Key updates to *Wisconsin Actuarial Memorandum and Certification Template (4/25/19)*:

Topic Area	Section(s) with Key Changes
Reporting plan base rate and minimum/maximum rate impacts	Section 2
WIHSP payment parameters	Section 2
Transitional plan experience	Sections 3 and 12
Reporting risk adjustment user fees	Section 9
Reporting in force transitional products	Section 12
Small group adjustments	Sections 13 and 17
Actuarial certification	Section 25

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Wisconsin Actuarial Memorandum and Certification Template

The Wisconsin Office of the Commissioner of Insurance (OCI) requires the format and content specified herein for federal Rate Filing Justification submissions, specifically Part III: Actuarial Memorandum. The memorandum must include information to support values entered in Part I: Unified Rate Review Template (URRT). All assumptions should be adequately justified with supporting data or actuarial reasoning, and methodologies should be clearly explained. The Appendix provides additional information regarding allowable variations in the rating methodology.

Contents

1. General Information

Company Identifying Information: Provide the following information that uniquely identifies the issuer submitting the memorandum. This information must match that which is provided in the URRT (see the Unified Rate Review Instructions for additional definition of these fields):

- Company Legal Name: the legal entity name associated with the HIOS Issuer ID
- State: the state that has regulatory authority over the policies
- HIOS Issuer ID: the HIOS ID assigned to the legal entity
- Market: the market in which the products and plans are offered
- Effective Date: the effective date of the change to the index rate
- SERFF ID(s): the SERFF tracking IDs for all filings associated with the submitted URRT

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

- Primary Contact Name
- Primary Contact Telephone Number
- Primary Contact E-mail Address

Description of Benefits: Provide a general description of the major benefits available under the affected products. Describe any benefits that exceed the Essential Health Benefits (EHBs). Describe any wellness benefits.

2. Scope and Purpose, Proposed Rate Change(s)

Provide information related to the scope and purpose of the filing, any proposed rate changes, and the prospective trend for the affected products. Include all products in the single risk pool, as defined by 45 C.F.R. §.156.80, including those products for which no rate adjustment is being proposed.

Scope and Purpose: Indicate or provide:

- Whether this filing is an initial (market entry) rate filing or a rate change filing
- A description of any requested rating factor changes (e.g., geographic or tobacco), if applicable
- A description of any significant changes in member cost-sharing, if applicable
- For each product in the single risk pool, the requested average plan base rate change (not applicable for an initial rate filing). This reflects ***only*** the plan base rate change, and should be based on current enrollment. Please provide the date of the enrollment used, being consistent with what is reported in field 2.10 in the URRT.
- For each product in the single risk pool, the minimum and maximum rate impact of the requested rate change (combined impact of plan base rate and other rating factor changes, or "overall rate change" minimum and maximum). The minimum and maximum relate to rate table changes, and may not reflect actual results experienced by members.
- If the requested rate change is not the same across all products and plans, a narrative discussion as to why the rate changes vary by product or plan given they are based on the same single risk pool of experience for the market

Reason for Rate Change(s): Provide a narrative description of all significant factors driving the proposed rate change. These factors could include, but are not limited to:

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

Reinsurance Impact: If the company is in the individual market and is participating in the Wisconsin Health care Stability Plan (WIHSP) for the upcoming benefit year, provide the following:

- The overall rate change *assuming 100% payment of reinsurance-eligible claims* (i.e., those claims which fall within the WIHSP reinsurance corridor, subject to WIHSP coinsurance rate)
- The overall rate change *assuming 0% payment of reinsurance-eligible claims*
- A brief description of how the impact to the rate change was estimated including estimates of the indirect impact of:
    - Improvement in overall morbidity due to the reinsurance program being available
    - Changes in risk adjustment transfers due to lower premiums resulting from the presence of the reinsurance program.

WIHSP payment parameters for the upcoming 2020 plan year are expected to include a $40,000 attachment point and $175,000 cap. The WIHSP coinsurance rate applied in the corridor is 50%.

Prospective Trend: Provide the following values as percentages to the hundredth percent:

- Annualized Medical Trend value expected for the 12 months directly following the effective date of the filing
- Annualized Insurance Trend value expected for the 12 months directly following the effective date of the filing

Medical Trend is defined as “the combined effect of medical provider price and/or capitation changes, utilization changes, medical cost shifting, and new medical procedures and technology.” Insurance Trend is defined as “the combined effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases, discontinuance of new sales, and any other factor affecting claims.”

3. Experience Period Premium and Claims

Provide the following 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 URRT. **Note:** Beginning in 2020, do not include transitional business in the experience period.

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

Premiums (net of MLR Rebate) in Experience Period: Provide support for how the amount of premium earned during the experience period, net of federal Medical Loss Ratio (MLR) rebates to policyholders, was developed. Do not include expected risk adjustment receivables or payables in the experience period premium.

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

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

- The actuary's best estimate of claims allowed and incurred during the 12-month experience period are reported in Worksheet 1, Section I of the URRT. Separately indicate the amount of allowed and incurred claims processed through the issuer's claims 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.

	From Issuer's Claims System	**Outside Issuer's Claims System**	**Incurred But Not Paid (IBNP)**
Experience Period Incurred Claims (E16)			
Experience Period Allowed Claims (E14)			

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

4. Benefit Categories

For each of the Benefit Categories in Worksheet 1, Section II, describe the methodology used to determine which category each claim in the experience period falls. For all benefit categories, describe the measurement units that were used.

5. Projection Factors

Provide 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, include a description of the source data or assumptions used, why they are appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for issuer-specific experience, industry or internal studies, benefit design and credibility of the source data. At a minimum, include support for the following factors:

Changes in the Morbidity of the Population Insured: Describe any adjustment factors applied to the experience period claims to account for anticipated differences in the average morbidity of the pooled population underlying the experience period and the issuer's population anticipated to be insured in the projection period. This adjustment is shown in the "Morbidity Adjustment" factor on Worksheet 1, Section II, and is 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 as separate adjustment factors as described below).

The morbidity of the population could be impacted by items such as guarantee issue, an individual mandate to maintain coverage, take-up rate of the uninsured, health status of the newly insured, induced demand of the newly insured, pent-up demand of the newly insured, effects of federal subsidies on utilization, a change in Medicaid programs, or the elimination of a state high-risk pool. Note that any adjustments made in this section indicate expected changes to morbidity at the statewide, market-wide level. Any changes to company-specific morbidity should be captured as a part of the federal risk adjustment assumption.

Changes in Benefits: Describe the development of a factor 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. This change is reflected in the "Plan Design Changes" adjustment factor on Worksheet 1, Section II. This factor could adjust for items including, but not limited to, the following:

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

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

Other Adjustments: Describe the development of any other adjustment factors, in addition to benefits and demographics which are specifically addressed above, that are reflected in the "Other" adjustment column on Worksheet 1, Section II. Possible adjustments may include, but are not limited to:

- Significant changes in the provider network (not shifts in the distribution of services)
- Projected changes in pharmacy rebates relative to the pre-rebate prescription drug allowed claims

Trend Factors (cost/utilization): Cost trend must include only the increase in cost for a fixed set of services, while utilization trend includes the change in the mix or intensity of services provided for a fixed level of illness burden. For example, a change in cost related to a changing distribution of services across network providers is considered cost trend. An increase in overall claims due to induced demand related to product shifts is considered utilization trend.

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

- 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

6. 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. Provide information related to the other experience and general methodology used in developing the manual rate.

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

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

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

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

7. Credibility of Experience

Provide support for the credibility level assigned to the base period experience, with the complement being applied to the credibility manual. The information should specifically include:

- A description of the credibility methodology used
- The resulting credibility level assigned to base period experience when applying the proposed credibility methodology

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

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

8. Paid to Allowed Ratio

Provide support for the Paid to Allowed Average Factor in Projection Period for the market. Using the table below, demonstrate that the ratio is consistent with the membership projections by plan included in Worksheet 2, Section IV.

Metal Level	Member Months	Paid Claims PMPM*	Allowed Claims PMPM*	Paid to Allowed Ratio
Platinum				
Gold				
Silver				
Bronze				
Catastrophic				
TOTAL				

*Before risk adjustment and reinsurance

The ratio for each plan should be relatively consistent with the AV Metal 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.

9. Risk Adjustment and Reinsurance

Provide the following 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 II, and Worksheet 2, Sections II and IV of the URRT (if applicable).

Experience Period Risk Adjustment PMPM: Since the final risk adjustment transfers may not be known at the time of the initial filing submission, provide an explanation of the methodology used to estimate the amounts in the experience period.

Projected Risk Adjustments and Reinsurance Recoveries PMPM Development: 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 transfers and reinsurance recoveries. The estimated reinsurance recovery under the WIHSP should be reported as a PMPM adjustment in cell F43 in Worksheet 1 of the URRT. Use row 71 of Worksheet 2 of the URRT to report reinsurance recoveries by plan.

Describe in detail the methodology used to calculate the underlying risk adjustment impact reported. Provide the information in the numbered list below appropriate to the methodology. Risk adjustment user fees should be reported in Worksheet 2 of the URRT under 3.7 Taxes and Fees.

All values must represent a composite average of all plans within a state and market (individual or small group). For individual rate filings, indicate whether catastrophic plans are combined with metal-level plans or considered separately.

If the Centers for Medicare & Medicaid Services (CMS) methodology was used, provide all data elements listed in numbers 1 – 11 below. If a methodology other than that described by CMS was used, provide the information for only items 2, 4, 6, 8, and 10 below.

1. Statewide Average Premium Per Member Per Month (PMPM) – represents the composite average premium PMPM for all plans within the state, market and risk pool
2. Average Company-Specific Metal Level Actuarial Value – represents the average theoretical actuarial value (i.e., 90%, 80%, 70%, or 60%) of all benefit plans offered by the company
3. Average Statewide Metal Level Actuarial Value – represents the average theoretical actuarial value (i.e., 90%, 80%, 70%, or 60%) of all benefit plans offered by all companies statewide
4. Average Company-Specific Allowable Rating Factor – refers to the average of the age rating factors, as specified in federal regulation, for all members in the company's covered population
5. Average Statewide Allowable Rating Factor – refers to the average of the age rating factors, as specified in federal regulation, for all members in the statewide covered population
6. Average Company-Specific Induced Demand Factor – refers to the average impact of induced demand from members enrolled by metal tier or associated cost-sharing reduction (CSR) subsidy using the associated factors specified in federal regulation
7. Average Statewide Induced Demand Factor – refers to the average impact of induced demand from members enrolled by metal tier or associated CSR subsidy using the associated factors specified in federal regulation
8. Average Company-Specific Geographic Cost Factor – refers to the average impact of geography as calculated using company-specific factors
9. Average Statewide Geographic Cost Factor – refers to the average statewide impact of geography as calculated using factors
10. Average Company-Specific Risk Score – refers to the company's average risk score as calculated by the Department of Health and Human Service (HHS) in the HHS Hierarchical Condition Categories (HCC) model
11. Average Statewide Risk Score – refers to the statewide average risk score as calculated by the HHS HCC model

Projected Risk Adjustment PMPM Allocation: Risk adjustment transfers must be allocated proportionally based on plan premiums for all plans within a risk pool by applying the risk adjustment transfer factor as a constant multiplicative factor across all plans. Confirm that the anticipated risk adjustment transfer revenue has been allocated as prescribed.

Projected WIHSP Reinsurance Recoveries: Companies in the individual market that are participating in WIHSP for the upcoming benefit year are required to make a market-wide adjustment to the pooled market-level index rate to account for WIHSP 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 provides a field for issuers to report reinsurance payments as a PMPM amount.
- Describe the underlying experience data and assumptions used to develop the reinsurance payment estimate.
- Provide an explanation of how the estimate of claims liability between the reinsurance attachment point and cap was developed.
- Describe any key aspects of the enrolled population that significantly impacted the claims assumptions.
- Describe how anticipated reinsurance payments were allocated across the plans in the risk pool (as noted above, reinsurance revenue should be allocated proportionally based on premium).

10. Non-Benefit Expenses and Profit and Risk

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

For reporting purposes, the Administrative Expense Load should not include the Profit and Risk Load or the Taxes and 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.

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

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

Taxes and Fees: Describe each tax and/or fee and indicate the amount for each, either as a percent of premium or a per member per month (PMPM) amount. Describe only the taxes and fees that may be subtracted from premiums for purposes of calculating MLR. Risk adjustment user fees should be reflected in the URRT under Taxes and Fees. Any additional taxes and fees should be reflected in the Administrative Expense Load.

Note that for pricing purposes, Taxes and Fees (including Exchange user fees) are considered part of administrative expenses per 45 C.F.R. § 156.80(d). They are described separately in the actuarial memorandum to facilitate rate review.

Exchange user fees should be included in the template in Taxes & Fees. 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.

11. Projected Loss Ratio

Indicate the projected loss ratio using the federally prescribed MLR methodology. If the projected loss ratio is less than 80%, explain the company's plan to comply with the federal MLR requirement found in section 2718 of the Public Health Service Act (PHSA).

12. Single Risk Pool

Provide support that the single risk pool in the above-referenced market in Wisconsin is established according to the requirements in 45 C.F.R. § 156.80(d). The single risk pool reflects all covered lives for every non-grandfathered product/plan combination for an issuer in a state and market. The single risk pool is specific to the legal entity for the state and market for which it is submitted.

Beginning with the new Unified Rate Review Template (URRT) format in 2020, transitional experience should not be included in the single risk pool experience period. The projection period must only reflect the experience of transitional policies to the extent the issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period.

Explain how projected experience of transitional policies was considered in the company's single risk pool rate development.

List all in force transitional products in the table below, using the OCI Product Name, and provide the anticipated nonrenewal date for each. If none, state none.

Transitional Product – OCI Product Name	Anticipated Nonrenewal Date

13. Index Rate

Index Rate Development: The index rate is specific to a legal entity within a market and state, and represents the estimated total combined allowed claims experience PMPM of all non-grandfathered, non-transitional plans for EHBs. The index rate 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 EHBs.

- State and provide support for the index rate reported in the **experience** period.
- Explain any difference between the total allowed claims PMPM for the **experience** period and the index rate for the experience period. For example, describe any covered benefits in excess of EHBs that are included in allowed claims but excluded from the indexrate.
- State and provide support for the index rate reported in the **projection** period. If the submission is for the individual market, the Index Rate for Projection Period must reflect the 12-month projection period shown on Worksheet 1, Section II.
- Explain any difference between the total allowed claims PMPM in the **projection** period and the index rate in the projection period. For example, describe any covered benefits in excess of EHBs that are included in allowed claims but excluded from the indexrate.

The projected index rate must reflect the anticipated claim level of the projection period with respect to trend, benefits and demographics. It must reflect the experience of all policies expected to be in the single risk pool (with all necessary adjustments to reflect the benefits, market rules, etc., applicable to policies upon issue or renewal during the projection period). For transitional policies, the issuer must include those policies anticipated to be enrolled in a fully ACA-compliant plan during the projection period at a point when the members in these plans move to an ACA-compliant plan.

Small Group Adjustment: As described in section 2.1.3.1 of the URR instructions, the trends for years one and two should lead to a projected index rate for the first effective date in the rate filing.

Provide a table of projected index rates for each effective date in the submission. Describe any adjustment (trend or health insurance tax) made to the index rate to reflect quarterly rate changes. Include a detailed breakdown of each adjustment.

14. Market-Adjusted Index Rate

The market-adjusted index rate is calculated as the index rate adjusted for all allowable market-wide modifiers defined under the market rating rules in 45 C.F.R. § 156.80(d)(1). The following market-wide adjustments are allowable under these rules:

- WIHSP reinsurance program adjustment
- Risk adjustment transfer
- Exchange user fee adjustment

State the market-adjusted index rate. Since the index rate is developed on an allowed claims basis, the reinsurance and risk adjustment amounts should be applied to the index rate on an allowed claims basis.

Similar to the index rate, the market-adjusted index rate reflects the average demographic characteristics of the single risk pool and is not calibrated.

15. Plan-Adjusted Index Rate(s)

The plan-adjusted index rate is calculated as the issuer's market-adjusted index rate further adjusted for all allowable plan-level modifiers defined under the market rating rules in 45 C.F.R. § 156.80(d)(2). The following plan-level adjustments are allowable under these rules:

- Actuarial value and cost-sharing adjustment
- Provider network, delivery system and utilization management practices adjustment
- Adjustment for benefits in addition to EHBs
- Adjustment for distribution and administrative costs
- Impact of specific eligibility categories for the catastrophic plan(s) only

Explain how the above modifiers were developed and applied to the market-adjusted index rate to derive each plan-adjusted index rate. Note that all non-claim costs/fees are included in the premium as a part of the plan-level distribution and administrative costs adjustment (except Exchange user fees, which are market-level). No additional fees may be charged outside the development of the plan-adjusted index rate(s). Adjustments not specified by 45 C.F.R. § 156.80(d)(2), such as adjustments to recoup revenue related to the three dependent child limit, are not allowed.

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

Similar to the index rate and the market-adjusted index rate, the plan-adjusted index rate(s) reflect the average demographic characteristics of the single risk pool and are not calibrated.

Since AV Pricing Values must capture all plan-level adjustments allowable under 45 C.F.R. § 156.80(d)(2), the market-adjusted index rate multiplied by each AV Pricing Value should equal each plan-adjusted index rate (before calibration).

16. Calibration

It may be necessary to calibrate the plan-adjusted index rate(s) (which are based on the average demographics of the entire single risk pool) to apply the allowable rating factors for age, tobacco use, and geography in order to calculate appropriate consumer-adjusted premium rates. The calibration for each allowable rating factor category (age, tobacco use, and geography) is described below. The calibration for each allowable rating factor category should be performed using a

unique weighting to determine a single calibration factor for the three categories. **Only one** calibration factor may be applied to all plan-adjusted index rates (i.e., the calibration may not vary by plan but is a common value to all plans in a state and market).

Age Curve Calibration: Provide a detailed explanation of the methodology used in the calibration to the age curve, including:

- The approximate weighted average age associated with the projected single risk pool, rounded to a whole number
- A description of the factors used in the determination of the risk pool weighted average age and any data used to weight the factors
- A description of the calculation used to determine the risk pool weighted average age, including a description of how dependent children under age 21 impact the calculation
- Justification that the calibration to the age curve complies with the rating rules specified in 45 C.F.R. § 147.102
- A demonstration of how the plan-adjusted index rate(s) and the age curve are used to generate the schedule of premium rates

Tobacco Use Factor Calibration: If a calibration to the tobacco use factors was required to remove the portion of the cost expected to be recouped through the tobacco surcharge, provide a detailed explanation of the methodology used in the calibration to the tobacco use rating factors, including:

- A detailed description of the development of the tobacco use factors
- A detailed description of the calculation of the tobacco use factor calibration adjustment
- A demonstration of how the tobacco use factors are applied to the plan-adjusted index rate(s)

Geographic Factor Calibration: Provide the geographic rating factors that will be applied to the plan base rates reported in the Wisconsin-specific Rate Data:

Geographic Factors	
Area	**Factor**
Rating Area 1	
Rating Area 2	
Rating Area 3	
Rating Area 4	
Rating Area 5	
Rating Area 6	
Rating Area 7	
Rating Area 8	
Rating Area 9	
Rating Area 10	
Rating Area 11	
Rating Area 12	
Rating Area 13	
Rating Area 14	
Rating Area 15	
Rating Area 16	

If a calibration to the geographic rating factors was required, provide a detailed explanation of the methodology used in the calibration to the geographic rating factors, including:

- A detailed description of the development of the geographic rating factors
- A detailed description of the calculation of the geographic rating factor calibration adjustment
- A demonstration of how the geographic factors are applied to the plan-adjusted index rate(s)

17. Consumer-Adjusted Premium Rate Development

The consumer-adjusted premium rate is the final premium rate that is charged to an individual, family, or small employer group for a specific plan utilizing the rating and premium adjustments as articulated in the applicable market rating rules. The consumer-adjusted premium rate is developed by calibrating the plan-adjusted index rate to the age curve as described above, calibrating for tobacco use and geography if necessary, and applying the rating factors specified by 45 C.F.R. § 147.102. Family premiums must be calculated on a per-member basis consistent with 45 C.F.R. § 147.102. The following adjustments are allowable under this rule:

- Age (using the standard federal age curve)
- Geographic rating area
- Tobacco status

Small Group Consumer-Adjusted Premium Rates: If the company files small group rates with quarterly adjustments, the index rate, market-adjusted index rate and plan-adjusted index rate reflect the first effective date in the filing. In the development of small group consumer-adjusted premium rates, the plan-adjusted index rate must be adjusted to reflect the appropriate quarter when the consumer-level modifiers are applied. Provide the adjustment factors that apply to the plan-adjusted index rates to develop the consumer-adjusted premium rates for each effective date in the submission.

Sample Rate Calculation: Provide a sample rate calculation, listing the parameters used in the example (i.e., plan choice, age, tobacco use status, county and, if applicable, effective date). If the sample rate calculation includes three or fewer child dependents, confirm in this section that family premiums are calculated consistent with 45 C.F.R. § 147.102(c)(1). If the company offers composite premiums to small groups, confirm in this section that composite premiums are calculated consistent with 45 C.F.R. § 147.102(c)(3)(iii).

18. AV Metal Values

Describe whether the AV Metal Values included in Worksheet 2 of the URRT 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.

For each bronze plan with an AV Metal Value greater than 62.00%, indicate:

- The major service covered prior to the application of the deductible;
- The cost-sharing for the major service covered before the deductible; and
- Whether the bronze plan is an HSA-eligible high deductible health plan (HDHP).

If an alternate methodology was used to develop the AV Metal Value(s), describe the methodology and provide a copy of the actuarial certification required by 45 C.F.R. § 156.135. The certification must be signed by a member of the American Academy of Actuaries and must indicate (1) that the values were developed in accordance with generally accepted actuarial principles and methodologies, (2) the reason an alternate methodology was used and why the benefits for those plans for which an acceptable alternative methodology was used are not compatible with the AV Calculator, and (3) the chosen alternate methodology that was used for each applicable plan.

Refer to applicable practice note(s) for guidance on alternate methods of calculating actuarial value.

19. AV Pricing Values

For each plan in the single risk pool, indicate:

- The portion of the AV Pricing Value attributable to each of the allowable modifiers to the index rate, as described in 45 C.F.R. § 156.80(d)(2). It is recommended the information be provided in table format with a column for each allowable plan-level adjustment.
- If the adjustment for plan cost-sharing includes any expected differences in utilization due to differences in cost-sharing, describe in detail how the difference was estimated and how the methodology ensures differences due to health status are not included in the adjustment.

Since AV Pricing Values must capture all plan-level adjustments allowable under 45 C.F.R. § 156.80(d)(2), the market-adjusted index rate multiplied by each AV Pricing Value should equal each plan-adjusted index rate (before calibration).

20. Membership Projections

Marketing Method: Provide a brief description of the market and marketing method including:

- Types of agents (i.e., career, independent, direct market, etc.)
- Types of customers/markets (i.e., employer group, association, etc.)

Development of Membership Projections: Provide a brief description of:

- The development of the membership projections found in Worksheet 2 of the URRT and any items impacting the projections
- Any differences between the projected and current membership distribution

For companies submitting Qualified Health Plan (QHP) applications for silver-level plans in the individual market, describe the methodology used to estimate the portion of projected enrollment that will be eligible for cost-sharing reduction subsidies at each subsidy level. State the resulting projected enrollment by plan and subsidy level.

21. Terminated Plans and Products

List the name and HIOS ID for each ACA-compliant plan and product that has been or will be terminated prior to the effective date. Include both plans and products that have experience included in the single risk pool during the experience period and any plans and products that were not in effect during the experience period but were made available thereafter. Do not list in this section any transitional plans and products that are terminating prior to the effective date. If the company is terminating all plans under a product, it is sufficient to list the HIOS Product ID that will be terminated.

If a terminated plan will be mapped to a different plan in the projection period, provide the HIOS Plan ID into which the plan's members will renew by default.

22. Plan Type

In the event that the plan types listed in the drop-down box in Worksheet 2, Section I, of the URRT do not describe the company's plan exactly and the company has selected the closest plan available per the instructions, describe the differences between the company's plan and the plan type selected.

23. Warning Alerts

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

24. Reliance

If, in preparing the URRT submission, the certifying actuary relied on any information or underlying assumptions provided by another individual, indicate the information relied upon and the name of the individual providing that information.

25. Actuarial Certification

If revised wording is included, that wording should be indicated in bold text. If additional wording is provided, it should appear under a separate heading after the prescribed wording.

This certification includes:

☐ Prescribed Wording Only
☐ Prescribed Wording with Additional Wording
☐ Revised Wording

PRESCRIBED WORDING:
I, _____, am a member of the American Academy of Actuaries (Academy) and I meet the Academy qualification standards for rendering this opinion.

I certify that, to the best of my knowledge and judgment:

- The entire rate filing is in compliance with the applicable laws of the state of Wisconsin and with the rules of the Office of the Commissioner of Insurance,
- The development of the projected index rate and all rating factors is in compliance with all applicable federal statutes and regulations,
- The index rate and allowable modifiers as described in 45 C.F.R. § 156.80(d)(1) and (d)(2), are used in the development of plan-specific premium rates,
- The essential health benefit portion of premium, upon which advanced payment of premium tax credits (APTCs) are based, is appropriate and was developed in accordance with Actuarial Standards of Practice,

- The methodology used to calculate the AV Metal Value for each plan complies with federal regulations,
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area,
- The entire rate filing, including development of the projected index rate and all rating factors, complies with all applicable Actuarial Standards of Practice,
- The projected index rate and rating factors are reasonable in relation to the benefits provided and the population anticipated to be covered, and
- The premium schedule, including the projected index rate and rating factors, is not excessive, deficient, nor unfairly discriminatory.

Name of Actuary	**Organization**	**Title**

Signature of Actuary	**Date**

Appendix: Market Rating Rules – Allowable Rating and Pricing

Allowable rating methods and factors:

- The single risk pool should include ***all*** (excluding grandfathered and transitional) covered persons (lives) an issuer has in a state, within a market (individual or small group). The projection period should reflect transitional policy experience to the extent the issuer anticipates the members in those policies will enroll in fully ACA-compliant plans duringthe projection period.

- The index rate is defined as the EHB portion of projected allowed claims divided by all projected single risk pool lives. As a result, the index rate should be the ***same*** value for ***all*** non-grandfathered, non-transitional plans for an issuer in a state and market. This includes claims and enrollment in transitional products/plans in the experience period and to the extent an issuer anticipates the members in those policies will be enrolled in fully ACA-compliant plans during the projection period. Note that if an issuer opted to continue policies under the transitional extension, experience for these policies should be excluded in the issuer's 2018 experience for developing rates for the 2020 year. Appropriate adjustments should be made in Worksheet 1, Section II, of the URRT to bring these policies in line with all requirements of non-grandfathered policies projected in the single risk pool in 2020. For example, in the projection period, include projected experience and membership at the point when these products become ACA-compliant and membership renews to the ACA-compliant plan.

- The market-adjusted index rate is the index rate adjusted for risk adjustment transfers, reinsurance, and Exchange fees (with impacts and costs spread across the whole risk pool). As a result, the market-adjusted index rate should be the **same** value for ***all*** non-grandfathered plans for an issuer in a state and market.

- The plan-adjusted index rate is the market-adjusted index rate further adjusted for plan-specific factors allowed by 45 C.F.R. § 156.80(d)(2), such as provider network, utilization management, benefits in addition to EHBs, actuarial value and cost-sharing, distribution and administrative costs (less Exchange fees) and catastrophic plan eligibility variation.

- Note, non-claim costs/fees are included in the premium and applied at the plan level as part of the distribution and administrative costs adjustment. The only exception is the application of the Exchange user fees, which are applied at the market level to the index rate. All other fees must be included in the development of the plan-adjusted index rate(s), prior to the application of member-level rating factors such as age factors. No additional fees may be charged outside of the development of the plan-adjusted index rate(s). For example, if it costs an issuer $35 to process an application, that cost must be included in the premium rate development of all policies (new issues and renewals) and subject to the member-level rating factors such as age, tobacco use, and geographic rating factors.

- A calibration may be required to allow the rating factors to be directly applied in order to generate the consumer-adjusted premium rates.

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

The calibration with respect to the age curve is allowed and identifies the value on the age curve associated with the weighted average age on the standard age curve. The plan-adjusted index rate and the age curve can then be used to generate the schedule of premium rates for all ages for each plan. Calibration may be required for the geographic factors. More detailed instructions are provided in the Unified Rate Review Instructions regarding the requirements for the calibration.

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

- The consumer-adjusted premium rate is the final premium rate for a plan that is charged to an individual, family, or small employer group utilizing the rating and premium adjustments as articulated in the applicable market reform rating rules. The consumer-adjusted premium rate is developed by calibrating the plan-adjusted index rate to the age curve as described above, calibrating for geography if necessary, and applying the allowable rating factors. Allowable rating factors are (1) age (3:1 standard age curve), (2) tobacco (1.5:1), (3) geography, and (4) family tiering/structure.

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

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

- Family structure takes into account family composition and the maximum of three child dependents. This is further clarified in federal regulation that the premium for family coverage is determined by summing the premiums for each individual family member, provided at most

three child dependents under age 21 are taken into account; this adjustment does not result in a separate rating factor. Family tiering only occurs in states that use pure community rating and are uniformly applied to all plans in the risk pool (and published to the cciio.cms.gov Web site). Wisconsin does not use pure community rating.

- The graphic below depicts the federally prescribed rate development flow, includingallowable adjustments (arrows) at each step: