



North Carolina Department of Insurance

North Carolina Actuarial Memorandum Requirements for Rate Submissions

Small Group Market – Non-grandfathered Business

These actuarial memorandum requirements apply to all products proposed to be offered in the North Carolina small group market which are subject to the single risk pool requirements of 45 CFR 156.80. An actuarial memorandum, including corresponding required actuarial certifications, must be included with each submission of rates to the North Carolina Department of Insurance (the Department). All items must be included in the actuarial memorandum in the order they are presented below and numbered accordingly.

The purpose of the actuarial memorandum is to provide certain information related to the filing, including support for the development of proposed rates, and required actuarial certifications. This information includes documentation and support for all assumptions utilized by the opining actuary and analysis performed in support of the proposed rates. All assumptions should be adequately justified with supporting data.

The actuarial memorandum should be provided with enough detail so that another actuary qualified in the same practice area is able to perform an independent review and evaluate the reasonableness of the proposed rates. Additional information will be required if, given the facts and circumstances of the filing, the Department determines that it is necessary to properly complete its review of the filing. Therefore, while these instructions outline the minimum requirements, filers are encouraged to provide as much detail and supporting documentation as possible with their initial submission.

Definitions

Throughout these instructions, the following terms have the following meaning:

Product – A “product” is defined as a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a carrier offers within the state, for which a rate adjustment is being requested. The term product includes any product that is discontinued and newly filed within a 12-month period when the changes to the product meet the standards of 45 CFR 147.106(e)(2) or (3) that relate to uniform modification of coverage. “Product” has the same meaning as included in 45 CFR Part 154.

Plan - A “plan” is defined as the pairing of the health insurance coverage benefits under the product with a particular cost sharing structure, provider network, and service area. “Plan” has the same meaning as included in 45 CFR Part 154.

Plan ID – When referencing specific Plan IDs, please use the Standard Component Plan ID as assigned in HIOS.

Rate Adjustment – A “rate adjustment” includes both proposed increases and decreases to rates, including increases to rates for advancing trend to reflect a more recent effective date. An increase or decrease to rates alters the underlying rate structure. This is in contrast to a “premium increase” which can occur even without any change to the underlying rate structure.

Index Rate – The index rate is defined as the average allowed claim cost per member per month (PMPM) of the single risk pool for coverage of Essential Health Benefits (EHB), prior to adjustment for payments and charges under the risk adjustment program.

Market Adjusted Index Rate – The Index Rate, adjusted for market-wide payments and charges under the risk adjustment program in the state, and Exchange user fees.

Plan Adjusted Index Rate – The Adjusted Index Rate, further adjusted for allowable plan-level modifiers as defined in 45 CFR 156.80(d)(2).

Consumer Adjusted Premium Rates - The final premium rates for a plan that are charged to individuals or families within a small employer group.

All reference to the number of employees included in these instructions shall be determined using the counting method set forth in NCGS 58-50-110(22a) and (22b). Specifically, in addition to the number of full-time employees working an average of 30 or more hours per week such count must also include the number of full-time employee equivalents determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

1. General Information

This section includes general information about the carrier and the policies which are the subject of this rate filing. The information provided in this section should include at least the following:

- a. **Carrier Information:** Provide the following information that uniquely identifies the carrier submitting the memorandum. The information must be consistent with information provided in Worksheet 1 of the Federal Part I Unified Rate Review Template and Worksheet 1 of the NC Rate Submission Template:
 - **Company Legal Name:** The organization's legal entity name associated with the HIOS issuer ID
 - **HIOS Issuer ID:** The HIOS ID assigned to the legal entity
 - **NAIC Number:** The NAIC company code assigned to the legal entity
- b. **Carrier Contact Information:** Provide the following information detailing how the Department should contact the carrier in the case additional information is needed.
 - **Primary Contact Name:** Provide the name of the person at the carrier who will serve as the primary contact for the rate filing submission. The Department will contact this person if there are questions related to the filing, or if additional information is needed.
 - **Primary Contact Telephone Number:** Provide the phone number for the primary contact
 - **Primary Contact Address:** Provide the address for the primary contact
 - **Primary Contact Email Address:** Provide the email address for the primary contact
- c. **Scope and Purpose of the Filing:** Describe whether the filing represents a rate revision or justification for continued use of existing rates. If the filing is a rate revision, the reason for the revision should be stated, as well as whether the rate revision impacts all rating cells equally. Provide whether pre-approval of future trend increases is being sought. The actuary should also identify all laws with which the filing is intended to comply. Identify any new products or plans that are included as part of the filing and indicate when and how the new products or plans were submitted (e.g., include the form filing number).
- d. **Market:** Indicate that the filing covers products that will be offered in the small group market

- e. **Policy Forms:** List all product and form numbers associated with policies included in the single risk pool. Include HIOS Product ID Codes and Product Names
- f. **Brief Description of the Benefits:** Provide a description of the benefits that will be provided by the policies which are the subject of the rate filing. In addition:
- Confirm that all EHBs are covered and indicate whether any substitutions were made from the State standard EHBs. If changes were made due to a different EHB benchmark being applicable to the projection period relative to the EHB benchmark that applied during the base period, please list each newly covered EHB benefit and any benefits that will no longer be covered as an EHB.
 - Indicate any benefits covered in excess of the State standard EHBs.
- g. **Marketing Method:** Provide a brief description of the marketing method(s) used to inform consumers of the availability and details of the product(s) included in the filing. The information provided is not intended to compromise the carrier's proprietary interests but rather to inform the Department's consideration of the allocation of expenses and acquisition costs.
- Clearly identify which, if any, products are marketed through associations. Indicate which methods will be used for plans sold through the Exchange only, which will be used for plans sold outside the Exchange only, and which will be used for plans sold both inside and outside the Exchange.
 - Confirm that agent/broker compensation is the same inside and outside of the Exchange, per 45 CFR 156.200(f).
- h. **Identification of Block as Open or Closed:** Confirm that all plans for which rates are included in the filing will be open to new sales. If any are not, indicate why they are not.
- i. **Minimum Participation and Contribution Requirements:** Provide the current and proposed minimum participation and employer premium contribution requirements.
- j. **Terminated Products/Plans:** List all products and/or plans that will no longer be offered as of the effective date of this filing. Provide current membership in the terminated plans. Indicate the percent of base period member months and allowed claims that are represented by terminated plans. Confirm that all terminated non-grandfathered plans are included in the base period experience reported in the URRT.

2. Proposed Rates

In this item the actuary must describe the proposed rate adjustment, how the proposed rates were developed and the resulting premium levels. If the requested rate adjustment varies by

plan, the information provided should clearly identify which requested adjustments apply to which plans and explain why the rate adjustments vary. Describe the rate adjustments for all products which are part of the single risk pool, including those products for which no rate adjustment is being requested.

- a. **History of Rate Adjustments:** Provide the month, year, and percentage amount of prior rate adjustment(s) for all rate adjustments over the past three years. Provide the SERFF tracking numbers for all rate changes effective during the 12-month period prior to the proposed effective date of the filed rates. If the rate adjustment(s) varied by plan, separately list the adjustment for each plan.
- b. **Effective Date and Implementation of Proposed Rate Adjustment:** Provide the effective date of the proposed rates filed for each product/plan and the proposed method of implementation. For example, indicate whether policyholders will be asked to pay the revised rates beginning on the stated effective date or on the next policy anniversary date on or after the stated effective date.
- c. **Months of Rate Guarantee:** Provide the number of months for which the proposed rates will be guaranteed to the policyholder.
- d. **Proposed Percentage Rate Adjustment:** Provide the proposed rate adjustment(s) as a percentage of current premium levels for each plan for which a rate adjustment is being proposed. If different rate adjustments are being requested for different plans, clearly identify the proposed rate adjustment for each. Provide the following adjustments:
 - The numerical calculation of the threshold rate increase as defined by CCIO, including the aggregate premium before and after the rate increase, number of members, number of enrollees (employees), number of policyholders (employer groups), and average rate increase for each rate increase effective date/month.
 - The average adjustment to rates across the entire small group market to which the filing applies, when measured relative to the rates in effect twelve months prior to the effective date stated in item 2c. If no change in rates is being requested for some plans, those plans should still be included in calculating the market wide average adjustment. The weighted average adjustment should be calculated using premium as a weight. The current premium used in this calculation is the annual premium that groups would pay based on the rate table that is in force for the one-year period that ends with the effective date of the rate table in the filing. The adjusted premium is the annual premium that groups would pay for the twelve-month period after the effective date based on the proposed rate table. The following example shows the calculation of the requested weighted average premium increase for a carrier offering three plans:

<u>Plan</u>	<u>Current Annual Premium</u>	<u>Rate Change</u>	<u>Adjusted Annual Premium</u>
A	\$10,000,000	10.00%	\$11,000,000
B	\$22,000,000	-2.00%	\$21,560,000
C	<u>\$16,000,000</u>	15.00%	<u>\$18,400,000</u>
	⁽¹⁾ \$48,000,000		⁽²⁾ \$50,960,000

$$\text{Weighted Average Rate Change} = (2)/(1) - 1 = 6.17\%$$

- The maximum rate adjustment among all products offered in the market, based on actual current enrollment.
- The minimum rate adjustment among all products offered in the market, based on actual current enrollment.
- If the requested rate adjustment is not the same across all products and plans, provide a narrative discussion as to why the rate adjustments vary by product or plan given, they are based on the same single risk pool of experience for the market. Also provide actuarial justification of the apportionment of the aggregate rate revision (within each policy form or between policy forms that have been grouped) and a demonstration that the apportionment of the aggregate rate revision yields the same premium income as if the rate revision had been applied uniformly.
- If pre-approval of future trend increases is being sought, provide a table that contains the proposed trend increases by effective date. Describe the basis of and provide support for the proposed trend amount(s) in item 5.b below.

e. Description and Numerical Demonstration of How Revised Rates were Determined:

Provide a brief narrative describing the process used to determine the requested rate adjustment(s). Discuss how the proposed rates were determined to meet the requirements of NCGS 58-50-130(b1) and 58-50-131 to be reasonable relative to the level of benefits provided, and not excessive, inadequate, or unfairly discriminatory. The numerical demonstration shall include sufficient detail and data to enable any qualified actuary to reproduce the requested rate change with the submitted rating methodology.

- f. Reason for Rate Adjustment:** Provide a narrative description of all significant factors driving the proposed change in rates. As an example, these factors could include but are not limited to experience which is more adverse than assumed in the current rates, medical inflation, increased utilization, benefit changes, new taxes and fees, and anticipated changes in the average morbidity of the population covered net of risk adjustment payments and charges.

- g. Percentage of Rate Adjustment Attributable to Experience:** Provide the percentage of the requested rate adjustment for each plan that is attributable to experience.
- h. Average Annual Premium per Member:** Provide the North Carolina average annual premium per member for the entire single risk pool, before and after the proposed rate adjustment. Provide this premium based on the expected distribution of membership during the projection period. Premium for any mandatory riders, endorsements and amendments should be included.
- i. Number of Policy Holders and Covered Lives in the State and Nationwide:** Provide the number of policy holders (i.e. groups), number of employees covered, and the total number of covered lives currently in force that are affected by the rate adjustments proposed in the filing. Include those products which are part of the single risk pool but for which no rate adjustment is being requested.

3. Base Period Premium and Claims

This section includes information related to development of the actuary's best estimate of earned premium and allowed claims during the base period for the single risk pool, and a description of the methodology used to develop them. Allowed claims should include an estimate for any claims incurred but not yet paid. In this section report the North Carolina experience prior to any adjustments for required changes in benefits due to EHBs, State mandates, or changes in cost sharing between the base period and the projection period. This should be consistent with the data included in the North Carolina Data Submission Template; if it is not, an explanation should be provided as to why. Typically, this would also be the same experience shown on Worksheet 1 of the Part I Unified Rate Review template if the template is required to be completed for the filing. However, it may differ since the Part I Unified Rate Review template is not a rate development tool. Any differences between the two data sources must be described. The experience reported in this section should include only North Carolina experience for the single risk pool; any usage of nationwide data in the development of rates should be reflected in the credibility manual rate.

- a. Dates of Service for the Base Period Used to Develop Rates:** Provide the dates of service during which claims were incurred during the base period of the single risk pool in North Carolina used to develop the index rate. Describe how the dates of service used to develop rates differ from that shown in the Part I Unified Rate Review template, if applicable.
- b. Date Through Which Claims Were Paid:** Provide the date through which claim payments were made on claims for the single risk pool in North Carolina, incurred during the base period used to develop rates.
- c. Estimate of Allowed Claims During the Base Period Used to Develop Rates:** Provide and provide support for the development of the actuary's best estimate of North Carolina

allowed claims incurred during the base period which will form the basis of the projected index rate, to the extent they are credible. Therefore, provide claims prior to any adjustment for risk adjustment and reinsurance programs in the State.

- The single risk pool of experience used as a basis to develop rates may include the experience of non-grandfathered groups covered by transitional policies.
 - Allowed claims are defined as total payments made under the contract on behalf of covered members and include liabilities of the carrier and member cost sharing. Allowed claims should exclude ineligible claims such as duplicate claims, third party liabilities, and any other claims that are denied under the contract terms.
 - Separately provide the amount of allowed claims that were processed through the carrier's claim system, processed outside of the claims system, and that which represents the actuary's best estimate of claims incurred but not paid as of the date through which claims were paid. Include a discussion of the methodology used for any allocation of non-system claims.
 - Claims should be prior to adjustments for items such as private reinsurance and large claim pooling.
 - Claims should include only those expenses that represent reimbursement for medical care provided; they should not include items such as medical management and quality improvement expenses.
- d. Treatment of Experience for Grandfathered Policies:** Provide a discussion of how grandfathered policies were handled in determining the base period experience. Specifically, indicate whether the experience of all grandfathered policies was excluded, or provide an explanation of why and how the experience of grandfathered policies was included in the base period experience of the single risk pool.
- e. Method Used for Determining Allowed Claims:** Describe the method used for determining allowed claims. For example, allowed claims could come directly from a carrier's claim records or alternatively could be developed by combining paid claims or capitation payments with member cost sharing.
- f. Incurred But Not Paid Claims:** Provide the following support for the estimated allowed claims incurred but not paid (IBNP) as of the date through which claims were paid.
- Describe the methodology used to develop the estimate of claims incurred but not paid. Indicate whether IBNP factors were calculated separately based on allowed and paid claims using the respective claims experience, or whether one method was used (i.e.

calculated only using allowed or paid claims) and applied to both allowed and paid claims.

- Indicate whether the claims used to develop any completion factors reflect the base period claims for this filing or some alternate claims set, such as a larger block of the carrier's experience. If an alternate claims set was used, please provide support for why it is appropriate.
- Describe any changes (e.g., in the claims payment system) that would result in change(s) to the completion factors.

g. Premium in Base Period (Before and After Risk Transfer and MLR Rebates): Indicate the earned premium both prior to risk transfers and MLR rebates and after risk transfers and MLR rebates refunded for the market during the base period. Earned premium prior to risk transfers and MLR rebates should not be reduced for any reductions prescribed when calculating the carrier's MLR, such as taxes and assessments. For portions of the base period for which the risk transfers and MLR rebates have not been finalized, a best estimate of these amounts is to be included. Describe the methodology used to estimate such transfers and rebates.

4. Adjustments to Allowed Claims During the Base Period Claims

This section includes a discussion of any adjustments made to the base period claims of the single risk pool used as the basis for developing the projected index rate. This section should not include the application of factors to project the experience forward to the projection period, but rather adjustments to address the potential volatile nature of the base period claims.

- a. Private Reinsurance:** Describe the impact of any privately purchased reinsurance during the base period. Separately provide the amount of reinsurance premiums paid, the reinsurance recoveries, and the net impact that such reinsurance had on the base period claims of the single risk pool.
- b. Pooling:** Describe any large claim pooling that was applied to the base period claims. Provide the level of the pooling attachment point used, verify that the level of the attachment point is not changing from the prior year (or provide support for any change), and indicate the types of services to which the attachment point applies.

Describe the source for the pooling charge. Provide the credibility formula used to determine that the source is fully credible and verify the following related to the source data:

- It consists of small group market experience (or describe any adjustment applied to adjust to the small group market)
- It reflects the same time period as the base period data (or describe any trend adjustments applied to reflect the time period of the base data)
- It is composed of North Carolina experience (or describe and support why the use of non-North Carolina experience is appropriate, and any adjustment applied to be reflective of North Carolina experience)
- The pooling charge is developed to be consistent with the attachment point used to cap claims
- And it contains the same types of services as the services applicable to the attachment point

Separately provide the amount of pooled claims removed from the base period, the pooling charge added, and the net impact that pooling had on the base period claims of the single risk pool.

5. Projection Factors

This section should include a description of each factor used to project claims of the single risk pool from the base period to the projection period as a basis for the development of the index rate, and supporting information related to the development of the factors. For each factor, the actuary should describe the source data used, why it is appropriate for the single risk pool, and any applicable adjustments made to the data, such as considerations for carrier specific experience, industry or internal studies, benefit design and credibility of the source data. At a minimum, support should be provided for the following factors:

- a. **Changes in Benefits:** Describe the benefit changes and the development of factors used to adjust the base period experience to reflect the benefits that will be covered during the projection period. These factors reflect changes in allowed costs due to changes in the services covered; they are not intended to reflect changes in the average member cost sharing. Separately specify which changes were made to comply with Federal law. The factors could adjust for items including but not limited to the following:
 - Addition of any benefits that must be covered under the North Carolina EHB package, including new EHB benefits during the projection period due to a new EHB benchmark plan
 - Any mandated benefits required under State law that are not reflected in the base period experience and are not part of the EHB

- Adjustments to reflect the removal of benefits covered in the base period that will not be covered in the projection period, including benefits that were EHBs during the base period but will not be EHBs during the projection period due to a new EHB benchmark plan
- Anticipated changes in the average utilization of services due to differences in average cost sharing requirements during the base period and average cost sharing requirements in the projection period

b. Trend Factors (Cost/Utilization): Provide the cost and utilization trend projection factors by major type of service that were used to project base period claims to the projection period in the development of the index rate. Provide the projections by major type of service in the following categories:

- Inpatient
- Outpatient
- Professional
- Other Medical
- Capitation
- Prescription Drugs

Describe the source claims data and methodology used for developing the projection factors and explain why the data is appropriate.

Describe and support each adjustment made to the raw data used for developing trends. Some examples of adjustments that may be appropriate to include, but are not limited to the following, are:

- Normalization for changes in age which are accounted for in the standardized agecurve that will be used in the development of rates
- Normalization for benefit and cost sharing changes that occurred during the experience period (even if allowed claims are used to calculate trend, a normalization adjustment may be warranted to account for the influence that changes in benefits have on utilization)
- Adjustments for any seasonality patterns underlying the claims that may skew calculated trends; this is particularly true if full calendar years of experience are not used.

- Normalization for any one-time events which occurred during the experience period and are not anticipated to reoccur during the projection period
- Adjustments for anticipated changes in provider contracts that differ from those underlying the experience used
- Adjustments for unusually large claims or a pattern of large claims that are skewed toward the start or end of the experience used
- Significant measurable shifts in the morbidity of the population underlying the experience period used
- If nationwide data is used, adjustments may be required to account for differences between changes observed nationwide as compared to those experienced in North Carolina. If no adjustments are made, provide support for why the nationwide experience without adjustment is appropriate.
- Adjustments may be necessary if a managed care program was introduced or revised during the experience period over which trends are measured
- Adjustment for the impact of deductible leveraging, if paid (allowed) claims are used as a basis for trend development and allowed (paid) claims are used as the starting point for rate development
- For prescription drugs, adjustments made to account for changes in the formulary, expiration of patents, or introduction of new drugs which are expected to impact claims at a different rate than these forces did during the experience period

If external sources are used as a basis for estimating trend (e.g., trend surveys, information from consultants, National Health Expenditures portion of GDP, Medical CPI, etc.), describe the source of the information and demonstrate why the trends from these other sources are appropriate. It may be necessary to adjust these external sources for one or more of the items listed above. If so, demonstrate the adjustments required and provide support that they are appropriate.

Also provide a comparison of actual vs. expected trends for the single risk pool for the past 36 months.

- c. **Projected Changes in the Demographics of the Population Insured:** Describe the development of factors used to adjust the experience of the single risk pool to account for differences between the average mix of the population by age and gender that was insured during the base period and the average mix of the population by age and gender anticipated during the projection period. (While gender is not an allowable characteristic for

determining Consumer Adjusted Premium Rates, it may be used to project future claim costs for the single risk pool in setting the index rate.) If changes in risk scores are used to estimate the change in the morbidity of the population in item 5d below, it is likely that the factor representing the change in demographics may be 1.00 given risk scores account for differences in age, gender and morbidity.

- d. Projected Changes in the Morbidity of the Population Insured:** Describe and support any adjustment factors applied to the base period claims to account for anticipated differences in the average morbidity of the population underlying the base period experience and the population anticipated to be insured during the projection period. These adjustments 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. These changes could be impacted by changes in items such as an individual mandate to maintain coverage or the introduction of a Basic Health Program. Explicitly provide the assumed percent of the projected population that was previously uninsured and their assumed morbidity relative to the base period experience as well as any assumed pent-up demand.

Also indicate whether the carrier will allow small groups to maintain their non-grandfathered pre-ACA policies during the projection period under the extended transitional relief granted by CMS. If the carrier will allow for these policies to be maintained beyond their scheduled policy renewal date in calendar year 2021, provide the number of members eligible for transitional relief, the number of members assumed to renew such policies in 2024 under the transitional relief provisions in the projection period, and the estimated impact on the morbidity of the population anticipated to be insured during the projection period as a result of these pre-ACA policies being maintained in the projection period.

- e. Other Projected Changes:** Describe any other adjustment factors applied to the base period experience in developing the actuary's best estimate of the average allowed claims PMPM during the projection period. Also describe and support how these factors were developed. For those carriers electing to complete Worksheet 10 of the North Carolina Data Submission Template as support for their index rate development, include in this section a description of any factors included in the "Other Change" column for either utilization or cost.
- f.** Include expected COVID and American Rescue Plan impacts.

6. Credibility Manual Rate Development

For carriers with base period claims that are not determined to be fully credible, the use of other experience must be employed in developing a manual rate for blending with the projected base period claims for the single risk pool. In this section the actuary must provide information related to the experience used to develop the manual rate, and the general methodology used.

- a. **Methodology Used to Develop the Credibility Manual Rate:** Describe the methodology used to develop the manual rate, including but not limited to how the data was gathered, how each of the adjustments to the data was applied, the trend utilized and how it was applied to project the data forward to the projection period.
- b. **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 policies for which rates are being filed
 - The carrier'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
- c. **Adjustments Made to the Data:** The experience upon which the manual rate is based must be adjusted to be reflective of the population, benefits and provider reimbursement levels anticipated under the policies for which rates are being filed. Describe and support all adjustments made to the data underlying the development of the manual rate to ensure that the result is appropriate for blending with the adjusted and projected base period claims.

These adjustments may likely include but are not limited to differences in:

- Covered services
 - Demographics
 - Morbidity
 - Provider reimbursement rates
- d. **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 manual rate.

7. Credibility

Provide support for the credibility level assigned to the adjusted and projected base period claims of the single risk pool, with the complement being applied to a credibility manual rate.

- a. **Credibility Methodology:** Describe the credibility methodology used and demonstrate that it is consistent with standard actuarial practices.
- b. **Credibility Level(s):** Provide the credibility level(s) assigned to the adjusted and projected base period claims PMPM of the single risk pool, resulting from the application of the proposed credibility methodology. If credibility is applied separately to unit cost and utilization or credibility varies by major benefit category, provide support for such variation.

When the adjusted and projected base period claims of the single risk pool are partially credible and are also included in the experience used to develop the manual rate, provide a demonstration of how the credibility methodology in item 'a' above was adjusted so the experience is assigned the appropriate credibility.

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."*

8. Covered Services

This section of the Actuarial Memorandum should provide a listing of services that are currently covered but will no longer be covered in the projection period and those that will be newly covered in the projection period that are not currently covered. This information provided should be included in the following categories:

- a. **EHBs:** List all benefits not covered during the entire base period that will be added in the projection period due to the fact they represent a North Carolina EHB. List the percentage of the base period claims that each benefit represents, on an allowed claim basis.
- b. **State Mandated Benefits Which are Not EHBs:** List any North Carolina State mandated benefits that will be covered services in the projection period and were not covered during the entire base period and are not a North Carolina EHB. List the percentage of the base period claims that each benefit represents, on an allowed claim basis.
- c. **Eliminated Benefits:** List all benefits covered during the base period that will not be covered during the projection period. List the percent of base period claims that each benefit represents, on an allowed claim basis.
- d. **Additional Supplemental Benefits:** List any benefit that will be covered in the projection period that is not an EHB and was not covered during the entire base period. To the extent that these benefits do not apply uniformly to all plans, please indicate which plans they apply to. List the percentage of the base period claims that they represent, on an allowed claim basis.

- e. **Changes in the Level of Covered Services:** List any benefits that were covered during the base period that will be covered during the projection period but at a different level. This is not in reference to changes in cost sharing applied to the benefit but rather limitations related to the number of days or visits, medical necessity, covered providers, etc. List the percentage of the base period claims that they represent, on an allowed claim basis.
- f. **EHB Substitutions:** For any benefits included in the North Carolina EHB package that have been substituted with other benefits, provide support demonstrating that the substitution is in compliance with 45 CFR 156115(b). Specifically, demonstrate that:
- The substituted benefits are from the same EHB category as the benefits they are being substituted for
 - The substituted benefits are actuarially equivalent to the benefits they are being substituted for
 - The substituted benefit is not a prescription drug benefit
 - The support for the substituted benefit was based on an analysis performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial practice
 - The analysis was performed using a standard plan population
 - The substitution is non-discriminatory
- g. **Changes in Formulary:** Describe any changes in the formulary and provide the impact on allowed claims (as a percentage of base period medical and drug allowed claims).

9. Credibility Adjusted Projected Claims

Demonstrate how the credibility adjusted projected claims per member per month were developed from the adjusted and projected base period claims and, if applicable, the credibility manual rate.

10. Projected Index Rate

Provide the projected index rate for the single risk pool for the projection period as defined by 45 CFR Part 156.80(d), for the effective date stated in item 2c above. Demonstrate how the projected index rate was developed from the credibility adjusted projected claims PMPM in item 9 above. The stated index rate should represent the actuary's best estimate of allowed claims PMPM for EHBs during the projection period for the single risk pool. The index rate should be calculated prior to adjustment for market-wide payments and charges under the risk adjustment program, and should reflect the average mix of benefits, demographics and morbidity anticipated to be in force during the projection period.

The stated projected index rate must be applicable to the first effective calendar quarter of issues or renewals in the filing. The projected index rate must reflect the experience of all policies projected to be in the single risk pool regardless of the effective date of the policies. If predefined quarterly trend changes that will be applied to the rates are being filed, also provide the calculation of the index rate included in the URRT which is equal to the member weighted average of the projected index rates applicable for each quarter covered by the filing.

11. Market Adjusted Index Rate

45 CFR 156.80(d) indicates that the index rate shall be adjusted for total market-wide payments and charges under the Federal risk adjustment program, and any Exchange user fees.

a. Risk Transfer Payments/Charges: Provide support for the risk transfer payment or charge anticipated to be received or paid for the projection period for the small group market. The calculation of the projected risk adjustments should consider the published transfer equation. The support provided should include:

- A description of the data used for the calculation
- A discussion of the methodology used to calculate the estimate
- Demonstration and support for any adjustments included in calculating the risktransfer payment/charge which are attributable to sequestration
- A comparison of the risk of the carrier's population covered in the small group market and the risk of the small group market state-wide, including a discussion and support for anticipated changes in this relationship
- The resulting estimated risk transfer payment or charge on a PMPM basis
- The actual historical risk transfer payment/charge by calendar year, on a PMPM basis

b. Exchange User Fees: Provide support for the estimated impact on the index rate of

exchange user fees that will be included in the rates. The support provided should include:

- A description of how the fees were calculated
- The estimated assessment on a PMPM basis
- The proportion of projected enrollees that are expected to enroll through the Exchange

12. Plan Adjusted Index Rates

Describe how the Market Adjusted Index Rate was further adjusted to arrive at the Plan Adjusted Index Rates. Include in this section a description of how the AV Pricing Value for each plan was calculated, where the AV Pricing Value represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rates. Plan Adjusted Index Rates must be developed by adjusting for only the following items, outlined in 45 CFR 156.80(d)(2), which must be actuarially justified:

- The actuarial value and cost-sharing design of the plan. It is anticipated that these factors represent differences in cost sharing for each plan, relative to the average assumed for the market adjusted index rate. It is important to note that the AV Pricing Value may be different from the AV Metal Value as the AV Pricing Value is determined from the carrier's own experience rather than the experience of the standard population or standard tables that are used in the calculation of the AV Metal Value. If the adjustment for plan cost-sharing includes any expected difference in utilization due to the difference in cost sharing, describe in detail how the expected utilization difference was estimated. Note that selection differences may not be accounted for in this adjustment. List any proposed changes in cost sharing provisions for each plan.

Federal guidance in the instructions to the Unified Rate Review Template is that carriers are to include tobacco calibration to a non-tobacco user in the actuarial value and cost-sharing design adjustment. Provide a demonstration of how the Market Adjusted Index Rate was calibrated (e.g., based on the carrier's weighted average tobacco status) in order to have the resulting Plan Adjusted Index Rates reflect non-tobacco users.

- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the EHBs. 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 the EHBs.
 - For each benefit that is offered which is not an EHB, please provide support for the development of the additional cost. Please clearly demonstrate any assumptions related

to selection that were included in the development of the cost due to the benefit being included in some plans and not others.

- Administrative costs, excluding Exchange user fees.

- Calibration:

As outlined in 45 CFR 156.80(d)(3), the carrier must calibrate the plan-adjusted index rate for its plans within the single risk pool to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco use rating factor of 1.0, in a manner consistent with the instructions provided through the 2024 Plan Year Unified Rate Review Instructions to ensure that any rating variation under 45 CFR 147.102 of this subchapter may be accurately applied with respect to a particular plan or coverage. The calibration must be applied uniformly to all plans within the single risk pool of the State market and cannot vary by plan.

13. AV Metal Values

Describe how the AV Metal Values for each of the plans were calculated. The AV Metal Values reflect the ratio of the anticipated claims paid by the plan to the total allowed costs of benefits for a given plan, for only EHBs. For example, the estimated paid costs for a gold plan as compared to the estimate allowed costs for the plan must generate a ratio between 0.78 and 0.82 (should the de minimis range be amended by federal regulation, then the range noted here will likewise be revised to reflect the final federal standard).

The AV Metal Value must be determined using the Federal AV Calculator unless the plan's design is not compatible with the AV Calculator. The carrier must describe whether the AV Metal Values were entirely based on the AV Calculator, or whether an acceptable alternative methodology, as outlined in 45 CFR Part 156, §156.135(b) was used to generate the AV Metal Value for one or more plans. If an alternate methodology was employed to develop the AV Metal Value(s), the actuary must identify those plans for which such alternate methodology was used and provide a description of the methodology. The alternate methodology must be consistent with the methodology underlying the AV Calculator. For example, for plan design features that cannot be fit into the AV Calculator the alternate methodology must also be based on coverage of EHBs for a standard population of individuals continuously enrolled for a twelve-month period, excluding out-of-network costs. In addition, a separate actuarial certification must be provided for these plans. If an alternate methodology was employed to develop the AV Metal Value(s), an actuarial certification must be included, as required by 45 CFR Part 156, §156.135.

14. Paid to Allowed Ratio

The carrier must provide support for the expected average paid to allowed ratio during the projection period, shown in Worksheet 1 of the Federal Part I Unified Rate Review Template.

Demonstrate that the ratio is consistent with membership projections by plan provided in Worksheet 2 of the template.

15. Non-Benefit Expenses Including Risk and Profit Margin

- a. **Projected Non-Benefit Expenses:** Provide support for all expenses which 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 market, which is the subject of this filing, 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.

The categories discussed must be mutually exclusive, and should include but not be limited to:

- **General Administrative Expenses:** This category includes expenses associated with the general operation of the health plan, and includes those such as allocated corporate overhead, finance, accounting, provider contracting, and member services.
- **Sales and Marketing:** Describe and provide the amounts anticipated to be paid for activities associated with obtaining new business in the small group market. This should not include expenses associated with enrollment related functions as these would fall into general administrative expenses.
- **Commissions and Broker Fees:** Describe amounts paid to brokers and agents for selling and servicing of plans sold in the market which is the subject of this filing.
- **Premium Tax:** Provide the amount of any premium taxes required to be paid by the carrier, as a percent of premium.
- **Other Taxes, Licenses and Fees:** Describe any other assessments the carrier is required to pay. Any Exchange user fees should not be included as they must be applied as a market wide adjustment to the index rate. Separately identify those taxes and fees that are imposed by the Affordable Care Act (ACA) and provide the projected cost of each. This could include items such as:
 - The patient centered outcomes research institute (PCORI) fee assessments mandated under the ACA through September 2024, and
 - The ACA insurer tax (**Note that this tax was permanently repealed effective 1/2/2021**).

- **Health Care Quality Improvement and Fraud Detection Expenses:** Describe any expense loads related to quality improvement and fraud detection/recovery. These expenses are to be treated as non-benefit expenses for the purpose of rate development even if those expenses are considered part of incurred claims for purposes of MLR rebate calculations.
 - **Other Expenses:** Describe and list any additional expenses included in the development of premium rates.
 - **Investment Income:** Describe and support the investment income anticipated to be earned during the projection period attributable to the policies that are the subject of this filing.
 - **Risk Margin:** Describe and support any risk margin included in the development of the premium rates.
 - **Profit or Contribution to Surplus Margin:** Describe the target underwriting gain/loss margin. To the extent that the target as a percent of premium has changed from the prior filing, provide additional support for why the change is warranted. For any plan with a negative margin, describe why a negative margin is included, provide additional support indicating such margins will not adversely affect the carrier's financial strength, and indicate the carrier's plans for future pricing margins by demonstrating the margin across all plans is non-negative. If the margin across all plans is negative, provide the following:
 - An explanation of the reason(s) for the expected losses
 - A demonstration that the carrier has sufficient surplus to withstand the losses anticipated to result from the proposed rates without having an adverse impact on the carrier's financial strength; the carrier shall include a numerical calculation of its Risk Based Capital Ratio
 - A demonstration that the carrier is not engaging in predatory pricing and subsidizing any expected losses with gains on another line of business
 - A financial projection that demonstrates the margin is expected to be at or above break even in the next 3-5 years; the carrier shall include a numerical calculation of its Risk Based Capital Ratio
- b. Comparison of Current and Proposed Non-Benefit Expenses:** Provide a comparison showing for each of the categories above the amounts as a percent of premium and on a PMPM basis for both the current and proposed rates.

- c. **Varying Non-Benefit Expenses by Plan:** To the extent that non-benefit expense loads do not represent the same percent of premium or PMPM for all plans, describe and support such variation. For example, it may be reasonable to vary general administrative expenses as a percent of premium in order to recognize that fixed expenses represent a different percent of premium for lower cost Bronze plans than they do for higher cost Platinum plans. To the extent that broker commissions are paid on a flat per member per month basis this same variation as a percent of premium by plan may be warranted.

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

16. Adjusted Community Rating Factors

A carrier is limited in the rating factors that may be applied to the Plan Adjusted Index Rate in the determination of Consumer Adjusted Premium Rates for an individual or family. Describe all factors by which the proposed rates vary. In any case where a carrier is changing a rating factor from its current level, the actuary will be required to document and provide support for the change. This applies to:

- a. **Age Factors:** Confirm that the **revised** federal age curve standardized age factors will be used. **Note that the federal age curve was amended in the HHS Notice of Benefit and Payment Parameters for 2018 published on December 22, 2017 and the new updated curve, providing single age specific rate bands for ages 15 through 20.**
- b. **Geographic Factors:** Provide the factor for each geographic rating area. Provide support for any proposed changes to the geographic rating adjustment factors used in developing premium rates, as well as a description of the methodology used for setting the geographic rating factors. Geographic factors should represent only differences in cost of the delivery of medical services between various geographic locations for a standard population and fixed market basket of covered services, or differences that are otherwise adjusted for morbidity. Confirm that only the geographic rating regions defined by the State are used.
- c. **Tobacco Factors:** List the proposed tobacco load factors and describe how those factors were developed. If the load varies by age, indicate to which age ranges each factor applies and provide support for the variance in factors.
- d. **Family Composition:** If a composite premium methodology will be used, describe how the composite premium rates will be developed to ensure that they are in compliance with 45 CFR 147.102(c)(3)(iii) for small groups sold through the FF-SHOP or an alternate composite premium methodology approved for small groups sold outside of the FF-SHOP in North Carolina. Demonstrate that the total premium charged to the group at the time the composite premium rates are determined will not differ from the total premium that would

be charged if the Consumer Adjusted Premium Rates as described in 45 CR 147.102, paragraphs (c)(1) or (c)(2), were used.

Under 45 CFR 147.102(c)(3)(iii), a “composite premium” or “average enrollee premium amount” may be used as long as the “composite premiums” or “average enrollee premium amounts” conform to the following:

- One composite premium is developed based on all adults age 21 and older in the group (regardless of status as an employee, spouse or dependent child);
- One composite premium is developed based on all individuals under age 21 in the group;
- Rates for a given family equal the sum of the applicable composite premium rates, taking into account charging for no more than three covered children under age 21;
- Any load for tobacco status must be applied at the member level to the composite premium (the tobacco load must be based on the applicable enrollee’s per-member premium, not a composite premium surcharge for all tobacco users);

Under the alternate composite premium methodology approved for small groups sold outside of the FF-SHOP, composite premium rates must conform to the following:

- The only tiers and tier ratios that may be used are as follows:
 - Employee Only = 1.00
 - Employee + Spouse = 2.00
 - Employee + Children (including all covered children up to age 26) = 1.85
 - Employee + Family (including spouse and all covered children up to age 26) = 3.10
- Employee premium must be calculated based on the coverage tier the employee selects using the following formula:
 - $\text{Final Employee Premium} = [\text{Group Aggregate Premium}] / [\text{Weighted Employee Count}] \times [\text{Employee Tier Factor}]$
- Any load for tobacco status must be determined at the member level (based on the premium that individual contributed to the group aggregate premium), and then added to the monthly premium for that individual based on their tier selection

Under either the method prescribed by 45 CFR 147.102(c)(3)(iii) or the Alternate Composite Premium Methodology approved for North Carolina the methodology must conform to the following:

- At the time of issue or renewal, the total group premium produced using the composite premium methodology must equal the total group premium using the applicable per-member premium rate tables.
- The composite premiums calculated at the time of issue or renewal must be locked in for the entire plan year, regardless of changes in the group's composition throughout the year; and,
- If composite premium is offered as an option to any small group, it must be offered to all non-grandfathered ACA compliant small group policies sold both inside and outside of the Exchange, except when employee choice is offered.

17. Development of Rate Tables

Provide a demonstration of how the Plan Adjusted Index Rates were calibrated (based on the carrier's weighted average age, weighted average geographic factor, and for the impact of non-rate table dependents in excess of three per family) in order to be able to apply the proposed rating factors (i.e., age, tobacco and geography) to calculate the Consumer Adjusted Premium Rates. Since tobacco calibration is performed as part of the actuarial value and cost-sharing design adjustment in developing the Plan Adjusted Index Rates, there should not be any additional tobacco calibration in this step. That is, show how the rate tables are derived from the Plan Adjusted Index Rates. If otherwise identical plans are offered, one with and one without the pediatric dental EHB, clearly indicate the amount of and methodology for applying the differential (e.g., PMPM or % of premium). Please clearly demonstrate any assumptions related to selection that were included in the development of the cost for the pediatric dental benefit due to the benefit being optional.

18. Company Financial Position

Provide a description of the carrier's current financial position. Include an exhibit of the historical and prospective RBC ratios. Discuss how the proposed rate adjustment is expected to impact the carrier's financial position, whether positively or negatively. Discuss how significant membership growth might impact the carrier's RBC ratio.

19. Loss Ratios

The actuary will be required to provide information on various loss ratios in this section. These include:

- a. **Loss Ratio Requirements:** Provide any North Carolina specific or Federal loss ratio requirements that the policies which are the subject of this filing are required to comply with.
- b. **Projected Federal MLR:** Provide an estimate of the anticipated Federal Medical Loss Ratio as outlined in 45 CFR Part 158 for the projection period. Provide the anticipated credibility adjustments as outlined in §158.230, however *do not include the adjustments in the calculation* as the experience used to project the loss ratio should be consistent with that used in the development of rates and should represent a credible base. Separately provide the following components of the calculation:

- Projected incurred claims
- Adjustments to the numerator for activities that improve healthcare quality as described in §158.150 and § 158.151
- Adjustments to the numerator for market stabilization payments or receipts as described in §158.140(b)(2)(i)
- Adjustments to the numerator for claim payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses, as described in §158.140(b)(2)(iv)
- Projected earned premium
- Adjustments to the denominator for Federal and State taxes and licensing and regulatory fees as described in §158.161(a) and §158.162(a)(1) and (b)(1)
- Expected credibility adjustments as outlined in §158.230

Utilize the following format in making this demonstration and separately provide support for any amounts included in either of the “Other Adjustments” fields:

Calculated Incurred Claims PMPM	\$X.XX
+ Risk Transfer Payment/Receipt	\$X.XX
+ Quality Improvement Expenses	\$X.XX
+ Other Adjustments	<u>\$X.XX</u>
Total Adjusted Medical Expense	\$X.XX
Calculated Overall Premium Rate PMPM	\$X.XX
- PCORI Fees	\$X.XX
- ACA Risk Adjustment Fees	\$X.XX
- ACA Insurer Fees	\$X.XX
- Exchange User Fees	\$X.XX

- State Premium Taxes	\$X.XX
- Federal Taxes	\$X.XX
- Other Adjustments	<u>\$X.XX</u>
Total Adjusted Premium	\$X.XX

- c. North Carolina Loss Ratio Requirements:** For HMO business, provide a demonstration that the estimated loss ratio during the projection period, calculated as incurred claims divided by earned premium, is in the required range of 75% to 90%. Since it is anticipated that this demonstration will be based on the projected index rate with allowable adjustments which is 100% credible, it is anticipated that the projected loss ratio will also be 100% credible.

20. Reliance

If, in developing the rates, 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 must be disclosed.

21. Actuarial Certifications

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. The actuary is required to provide, at a minimum, the following certifications:

- a. Identification of the Certifying Actuary:** The actuary must identify themselves by name and include a statement that he/she is a member of the American Academy of Actuaries
- b. Certification of the Index Rate:** A certification must be included that indicates that the projected index rate is:
 - i. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
 - ii. Developed in compliance with the applicable Actuarial Standards of Practice
 - iii. Reasonable in relation to the cost of the benefits provided
 - iv. Neither excessive, inadequate nor unfairly discriminatory
 - v. Developed using only the permitted rating classifications

- c. **Certification of Plan Adjusted Index Rates:** A certification must be included stating 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 Adjusted Index Rates.
- d. **Certification of Calibration of Plan Adjusted Index Rates:** A certification must be included stating that the Plan Adjusted Index Rate for all plans within the single-risk pool were calibrated to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco use rating factor of 1.0, in a manner consistent with that specified by the Secretary through the URRT instructions.
- e. **Certification of Metal AV:** A certification must be included stating that the Federal AV Calculator was used to determine the Metal AV Value shown in Worksheet 2 of the Part I Unified Rate Review template for all plans except those specified in the certification. For any unique plan designs, the actuary must provide a completed Unique Plan Design Supporting Documentation and Justification form, whether or not the plan is being submitted for QHP certification.
- f. **EHB Substitutions:** If substitutions were made for EHBs the actuary must provide a completed EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form, whether or not the plan is being submitted for QHP certification.
- g. **Geographic Factors:** A certification must be included stating that the geographic factors reflect only differences in the costs of delivery (including both unit costs and provider practice patterns) or are otherwise adjusted for differences in morbidity.
- h. **Threshold Rate Increase:** A certification that the threshold rate increase for each plan has been calculated as the average increase for all enrollees over the 12-month period preceding the date on which the rate increase would become effective, weighted by premium volume, as required by 45 CFR 154.200.
- i. **Uniform Modification:** A certification that all products and plans that qualify as a uniform modification of coverage under 45 CFR 144.103 and/or 147.106 have maintained the same HIOS product and plan IDs as currently attached to each plan.
- j. **Compliance With North Carolina General Statutes:** A certification indicating compliance with applicable North Carolina General Statutes must be provided and must include the following or similar language:
 - i. “I, (name and professional designations of actuary) am of the opinion that upon my next annual retrospective analysis of all small employer groups, that the proposed rates will be in compliance with NCGS 58-50-130(b1) and 58-50-131.”
 - ii. “I, (name and professional designations of actuary) am of the opinion that this filing is in compliance with the applicable Federal and State Laws and Regulations

concerning the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010.”

- k. Compliance with Applicable Federal Regulations:** A certification must be included indicating that the proposed rates were developed in compliance with all applicable Federal regulations.
- l. Compliance with Actuarial Standards of Practice:** A certification indicating compliance with applicable Actuarial Standards of Practice must be provided and must include the following or similar language:

“I, (name and professional designations of actuary) do hereby certify that each rate filing has been prepared in accordance with the following:

- i) Actuarial Standard of Practice No. 5, “Incurred Health and Disability Claims”
- ii) Actuarial Standard of Practice No. 8, “Regulatory Filings for Rates and Financial Projections for Health Plans”
- iii) Actuarial Standard of Practice No. 12, “Risk Classification”
- iv) Actuarial Standard of Practice No. 23, “Data Quality”
- v) Actuarial Standard of Practice No. 25, “Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages”
- vi) Actuarial Standard of Practice No. 26, “Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans”
- vii) Actuarial Standard of Practice No. 41, “Actuarial Communications”
- viii) Actuarial Standard of Practice No. 50, “Determining Minimum Value and Actuarial Value under the Affordable Care Act”