

Montana Individual and Small Group Rate Filing Instructions

***** These Instructions correspond to the Excel template and the rate filing in general*****

INSTRUCTIONS

These instructions and corresponding exhibits were developed to bring increased efficiency and standardization to the health insurance rate review process in Montana for the Individual and Small Group Markets. These instructions describe how to complete the corresponding set of exhibits and also provide information as to how the Office of the Commissioner of Securities and Insurance (CSI) will use and interpret each exhibit including areas where additional follow-up with the insurer may be necessary depending on the information provided by the insurer. It is expected that every time rates are filed a single set of exhibits will be provided for the corresponding market segment. Note that these exhibits (labeled Exhibit A through Exhibit J) are requested in addition to the federal URRT Part I, Part II (if applicable) and Part III requirements.

RATE FILINGS ARE DUE JUNE 15, 2016

When completing these templates and the URRT, insurers must also keep in mind the requirements of Mont. Code Ann. 33-22-156 and 157, the Affordable Care Act (ACA), the federal instructions for the URRT for 2017, and the actuarial principles used to complete health care rate filings and the following Actuarial Standards of Practice (ASOP's):

1. ASOP 5: Incurred Health and Disability Claims;
2. ASOP 8: Regulatory Filings for Health Plan Entities;
3. ASOP 12: Risk Classification (for All Practice Areas);
4. ASOP 23: Data Quality;
5. ASOP 25: Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages;
6. ASOP 26: Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans; and
7. ASOP 41: Actuarial Communications.

CSI may request additional information beyond the items requested in these instructions and templates if deemed necessary to complete their rate review. CSI will request some additional claims and demographic information from the 2016 plan year in July 2016. Detailed information about what must be submitted will be sent later.

GENERAL CONSIDERATIONS

1. All insurers operating in the Individual and Small Group major medical market must submit the federal rate data templates (contained in the plan binder) and the URRT, even if they do not intend to sell in the federally facilitated marketplace (FFM). Because the 2017 rates are due later than 2016 forms and templates, the URRT is not due and does not need to be filed in HIOS until June 15, 2016, which is Montana's rate filing deadline. However, the rate template is part of the form filing binder, which is due on May 9, 2016. In order to get the binder to "validate" the rates template must have fields filled out. Therefore, "dummy" rates template must be submitted as part of the binder submitted on May 9, but do not spend any extra time attempting to fill in correct estimates of rates. The CSI will not review this "dummy" template. When the filing is due on June 15, a new rate template will need to be submitted along with the URRT and other required documents.
2. A rate filing that contains the URRT and is separate from the form filing and the plan binder must be filed. Do not duplicate templates submitted in the plan binder (the rates template) in the rate filing. Part I (Unified Rate Review Template), Part II (Consumer Justification Narrative) and Part III (Actuarial Memorandum) of the Rate Filing Justification and all supporting documentation for the rates should be submitted in a separate SERFF rate filing. These files are not part of the plan binder.
3. Parts I, II and III of the Rate Filing Justification for ALL individual and small employer group health plans must be completed and submitted to both CMS and the CSI in HIOS and SERFF.
4. Please fill out the company rate information on the rate/rule schedule tab in SERFF (i.e. R2D2.)
5. Tobacco use rate ups are not allowed for anyone under the age of 21. This applies to policies sold both on and off the exchange.
6. Individual Market health plan rates, both on and off the exchange, must be guaranteed for the calendar year beginning January 1, 2017. No interim rate revisions will be permitted.
7. Rates for the Small Group Market, both on and off the exchange, must be filed for the entire calendar year of 2017. The initial rates for 2017 may be submitted with quarterly trend factors for the entire year. Subsequent quarterly rate revisions will be accepted, but they must be submitted 60 days in advance of use, as outlined in Mont. Code Ann. 33-22-156.
8. Rates entered into the rate filing or plan binder by the insurer should have no more than 2 decimal places in order to avoid validation errors later in the review.

CONFIDENTIALITY AND RATE JUSTIFICATIONS

If an issuer wishes to identify any part of the rate filing as confidential, it must first be identified as a "trade secret." Do not mark the entire filing as "confidential". Reasons for a trade secret determination must be specific for each item of information in the rate filing. Each item that properly deserves trade secret status must be clearly identified and accompanied by a separate affidavit from an authorized company representative who identifies specific reasons under Montana law that serve as a legal justification for the company to seek a trade secret designation for that particular information. The following are examples that may not be

considered trade secret: information that is already disclosed in another public source of information; or information that is readily disclosed by other health insurers. The Part II justification for a rate increase must be published pursuant to federal law and cannot be designated a trade secret. The Commissioner or her designee will make the final agency determination as to trade secret status. After the rate review process is complete, all parts of the rate filing will be treated as public unless trade secret status as been granted by the Commissioner. Contact the CSI for more detailed instructions if you have questions.

Rate justifications, as required by applicable federal regulations and contained in Part II of the URRT, must be submitted with the initial rate filing and for all subsequent rate increases, no matter how large or small the increase. The Part II rate justification is the consumer-friendly explanation/justification for the rate. Those rate justifications will be posted on the CSI website immediately after they are received for all health plans sold in Montana, both on and off the exchange. **The CSI will send additional instructions about the Part II requirements later. For 2017, the CSI will require more uniformity in the Part II consumer justification narrative.**

RATE FILING EXHIBITS

The table below lays out each of the requested exhibits and whether it is requested in part of the Excel Template or as a supplemental document. This table is also found in Exhibit A: Cover Sheet. These rate filing exhibits are requested to be submitted in SERFF in addition to the federal Part I, Part II (if applicable) and Part III requirements

Throughout the Excel-based exhibits specific items are shaded in blue, green or gray. Items in blue represent numerical inputs. Items in green represent text inputs. Items in gray represent pre-populated items, either as the result of a calculation from a formula or a direct input from another source within the rate filing.

Exhibit Name	Excel Template or Supplemental Document?
Exhibit A: Cover Sheet	Excel
Exhibit B: Modified URRT Worksheet 1	Excel
Exhibit B1: Description of Trend Development	Supplemental Document
Exhibit B2: Supporting Schedules for Trend Development	Supplemental Document
Exhibit C: Proposed Rate Change and Enrollment	Excel
Exhibit D: Components of Rate Change	Excel

Exhibit E: Claims Experience	Excel
Exhibit F: IBNR	Excel
Exhibit G: Demographics	Excel
Exhibit H: Retention Charges	Excel
Exhibit I: Projected MLR	Excel
Exhibit J: Rating Factors	Supplemental Document

- **Exhibit A: Cover Sheet**

Instructions: This exhibit contains two sections: Rate Filing Information and Rate Filing Exhibits. The first section contains a series of several items, some items with multiple sub-parts. The insurer is asked to state their name, NAIC Company Code, HIOS Issuer ID and SERFF Tracking ID, market segment, rate effective date for this rate filing and the rate effective date for the most recently approved rate filing. The insurer is then asked to provide contact information for **the person responsible for completing the filing**. The CSI wants to interact directly with the individual(s) who actually performed the work to complete the templates. The insurer is also asked to indicate whether there have been any changes to the rating methodology, benefits offered or cost sharing, and, if so, to describe these changes. This may also be provided in a supplemental document. The insurer is asked to indicate if this filing represents an amendment to a previously submitted filing or not. The insurer is also asked to indicate whether it intends to charge rates for subsequent renewal or issue dates by multiplying the rates within the rate filing by prospective trend adjustments. If yes, the insurers must indicate all the rate effective dates included with this filing and include the prospective trend adjustments in Exhibit B. The second section of this exhibit asks the insurer to indicate that all requested exhibits have been provided and are complete.

Exhibit Purpose: This exhibit provides high-level information to CSI related to the rate filing.

- **Exhibit B: Modified URRT Worksheet 1**

Instructions: The top part of this exhibit mirrors the federal Unified Rate Review Template (URRT) Worksheet 1. The insurer should complete this portion exactly as it would complete the URRT Worksheet per the federal instructions.¹

¹ https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/508_CMS-10379-2017-Unified-Rate-Review-Instructions.pdf

Starting in row 49, there are several pieces of information requested in this exhibit in addition to the information requested as part of the federal URRT. If the projected allowed claims experience PMPM with the credibility adjustment does not equal the projected index rate (as demonstrated in item 1a), the insurer is asked to comment on this. See the URRT instructions for possible valid reasons. Item 2a requests the total annualized trend assumptions from this filing. If this trend does not equal the trend calculated from the URRT Worksheet 1 information above, then the insurer is asked to explain in item 2c. Item 3a requests the total annualized trend assumptions from the prior year's filing. Item 4 requires the insurer to input the projected index rate for the first effective date of this filing. This amount would only differ from the projected index rate entered above in the URRT section (cell V44) if the insurer is filing for the Small Group Market and the filing includes prospective trend adjustments. This number is used as the starting point for the plan index rate adjustments applied in Exhibit C. If the insurer intends to charge rates for subsequent renewal or issue dates by multiplying the rates within this rate filing by prospective trend adjustments, the insurer will provide the quarterly prospective trend adjustment in the table requested for item 5. These trend adjustments should be entered as percentages. These trend adjustments are NOT cumulative.

Exhibit Purpose: This exhibit requires information directly from the federal URRT Worksheet 1 helping to facilitate the CSI's review and ensuring that the insurers can demonstrate the development of the proposed calibrated plan adjusted index rate from the projected index rate in the subsequent Exhibit C. The experience period information allows the CSI to understand the details of the experience used in the development of the projected index rate. The CSI will use the trend information presented in this exhibit to compare among insurers to understand if there are any outliers. It can also be used to compare trend assumptions used over time to understand how a specific insurer's assumptions have changed. In addition, overall trend assumptions can be compared to actual requested rate changes, and variances can be investigated. It is important that the trend information presented in the subsequent Exhibits B1 and B2 clearly and directly provide the necessary detail for The CSI to understand the methodology used to develop the final trend assumptions presented in this exhibit.

- **Exhibit B1: Description of Trend Development**

Instructions: This is a written response with no corresponding Excel exhibit. This document should include an explanation of the development of trend assumptions and how they were developed based on generally accepted actuarial principles. This document should address the items listed below if they are applicable to how the insurer developed their trend assumptions. Note that specific numbers are not being requested for each of these items, rather a written discussion on if and how these items were considered in the trend development.

1. Description of the data source used to develop the trend assumptions, specifically pointing out if any information outside of the Montana market was used, such as company-wide information or consultant survey data;
2. The differences in methodology used to project utilization versus unit costs trends;
3. Leverage on trend from fixed cost sharing;
4. Capitation payments and other provider payments;
5. Provider reimbursement and contracting strategy;
6. Care management programs;
7. Large claims;
8. If the trend assumptions have changed since the prior year's rate filing, this should be pointed out and a brief explanation should be provided as to the drivers of this change. (Exhibit B asks for the insurer to report the annualized trend assumption from the most recently approved rate filing.);
9. A clear and direct explanation as to how the supporting documentation information provided in Exhibit B2 relates to the final trend assumptions in Exhibit B;
10. Specific documentation on how the population risk morbidity adjustment and the other adjustment was developed in Exhibit B.

Exhibit Purpose: This exhibit is instrumental in providing the necessary background to understand how the trend assumptions were developed and if they are reasonable in light of the information provided in the rate filing. While there is no standard format required, it is important that the insurer provide enough information so that the CSI can understand the narrative in this exhibit and how it relates to Exhibits B2 and the trend information in Exhibit B.

- **Exhibit B2: Supporting Schedules for Trend Development**

Instructions: The insurer is expected to provide supporting schedules to support the trend assumptions used in the rate development. There should be enough detail provided in this exhibit along with the narrative description in Exhibit B1, so that the CSI can clearly understand how the final trend assumptions presented in Exhibit B were developed. The information provided in this exhibit should clearly document the data used in the trend development. **Note that this information is not requested in a standardized format.**

Exhibit Purpose: Similar to Exhibit B1, this exhibit is instrumental to providing necessary background to the CSI so that they can understand how the trend assumptions were developed and if they are reasonable in light of the information provided in the filing. While there is no standard format required, it is important that the insurer provide enough background information so that the CSI can review the data along with the information in Exhibits B1 and the trends in Exhibit B.

- **Exhibit C: Proposed Rate Change and Enrollment by Plan**

Instructions: This exhibit requests information by plan to illustrate rate change differences. In addition, the total weighted average rate change is calculated across all plans included in the rate filing. A row must be completed in this exhibit for each plan (terminating, renewing and new.) This should be consistent with the plans provided in the URRT Worksheet 2. It is also expected that the insurer provides a plan name or code for each plan in column B. The insurer will also provide the HIOS Plan ID (Standard Component) in column C for each health coverage plan.

Total enrollment and impacted enrollment is requested by plan. “Impacted” enrollment is defined as those members (or policyholders plus covered dependents), subscribers (or policyholders) and groups (where applicable) impacted by the proposed rate change in this rate filing. In cases where the insurer is intending to charge rates for subsequent renewal or issue dates by multiplying the rates within the rate filing by prospective trend adjustments, the impacted enrollment should reflect just the enrollment for the quarter of the first rate effective date. In cases of an Individual Market filing, the impacted and total enrollment will be the same. The enrollment information should be based on the insurer’s most recent data.

Calibrated Plan Adjusted Index Rates PMPM’s are requested for several different time periods: The calibrated plan adjusted index rate PMPM from 12 months prior to the rate effective date (column R), the calibrated plan adjusted index rate PMPM from the most recently approved rate period (column S), and the proposed calibrated plan adjusted index rate PMPM for the rate effective date (column T.) These calibrated plan adjusted index rates are as defined in the URRT instructions. If the insurer intends to charge rates for subsequent renewal or issue dates by multiplying the rates within this rate filing by prospective trend adjustments, the insurer is asked to provide the rates for those subsequent renewal or issue dates using columns U through W. If the rates will not be changed for subsequent renewal or issue dates, the insurer should leave these columns blank.

The weighted average calibrated plan adjusted index rate PMPM is automatically calculated using both the impacted number of members and the total number of members. In addition, a weighted average calibrated plan adjusted index rate PMPM is calculated just for renewing plans in cells R9, S9 and T9. The weighted average rate changes are calculated by comparing the weighted average PMPM’s from the applicable time periods. The group information will only be applicable for a Small Group Market filing.

The insurer is asked to indicate in column D whether the plan is new, terminating or renewing:

- For new plans, the insurer should complete the proposed calibrated plan adjusted index rate PMPM for the rate effective date in column T, but the prior year and most recently approved calibrated plan adjusted index rate will be blank and the total and impact membership in columns F through L will be blank.

- For terminating plans, the insurer should report which plan members are mapped to in column E. We expect this mapping to be 1 to 1. The prior periods' calibrated plan adjusted index rates of the terminating plan should be shown in columns R and S. The proposed calibrated plan adjusted index rate for the rate filing effective date in column T should be that of the mapped plan's calibrated plan adjusted index rate. The enrollment information for the terminating plan should reflect those enrollees that are mapped from the terminating plan to the new or renewing plan.

Insurers will input the allowable adjustments to the projected index rate in columns AE through columns AO to arrive at the calibrated plan adjusted index rates. These allowable adjustments include two market-wide adjustments (risk adjustment and user exchange fee) and several allowable plan allowable index rate adjustments. Each of the adjustments should be entered as a multiplicative factor where a factor less than 1.000 represents a decrease to the projected index rate and a factor greater than 1.000 represents an increase to the projected index rate. The risk adjustment factor should be less than 1.0 if the insurer is expecting to receive risk adjustment payments and greater than 1.0 if the insurer is expecting to submit risk adjustment payments. These adjustments (both market-wide and plan specific) will be applied to the projected index rate for the first rate effective date. Column AR checks that the product of all of the adjustments and the projected index rate equals the proposed calibrated plan adjusted index rate entered in column T. The intent is for the CSI to be able to calculate the consumer adjusted premium rates to a policyholder by utilizing the calibrated plan adjusted index rate PMPM's in this exhibit and all applicable rating factors, as described in the rating formula.

There are several additional pieces of ACA related information requested in this exhibit for each plan. This includes the level of coverage (i.e. Platinum, Gold, Silver, Bronze or Catastrophic); indication as to whether the plan design is a "Unique Plan Design"²; indication as to whether the plan is offered on the exchange, off the exchange or offered both on and off the exchange; an indication of whether the plan is considered a tiered network³ or limited network plan⁴; the AV metal value for both the current period and prior period; the AV pricing value from the prior period; and the percentage of the plan that is for EHB. Note that the "percentage of the plan that is for EHB" should be analogous to the information from the URRT Worksheet 2, line 84

² A "unique plan design" is a health plan design that is not compatible with the federal AV calculator in accordance with 45 CFR 145.135.

³ A tiered network is defined as varying levels of cost sharing based on different networks of providers set up to cover a broad range of services that are considered in-network. An arrangement that is specific to a limited number of services, such as gastric bypass or transplants, would not be considered a Tiered Network for the purposes of this request.

⁴ A limited network (also referred to as select network) is defined as a network that includes a smaller or limited number of providers considered in-network compared to the insurer's standard (or broad) full network.

“EHB Basis or full portion of TP.” See the specific instructions from the federal URRT instructions.

Exhibit Purpose: This exhibit allows the CSI to understand the weighted average rate change as well as variation in the changes in each calibrated plan adjusted index rate. The CSI can identify possible outliers that may warrant further investigation. In addition, the CSI can place more emphasis on its review of plans that have significant enrollment versus plans that have minimal enrollment. This exhibit also requires insurers to demonstrate that the calibrated plan adjusted index rates are developed directly from the projected index rate which will facilitate CSI’s review of the single risk pool requirement.

- **Exhibit D: Components of the Average Proposed Rate Change**

Instructions: This exhibit breaks out the average proposed annual rate change into several components, each of which is described in further detail below.

1. **Utilization (including mix):** This component is the overall impact that changes in utilization have on the average annual proposed rate change. The utilization change should include the impact of changes due to the mix of services provided. Some insurers’ current rating practice may not include a calculation of an overall utilization change. CSI recognizes that there are different methodologies to calculate average utilization change, since there are different types of services with different types of counting metrics (e.g. inpatient admissions, physician office visits, pharmacy prescriptions, etc.) One suggested methodology is to weight the utilization change assumption for each type of service by the PMPM for that service category. The CSI requests that whatever methodology chosen, it is based on actuarial principles and generates results that are reasonable in light of the underlying assumptions used in the rate filing. Any benefit changes that impact utilization trend assumptions should be included here.
2. **Unit Cost:** This component is the overall impact that changes in unit cost have on the average proposed rate change. The unit cost price changes shown should exclude the impact of changes due to the mix of services. Therefore, the unit cost impact represents a pure unit cost trend and assumes the trend analysis was based on a common basket of services from both the proposed and prior period. Similar guidance applies to unit cost price change as was made for the utilization change, in that some insurers’ rating practice may not include a calculation of an overall unit cost price change. One suggested approach would be to weight the expected unit cost price change for each service category by the PMPM for that service category. CSI requests that whatever methodology chosen, it is based on actuarial principles and it generates results that are reasonable in light of the underlying assumptions used in the rate filing. Any changes in

capitated payments or other provider payments that can be attributed to changes in unit cost or price should also be included in this category. Any benefit changes that impact unit cost or price assumptions should be included here.

3. Change in cost sharing: This component should include the overall impact on the average proposed rate change due to changes in cost sharing to the plans included in the filing. This change will include the impact of mapping members from terminating plans to new or renewing plans.
4. Changes in benefits required by law: Benefit changes required by law could include benefit changes required either by state or federal mandates including changes due to essential health benefit requirements. Note that since this calculation is based on a weighted average of all plans included in the filing, if there are only benefit changes to some of the health coverage plans, this calculation should appropriately calculate the effect of those changes spread over all health coverage plans.
5. Changes in benefits NOT required by law: Benefit changes not required by law include any instances where the insurer is removing or adding benefits for the plans covered in this filing. Note that since this calculation is based on a weighted average of all plans included in the filing, if there are only benefit changes to only some of the plans this calculation should appropriately calculate the effect of those changes spread over all health coverage plans.
6. Changes in the provider network: This component should include the overall impact on the average proposed rate change due to change in provider networks. This does not include changes to unit cost, which is captured in a separate item, rather it includes changes due to either addition or deletion of providers, or implementation of limited network or tiered network products.
7. Population risk morbidity: This component should be consistent with the definition of population risk morbidity from the federal Part I instructions.
8. ACA Insurer Fee: This component should include the impact to the average proposed rate change of the ACA insurer fee, also referred to as the health insurance tax (HIT).
9. PCORI Fee: This component should include the impact to the average proposed rate change of the patient-centered outcomes research institute (PCORI) fee.
10. Exchange User Fee: This component should include the impact to the average proposed rate change of the exchange user fee.
11. Risk Adjustment User Fee: This component should include the impact to the average proposed rate change of the risk adjustment user fee.
12. Risk Adjustment Receipts/Payment: This component should include the impact to the average proposed rate change of the projected risk adjustment charge or payment.
13. Contribution to Surplus/Profit/Reserve: This component should include the impact to the average proposed rate change of the contribution to surplus/profit/reserve.
14. All Other Retention: This component should include the impact to the average proposed rate change of any other retention component, including the administrative charge and the investment income component.

15. Over/Understatement of Prior Rates: The impact of the over/understatement of prior rates can be developed by recalculating the expected revenue requirement for the prior period using the most recent claims experience and updated pricing assumptions. The variance from this reevaluated rate and the actual charged rate is the over/understatement adjustment. Note that this line item is not suggesting that the proposed average rate change should include any “recoupments” or “refunds” based on past losses or gains; rather it is meant to reflect that actual experience may be different from what was anticipated in prior periods, and therefore will impact future rates.
16. Other: This “Other” category is included as a “catch-all” for other items not specifically addressed in the above four categories. If this amount is greater than 0.5% then the exhibit requests an explanation of what is included in this amount. This category may include, but is not limited to, the following:
- i. Impact due to the leverage impact of fixed cost sharing;
 - ii. Impact due to changes in global capitated arrangements or any other provider payments such as provider payment incentives that cannot be attributed to one of the items listed above; and
 - iii. Impact due to any rating factor changes that are not revenue neutral.

Below is an illustration of the “Total” calculation within this exhibit:

Utilization (including mix)	3.0%
Unit Cost	4.0%
<i>Etc.</i>	
All Other Retention	0.5%
Over/Understatement of Prior Rates	-1.0%
Other	1.0%
Overall Average Rate Change	7.6%

$$\text{Where } 7.6\% = [(1 + 3.0\%) * (1 + 4.0\%) * (1 + 0.5\%) * (1 - 1.0\%) * (1 + 1.0\%)] - 1$$

Note that the overall average rate change from this exhibit should correspond to the average annual proposed rate change reported in Exhibit B column Y weighted by total enrollment. Also note that this total rate change would include the impact of any benefit or cost sharing changes. The exhibit does continue on to calculate the average proposed rate change excluding benefit changes and cost-sharing changes.

Exhibit Purpose: The information in this exhibit provides an overview of the major components driving the average proposed annual rate change. This will be a useful exhibit to compare among insurers and over time to understand if there are any outliers or if the magnitude of the various components has changed over time. The CSI will be able to identify what portion of the rate change is due to benefit changes. In addition, the exhibit allows the CSI to compare rate changes among insurers excluding the impact of benefit changes. The information in this exhibit

will also allow the CSI to understand how unit cost and utilization trend assumptions affect the rate change. Any outliers in these assumptions can be further investigated and also compared to the trend information provided in Exhibit B. If the overstatement or understatement of prior rates is a significant driver of the rate change, the CSI could request an actual to expected claims analysis on historical claims to review this impact further.

- **Exhibit E: Claims Experience**

Instructions: This exhibit requests historical claims information (both based on incurred and allowed claims as defined in the URRT instructions) for several time periods. It is requested the insurer provide CY 2014 and CY 2015 information consistent with the market segment included in the rate filing. The insurer is also asked to provide the paid through date for the claims in cell B6. Note that the paid through date must not be any earlier than April 2016. The total incurred claims and allowed claims for CY 2015 should tie to the information from the URRT Worksheet 1, Section I (also shown in Exhibit B.) The information is requested for several different claims categories which are further defined below. The categories will not necessarily tie to the categories in the URRT. If it is not possible to report on the data the way it is suggested below, please provide a detailed explanation of the reason.

1. Inpatient Facility (excluding MH/SA): Includes claims based non-capitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility, excluding mental health and substance abuse. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician.
2. Inpatient Professional Facility (excl. MH/SA): Includes claims based non-capitated inpatient professional services excluding mental health and substance abuse.
3. Inpatient Facility & Professional- MH/SA): Includes claims based non-capitated inpatient hospital & inpatient professional services for mental health & substance abuse services only.
4. Outpatient Facility- Ambulatory Surgery: Includes claims based non-capitated facility services for surgeries provided in an outpatient facility setting and billed by the facility. This category should include the facility services billed by free-standing outpatient facilities, including free-standing surgical centers and, ambulatory surgical centers. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
5. Outpatient Facility- Emergency Department: Includes claims based non-capitated facility services for emergency department services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
6. Outpatient Facility- High End Radiology (MRI's, CAT Scans & Pet Scans): Includes claims based non-capitated facility services for high-end radiology such as MRI's, CAT Scans

and PET Scans provided in an outpatient facility setting and billed by the facility. This category should include the facility services billed by free-standing outpatient facilities and clinics with high-tech diagnostic testing. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

7. Outpatient Facility- Non-High End Radiology: Includes claims based non-capitated facility services for all other radiology services excluding MRI's, CAT Scans and PET Scans provided in an outpatient facility setting and billed by the facility. This category should include the facility services billed by free-standing outpatient facilities and clinics with high-tech diagnostic testing. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
8. Outpatient Facility- Lab/Pathology: Includes claims based non-capitated facility services for lab and pathology services provided in an outpatient facility setting and billed by the facility. This category should include the facility services billed by free-standing outpatient facilities and laboratories. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
9. Outpatient Facility- All Other: Includes claims based non-capitated facility services for all other outpatient services not included above such as therapies and observation. This category should include the facility services billed by free-standing outpatient facilities. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
10. Outpatient Facility- MH/SA: Includes claims based non-capitated outpatient facility services for mental health and substance abuse only. Does not include payments made for physician MH/SA services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
11. Outpatient Professional- Primary Care Visits: Includes claims based non-capitated professional services performed by a primary care provider.
12. Outpatient Professional- Specialty Visits: Includes claims based non-capitated professional services performed by a specialty care provider.
13. Outpatient Professional-MH/SA Visits: Includes claims based non-capitated professional services performed by a mental health/substance abuse provider.
14. Outpatient Professional- All Other: Includes claims based non-capitated professional services for all services not included above including therapy services and the professional component of laboratory and radiology.
15. Other Medical: Includes claims based non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other medical services not included in the categories above.
16. Prescription Drug- Specialty: Prescription medications dispensed by a pharmacy that require special handling, administration or monitoring. This amount should be net of rebates received from drug manufacturers.

17. Prescription Drug- Non Specialty: Prescription medications dispensed by a pharmacy for all other drugs excluding specialty drugs. This amount should be net of rebates received from drug manufacturers.
18. Capitation & Non Claims Payments: Includes all services provided under one or more capitated arrangements and all other non-claims payments. Non-claims payments include all payments made pursuant to the insurer's contract with hospitals, provider groups or any other medical provider that were not made on the basis of a claim for medical services including management fees, infrastructure payments, quality or efficiency bonuses and supplemental payments.

Exhibit Purpose: The information in this exhibit provides an understanding of the historical claims experience by service category which will be used to understand historical trends and drivers of historical claims experience which may be impacting the rate development presented in this filing.

- **Exhibit F: IBNR (Incurred but not Reported)**

Instructions: This exhibit requests both incurred and paid data without an estimate for IBNR (column B) and incurred and paid with an IBNR estimate (column C) by month for CY 2015. The total incurred and paid with the IBNR estimate should equal the corresponding incurred claims information from the URRT Worksheet 1, Section I (also shown in Exhibit B.) From this information, an IBNR factor is calculated for each month.

In addition, the insurer is asked to provide the incurred estimate from CY 2014 used in the prior year's filing (which should tie to the prior year's URRT, Worksheet 1, Section I.) This is compared to the restated CY 2014 incurred claims reported in Exhibit E. From this information, an over or underestimate of the IBNR factor used in the prior year's filing is calculated.

Exhibit Purpose: The information in this exhibit provides an understanding of the IBNR assumptions used in the current rate filing along with a calculation demonstrating the accuracy of the IBNR assumption from the prior year's filing. Any discrepancies or outliers will be examined further.

- **Exhibit G: Demographics**

Instructions: This exhibit requests membership by age for three different time periods: end of year 2014, end of year 2015 and April 1, 2016. This information is also requested for the exchange versus non-exchange populations.

Exhibit Purpose: The information in this exhibit provides an understanding to how the membership distribution has changed over the past couple years which may be impacting trends and historical claims experience.

- **Exhibit H: Retention Charges**

Instructions: This exhibit requests the average retention charges on a PMPM basis for two time periods: the retention charge from 12 months prior to the rate effective date and the proposed retention charge for the rate effective date. The information in this exhibit should be presented in a manner consistent with the calibrated plan adjusted index rates PMPM from Exhibit C. The information is requested to be separated into several categories:

1. Health Care Quality Improvement Expenses;
2. Deductible Fraud and Abuse Detection Recovery/Expense
3. Administrative Charge (excluding Health Care Quality Improvement Expenses
4. Contribution to Surplus or Profit or Reserve
5. Reinsurance Fee
6. ACA Insurer Fee
7. PCORI Fee
8. Exchange User Fee
9. Risk Adjustment User Fee
10. All Other Federal and State Taxes and Assessments
11. All Other Retention

Many of these categories correspond to the retention categories in Exhibit D and further explanation of these categories is provided in that section of these instructions.

If the retention charges vary by plan, the amounts entered in this exhibit should be based on a weighted average of total members across all plans in the filing.

This exhibit utilizes the inputs and calculates the retention charge change by comparing the proposed retention charge to the prior periods. In addition, a retention percentage is calculated by comparing the proposed retention charge to the weighted average calibrated plan adjusted index rate from Exhibit C for the applicable time period (either cell R7 or T7 from Exhibit C).

Exhibit Purpose: This exhibit allows the CSI to make comparisons of the retention charge which can then be used to compare among insurers or within an insurer over time. This information can be tracked over a period of time to determine typical ranges of retention charges and more easily identify possible outliers or rate filings that may require additional follow-up.

- **Exhibit I: Projected MLR**

Instructions: The insurer is asked to input the projected information for the twelve months immediately following the rate effective date. The numerator and denominator of the medical loss ratio are defined as stated in 45 CFR 158.221. The information in this exhibit should be presented in a manner consistent with the calibrated plan adjusted index rates PMPM from Exhibit C.

Exhibit Purpose: The information in this exhibit will allow the CSI to understand the future projected medical loss ratio. If the proposed rate change in this rate filing does not appear consistent with the information in this exhibit, then the CSI will follow-up with the insurer.

- **Exhibit J: Rating Factors**

Instructions: In a supplemental file, the insurer should provide the geography and tobacco usage rating factors used to determine the consumer adjusted premium from the calibrated plan adjusted index rate. The insurer should provide documentation as to how the rating factors were determined and identify if there have been any changes to those rating factors since the most recently approved rating filing.

Exhibit Purpose: The purpose of this exhibit is for the CSI to understand the rating factors used, if there have been changes to those rating factors and to understand if the rating factors were determined in an actuarially appropriate manner and comply with the URRT instructions.

If you have questions about these instructions, please contact Christina L. Goe, General Counsel, Office of the Commissioner of Insurance and Securities at cgoe@mt.gov or 406-444-2040.