policyholders for the minimum and maximum rate increases.

Past Experience

This review is focused on the development of projected costs and the relationship of projected allowed costs to base period experience.

Some Review Considerations

1. For all service categories, review the development of the projected allowed costs for reasonableness and appropriateness.
 - Review the supporting documentation that is required, e.g., the product narrative, credibility assumptions, base period experience and assumptions, and manual rate development experience
2. Is the base period experience appropriate given the level of credibility?

3. A manual rate is blended with the experience:
 - Is the source population of the manual rate appropriate for the type of plan?
 - Are product's plan benefit characteristics taken into account in the manual rate?
 - Is the distribution of costs by service category reasonable?
 - If the issuer used nationwide experience, was there a logical explanation for why nationwide experience was used and were reasonable adjustments made to reflect Arkansas specific utilization, price levels or other regional specific attributes.
4. Has there been a change in the source of the data used in the rate development from the most recently approved rate filing?
 - For example, if the insurer used product specific experience for the base rate development in the prior filing, but in this filing is using a blend of the manual rate and the product experience.
5. Determine if smoothing techniques that shift projected allowed costs to a different reporting affect the experience pmpm.
 - For example, are cost and utilization trends that typically vary significantly by service category inappropriately combined into a single factor?
6. Is there evidence supporting how the assumptions were determined?
7. For each rating factor, is the documentation provided:
 - Complete;
 - Adequately detailed; and
 - Clear.
8. Assess whether assumptions are reasonable individually as well as in the aggregate.
9. Evaluation of the health insurance issuer's aggregation of experience data, e.g. across product line and geographic locations.
10. Evaluate the base period allowed costs on a pmpm basis by service category versus other products in marketplace.
 - The Exhibit 1 file can be used.
11. If further detail is needed, AID can request the issuer to reconcile the experience data presented in Exhibit 1 to the issuer's financial statements.

Changes in Rating Methodology

Review any changes to a health insurance issuer's premium rating methodology.

Some Review Considerations

1. What is the reason for the change?
2. Is the change the actuarially sound?

Cost Sharing

To ensure the changes in plan cost sharing is reasonable and to ensure consistency between a product's benefit plan and the assumed pricing impact.

Some Review Considerations

1. Are the projected cost sharing impacts in section B.2. of the Rate Summary worksheet similar to the cost sharing impacts in sections B.1. of the Rate Summary Worksheet?
 - Are any material differences adequately accounted for in the provided reporting requirements?
2. What is the reason for the change in cost sharing, if any?
 - Is this due to benefit buy-downs for employer coverage?
 - Is the change the actuarially sound?
 - Does the change in the cost-sharing impacts appear to appropriately reflect changes to deductibles, copays, or coinsurance levels?
3. Which cost sharing elements have the greatest impact on rates?

Analysis of Trends and Other Changes in Prior Medical Cost

To review the reasonableness of the projection factors applied to the experience data in determining the projected future rates.

Some Review Considerations

1. Are the factors consistent with changes described in the reporting requirements:
 - True inflation in unit prices of medical services (most comparable to Medical CPI),
 - Deductible leveraging, e.g. higher deductible plans tend to have higher trend levels,
 - Risk profile changes,
 - Aging of population (both utilization & mix of service changes)
 - Changes in gender and other demographic characteristics
 - Increases portion of pool from conversion policies
 - Benefit changes, e.g. benefit buy-down impacts for employers,
 - Expected enrollment changes,
 - Marketing,
 - Changes in delivery system and provider contracting,
 - Utilization changes
 - Medical technology cause of increased utilization
 - Anti-selection from losing healthy insureds as block of policies age (e.g. anti-selection spiral)
 - Loss of initial policy year's lower-than-normal claims costs (primarily for individual business with underwriting)
 - Changes in claims procedures.
2. Request and review required supporting documentation for the development of the projection assumptions entered in Exhibit 1 to determine if the factors are supported.
3. Are cost and utilization trends that typically vary significantly by service category inappropriately combined into a single factor? Review Exhibit 3 information provided.
4. Determine that the information is not distorted by the shifting of projected allowed costs among service categories.
5. Analyze impact of any overestimate or underestimate of medical trend for prior years related to the rate increase.
 - If the overstatement or understatement of prior rates is a significant driver of the rate change, an additional actual-to-expected claims analysis on historical claims could be requested to further review the impact.

Administrative Expenses

Administrative expenses are evaluated to determine that they are reasonable, appropriate, and supported.

Some Review Considerations

1. Review the supporting documentation for administrative expense development:
 - Determine if there is a justification for the level of administrative costs, including services provided under administrative agreements with related or non-related parties.
 - Look at the distribution by expense category.
2. Are changes from the actual reporting period to the projection period reasonable?
 - Review the supporting documentation for a description of changes since the experience period that may explain the deviation of the projected from actual, e.g. enrollment, contractual arrangements, allocation methodology, etc.
 - Consider the exposure basis, credibility, associated with actual versus projected values.
3. Consider if the product was a new plan in the experience period.
4. Consider that administrative expenses such as overhead expenses may be more reflective of the overall operations of the health insurance issuer rather than the specific product.
5. Evaluate the impact of changes in administrative costs related to programs that improve health care quality.
6. Evaluate the overall level of commission/distribution costs and any changes for the projection period.

7. Evaluate the base period allowed costs on a pmpm basis by service category versus other products in the marketplace.

Profit Margin and Issuer Financial Condition

Review that the overall profit margin level and the changes from the experience period are reasonable.

Review how the health insurance issuer's financial condition may affect the level of rate change proposed.

Some Review Considerations

1. The profit should be assessed on both a percent of premium basis and a pmpm basis.
2. Projected margin levels should be relatively consistent on a year-by-year basis. Significant annual variations should be supported.
3. For products with projected negative margins, the issuer must demonstrate that this is not anti-competitive behavior.
4. Projected profit can be compared to actual levels reported in statutory financial statements.
5. Does the documentation provide adequate narrative and quantitative support for variations in margin due to differences in the degree of risk or surplus requirements for the particular product line?
6. Consider if the plan's projected gain load includes a contingency margin that correlates to the "risk" in the product.
 - For example, a product with low inpatient cost sharing may be an indicator of the "richness" of the plan. A plan with "richer" benefits might attract enrollees with anti-selective behavior.
7. Is the proposed rate change necessary for the issuer to stay solvent?
8. Is the proposed rate change necessary to maintain rate stability and prevent excessive future rate increases?
9. How sensitive is the level of company surplus to different rate increase scenarios?
10. Are there any transactions between affiliates that could distort profit levels or surplus levels?
11. How material is the impact of the health issuer's investment income?

Compliance with Regulatory Quantitative Requirements

Review loss ratio projections to confirm that they are reasonably projected and that they meet state and federal guidelines. A Loss Ratio Exhibit demonstrating the calculation and a description of the methodology should be included.

Some Review Considerations

1. Lifetime Loss Ratio Analysis
 - Review lapse assumptions;
 - Assess the impact of underwriting by policy duration and overall;
 - What is the anticipated loss ratio before and after implementation of proposed rate increase?
 - Assess the reasonableness of projection/calculation method;
 - Assess the impact of the credibility level assigned to base period data;
 - What is the basis for the interest rate assumption;
 - Evaluate the change in lifetime loss ratio since the last rate filing.
2. Additional Loss Ratio Analysis
 - Does the projected loss ratio appear reasonable in light of the historical loss ratio and the level of the projected rate increase?
 - Is the projected aggregate medical loss ratio less than projected federally-adjusted medical loss ratio?
 - Does the relationship between the medical loss ratio and federally-adjusted medical ratio appear reasonable based on the justification provided
 - How does the calculated value, $\text{Estimated Rate Increase} = \text{Historical Loss Ratio} / \text{Target Loss Ratio} - 1$, compare to the proposed rate increase?
 - Are differences between these two amounts adequately explained by changes in other factors, such as benefit changes, age and gender factors?
 - If the projected medical loss ratio is significantly greater than historical medical loss ratios, but the carrier is requesting a large rate increase, then there may be an inconsistency in the filing that requires additional inquiry.
3. Federally Adjusted Loss Ratio
 - Does the issuer provide enough detail to understand how the federally adjusted loss ratio was developed?
 - Is the federally adjusted loss ratio targeted at 80%? Is the issuer planning to file rebates?

Actuarial Certifications

Arkansas Bulletins 6A-2011 and 7-2011 require an actuarial certification to accompany every rate filing submitted to AID. A qualified actuary who is a member of the American Academy of Actuaries (MAAA) must complete the certification.

The objective of obtaining an actuarial certification is to place greater responsibility on the actuary's professional judgment and to hold the actuary accountable for the reasonableness of the assumptions and projections.

Designations and Qualifications

It should be verified in the actuarial directory, www.actuarialdirectory.org, that the certifying actuary is a member of the American Academy of Actuaries (AAA) and compliant with professional continuing education requirements.

It should be noted that not all members of the AAA are qualified to perform all actuarial tasks. Certifying actuaries must be qualified under Precept 2 of the Code of Professional Conduct and thus must also have pricing experience in order to do rate filings.

If the reviewer has reason to doubt the actuary's qualifications, the reviewer can contact the Actuarial Board for Counseling and Discipline (ABCD), www.abcdboard.org. The reviewer can request the ABCD to investigate the certifying actuary's qualifications in accordance with its Rules of Procedure.

Actuarial Standards of Practice

In the actuarial certification, the actuary must certify that the actuarial work supporting the bid conforms to the current Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. 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. 41, *Actuarial Communications*.

ASOP 8 applies most directly to requirements for a rate filing submission. The additional ASOPs contain more detailed considerations for items such as claim reserves and credibility.

Opinion Language

An important step in evaluating the actuarial certification is to carefully read the language used to determine whether it is a clean opinion or a qualified opinion.

A qualified opinion would typically use wording such as the following: “except for the issue referred to in the preceding paragraph...”. This is an indication that the information provided modifies the actuary’s opinion and in some manner weakens the actuarial certification.

The reviewer should carefully read any apparent qualifying language and discuss the specific meaning of the qualification with the certifying actuary.

If the qualification is deemed significant, it may be that the health insurance issuer has not complied with the requirements of Bulletins 6A-2011 and 7-2011.

Additional Considerations

The certifying actuary must also certify that the actuarial work supporting the bid complies with applicable federal and state laws, rules, and bulletins.

APPENDIX I: Completed Exhibit 1 Sample

Summary Worksheet

Per the Instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.

A. Base Period Data

Start Period: 05/01/2009 End Period: 04/30/2010

Service Categories	Member Months	Total Allowed	Net Claims	Member's Cost Sharing	Member's Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	10,000	\$ 313,250.00	\$ 244,355.00	\$ 68,895.00	\$ 6.89	\$ 24.44	\$ 31.33
Outpatient	10,000	\$ 311,000.00	\$ 242,580.00	\$ 68,420.00	\$ 6.84	\$ 24.26	\$ 31.10
Professional	10,000	\$ 774,000.00	\$ 603,720.00	\$ 170,280.00	\$ 17.03	\$ 60.37	\$ 77.40
Prescription Drugs	10,000	\$ 498,000.00	\$ 368,500.00	\$ 129,500.00	\$ 12.95	\$ 36.85	\$ 49.80
Other	10,000	\$ 45,800.00	\$ 35,700.00	\$ 10,100.00	\$ 1.01	\$ 3.57	\$ 4.58
Capitation	10,000	\$ 75,000.00	\$ 75,000.00	\$ -	\$ -	\$ 7.50	\$ 7.50
Total	10,000	\$ 2,017,050.00	\$ 1,569,855.00	\$ 447,195.00	\$ 44.72	\$ 156.99	\$ 201.71

B. Claim Projections

B1. Adjustment to the Current Rate

Start Period: 01/01/2010 End Period: 12/31/2010

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0154	\$ 31.81	\$ 25.13	0.21
Outpatient	1.0182	\$ 21.64	\$ 25.70	0.21

B2. Claims Projection for Future Rate

Start Period: 01/01/2011 End Period: 12/31/2011

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0783	\$ 34.30	\$ 26.75	0.22
Outpatient	1.1185	\$ 36.30	\$ 28.70	0.22

APPENDIX J: Exhibit 3 Checklist

The checklist below is applicable to Exhibit 3 of the Preliminary Justification for the rate filings of grandfathered plans.

Description of the type of policy, benefits, renewability, general marketing method and issue age limits			
Required Items	Yes	No	Notes
Insurance Company Name	<input type="checkbox"/>	<input type="checkbox"/>	
NAIC Company Code	<input type="checkbox"/>	<input type="checkbox"/>	
Contact Person and Title	<input type="checkbox"/>	<input type="checkbox"/>	
Contact Telephone Number and Email	<input type="checkbox"/>	<input type="checkbox"/>	
Date of Submission	<input type="checkbox"/>	<input type="checkbox"/>	
Proposed Effective Date	<input type="checkbox"/>	<input type="checkbox"/>	
Insurance Company's Filing Number	<input type="checkbox"/>	<input type="checkbox"/>	
Form Number	<input type="checkbox"/>	<input type="checkbox"/>	
Product Number	<input type="checkbox"/>	<input type="checkbox"/>	
Market Type (Individual/Small Group)	<input type="checkbox"/>	<input type="checkbox"/>	
Status (Open/Closed Block)	<input type="checkbox"/>	<input type="checkbox"/>	
Brief Description:			
i. Type of Policy	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Benefits	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Renewability	<input type="checkbox"/>	<input type="checkbox"/>	
iv. General Marketing Method	<input type="checkbox"/>	<input type="checkbox"/>	
v. Underwriting Method	<input type="checkbox"/>	<input type="checkbox"/>	
vi. Premium Classifications	<input type="checkbox"/>	<input type="checkbox"/>	
vii. Age Basis and Issue Age	<input type="checkbox"/>	<input type="checkbox"/>	

Scope and reason for the rate increase			
Required Item	Yes	No	Notes
Number of Individuals Impacted by the Rate Change	<input type="checkbox"/>	<input type="checkbox"/>	

Explanation of any Variation in the Rate Change Among Affected Individuals	<input type="checkbox"/>	<input type="checkbox"/>	
Description of the Proposed Changes to the Base Rate or Rating Factors	<input type="checkbox"/>	<input type="checkbox"/>	
Average annual premium per policy, before and after the rate increase			
Required Items	Yes	No	Notes
Outline of Past Rate Increases	<input type="checkbox"/>	<input type="checkbox"/>	
Description of Proposed Increased in Dollar Amount	<input type="checkbox"/>	<input type="checkbox"/>	
Past experience, and any other alternative or additional data used			
Required Items	Yes	No	Notes
Number of Policyholders	<input type="checkbox"/>	<input type="checkbox"/>	
Number of Covered Lives	<input type="checkbox"/>	<input type="checkbox"/>	
Total Written Premium	<input type="checkbox"/>	<input type="checkbox"/>	
Evaluation Period, Experience Period, Projection Period	<input type="checkbox"/>	<input type="checkbox"/>	
Past Experience, including:			
i. Cumulative Loss Ratio (Historical/Past)	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Any Alternative Experience Data Used	<input type="checkbox"/>	<input type="checkbox"/>	
Credibility Analysis	<input type="checkbox"/>	<input type="checkbox"/>	
Incurred But Not Reported (IBNR) Claims	<input type="checkbox"/>	<input type="checkbox"/>	
Contract Reserves	<input type="checkbox"/>	<input type="checkbox"/>	

Description of how the rate increase was determined, including the general description and source of each assumption used

Required Items	Yes	No	Notes
Expenses:			
i. Profit and Contingency	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Commission and Brokers Fees	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Taxes, License and Fees	<input type="checkbox"/>	<input type="checkbox"/>	
iv. General Expenses	<input type="checkbox"/>	<input type="checkbox"/>	
v. Other Administrative Costs	<input type="checkbox"/>	<input type="checkbox"/>	
vi. Reinsurance	<input type="checkbox"/>	<input type="checkbox"/>	
Impact of Statutory Changes, Including Mandates	<input type="checkbox"/>	<input type="checkbox"/>	
Overall Premium Impact of Proposed Increase:			
i. Average Annual Premium Per Policy	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Before and After Rate Increase	<input type="checkbox"/>	<input type="checkbox"/>	
Descriptive Relationship of Proposed Rate Scale to Current Rate Scale	<input type="checkbox"/>	<input type="checkbox"/>	
Premium Basis:			
i. Brief Description of How Revised Rates were Determined, including:			
1. General Description	<input type="checkbox"/>	<input type="checkbox"/>	
2. Source of Each Assumption Used	<input type="checkbox"/>	<input type="checkbox"/>	
ii. For Expenses, including:			
1. Percent of Premium	<input type="checkbox"/>	<input type="checkbox"/>	
2. Dollars Per Policy or Dollars Per Unit of Benefit or All	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Trend Assumptions	<input type="checkbox"/>	<input type="checkbox"/>	
iv. Interest Rate Assumptions	<input type="checkbox"/>	<input type="checkbox"/>	
Other Assumptions, including Morbidity, Mortality and Persistency	<input type="checkbox"/>	<input type="checkbox"/>	
Company Financial Condition:			
i. Risk Based Capital	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Company Surplus	<input type="checkbox"/>	<input type="checkbox"/>	

Loss Ratio Exhibit

Required Items	Yes	No	Notes
Cumulative Loss Ratio and a Description of how it was calculated	<input type="checkbox"/>	<input type="checkbox"/>	
Projected Future Loss Ratio and a Description of how it was calculated	<input type="checkbox"/>	<input type="checkbox"/>	
Projected Lifetime Loss Ratio that Combines Cumulative and Future Experience and a Description of how it was calculated	<input type="checkbox"/>	<input type="checkbox"/>	
Federal Medical Loss Ratio (MLR) Standard in the applicable market to which the rate change applies, accounting for any adjustments allowable under Federal law:			
i. Anticipated loss ratio presumed reasonable according to the guidelines including adjustment for credibility if applicable	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Quality Improvement Costs	<input type="checkbox"/>	<input type="checkbox"/>	
Justification for the Projected Future Loss Ratio less than the Federal MLR Standard, if applicable	<input type="checkbox"/>	<input type="checkbox"/>	