INSTRUCTIONS FOR COMPLETING THE PRELIMINARY JUSTIFCATION

I. Overview

Under the Rate Review regulation, health insurance issuers are required to provide HHS and States with a Preliminary Justification for rate increases that are above a defined threshold (referred to in the regulation as the "subject to review" threshold). This document provides instructions for completing the Preliminary Justification. Health insurance issuers should refer to the regulation for additional information on the rate increases that require the submission of a Preliminary Justification.[[Link TBD]]

The preliminary justification consists of three parts:

1. Part I- Rate Increase Summary;
2. Part II- Written Explanation of the Rate Increase;
3. Part III- Rate Filing Documentation.

Parts I and II of the Preliminary Justification must be completed for all rate increases that exceed the "subject to review" threshold. Part III of the Preliminary Justification is only required in cases in which HHS is reviewing the rate increases (i.e., rate increases in states without effective review programs).

The proposed regulation requires issuers to identify and report on "subject to review" rate increases at the product level. The regulation defines the term 'product' as a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State for which a rate increase is being requested. If an issuer has a rate increase that meets or exceeds the reporting threshold for multiple products, the issuer may submit a single preliminary justification for the combination of those products, provided that: 1) the experience of all combined products has been pooled to calculate the rate increases; and, 2) the rate increase is the same across all combined products. Separate preliminary justifications must be submitted for products that do not meet both of these criteria.

This process is intended to measure changes in the underlying rate structure, not changes resulting from the application of previously approved elements of premium such as aging, moves across different geographic rating zones, population changes, benefit changes, or even changes in the employer contribution for small group resulting in a change in the employee's contribution for coverage. Of course, a filing that proposed a change in the factors per se underlying such elements as aging, geography, or benefits would be considered a rate change and would be studied as part of the rate filing. If there is no change in the rate structure per se, but only the application of a previously approved or implemented element of premium that is not a rate, the change being studied is zero.

The information reported on the preliminary justification form for a reportable rate increase is the same basis that is used to determine whether an increase meets or exceeds the 10% threshold, making it subject to review.

The frame of reference for the preliminary justification submission is the effective date of the rate increase, seen on an annual window of time.

If multiple increases are implemented within the annual window their cumulative effect will be considered. Thus, the threshold test that determines whether an increase is subject to review would include the cumulative effect of any increases implemented within a year of the increase being considered. The frames of reference are each increase effective date within a one year period from the effective date of any increase.

Examples:

1) If there was a simple 12% increase effective on January 1, the threshold test would be triggered as this exceeds the 10% threshold.

2) If there was a simple 8% increase effective on January 1, the threshold test would not be triggered as this does not exceed the 10% threshold.

3) If there were already a simple 8% increase effective January 1, and there was a compound 4% increase effective July 1 added to the same product, then, using the annual window and the point of reference of the effective date of the 8% increase January, 1 the average compound increase for one year would be 10.16% which exceeds the 10% threshold and makes the increase subject to review.

4) If there was a 6% increase implemented semi-annually beginning January 1, the first 6% increase would not trigger the 10% threshold in and of itself. The second semi-annual increase when combined with the 6% increase would result in a combined 9.18% average annual increase and also not trigger the threshold from the point of reference of the effective date of the first increase. However, the second increase when combined with the first would exceed the threshold since it would comprise a 12.36% annual increase at the point of reference of the second increase.

In the case of rolling m-thly periodic increases, each cumulative increase would be examined from within the one year window period measured from the effective date of each increase. Thus, in the case of quarterly increases implemented upon renewal effective January 1, and quarterly thereafter. Each quarter the combined four quarter increase spanning that annual period would be tested against the 10% threshold. If the average increase exceeds the threshold then the combined increase would trigger reporting, if it does not exceed the threshold increase it would not be subject to review. Thus, a 2.2% compounded quarterly increase would not exceed the threshold, but a similar 3% quarterly increase would exceed the threshold using the frame of reference of the fourth such quarterly increase.

All Preliminary Justifications must be submitted in the Rate Review Reporting Module of Health Insurance Oversight System (HIOS). Please refer to [[*LINK TBD*]] for more information on accessing and using the Rate Review Reporting Module.

Please submit questions regarding the completion of the Preliminary Justification to [[*Contact Information TBD*]].

II. Instructions for Completing Part I of the Preliminary Justification

A. General Information

Issuers must use a standardized Microsoft Excel worksheet for completing Part I of the Preliminary Justification, the Rate Summary Worksheet. The worksheet is available in HIOS. A sample of a completed version of the worksheet is provided at the end of the instructions.

Sections A and B of the worksheet requires issuers to provide historical and projected claims experience data (referred to on the form as the 'Base Period' data and 'Projection Period' data, respectively):

- **Base Period Data:** The base period data is the data from the base period that was used to develop the rateprojections that are calculated in the Rate Summary Worksheet. The base period data may include data from other products or sources if the experience for the product is not fully credible (e.g., national level data). In general, this section should be completed using the same data that was used to develop the rate increase and/or prepare any applicable state rate filing.

- **Projection Period:** The allowed costs are projected from the base period to the projection period for the proposed rates in two steps. Section B1 projects allowed costs from the base period to the 12-month period immediately preceding the effective date of the proposed rate change based on updated pricing assumptions. Section B2 further projects allowed costs from the projection period for current rates to the projection period representing the effective dates of the proposed rates. The projection periods are 12-month periods immediately before and after the effective date of the proposed rate increase.

The claims data entered in the base period are trended forward for each of the projection periods by an overall medical trend factor. Issuers must enter an overall medical trend factor for each of the claims service categories provided on the worksheet. The overall medical trend factor should reflect all of an issuer's cost, utilization, and other trend assumptions for the projection periods.

Note that in the process of calculating rate increases, wherever that occurs, the populations must be identical immediately before and immediately after the rate increases. This is necessary in order to capture only the rate changes per se and not additional premium changes (such as aging or moving across geographic rating zones) that are outside the scope of the pure rate increases.

Issuers should use the following definitions for reporting service category data on the worksheet:

- **Inpatient:** Includes non-capitated facility charges for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other inpatient facility.

- **Outpatient:** Includes non-capitated facility charges for surgery, emergency room, lab, radiology, observation and other outpatient facility.

- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose reimbursement is included in facility fees.

- **Prescription Drugs:** Includes drugs dispensed by a pharmacy.

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

- **Capitation:** All items capitated.

B. Description of Worksheet Data Elements

Section A: Base Period Data

- **Base Period Data - Start and End ~~Dates~~Periods:** Enter the beginning and end dates of the base period in "MM/DD/YYYY" format.
- **Member Months:** Enter the total member months for the base period data for each service category. Where necessary one may use total membership for base medical coverage for all service categories for purposes of PMPM calculations in Parts 1 and 2 of the preliminary justification form.
- **Total Allowed ~~Cost~~:** Enter amount of claims incurred in the base period by service category on an allowable basis including estimates of unpaid claims. If IBNR values are not developed on an allowed basis one may adjust this value accordingly. This value may also be adjusted for coordination of benefits. Total allowed costs are summed automatically.
- ~~Member's~~ **Cost Sharing:** Calculated automatically by service category from total allowed dollars and net claims (dollars).
- Net **Claims:** Enter amount of claims incurred in the base period by service category including estimates of unpaid claims and net of member cost sharing. Total net claims (dollars) are summed automatically.
- **Cost Sharinge Per Member Per Month ~~(PMPM)~~Percentage:** Calculated automatically by service category and in total based on member's cost sharing (dollars) and member months.
- **Net Claims ~~PMPM~~:** Calculated automatically by service category and in total based on net claims and member months.
- **Allowed Claims PMPM:** Calculated automatically by service category and total based on allowed dollars and member months.

Section B Claims Projections

B1 Adjustment to the Current Rates

This section projects allowed costs from the base period to the projection period for current rates based on updated pricing assumptions.

- **Start and End ~~Dates~~Periods:** Enter the starting date of the projection period for current rate, which is 12 months prior to the effective date of the proposed rate change. Enter the ending date of the projection period for current rate, which is one day prior to the effective date of the proposed rate change. Dates should be entered in "MM/DD/YYYY" format.
- **Overall Medical Trend:** Enter the overall medical trend factor for each service category. Values are displayed in the format "1.xxxx"

- **Projected Allowed ~~Claims~~ PMPM**: Calculated automatically by service category as the product of the base period allowed claims PMPM, and the overall medical claims trend in this section (projection period for current rate).

- **Cost Sharinge:** Enter the average of all cost sharing for the projection period for current premium rates (for example, deductibles, co-pays, and coinsurance) by service category. Values are displayed in the format in the decimal format ".xx~~x~~". This factor is used to calculate net claims PMPM from projected allowed claims PMPM. The total member cost share factor is calculated automatically as 1 minus the ratio of net claims PMPM to total projected allowed claims PMPM.

- **Net Claims PMPM:** Calculated automatically by service category based on projected allowed PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

B.2 Claims Projection for the Future Rates

This section projects the claims experience from the midpoint of the projection period for current premium rates to the midpoint of projection period for future premium rates.

- **Projection Period for Future Rates - Start and End Period~~Date~~:** Enter the effective date of the proposed rates, for example, 1/1/2012. The end date should be exactly one year after the start date.

- **Overall Medical Trend:** Enter the overall medical trend factor for each service category. Values are displayed in the format "1.xxxx".

- **Projected Allowed ~~Claim~~ PMPM:** Calculated automatically by service category as the product of the current rate allowed PMPM, and the overall medical claims trend in this section (projection period for the future premium).

- **Cost Share:** Enter the average of all cost sharing for the projection period for future rate (for example, deductibles, copays, and coinsurance) by service category. Values are displayed in the format ".xx~~x~~". This factor is used to calculate net claims PMPM from projected allowed PMPM. The total member's cost share factor is calculated automatically as 1 minus the ratio of total net claims PMPM to total projected allowed PMPM. If the issuer believes that not all cost sharing has been captured (a situation that can easily arise in a number of situations including but not limited to capitation), an estimate of missing cost sharing should be used to provide the insureds a good estimate of their cost sharing.

- **Net Claims ~~PMPM~~:** Calculated automatically by service category based on projected allowed claims PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

Section B3. Medical Trend Breakout

For the impact of medical trend, estimate the proportions of trend attributable to each of (1)

utilization changes, ~~unit cost changes~~, (2) unit cost changes, ~~utilization changes,~~ and (3) all other components of trend combined. These fields should sum to one.

Section C: Components of Current and Future Rates

This section collects information on the net claims, administrative, and underwriting gain/loss components of the current and future rates. The administrative and underwriting gain/loss components should be reported consistent with how these terms are determined for state rate filings and financial reporting .

Future Rates

- **Line 1 – Projected Net Claims:** Populated based on net claims amount in Section B.2.
- **Lines 2 – Administrative Costs:** Enter estimated administrative costs for the future rate.
- **Line 3 – Underwriting Gain/Loss:** Enter the gain loss estimate for the future rate
- **Line 4 – Total Rate:** Calculated automatically as the sum of lines 1 through 3.
- **Line 5 – Overall Rate Increase:** Calculated automatically.
- **Percentage of Rate (Lines 1-4):** Calculated automatically.

Prior Estimate of Current Rate

Complete these fields with the net claims PMPM and projected non-claim expenses PMPM based on the pricing assumptions in an earlier rate filing for the current rate.

- **Line 1 – Projected Net Claims:** Enter prior estimate of net claims from prior rate filing using enrollment and product mix that will be affected by the increase. The estimated projected net claims should be developed off of the rates that were in effect 12 months prior to the proposed rates and reflect the same population and benefits that are included in the claims projections in section B2. If recent filings have been on a more recent basis than annual, and the review threshold is reached based on those multiple increases, report for this purpose the net claims one year prior to the effective date of the increase that engages the trigger.
- **Lines 2 – Administrative Costs:** Enter prior estimate of estimated administrative costs for the future rate.
- **Line 3 – Underwriting Gain/Loss:** Enter prior estimate of the underwriting gain/loss for the current rate period
- **Line 4 – Total rate:** Calculated automatically as the sum of lines 1 through 3.
- **Percentage of rate (Lines 1-4):** Calculated automatically.

Difference

These fields are calculated automatically.

Section D: Components of ~~Medical Claims Changes~~Rate Increase

This section displays the difference in medical claims between the projected rate and the current rate.

- **Line 1 – Inpatient:** Calculated automatically as the product of the overall trend for inpatient entered in B2 (the projection period for future rate) minus 1 and the inpatient net claims amount in B1 (the projection period for the current rate).

- **Line 2 – Outpatient:** Calculated automatically as the product of the overall trend for outpatient entered in B2 (the projection period for future rate) minus 1 and the outpatient net claims amount in B1 (the projection period for the current rate).

- **Line 3 – Professional:** Calculated automatically as the product of the overall trend for professional entered in B2 (the projection period for future rate) minus 1 and the professional net claims amount in B1 (the projection period for the current rate).

- **Line 4 – Prescription Drugs:** Calculated automatically as the product of the overall trend for prescription drugs entered in B2 (the projection period for future rate) minus 1 and the prescription drugs net claims amount in B1 (the projection period for the current rate).

- **Line 5 – Other:** Calculated automatically as the product of the overall trend for other entered in B2 (the projection period for future rate) minus 1 and the other net claims amount in B1 (the projection period for the current rate).

- **Line 6 – Capitation:** Calculated automatically as the product of the overall trend for ~~other~~ capitation entered in B2 (the projection period for future rate~~-~~) minus 1 and the ~~other~~ capitation net claims amount in B1 (the projection period for the current rate).

- **Line 7 – Cost Share ~~Change~~:** Calculated automatically by summing the products of

  - the difference in cost sharing amounts entered in B2 and B1 (the projection periods for the future and current rate) for each service category, and

  - the allowed claims amount in B2 for each service category.

- **Line 8 – Correction of Prior Net Claims Estimate:** Calculated automatically based on the difference between 8b and 8a.
  - **Line 8a– Prior Net Claims Estimate for Current ~~Premium~~ Rate Period:** Populated as the projected net claims for the current rate prior estimate in Section C, line 1.

  - **Line 8b – Re-Estimate of Net Claims PMPM for Current ~~Premium~~Rate Period:** Populated as the total net claims PMPM for the projection period for the current rates in Section B1.

- **Line 9– Total:** Calculated automatically as the sum of lines 1-8.

~~**Non-Claims Components - PMPM**~~

~~**Line 9 – Administrative Costs:** Calculated automatically based on the administrative cost entered for the projected rate and for the current rate prior estimate in Section C, line 2.~~

- ~~**Line 10 – Underwriting Gain/Loss:** Calculated automatically based on the underwriting gain / loss PMPM for the projected rates and for the current rates prior estimate in Section C, line 5.~~
- ~~**Line 11 – Total Change in Claims Components:** Calculated automatically as the sum of lines 1 through 8.~~
- ~~**Line 12 – Total Change in Non-Claims Components:** Calculated automatically as the sum of lines 9 and 10.~~
- ~~**Line 13 – Total Change in Rate:** Calculated automatically as the sum of lines 11 and 12.~~
- ~~**Claims and Non-Claims Components – Percent Change:** Calculated automatically as the impact on rate PMPM divided by the total current rate in Section C, line 4.~~

- **Claims Restatement for Current Rate Period**
  - Line 8a - Prior net claims estimate for current rate period: Populated as the projected net claims for the current rate prior estimate in Section C, line 1.
  - Line 8b - Re-estimate of net claims PMPM for current rate period: Populated as the total net claims PMPM for the projection period for the current rate rates in Section B1.

New Section E: Components of the Rate Increase

This section displays the difference in the medical and non-medical claims between the projected rate and the current rate for the claims and non-claims components.

Section E: List of the Annual Average Rate Change ~~Proposed~~Requested and Implemented in the Past Three Calendar Years

- For the past three calendar years enter:
- **Calendar Year:** The calendar years (in reverse chronological order).
- **New form:** Input "Y~~es~~", ~~"no", or "new", with "new"~~ to indicate~~ing~~ that the product ~~did not exist in that year or the product~~ was in its first year and there was~~ere~~ no rate increase and fill in a numerical zero value in the requested and implemented fields; or input "N". Fill in a numerical zero in all blocks in section E where there are no rate increases.
  - **Requested:** The average rate increase that was filed or otherwise placed into effect (for example, in a state that did not approve rates in advance) for this product(s). The average annual rate increase should be weighted by premium and should be calculated for each calendar year. A

zero value should be entered for any year where there was no rate increase. Decreases should be entered as a negative number.

- **Implemented:** The average rate increase that was implemented for this product. The average annual rate increase shoul d be weighted by premium and should be calculated for each calendar year. A zero value should be entered for any year where there was no rate increase. Please note for emphasis that the population should be the same before and after the rate increase. Decreases should be entered as a negative number.

Section F: Range and Scope of ~~the Rate~~Proposed Increase

- **Number of Covered Individuals:** Enter the number of covered individuals as of the effective date of the increase.
- **Minimum and Maximum Rate Increases:** enter the minimum and maximum percentage rate increasesas determined by changes in the rate table and its various factors. Note again that the population before and after the rate increase should be identical, and that a change in the employer contribution is not to be considered a rate increase.

Section G. Relative Impact of unit cost and utilization changes

Estimate the dollar amount of the difference between the claims estimates in the Future and Current claims periods that is attributable to unit cost and utilization changes. For the difference in claims estimates attributable to unit cost and utilization, provide an estimate in Section G of the proportion of this amount that is attributable to unit costs changes and the proportion that is attributable to utilization changes. The values entered for these fields should sum to one.

III: Instructions for Completing Part II of the Preliminary Justification

Provide a brief, non-technical description of why the issuer is requesting this rate increase. This explanation should help consumers interpret the rate summary data provided in Part I of the Preliminary Justification. Accordingly, it should identify and explain the key drivers of the rate increase in Part I of the Preliminary Justification. For example, if inpatient costs are reported as the main factor of the rate increase, the written explanation should describe why hospital costs are increasing.

The explanation should include information on the following components related to the rate increase:

- Scope and range of the rate increase: Provide the number of individuals impacted by the rate increase. Explain any variation in the increase among affected individuals (e.g., describe how any changes to the rating structure impact premium).

- Financial experience of the product: describe the overall financial experience of the product, including historical summary-level information on historical premium revenue, claims expenses and profit. Discuss how the rate increase will affect the projected financial experience of the product.

- Changes in Medical Service Costs: Describe how changes in medical service costs are contributing to the overall rate increase. Discuss cost and utilization changes as well as any other relevant factors that are impacting overall service costs.

- Changes in benefits: Describe any changes in benefits and explain how benefit changes affect the rate increase. Issuers should explain whether the applicable benefit changes are required by law.

- Administrative costs and anticipated profits: Identify the main drivers of changes in administrative costs. Discuss how changes in anticipated administrative costs and ~~profit~~ underwriting gain/loss are impacting the rate increase.

There is no standardized reporting form for Part II of the Preliminary Justification, but issuers are expected to cover items listed above in their submissions. The written statement must be submitted as *[[Format TBD]]* file.

IV: Instructions for Completing Part III of the Preliminary Justification

Health Insurance issuers are only required to complete Part III of the Preliminary Justification, the rate filing documentation, when HHS is reviewing the rate increase. HIOS will automatically prompt issuers to submit Part III when it is required.

The final rule states that HHS will conduct the rate review using the criteria that the effective rate review states will follow. This review must take into account, to the extent appropriate, the following factors:

(i) The impact of medical trend changes by major service categories;
(ii) The impact of utilization changes by major service categories;
(iii) The impact of cost-sharing changes by major service categories;
(iv) The impact of benefit changes;
(v) The impact of changes in enrollee risk profile;
(vi) The impact of any overestimate or underestimate of medical trend for prior years related to the rate increase;
(vii) The impact of changes in reserve needs;
(viii) The impact of changes in administrative costs related to programs that improve health care quality;
(ix) The impact of changes in other administrative costs;
(x) The impact of changes in applicable taxes, licensing or regulatory fees;
(xi) Medical loss ratio; and
(xii) The health insurance issuer's capital and surplus.

In order for HHS to conduct the review, the issuer must provide the following items.

List of Part III Reporting Requirements:

1. **Description of the type of policy, benefits, renewability (individual business only), general marketing method and issue age limits (individual business only).**
    a. Insurance Company Name
    b. NAIC Company Code
    c. Contact Person and Title
    d. Contact Telephone Number and Email

e. Date of Submission
f. Proposed Effective Date
g. Insurance Company's Filing Number
h. Form Number
i. Product Number
j. Market Type (Individual/Small group)
k. Status: (Open/Closed Block)
l.

2. Brief Description:

i. Type of Policy
ii. Benefits
iii. Renewability(individual business only)
iv. General Marketing Method
v. Underwriting Method,
vi. Premium Classifications (an explanation of rating factors used for the product).
vii. Issue Age or Attained Age Rating Structure, Issue Age Range (individual business only),

3. Scope and reason for the rate increases.

4. Average annual premium per policy, before and after the rate increase.

a. Describe past rate increases. For any increase having even partial implementation in 2008 or later, give implementation details including the initial effective date, range of effective dates, and the method of implementation (on policy anniversaries, etc.)
b. Description of Proposed Increase in Dollar Amount

5. Past experience, and any other alternative or additional data used.

a. Number of Policyholders
b. Number of Covered Lives
c. Total Written Premium
d. Experience Period, Projection Period
e. Past Experience, including:
    i. Cumulative Loss Ratio (Historical/Past)
    ii. Any Alternative Experience Data Used
f. Credibility Analysis
g. Claims incurred but unpaid included in the experience in (e) above, with disclosure of the "paid through" date of the claims used to generate that data. The "paid through" date should be the same for purposes of these claims incurred but unpaid as for the calculation of paid claims.
h. Contract Reserves

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

a. Expenses
    i. Profit and Contingency

ii. Commissions and Brokers Fees
iii. Taxes, License and Fees
iv. General Expenses
v. Other Administrative Costs
vi. Reinsurance

b. Impact of Statutory Changes, including Mandates
c. Overall Premium Impact of Proposed Increase, showing the
    i. Average Annual Premium Per Policy
    ii. Before and After Rate Increase
d. Descriptive Relationship of Proposed Rate Scale to Current Rate Scale
e. Premium Basis
    i. Brief Description of How Revised Rates were Determined, including:
        1. General Description
        2. Source of Each Assumption Used
    ii. For expenses, including:
        1. Percent of Premium
        2. Dollars Per Policy or Dollars Per Unit of Benefit
    iii. Trend Assumptions
    iv. Interest Rate Assumptions
    v. Other Assumptions, including but not limited to Morbidity, Mortality and Persistency
f. Company Financial Condition
    i. Company Surplus

7. The cumulative loss ratio and a description of how it was calculated (for individual only).

8. The projected future loss ratio (a one year projection from the effective date of the rate increase) and a description of how it was calculated. This is not the "adjusted" federal loss ratio.

9. The projected lifetime ~~(a projection of the kind normally used in calculating a state level lifetime loss ratio, and the future loss ratio included is not the same as the future loss ratio in (7) above – the future loss ratio is not "adjusted" and is not under the federal standard)~~ loss ratio[1] that combines cumulative and future experience, and a description of how it was calculated. This is for individual business only. Include a loss ratio exhibit that shows the details of the loss ratio. Issuers should provide this information in a manner that will allow for testing associated with any applicable State lifetime loss ratio calculation. In the absence of a State standard, issuers should provide data that will allow for lifetime loss ratio testing under the National Associations of Insurance Commissioners' Model Rule,

[1] The projected lifetime loss ratio is a projection of the kind normally used in calculating a state level lifetime loss ratio. A traditional state lifetime loss ratio does not include quality improvement expenses, for example, which is included in the Federal standard. The future loss ratio included is not the same as the future loss ratio in (7) above, in that this is not "adjusted" and is not under the federal standard.

"Guidelines for Filing of Rates for Individual Health Insurance Forms" (MDL 134) (2000).

10. **The Federal medical loss ratio (MLR) standard in the applicable market to which the rate increase applies~~, accounting for any adjustments allowable under Federal law~~.** Issuers must provide a 12-month projected loss ratio for the period of the rate increase both at the market level and at the applicable filing level using the loss ratio calculation provided in the Federal MLR regulation. Consistent with the regulation issuers may make adjustments for costs related to quality improvement, taxes and fees. However issuers may not apply the credibility adjustments described in the regulation. Rather, issuers should take credibility into account as part of their projection estimates, using the assumptions and adjustments that they would normally apply to address credibility in projection calculations. Issuers must provide data supporting their projected loss ratio, including data supporting any applicable adjustments.

11. **If the result under (7.) is less than the standard under (9.), a justification for this outcome is required.**

Issuers must clearly identify any element listed above that the issuer believes is not relevant to the development of the rate increase, and explain in detail why the issuer believes it is not relevant. Information must be provided on the remaining elements. Health Insurance issuers have the discretion to select the format in which they present the required Part III reporting elements. As a general rule, Part III submissions must contain sufficient detail to allow HHS to conduct a thorough actuarial review of the rate increase. Part III submissions must clearly describe the rate making methodology, underlying data, and assumptions that were used to develop the rate increase.

Issuer may submit one or more files in HIOS using PDF, Microsoft Excel, or Microsoft Word format. As stated in the regulation, issuers may submit their state rate filing in lieu of the Part III requirements if the rate filing satisfies all of the Part III data reporting requirements. If the issuer's state rate filing only partially meets the Part III reporting requirements, the issuer may submit its state filing and supplement it with the remaining Part III materials.